The implementation of Jordan's Principle in Manitoba: Interim report

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Executive summary

This study aims to describe the impact of Jordan's Principle on the structure of health, education, and social services for First Nation children in Manitoba, including those living on reserve and those living off reserve in urban and rural centres. The goals of the study are to provide a descriptive portrait of the policy framework for, as well as the programs supported by, Jordan's Principle.[1] More specifically, this study aims to:

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

This study was commissioned by the Public Interest Law Centre and is being implemented by a research team working in partnership with the Assembly of Manitoba Chiefs (AMC).[2] The research team includes scholars in the fields of social policy, social work, child and youth care, and community health, as well as policy experts from the Jordan's Principle Service Coordination Unit at the AMC. The research is guided by an Advisory Committee that includes broad representation from First Nations across Manitoba. Funding for the study was allocated as part of the systemic remedies outlined by the Canadian Human Rights Tribunal (CHRT) in the settlement of *Sumner-Pruden v. Canada.* In that case a family from Pinaymootang First Nation in Manitoba alleged their son was denied equitable services because he was a First Nation child living on reserve. Findings from this study may inform settlements or orders around further, systemic remedies in *Sumner-Pruden v. Canada*.

We hope that this study will also support the ongoing efforts of First Nations in Manitoba to achieve a system of effective and appropriate services for First Nation children. The current disparities in services, access to opportunities, and outcomes for First Nation children are the result of long-term and ongoing failures to: respect the sovereignty and self-determination of First Nations; honour Treaty agreements, and to fulfill legal obligations to ensure

[1] Throughout this report, we refer to Jordan's Principle funded "programs" in order to represent the long-term, sustainable services that First Nations are working to develop. However, we note that, Jordan's Principle was established as an initiative and continues to be funded in a way that is more commonly used to support short-term "projects" or services and supports.

[2] See appendix one for research team member bios.

children's rights.[3] Broad systemic and structural changes will be necessary to redress the systemic discrimination that has created these disparities.

This report focuses on the implementation of Jordan's Principle since 2016, when CHRT rulings in *Caring Society and the Assembly of First Nations v. Canada* began to transform the federal approach to Jordan's Principle. The approach to implementing Jordan's Principle in Manitoba since 2016 has been comprehensive, but also complex. There are multiple, distinct components of the approach to funding and providing services through Jordan's Principle. Opportunities for ongoing learning and relationship building that cut across these distinct components have been limited. We hope that documenting the approach to implementing Jordan's Principle, successes and challenges, and perspectives on how to build on existing resources will support increased understanding of Jordan's Principle in Manitoba. This study may also facilitate ongoing discussion about how Jordan's Principle can facilitate the development of a more coordinated, unified, and sustainable system of services for First Nation children.

STUDY APPROACH AND METHODS

We approached this study in two stages. The first stage, summarized in this interim report, focused on producing a broad, regional overview of the implementation of Jordan's Principle. Our goal was to gather information and perspectives that spanned across First Nations in Manitoba and included services for First Nations people living both on and off reserve.

A key goal in analyzing and writing about this information was to ensure that we placed study findings in appropriate historical and policy context. **Situating study findings in context supports an examination of the ways in which the current implementation of Jordan's Principle is shaped by and replicates - as well as the way it diverges from - the policies, practices and power dynamics that have served to disempower and disadvantage First Nations people in the past and in the present day.** The second stage of this study will incorporate a small number of case studies that give a much more in-depth and locally grounded portrait of the implementation of Jordan's Principle across multiple First Nations. The focus on historical and policy contexts will persist during the second stage of the study.

For the first stage of the study, we drew on diverse sources of information and methods of data collection. These included:

- Literature review,
- Content analysis of policy documents,
- Individual and group interviews,
- Focus groups, and
- A survey of Nation-level service directors and Case Managers.

We also engaged in participant observation in Jordan's Principle Technical Advisory Group (TAG) meetings, which bring Jordan's Principle Case Managers together to share experiences, questions and issues of concern.

[3] Self-determination entails the development and implementation of independent First Nations' political structures and systems, the pursuit of economic self-reliance, and territorial independence. Jurisdiction over services, such as healthcare, social services, and education is an integral aspect of self-determination.

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

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

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

Study data collection methods and the data collected thus far are summarized in table one.

CONTEXT OF DATA COLLECTION

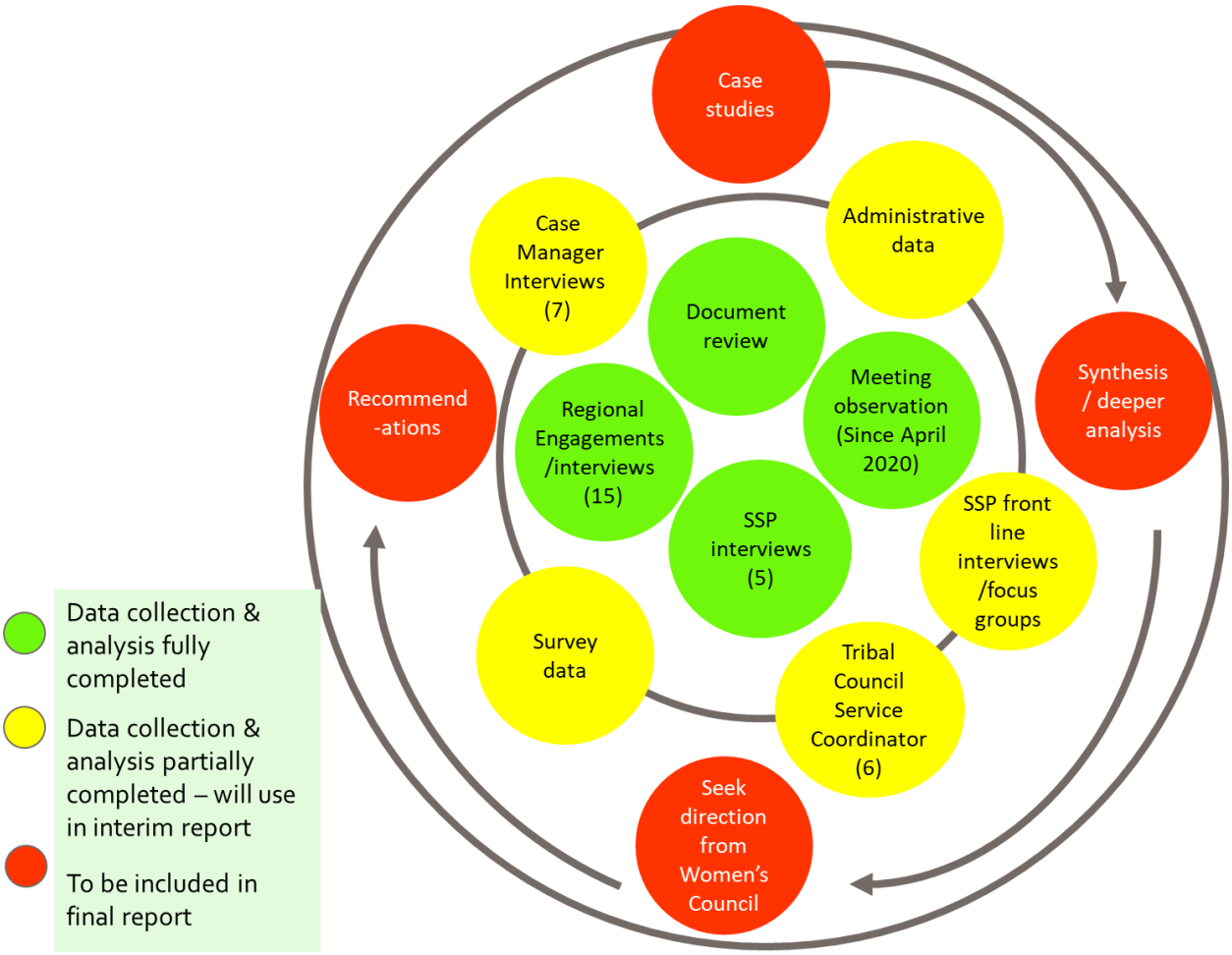
Discussions around this study began in the fall of 2018, and an initial research agreement was drafted in March of 2019, but finalization of this agreement was delayed by a complicated series of administrative processes. A research agreement was finalized in April 2020, and consideration of ethics applications by the Health Information Research Governance Committee (HIRGC) and all universities represented on the research team was concluded by October 2020.

Data collection was deeply affected by COVID-19 related travel restrictions and by the situations in First Nations in Manitoba. Research proceeded despite the growing impact of the COVID-19 pandemic. As described in Case Study One, at the end of this executive summary, service providers, coordinators and Case Managers affiliated with Jordan's Principle faced incredible challenges during this period. They worked to sustain essential supports and services, while also extending new services and supports to meet the needs of children and families through extended periods of lockdown and other COVID-19 restrictions. Many were on the front lines of COVID-19 response efforts. Thus, data collection for this interim report took place in a context in which study participants were carrying heavy burdens. Nonetheless, we were able to work closely with the project Advisory Committee and AMC to ensure that the research stays on track. Interviews, focus groups, and meetings that would normally take place in person took place virtually. Our progress across each area of data collection is summarized in figure one. While the data collected up to this point are fairly comprehensive, there are several data sources that we have not yet had a chance to fully analyze and incorporate into the findings presented in this report.

Table one: Data collection methods and sample summary

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

Figure one: Number of interviews by participant role in Jordan's Principle, additional forms of data collection, and progress towards data collection and analysis.



STRUCTURE OF THIS REPORT

This report is structured in five chapters. In chapter one, we describe some of the historical and policy context that is essential to understanding the need for and approach to Jordan's Principle in Manitoba. We provide an overview of the policy framework that has shaped services for First Nation children in Canada and of the roles, responsibilities, and identified challenges in the system of services for First Nation children that existed in Manitoba prior to the implementation of Jordan's Principle. Jordan's Principle has, in essence, been layered over this complex pre-existing service system. The services and supports funded through Jordan's Principle seek to address gaps and disparities in services without fundamentally altering the pre-existing service structure. For this reason, understanding of the pre-existing system is essential to understanding Jordan's Principle.

In chapter two, we describe the emergence of the current approach to Jordan's Principle in Manitoba, placing Jordan's Principle implementation in the context of ongoing advocacy by First Nations. We outline a persistent pattern in which:

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

The approach to implementing Jordan's Principle in Manitoba has defied this pattern in important ways, laying the foundation for a systemic approach to services that includes services developed at the local, First Nations level. In doing so, the implementation of Jordan's Principle has simultaneously addressed some persistent First Nations demands *and* strained the capacities and mandates of existing structures to realize a First Nations led system of services. First Nations have identified the process of developing the mechanisms and capacity to manage a First Nations system of service as being "complex" and requiring "time and care."[i] However, the resources to support this complex process have not yet been made available.

In chapter three, we describe the current structure of Jordan's Principle in Manitoba. We outline the First Nations and regional-level services that are funded through Jordan's Principle. These include:

- First Nations developed programs implemented at the First Nation level,
- A system of region-wide allied health and mental health/wellness supports provided by Specialized Service Providers located in Winnipeg,
- Coordination of services for First Nation families living or accessing services off-reserve,
- Support in accessing Jordan's Principle funds to address the needs of individual children, and
- Additional, regional initiatives that focus on addressing specific gaps in services - such as the need for pediatricians and child psychologists in northern communities -

and on supporting First Nations engagement with Jordan's Principle.

This purely descriptive chapter offers a portrait of the Jordan's Principle funded services that supplement, complement, and interact with the system of services described in chapter one, and lay the foundation for the analysis presented in chapters four and five.

In chapter four, we present key themes in the current implementation of Jordan's Principle that emerged from our analysis of the qualitative and quantitative data that we collected thus far. We found that:

- There has been a systemic approach to implementing Jordan's Principle, but this approach is undermined by the provision of short-term, demand driven funding.
- The services available to First Nation children have been greatly expanded through Jordan's Principle, but vulnerable groups continue to be excluded and important gaps and disparities in services persist.
- First Nations leadership has been both supported and hampered by a discretionary, federal approach to the implementation of Jordan's Principle in Manitoba.
- The flexibility of Jordan's Principle offers opportunities for self-determination in services, but significant supports are required to ensure all First Nations can exercise self-determination and to ensure equitable services for all First Nation children.

In chapter five, we present a summary of key needs identified by study participants. We draw on our analysis of interviews, focus groups, participant observation, and policy documents to summarize the supports that policy experts, Case Managers, Service Coordinators, and service providers identified as being critical to the further development of Jordan's Principle in Manitoba. They indicated that:

- There is a need for increased coordination and collaboration around the implementation of Jordan's Principle at the First Nations and regional levels.
- There is a need for increased systematic approaches to data collection, data sharing, research, and translation of knowledge related to Jordan's Principle in Manitoba.
- There is a need for resources to support systematic efforts to identify promising practices and facilitate the development of policies that maintain the flexibility of the current approach to Jordan's Principle while also ensuring a consistent baseline standard of services across Nations and organizations.[ii,4]
- There is a need for the development of physical and digital infrastructure that supports effective and meaningful engagement with children and families with a broad range of needs.

[4] Promising practices have specific characteristics including: the advancement of First Nations health, inclusion of diverse perspectives and experiences, support by stakeholders, being well known with historic success, adaptation to community context, and (when possible) formal evaluation. Promising practices are developed by the communities they serve, and integrate contextual specificity in terms of culture, community values, and evidence based practices.

- There is a need for a long-term approach to funding and capacity building that supports First Nations in moving towards a system of services that is truly self-determined.

LIMITATIONS OF THIS STUDY

The interim findings presented in this report should be considered preliminary and incomplete. Data collection and analysis is still in progress. In particular, **our analysis of interviews and focus groups with front line service providers is still preliminary**. Nation-specific case studies are to be completed in the second stage of this study, and we would also like to have access to additional, more detailed administrative data pertaining to Jordan's Principle in Manitoba. **Accordingly, the analysis presented in this interim report presents an incomplete portrait, privileging a regional overview over a focus on the experiences and perspectives of those who are doing the day-to-day work of supporting First Nation children and families.** As a result, the report also gives a limited portrait of the diversity of First Nations in Manitoba and in approaches to Jordan's Principle. We are working towards a more balanced portrait in our final report and offer these preliminary findings as a means of engaging people in specifying the types of data, or areas of concern, that should be more fully incorporated in the final report.

Reviewers of this report should note that it describes the current system of services for First Nation children in Manitoba but does not address outcomes for First Nation children that engage with this system of services. The Nation-level case studies to be included in the final report from this study may more directly discuss proximal outcomes – such as access to services – in a small number of First Nations. Moving beyond this study, the next step would be to systematically examine proximal outcomes for First Nation children across the Manitoba region. Neither this interim report, nor the final report on this study will address the distal outcomes of Jordan's Principle - the *impact* of Jordan's Principle services for First Nation children and families**. Distal outcomes are, ultimately, the standard by which Jordan's Principle implementation should be assessed.** However, assessment of distal outcomes is a longer-term project that extends beyond the scope of this study. The development of reliable and valid outcome measures is a time-consuming process that will require longitudinal study. Constructing valid longitudinal measures will also be complicated by the COVID-19 pandemic, which has disrupted normative patterns of service use and placed unique restrictions on research. By describing the structure and context of Jordan's Principle services, this research can support on-going and future research that more directly addresses the proximal and distal outcomes of Jordan's Principle.

Case study one: Implementing Jordan's Principle in the midst of a global pandemic[5]

In December of 2019 the COVID-19 respiratory virus was discovered in Wuhan, China.[iii,iv] The virus spread quickly and a global pandemic was formally declared by the World Health Organization on March 11, 2020.[v] On March 12th the Manitoba government confirmed presumptive cases in the province and by March 20th a state of emergency was declared.[vi] Some Nations went into lockdown as early as the following week, requiring all staff to work from home with a general "stay at home" order for Nation residents.[vii]

First Nations people have increased risk of contracting communicable diseases as a result of settler colonial and ongoing discriminatory policies that have undermined local economies and food security, impacted Nations' capacities to deliver health services, and created unmet needs by contributing to a high prevalence of underlying medical conditions, underfunding of health centres, and failing to ensure access to essential services, safe drinking water, or adequate housing.[viii,ix,x,xi,xii,xiii,xiv,xv] First Nations across Manitoba responded quickly to COVID-19 with Chiefs calling for a travel ban, the independent collection and monitoring of First Nations data surrounding COVID-19, and many Nations implementing and enforcing lockdowns.[xvi,xvii] Still, as of May 5th, 2021, First Nations people – who comprise 15% of the total Manitoba population - represented 35% of active cases in the province.[xviii,xix]

For Jordan's Principle funded services on-reserve the impact of COVID-19 has been severe. Many off-reserve organizations that typically provided on-reserve services through a mix of in-person and distance services transitioned to exclusively offering services through online platforms, telehealth, and phone.[xx,xxi] As a result of the shift to remote services, interviewees noted: delays in service provision; disruptions of services because of technological challenges and unreliable internet and telephone service; limitations in specialized services such as assessment; and difficulties building trust with children and families as impacts of shifting to remote service delivery.[xxii,xxiii,xxiv,xxv,xxvi,xxvii,xxviii] Supporting families who required access to off-reserve services was also complicated by the COVID-19 pandemic, which necessitated coordination of transport, off-reserve accommodations, and quarantine accommodations when families returned to their homes.[xxix,xxx,xxxi,xxxii,xxxiii]

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

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

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

[5] This case study draws on data spanning the Spring of 2020 to the Spring of 2021; the contexts within Nations have shifted rapidly since the beginning of the pandemic and continue to evolve.

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

Interviewees noted positive outcomes of the COVID-19 pandemic including and increased time to create inter-organizational collaborations and an increased use of communication tools such as phone calls, emails, texting, and on-line platforms which can be utilized to increase accessibility of services moving forward.[xxxvi,xxxvii, xxxviii] However, these positive outcomes were coupled with significant challenges arising from the interactions between COVID-19 related shifts in services and underlying tensions in service provision. For instance, in a context in which the rate of First Nation children in out of home care is higher than in any other province, staff noted that families feared COVID-19 measures could trigger the involvement of the child welfare system and the removal of children from family care.[xxxix] One SSP noted:

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

Alongside stigma and fear created by discriminatory colonial policies, attempts to address the COVID-19 pandemic were complicated by a lack of the necessary infrastructure to ensure basic social determinants of health, such as a reliable water source. A Case Manager discussed pandemic planning without access to a reliable water supply.

> We are facing many challenges. We have had no water. Our school is closed right now … During COVID-19 we are at state of urgent care, especially for the youth mental wellness … What are we doing for them to understand their mental wellness needs, many at six years old and up, are unable to read therefore they come to school with frustration and behavioural issues? … How

> can the therapist help at this level? Because of this, we need a number of people of our own to be able to work with the unmet needs.[xli]

Jordan's Principle Case Managers and workers attempted to address these complex challenges and respond to increasing needs even as they experienced staff shortages caused by a limited pre-existing workforce, short-term loss of staff due to quarantine from COVID-19 exposure, extended loss of staff due to pandemic stressors, and staff reassignment for Nation pandemic responses.[xlii,xliii] For example one Nation had four out of six Jordan's Principle staff reassigned, with three positions vacant, and one staff on a medical leave. This short staffing resulted in there being only one person, under a work from home mandate, to implement Jordan's Principle services during the initial months of the COVID-19 pandemic.[xliv] Chief and Councils' rapid action to mobilize resources added created pandemic tasks and reassignment of duties in addition to the pre-existing responsibilities associated with Jordan's Principle.[xlv,xlvi,xlvii] Some Jordan's Principle staff noted working "11 days, 14 hour days, with no breaks" in response to emergency COVID-19 measures.[xlviii] A Jordan's Principle Case Manager reflected on the stress of the position, which was compounded by the COVID-19 pandemic.

> I worked in the emergency room [for] years before I started this job and I've never felt the pressure and the stress of all the things that we deal with on a daily basis, Monday to Sunday, weekends, evenings, as I have in this job. It's a great job, don't get me wrong, we do amazing work and that's what makes it all worth it, but it can be very hard … and I'm saying that it's really stressful for me right now.[xlix]

Thus, the COVID-19 pandemic amplified pre-existing challenges faced by First Nations in Manitoba. Jordan's Principle provided necessary financial support and a base of staff to respond to crisis in Nations, but the strains on this system of services highlights the need for more comprehensive funding and intensive capacity building. Nations must have the human resources and infrastructure for locally based services with sufficient capacity to address child and family needs through extended periods of crisis, such as the COVID-19 pandemic or the long-term displacement of First Nations people in the Interlake region caused by flooding.[l] Nations must also have the resources to address the underlying challenges to the social determinants of health – such as inadequate water treatment infrastructures and insufficient housing – that pose continuous and ongoing challenges to the health and safety of First Nation children.

1 CONTEXT FOR JORDAN'S PRINCIPLE –THE PRE-EXISTING STRUCTURE OF SERVICES FOR FIRST NATION CHILDREN

In this chapter, we outline some of the historical and policy contexts that are essential to understanding the need for and approach to Jordan's Principle in Manitoba. We describe a complex, settler-colonial policy framework that has long shaped services for First Nation children in Canada. We provide an overview of the roles, responsibilities, and identified challenges in the system of services for First Nation children that existed in Manitoba prior to the implementation of Jordan's Principle. We focus our analysis on health services, education, child welfare, and services for children with disabilities, but note the following important caveats:

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

"Patchwork" is a metaphor that has often been used to describe the structure of services in Canada, and services for First Nations people in particular. We also use patchwork as a metaphor in this report. The image of a quilt, patched together from different connecting pieces, is apt because it conveys the potential for gaps and disconnections within a complex structure of services. Programs and services for First Nations people may be operated, funded and administered by provincial or federal governments. First Nations may also have responsibility for the provision and administration of services. Within each government there is further potential for disconnections between health, education and social services. Consistent issues of underfunding, lack of administrative flexibility, and lack of coordination translate the potential for gaps and disconnections into reality.

However, we use the metaphor of a patchwork knowing that it fails to capture the dynamic nature of the systems which deliver services to First Nation children. Funding, policies, and service priorities may shift within any service domain at any time, creating new gaps and disconnections in services. In this chapter we draw on publicly available information to provide a broad overview of the structure of services for First Nation children in Manitoba. We searched for and drew on the most up-to-date publicly available information about the structure of services that we could locate. However, as is clear in our discussion of these services, each service system is continuing to change and evolve.

In subsequent chapters we shift focus to Jordan's Principle funded services. Jordan's Principle has, in essence, been layered over the fragmented and dynamic structure of services described in this chapter. The services and supports funded through Jordan's Principle seek to address gaps and disparities in the services provided through this system, but they have not fundamentally altered the underlying structure of services.

1.1 Brief historical context

There are 63 First Nations in Manitoba today; these Nations represent five different language groups including Nehetho/Ininew (Cree), Dakota Oyate (Dakota), Denesuline (Dene), Anishinaabe (Ojibway), and Anishininew (Ojibwe-Cree).[li] As seen in figure two, these First Nations stretch across the province's vast geography; Manitoba encompasses 650, 000 square kilometers and seven different Treaty territories.[lii,liii,liv] Diverse cultural traditions are practiced by First Nations people in Manitoba, who account for 15% of the provincial population.[lv,6] First Nations in Manitoba are supported in the negotiation, development and implementation of health, education, and social services by a complex network of regional organizations. See textbox one for a description of key regional organizations.

Prior to settler colonization, First Nations peoples across Canada had diverse child rearing practices that were grounded in the knowledge, language, culture, economy, and worldview of each Nation. First Nations had their own laws and systems of caring for children and supporting families.[lvi] Caring for and educating children was not a responsibility exclusive to the nuclear family, but was instead viewed as a highly valued, shared responsibility of the extended family and Nation, in which all adults participated.[lvii,lviii] Families organized themselves to provide mutual aid through shared harvests in times of stability and scarcity.[lix,lx] The wellbeing of families was supported by the community, which was reliant on the surrounding environment for trade, shelter, medicines, and other basic needs.[lxi,lxii,lxiii] Traditional medicine addressed individual needs with medicinal plants and emphasized the ways individual wellbeing was interconnected to the surrounding community and the environment.[lxiv,lxv]

From the mid-1700's into the late 1800's, the arrival of settler colonization fundamentally changed life for First Nations peoples.[lxvi,lxvii] Significant environmental impacts occurred as trading companies and fur traders decimated buffalo and beaver populations. Southern communities experienced increased risk and severity of droughts and traditional, non-disruptive hunting practices were destabilized across the northern and southern regions. With the droughts, consecutive years of crop failure, and significant population loss of buffalo and beaver came ecological devastation and, subsequently, deprivation of economic and resource stability.[lxviii] The stability of Nations across the prairies was intricately connected with the surrounding environments and sustained through traditional practices grounded in years of intergenerational knowledge that was specific to survival in those territories. Accordingly, the environmental impacts of settler colonialism affected the

[6] The 2016 census reported 223, 310 respondents indicating Indigenous identity with 58.4% indicating First Nation identity.[6]

health and wellbeing of First Nations by increasing the prevalence of starvation.[lxix,lxx] With the increasing ecological instability, many Nations entered Treaty negotiations after years of resistance.[lxxi]

From 1871-1920, Canada began negotiating the Numbered Treaties which span the prairie region. The Numbered Treaties in present day Manitoba include Treaty 1, 2, 3, 4, 5, 6, and 10; multiple First Nations in Manitoba remained non-signatories or were refused rights to any Treaty.[lxxii,lxxiii] Canada approached the Treaty process with the aim to remove First Nations land title and increase exploitive access to natural resources for settler populations.[lxxiv] More than a century of oppression followed. Colonial settlers introduced assimilationist and genocidal policies including the imposition of the residential school system and the mass separation of families and children by the child welfare system during the Sixties Scoop and into the present day.[lxxv,lxxvi,lxxvii] 17 residential schools operated in Manitoba, 14 were federally funded and others exclusively relied on missionary funds.[lxxviii,lxxix] Survivors of the residential school system have provided detailed accounts of school employees punishing students for speaking their languages and participating in cultural traditions while at and away from school.[lxxx] Children in the school also faced neglect as well as sexual and physical abuse.[lxxxi,lxxxii] The inter-generational impacts of family separation through the residential school system and continued separation of families through the child welfare system include increased risk of: suicidal ideation, suicide attempts, and mental health distress; child and family service involvement; and growing up with food insecurity in crowded, low income households.[lxxxiii,lxxxiv,lxxxv,lxxxvi,lxxxvii,lxxxviii,lxxxix,xc,xci,xcii,xciii,xciv,xcv]

These increased risks and corresponding service needs were created by colonial, federal and provincial/territorial policies, yet federal and provincial/territorial governments have failed to take necessary steps towards reconciliation by redressing past and ongoing harms.[xcvi,xcvii] Numerous reports and legal decisions have noted the federal government's failures to provide adequate funding for health, education, and social services for First Nation children living on reserve. These reports have also noted the failures to reform federal and provincial policies in order to eliminate racial discrimination, honour Treaty obligations, and fulfill Crown responsibilities to Indigenous peoples across Canada.[xcviii,xcix,c,ci,cii,ciii,civ,cv,cvi]

The ravages of settler colonial history, notwithstanding, First Nations in Manitoba have consistently advocated for their rights to self-determination.[7] A systemic approach to the provision of services for children have been integral to the calls that First Nations leadership has made regarding the implementation of services.[cvii,cviii] The Wahbung reports, which were first published in 1971 and re-visited in 2019, set out a clear vision for self-determination in the development,

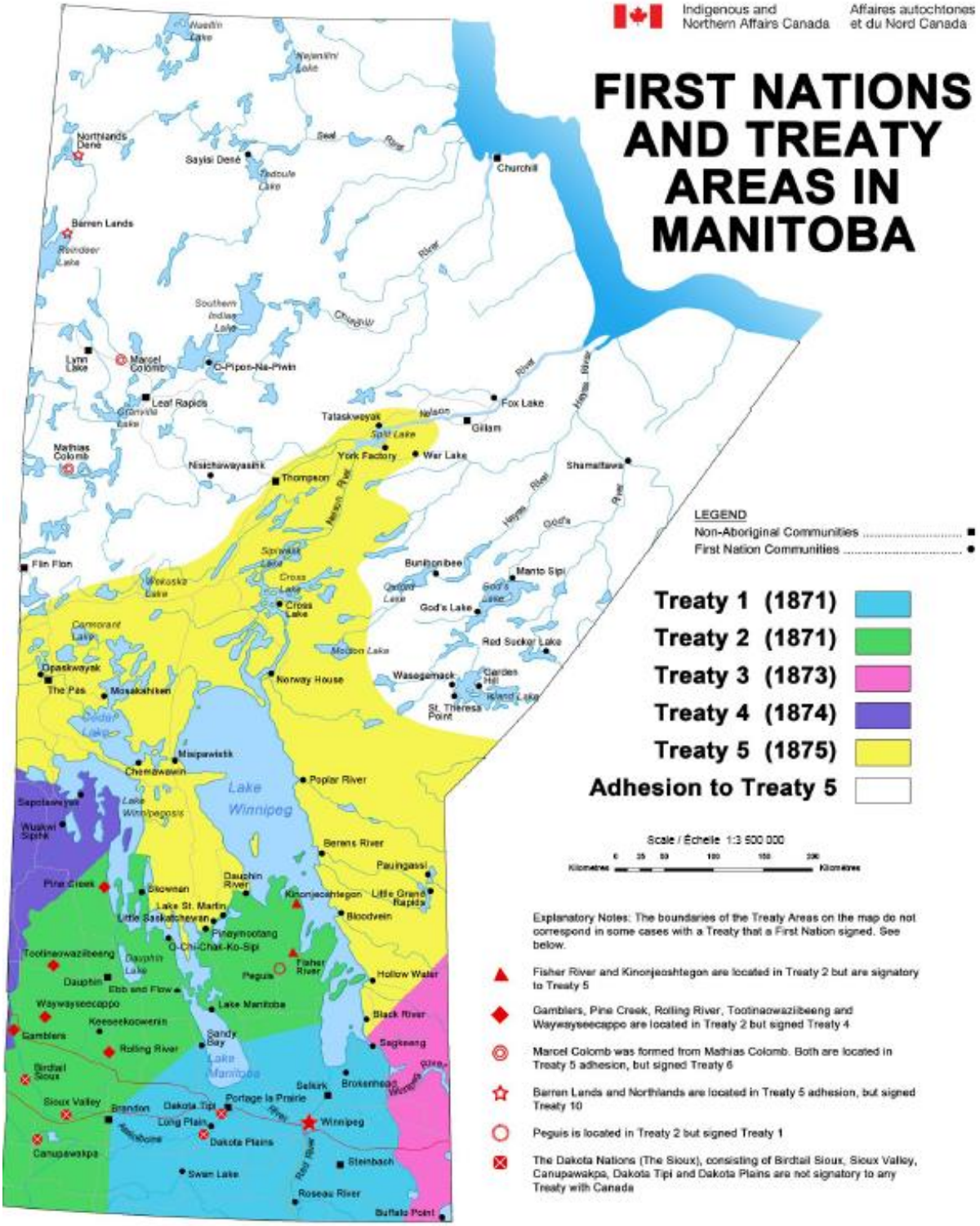
[7] Self-determination entails the development and implementation of independent First Nations' political structures and systems, the pursuit of economic self-reliance, and territorial independence. Non-exhaustive examples of areas that can be impacted by self-determination include religion, cultural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

implementation, and operation of health, education, and social services as well as resource extraction, and economic development. The reports were created almost 50 years apart, but both reports identify the impacts of settler colonization, on-going discrimination, and a failure to honour Treaty obligations, while simultaneously proposing mechanisms of self-determination that facilitate meaningful collaboration with provincial and federal governments.[cix,cx]

The transformation of Child and Family Services (CFS) in Manitoba is one example, among many, of the ways in which First Nations continue to work towards a system of self-determined services. The Aboriginal Justice Implementation Commission, which was created by the provincial government in 2000, was tasked with implementing a process that honoured a 1991 child welfare report recommendation to devolve services to Indigenous peoples.[cxi] While significant steps have been taken to formalize devolution in CFS, on-going reforms are needed to ensure adequate funding, the recruitment of First Nations staff and foster families, additional training and supports for families with high needs children, and additional training supports for CFS staff.[cxii,cxiii]

Another example of First Nations' efforts to realize self-determination in services is the 1998 founding of the Manitoba First Nations Education Resource Centre (MFNERC) by the Assembly of Manitoba Chiefs. Founded in recognition of the challenges that First Nations faced in independently meeting the needs their children, MFNERC was established to provide "education, administration, technology, language and culture services to First Nations schools in Manitoba."[cxiv] In 2016 MFNERC partnered with First Nations across Manitoba and the federal organization now known as Indigenous Services Canada (ISC) to create a pioneering First Nations school system. As the first such system in Canada, the Manitoba First Nations School System (MFNSS), currently provides leadership and administration in partnership with 11 First Nations schools where over 2,000 students have access to a culturally relevant, holistic education.[cxv,cxvi,cxvii] The establishment of systems that advance self determination in services for First Nations occurs within a complex and longstanding policy framework; the current system of services for First Nation children in Manitoba can only be understood in the context of this policy framework.

Figure two: Map of First Nations and Treaty areas in Manitoba[cxviii]



Textbox one: Regional First Nations organizations in Manitoba (2021)

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

- **Eagle Urban Transition Centre (EUTC)—**The EUTC was created by AMC in 2005.The organization provides culturally appropriate supports and referrals to all First Nations in Manitoba to ensure children and families have access to health, social, education, housing, employment, legal, and Jordan's Principle supports when relocating to urban centres in Manitoba.[cxx,cxxi]

- **First Nations Family Advocate Office—** The First Nations Family Advocate Office was created by AMC in 2015, following community consultations and the publishing of the Bringing our Children Home report. The office is mandated to "support and advocate for First Nations families" who have CFS involvement through advocacy and reforms to policy, laws, and organizations by utilizing First Nations traditions and knowledge.[cxxii]

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

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

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

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

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

SCO Affiliated Nations

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

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

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

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

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

MKO affiliated Nations

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

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

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

Nations not affiliated with SCO or MKO

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

*Independent Nation, not affiliated with a Tribal Council

1.2 The policy framework for services to First Nation children in Canada

The current structure of services for First Nation children is shaped, in part, by colonial legislation. Jordan's Principle can only be understood in the context of this policy framework. Articles 92 and 93 of the *Constitution Act* assign responsibility for the provision of most health, education, and social services to the provinces. Accordingly, each province has its own health, education, and social legislation, programs, and administration.[cxxxiv,cxxxv,cxxxvi] Section 88 of the federal *Indian Act* extends provincial laws of general application to First Nations peoples living in First Nations.[cxxxvii,cxxxviii,cxxxix]

Article 91(24) of the *Constitution Act* assigns responsibility for "Indians, and Lands reserved for the Indians" to the federal government.[cxl,cxli] The *Indian Act*, in turn, defines eligibility, acquisition, and transmission of Indian status, which is the mechanism used by the federal government to define the First Nations population directly under its jurisdiction.[cxlii] In combination, these sections of *Constitution* and *Indian Acts* have been interpreted as establishing the federal government's jurisdictional responsibility for on-reserve services.[cxliii]

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

Off-reserve services are funded and legislated by the provincial government, either directly or through contracts with independent service organizations. In contrast, on-reserve services are typically federally funded.[cxlix] Services are often provided by First Nations, which are bound by both provincial laws and standards and the terms of federal funding, but they may also be provided by the federal government. In some cases, provincial services may also be extended on reserve, but the details of the provision of services vary from Nation to Nation. Some of this variation is celebrated as an expression of self-determination, and of responsiveness to local needs.[cl,cli,clii,cliii,cliv,clv]

This historically entrenched approach to the funding of public services results in areas of jurisdictional ambiguity and, as happened in the case of Jordan River Anderson, in whose honour Jordan's Principle is named, disputes over responsibility for services (see case study three, chapter two).[clvi,clvii,clviii] Confusion regarding responsibility for "Indian health and health-related services" was flagged at least as far back as 1969 and has continued into the present day. Recent examples of jurisdictional disputes include cases involving status-eligible children, First Nations people temporarily living on or off reserve, and children who transition from institutional care outside of First Nations to on reserve settings.[clix,clx,clxi]

The configuration and names of federal government departments responsible for First Nations services and programs have changed

over time. The current configuration places all services under the auspices of ISC. Within ISC structures and responsibilities are the vestiges of two, previously distinct departments – the First Nations Inuit Health Branch (FNIHB) and Indigenous and Northern Affairs Canada (INAC). Within ISC the FNIHB continues to oversee health and Jordan's Principle. Other units within ISC oversee education, child welfare, and other social services.[clxii,clxiii,clxiv]

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

Due to the complexity of the Canadian policy framework, services for First Nation children in Manitoba are a complicated mix of federal and provincial funding and are provided by diverse service providers. Arrangements and options differ by service domain and are affected by changes in provincial policy and federal policy as well as First Nations decisions, on-going advocacy, and program development. In this report, we draw on the most recent, *publicly available* information to document the structure of health, education, and child welfare services, as well as services for children with disabilities. Services extended through Jordan's Principle, which are discussed in the next chapter of this report, **supplement** the services that are typically offered through these complex service systems.

Existing research on services for First Nation people yields several consistent findings that apply across diverse contexts and service domains, and over time.

- Service delivery is hampered by a complex and fragmented administrative structure which can lead to gaps in services, as well as denials and delays in services, because of jurisdictional disputes between governments or government departments over responsibility for funding services. First Nation and First Nation families, along with service providers serving First Nation families must navigate through these challenges and fight for needed services for their children.[clxv,clxvi,clxvii,clxviii,clxix,clxx]
- There is a persistent pattern of underfunding of services for First Nations. In order to address this problem, funding models should systematically incorporate inflation adjustments; be based on actual needs and services provided rather than population estimates; be regularly updated to reflect changes in provincial and territorial legal standards; include enhanced operations funding for small and geographically remote agencies; include allocations for development of data collection and research capacity; and include funds for infrastructure maintenance and improvement.[clxxi,clxxii,clxxiii,clxxiv,clxxv,clxxviclxxvii]
- Challenges in service delivery are compounded in rural and remote communities where qualified service providers can be limited and the cost of supplies can be high. As a result, First Nations people may have to travel or relocate to urban centres, or even place their children in care of CFS, in order to access needed services.[clxxviii,clxxix]

As a result of all these factors, First Nation children consistently experience higher levels of risk and poorer outcomes, across a broad range of health and wellness measures, than other children in Canada. See, for example, the data on key indicators for First Nation and

other children in Manitoba, that are presented in table two. The high levels of risk and poor outcomes experienced by First Nation children are also driven by the harmful effects of systemic issues such as racism and poverty. Current systemic issues compound the impacts of policies of cultural genocide and settler colonization that disrupted First Nation family and community networks, culturally based systems of care, and traditional economies while inflicting intergenerational trauma. Though First Nations have advocated for increased control of services, the transfer of power is often constrained by provincial or federal policies and procedures, and amount to a pro forma transfer of administrative duties.[clxxx,clxxxi,clxxxii,clxxxiii,clxxxiv]

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

Child health and wellness outcomes	**Incidence per 100 children**			
	First Nations	All other Manitobans	On-Reserve	Off-Reserve
Infant mortality	.8	.3	.9	.6
Children in Care	14	2	12	17
Grade 3 reading meets/ approaches expectations	56	84	52	61
Grade 3 math meets/ approaches expectations	56	81	52	61
Graduated high school	47	90	42	55
Teen births	8.7	1.1	9.9	6.6
Suicide attempts	.7	.1	.9	.4
Substance use disorders	7.6	1.5	7.7	7.5
Child Poverty[clxxxvi]	__	18	65	54

1.3.1 Health services

Health services in Canada are provided through a fragmented system in which the provision of services differs by jurisdiction, area of specialization, and level of care in primary, secondary, and tertiary care services.[clxxxvii] The Supreme Court has ruled that provinces have general jurisdiction over health matters.[clxxxviii,clxxxix] Accordingly, provinces and territories legislate, fund, and oversee most health services. However, the federal government also plays a legislative role in health services. For example, the Canada *Health Act* (1984) mandates that each province and territory must have a universal insurance plan that covers medically necessary hospital, physician, surgical-dental services, and a minimum of extended health care services for residents. Provision of such services is required in order for a province or territory to receive federal subsidies for health services through the Canada Health Transfer.[cxc] Accordingly, provincial and territorial services must, at least in theory, remain in keeping with broad federal legislation.[cxci]

The federal government's role in on-reserve health services sometimes includes directly funding First Nations to provide preventative services such as immunizations, child development screenings and injury prevention programs (see figure four, at the end of this chapter for a more comprehensive listing of health services the federal government may fund).[cxcii] In addition, the federal government provides primary care delivered on-reserve by nurses (in remote communities only) and funds physicians remunerated by the province for additional costs associated with traveling to selected communities.[cxciii] The federal government has promoted the transfer of responsibility for health services to First Nations authorities, formalizing the transfer with the 1989 Health Transfer Policy, which allows First Nations south of the 60th parallel to control resources and community-based health programs.[cxciv] The extent of responsibility for service delivery varies from Nation to Nation, depending on the specific transfer agreement.[cxcv] In Manitoba, all Nations manage at least part of their on-reserve health services.[cxcvi]

First Nation people living on reserve must utilize provincial health services for needs that extend beyond what is available in their Nations. For example at the Health Sciences Centre in Winnipeg up to 40% of emergency department visits are made by someone who is Indigenous, including transfers from other parts of the province.[cxcvii] The provincial system may also support "resource sharing" between regional health authorities and First Nations by, for example, testing blood samples that are drawn by a phlebotomist working on-reserve and delivered to a regional testing site. It is left to each First Nation to individually negotiate such arrangements and navigate shifting provincial policies and expectations.[cxcviii]

While eligibility for most federal First Nations health programs is limited to First Nation individuals living on reserve, the federal government also plays a unique role in the funding of health services for First Nation children living off reserve. Through the Non-Insured Health Benefits (NIHB) program, the federal government provides status First Nation people and Inuit, regardless of on- or off-reserve residence, with supplementary health benefits "to meet medical or dental needs not covered by provincial, territorial or third-party

health insurance plans."[cxcix] While the federal government takes the position that NIHB was extended on humanitarian grounds and sees its responsibility as being the payer of last resort, First Nations often identify NIHB services as stemming from a Treaty right to health care. A 1999 Federal Court ruling supports the assertion that the federal government bears obligations; however, this ruling has yet to impact policy.[cc,cci,ccii]

In Manitoba, where First Nations constitute 15% of the overall population, approximately 30% of healthcare expenditures in 2015 were for services provided to First Nations. Accordingly, both the federal and provincial governments carefully make decisions to avoid creating precedents and additional financial responsibility.[cciii,cciv,ccv,ccvi,ccvii,ccviii] Evaluations of the provincial healthcare system have documented the barriers created as a result of this complex service and funding structure, including limited access to primary and preventative care, as well as diagnostic services in rural and remote regions across the province.[ccix,ccx,ccxi] These limitations, along with emergency department closures create high caseloads for the remaining emergency rooms. In addition, significant gaps in and barriers in access to mental health services in rural and remote communities have been connected to increased child deaths.[ccxii,ccxiii,ccxiv]

First Nation people living off reserve can face issues related to racism, culturally inappropriate services, and distrust of governmental systems based on past experiences and history. Those living on reserve face similar challenges that are compounded by inequities and inefficiencies in federally funded primary and preventative care. Recent research has proposed a variety of reforms including a focus on prevention, primary care, and diagnostic capacity that reduces the need for medical transportation and relocation. Reform recommendations also highlight the need for an integrated approach to health care that offers access to both western medicine and traditional healing. First Nations have also advocated for additional training, competitive salaries, adequate staffing, and infrastructure development to support self-determined development of First Nations health services, to an extent that is comparable to similarly sized, non-First Nation communities.[ccxv,ccxvi,ccxvii]

1.3.2 Education services

Like health services, education services for First Nation children involve a complex patchwork of different arrangements involving the provincial government, the federal government, and First Nations. Off-reserve public schools are typically provincially operated, though the Manitoba education system also includes independently operated schools that are monitored, supported, and sometimes funded by the Manitoba Education Ministry.[ccxviii] On-reserve schools are federally funded. First Nations may administer their own on-reserve schools or they may enter into educational agreements for a provincial public school division to administer on-reserve schools.[ccxix,ccxx,ccxxi,ccxxii]

Data from the 2016 Statistics Canada National Household Survey indicates Manitoba has low rates of high school completion for First Nation people. Overall, 50.9% of First Nation people aged 20-24 reported not having a certificate, diploma, or degree. The percentage was higher for First Nation people living on reserve: 63.6% of on-reserve First Nation people and 39% of First Nation people living off reserve did not have a certificate, diploma or degree. In

Manitoba as a whole, 13.62% of the total population aged 20-24 had no certificate, diploma, or degree.[ccxxiii] Though data specific to First Nations are not publicly available, more recent data, which exclude on-reserve schools, suggest the possibility of a slight improvement over time. The rate of Indigenous students graduating high schools within six years increased from 55.5% in 2015 to 61.3% in 2019; during the same time frame, the six-year graduation rate for non-Indigenous students ranged from 88.6% to 91.7%s.[ccxxiv] In general, graduation rates were lower in the north than in the rest of Manitoba. Frontier School Division, which serves the vast northern region of Manitoba, had the lowest on-time graduation rate in 2019, with only 31.4% of the 2015 grade nine cohort graduating on-time.[ccxxv]

The provincial education system in Manitoba includes 690 public schools that are organized in 37 school divisions, each of which is guided by a locally elected school board that works with communities to ensure that schools meet the needs of their children and families.[ccxxvi] The provincial system is currently restructuring its 37 school divisions into 15 regions that will be guided by two provincially appointed school boards that oversee service delivery.[ccxxvii] Opposition leaders have expressed concern that the amalgamation of diverse school divisions increases centralized control at the provincial level while decreasing localized decision making by eliminating locally elected school boards.[ccxxviii] The restructuring of the provincial system is guided by "priority actions," including: curricular reforms focused on Indigenous history, monitoring of student outcomes, unspecified "concrete actions" for principals to improve outcomes for Indigenous students, the creation of an Elders and Knowledge Keepers in Schools Initiative to improve culturally relevant curriculum, and the implementation of an Indigenous Inclusion Strategy. The proposed reforms for Indigenous students in Manitoba's restructuring do not include earmarked funding or outline annual markers for implementation monitoring.[ccxxix] The restructuring of the provincial system will affect off-reserve schools, it will also affect on-reserve schools that have entered into educational agreements with the province. For example, Frontier School Division, has education agreements with 15 First Nations for administration of on-reserve schools.[ccxxx]

Funding for provincially operated schools is based on a formula that takes into account the previous year's enrollment, increased costs associated with remoteness, and specialized grants to address the unique needs of the student population such as children in the care of CFS or children with unique psycho-social or socio-economic needs.[ccxxxi] The federal government pays tuition fees for on-reserve First Nation students attending provincially administered schools.[ccxxxii] Despite several years of calls to reform the funding of special needs services, such as mental health and learning supports, the provincial re-structuring proposal provides no targeted plan for special needs service funding.[ccxxxiii,ccxxxiv] Since the 2017-18 fiscal year, school districts have received baseline funding for a continuum of school based services to address the districts' needs. Special needs funding for students who require tailored supports for physical and mental health needs is applied for on an individual (student-by-student) basis. Children and families who require individualized services are reliant on school staff to submit a funding application, which must include diagnosis or assessment

documentation such as a hearing assessment or mental health diagnosis.[ccxxxv,ccxxxvi]

First Nations may choose to operate their own, federally funded schools; currently 58 schools working in partnership with MFNERC are operated by 48 different Nations in Manitoba; in addition some Nations have independent schools.[ccxxxvii,8] Documented challenges in federal funding for on-reserve schools operated by First Nations include: variations in funding for remoteness, insufficient funding for high cost special education programming, addressing the unique needs presented by inter-generational trauma, and chronic underfunding of infrastructure and capital needs.[ccxxxviii] In addition, reliance on proposal-based funding, which Nations/schools must apply for and have approved annually, has produced significant variation in the per-pupil funding available over time and across schools. For example, a 2016 examination of budgets for three small, fly-in communities showed that per-pupil funding fluctuated dramatically from year to year because of federal reliance on proposal-based funding, which required school administrators submit proposals for short-term initiatives. Fluctuating funding meant that budgets in the examined schools were much lower than average even though the schools required higher expenditure due to increased operating costs associated with remoteness, northern conditions, and working in communities with high socio-economic needs.[ccxxxix,ccxl]

The federal government has been made aware of deficits in funding to First Nations by the office of the Auditor General since 2000, and First Nations leadership has long advocated for self-determination in the implementation of education for First Nation children.[ccxli,ccxlii,ccxliii, ccxliv,ccxlv] In 2019, ISC undertook reforms in First Nation education funding to ensure core funding was more comparable to provincial funding levels, and to stabilize funding by shifting from project/application based models to core funding. For example, federal funding for projects that address the inclusion of First Nations language and culture in First Nations education shifted away from an application based funding model and was integrated into the core funding of First Nations schools.[ccxlvi] Additional pilot project funds from the federal government are now available through the Innovation in Education program.[ccxlvii] Despite the 2019 funding reforms, high cost special education continues to be underfunded due to a lack of comprehensive, needs-based data and continued failures to address the real costs of education programming, professional development, data sharing and technological infrastructure, physical infrastructure funding, and other expenses.[ccxlviii] The integration of community wellbeing indexes and substantive equality into funding formulas have been proposed as reforms to address on-going and unaccounted for funding deficits.[ccxlix]

First Nations have also faced educational challenges related to the absence of coordinating and support structures such as the school divisions that exist within the provincial school system. In Manitoba, the MFNERC was created to address this challenge. MFNERC currently supports 58 First Nations schools in Manitoba. The organization has provided administrative, technical, professional development, and psycho-social supports to

[8] An earlier version of this report did not include reference to independent schools.

First Nations led schools since the organization's founding in 1998.[ccl,ccli] In 2009 the AMC, the MKO, the province of Manitoba, and the SCO signed a partnership agreement to work together to improve educational outcomes for First Nation students by focusing on: early learning in order to support the school preparedness of First Nation children; virtual learning to increase accessibility to schools, capacity development opportunities for First Nations professionals; on transition protocols to support children who transition between First Nations and provincially operated schools; and reciprocal education agreements.[cclii] MFNERC has made significant steps to honour this agreement by expanding the formal implementation of programs that provide "school division-type services that enhance and strengthen educational programming for students, staff, and school administrators" as well as services that assist "in education development, accreditation, certification, curriculum, training, advocacy, and other supports."[ccliii]

In 2016, MFNERC, in collaboration with INAC, (which is now consolidated as part of ISC) created the MFNSS.[ccliv] The school system was created to ensure First Nations schools had the benefits of the economies of scale, human resources, funding and other supports provided by school divisions. By 2019, MFNSS administered and managed 11 First Nations schools, providing supports and services to 1, 900 students.[cclv] First Nations operated schools follow a funding formula that utilizes annual enrollment numbers from the prior year to fund the upcoming school year; MFNSS schools also utilize enrollment numbers alongside "price and volume adjustments" which account for shifting expenses such as the price of fuel and changing enrollment numbers.[cclvi] This funding formula also includes Band employee benefits, instructional services, student supports, operations and maintenance, minor capital expenses, and programming previously available through the ISC proposal- based programs such as New Paths for Education Program and the First Nation Student Success Program.[cclvii] Through advocacy and strong leadership MFNSS was able to secure $18, 878 per student in the 2017-18 school year; the provincial expenditure per student sits at $14, 7333 and the funding impacts of the recent restructuring have yet to be seen.[cclviii,cclix,cclx]

1.3.3 Child welfare services

Canada has a decentralized child welfare system in which child welfare agencies operate under provincial/territorial jurisdiction. Until the 2019 passage of the *An Act respecting First Nations, Inuit and Métis children, youth and families,* there was no federal child welfare legislation, and child welfare was governed solely by provincial/territorial legislation.[cclxi,cclxii] Funding and service agreements differ by jurisdiction. Manitoba has a unique system in which First Nation child welfare agencies receive both provincial and federal funding, serving First Nation children and families both on and off reserve. The Manitoba CFS system provides services to families and children voluntarily seeking support and intervenes, including through out of home placement, when a child is in need of protection.[cclxiii] In some cases, families may be forced to place children with disabilities in the care of CFS, through a voluntary placement agreement (VPA), in order to access services or specialized care that is not otherwise available.[cclxiv] In Manitoba the age of majority is formally

recognized as 18, however, with the consent of a youth, CFS services can be extended until the age of 21.[cclxv,cclxvi]

The current structure of the child welfare system in Manitoba emerged from the Aboriginal Justice Inquiry – Child Welfare Initiative, sometimes referred to in Manitoba as the "devolution" of the CFS system. In order to address inequities and inadequacies within the child welfare system, services were restructured to include off-reserve authority for First Nations.[cclxvii] In 2003 the government of Manitoba passed legislation to create culturally based child and family service authorities responsible for overseeing and coordinating the delivery of child welfare services throughout the province. The authorities include the Southern First Nations Network of Care, First Nations of Northern Manitoba CFS Authority, Métis CFS Authority, and the General Authority. Initial intake and assessment is conducted by 14 designated intake child welfare agencies within a defined geographic catchment area.[cclxviii,cclxix] At the end of the intake period, the intake agency does an assessment to determine the most culturally appropriate child welfare authority and any case remaining open for ongoing services is transferred to the agency within that authority for ongoing services. In many cases this means a child and family are being followed by a local agency within their First Nation, in other cases it means they are served by workers at an urban office or by another First Nation agency. Manitoba policies indicate that families have the right to determine the *authority* from which they receive services. Once the authority is determined, it assigns the family to an agency. Families may, at times, have little input on the agency to which they are assigned.[cclxx,cclxxi] The transfer of cases means that all First Nations child welfare agencies may also serve children living both on and off reserve.[cclxxii,cclxxiii] Accordingly, these agencies receive both provincial and federal funding.

Manitoba has a high number of Indigenous children and youth in foster care. As of March 31, 2020, there were 9,849 children in care, 90% of whom are Indigenous.[cclxxiv] Recent research indicates that, in 2016-17, 14% of First Nation children in Manitoba were in care compared to 2.0% of non-Indigenous children.[cclxxv] The rate of First Nation children in care was highest in urban areas, and higher than the rate for non-Indigenous children in every region of the province.[cclxxvi] Manitoba has the highest rate of children in care of any Canadian province, and nearly 60% of children in care in Manitoba are permanent wards of the state. Annual provincial funding for off-reserve services nearly tripled between 2004 and 20016-17, but there was an 85% increase in the number of children in care between 2006 and 2016.[cclxxvii]

The limitations on child welfare practice that perpetuate the overrepresentation of Indigenous children in the child welfare system have been explored in a series of reviews and public consultations in recent years. Examples of these limitations include chronic and discriminatory underfunding of on-reserve CFS agencies, a lack of culturally relevant supports and services, and limited access to prevention services, amongst others.[cclxxviii] Public consultations have recommended developing: First Nations led CFS agencies that address needs across the lifespan, education programs to ensure First Nation workers implement CFS measures, and advocate offices for First Nation children.[cclxxix] A June 2014 report included ten

recommendations addressing "the devastating impact that the current child welfare system's policies and practices are having on the First Nation children and families in Manitoba."[cclxxx] In response to one of the recommendations, in 2015, AMC opened the Manitoba First Nations Family Advocate Office, which supports and advocates for First Nation families involved with the CFS system.[cclxxxi] In 2017, this office and the AMC released the results of a new round of child welfare engagements, identifying both short-term and long-term actions needed to ensure Indigenous children live with dignity and respect.[cclxxxii,cclxxxiii]

In recent years, there have been several important developments affecting child welfare for First Nation children. At the federal level, recent Canadian Human Rights Tribunal (CHRT) rulings and new federal policies have introduced significant child welfare reforms. Starting in 2016, the CHRT issued a series of decisions and orders in response to *the First Nations Child & Family Caring Society of Canada and the Assembly of First Nations v. Canada.* These decisions and orders highlighted the inequitable nature of federal funding for on-reserve child welfare services and ordered the federal government to fund the full cost of on-reserve child welfare prevention services.[cclxxxiv,cclxxxv,cclxxxvi] In response, the federal government has increased funding to First Nations CFS agencies by 68% since 2016.[cclxxxvii] Despite the funding increases that began in 2016, a 2018 study found that additional funding was needed in order to support: salaries comparable to those of provincial child welfare workers, anti-poverty programming, universal prevention services, data collection and infrastructure development.[cclxxxviii]

In January of 2020, the federal legislation *An Act respecting First Nations, Inuit and Métis children, youth and families* came into force. The act affirms the inherent right of Indigenous people to self-determination and self-government, including jurisdiction in relation to child and family services.[cclxxxix,ccxc] The act specifies the terms under which First Nations, Métis, and Inuit groups and communities that have created their own child welfare legislation may assume partial or complete jurisdiction over CFS at a pace they choose. Though the federal act envisions substantial and positive changes to First Nations, Métis, and Inuit child and family services, analyses of the legislation suggest five critical areas that must be addressed in order to avoid replicating the current situation: national standards, jurisdiction, funding, accountability, and data collection.[ccxci,ccxcii] An AMC analysis comparing the new federal legislation to the *Bringing Our Children Home Act,* Manitoba-specific federal legislation that the AMC Chiefs in Assembly endorsed in 2018, highlighted the ways in the new federal act fails to adequately ensure First Nations control over child welfare.[ccxciii] Within Manitoba, Opaskwayak Cree Nation is the only Nation that has begun developing a law to assume full authority for child welfare services.[ccxciv]

There have also been legislative changes at the provincial level. In February 2019, the Manitoba government announced a shift to single-envelope funding, which provides each CFS authority with block child maintenance funding, allowing the flexibility to move provincial funding toward prevention, early intervention, community and kinship involvement and other positive supports. The province has indicated an expectation that this

will reduce average per diem costs and the number of children entering into care.[ccxcv] However, agencies participating in a single envelop pilot project indicated that block funding was not sufficient to cover expenses when the number of children spiked; the funding model forced them into deficit spending and Nations subsequently advocated for the development of a contingency fund that could be accessed in case of increased expenditures.[ccxcvi,ccxcvii] Available documentation makes no mention of a contingency fund being incorporated and the 2020-21 from the Métis Authority indicates that child welfare authorities in Manitoba have not given any indication of the provincial plan for covering the unanticipated costs of operating during the COVID-19 pandemic.[ccxcviii,ccxcix]

In addition, in 2020, the province of Manitoba passed legislation to address the administration of the Children's Special Allowance (CSA), which provides payments to the CFS agencies to support the care, maintenance, education, training, or advancement of the child for whom it is paid. Ten years ago, the Provincial Government began to hold a portion of CSA funding back from the Indigenous CFS organizations, requiring CFS organizations to remit any CSA funding they received directly to the government of Manitoba. *The Budget Implementation and Tax Statutes Amendment Act*, 2020 removes the right to sue the Province of Manitoba for actions regarding the CSA, both retroactively and in the future.[ccc,ccci] AMC has launched a legal challenge the validity of this element of *The Budget Implementation and Tax Statues Amendment Act*.[cccii]

1.3.4 Services for children living with different abilities

In addition to the services provided through the health, education, and social service systems, specialized services for children with different abilities address important child and family needs. The Children's disABILITY Services Program (CDSP), which offers services through seven regional offices spread across Manitoba, is a key component of the off-reserve services for children with different abilities.[ccciii,9] Off-reserve families accessing services through these regional offices are matched with care coordinators who provide recommendations within the available services and follow families until their children reach the age of 18.[ccciv] Services provided by CDSP include transportation subsidies, funding for products such as home equipment or basic vehicle modification, after-school care, summer programming, behavioural services and supports, autism supports including outreach and applied behaviour analysis, developmental supports for children aged 0-6, occupational therapy (OT), speech and language therapy (SLP), physiotherapy (PT), audiology services,

[9] In March 2021 the Manitoba Advocate for Children and Youth published a report that provided the first systematic, independent review of Children's Disability Services in Manitoba, this summary draws heavily from the report which is available at https://manitobaadvocate.ca/wp-content/uploads/MACY-Report-Bridging-the-Gaps-Achieving-Substantive-Equality-for-Children-with-Disabilities-in-Manitoba.pdf. No accurate data on the number of children living with disabilities in Manitoba is currently available. However, the growing number of children served through the CDSP indicates that increasing demands are being placed on services for children and families with disabilities. Currently, there are no statistics available to indicate the number of children receiving CDSP services who are First Nations, Métis, or Inuit; the organization indicated it will begin collecting data on children with Indian status as of May 2020.

and in-home or out of home respite supports.[cccv] Access to respite services requires a diagnosis, typically through child development centres such as the Specialized Services for Children and Youth, as well as referral to and assessment by CDSP. CDSP can provide the family with funding to hire a respite workers or directly contract a respite worker for the family.[cccvi] CDSP enrollment figures increased approximately 3% annually from 2014-2017 with roughly 6, 000 children enrolled in CDSP during the 2019-2020 fiscal year.[cccvii,cccviii]

Access to CDSP services is limited due to extensive waitlists and many families are faced with paying for costly private services or entering voluntary agreements with CFS to access necessary services for their children.[cccix,cccx] For families living in rural or remote regions access to services from CDSP and allied health professionals is extremely limited; many services are based in Winnipeg and the availability of rural allied health professionals is extremely limited across Canada, with only 10% of the PT workforce located in rural regions and even lower rates of OT, SLP, audiology, and psychology professionals in rural locations.[cccxi,cccxii,cccxiii]

CDSP services are not available to First Nation families living on reserve. The government of Manitoba takes the position that funding for services to status First Nation children living on reserve is the responsibility of the government of Canada and should be provided through Jordan's Principle.[cccxiv]

Alongside CDSP, additional off-reserve organizations provide supports and services to children with disabilities and their families. For example, St.Amant provides a variety of services that can be accessed in Winnipeg. These include: supports to mitigate family crisis and breakdowns; autism services; SLP services; OT; PT; assessments that support the purchasing of adaptive equipment; respite services; specialised training for service providers; support from a a feeding, swallowing, and nutrition team; and transition to adulthood supports, among others.[cccxv,cccxvi,cccxvii] The provincially administered Disability and Health Supports Unit offers assessment services and approval for medical products; the Early Learning and Childcare Division provides professional licensing and funding for childcare programs to reduce barriers to services for children with disabilities. The federal government also provides income supports through tax and benefit programs to supplement the incomes of families with low incomes or people who provide ongoing care to family members. First Nation people experience numerous barriers when attempting to apply for federal disability benefits including limited access to: assessments, health care providers who can complete necessary federal forms, and general information on what benefits they can qualify for.[cccxviii,cccxix,cccxx,cccxxi]

Off-reserve, services for adults with disabilities are minimal and difficult to access for all people. The province funds therapies for which adults need a referral from a family doctor such as OT, PT, SLP, and audiology.[cccxxii] Regional health authorities also provide limited homecare services and employment assistance programs.[cccxxiii] Homecare services are typically limited to 55 hours per week in accordance with a 1987 cost limit policy that requires the cost of homecare not exceed the cost of facility based long-term care. Short-term increases for up to three months are considered if: early discharge

requires care that is normally available in an "acute care setting"; a short-term increase in care needs occurs; the increase in care occurs due to end of life or palliative care; or the client is awaiting placement in an "alternate care environment" and no other options are available in the interim. Long-term regional health authority homecare funding may be considered if a facility placement would not be appropriate due to the client's continued ability to "self-direct care", strong coping skills and high social supports are in place; or the level of care is above that which can be met in a personal care home.[cccxxiv] It is unclear if all these criteria must be met or if each case is assessed on individual merits.

Off reserve services for adults with intellectual and developmental disabilities can be slightly more extensive. The Community Living disABILITY Services program (CLD) services for adults who have "significantly impaired intellectual functioning accompanied by impaired adaptive behavior" includes residential and transitional supports, employment support, and on-going assessment and case coordination supports.[cccxxv] For families who can access services in Winnipeg, St.Amant provides supports to people with developmental disabilities and autism, short-term community living services, supports through the transition back to living independently and daily recreation services with education, leisure, and work-experience programming options. Many of the specialized services St.Amant provides to children are also available to adults.[cccxxvi,cccxxvii,cccxxviii,cccxxix]

This complex web of off-reserve services and organizations are guided by 12 different provincial acts that address services for children with disabilities and their families. Figure three, which is excerpted from the 2021 Manitoba Advocate for Children and Youth report, details the complexity of service navigation experienced by service providers, families, and their children. Nine recommendations were made by the Manitoba Advocate for Children and Youth including:

- The development of legislation to ensure continuity of care and basic rights for children with disabilities;
- The development of CFS protocols that support families in accessing services;
- A funded plan to reduce assessment wait times;
- The provision of systems navigation support to people who are waitlisted;
- A review of current Children's Disability Services caseloads, which can reach over 100 children per worker;
- Accurate data on the needs of First Nations, Inuit, and Métis children to ensure the provision of culturally relevant services;
- The development of a system to regularly collect child and family experiences and adapt policy in accordance with their feedback;
- A publicly available policy and procedure manual to ensure transparency between Children's Disability Services organizations, children, and their families; and
- The establishment of flexible, easily accessible respite care that meets the needs of families.[cccxxx]

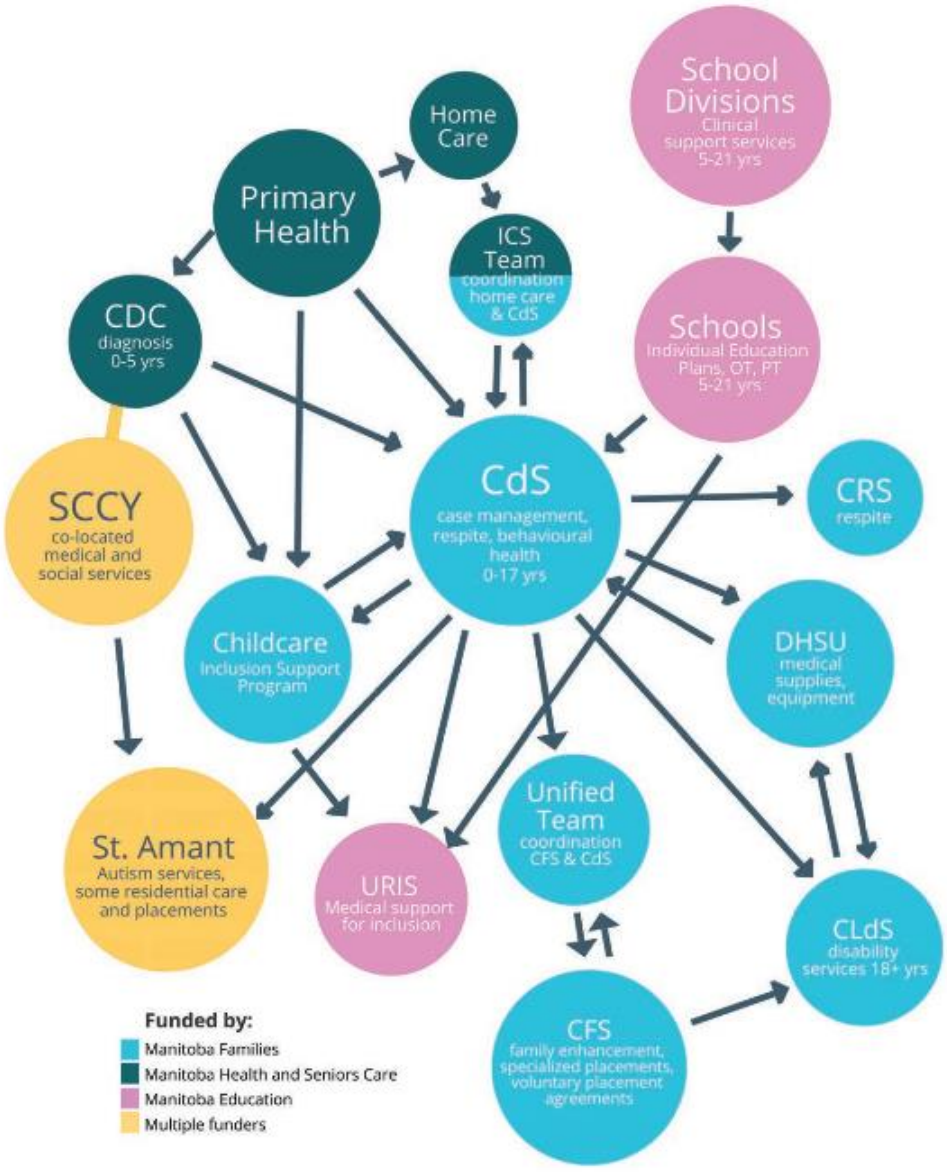
The federal government is fiscally responsible for all disability supports and services available on reserve. The ISC Assisted Living program,

which was created in 1983, requires a Nation to apply on behalf of on-reserve families.[cccxxxi,cccxxxii,cccxxxiii] Federal funding for in home care services include transport supports, *short-term* respite, attendant care, and supports to provide meals and housekeeping. Federal funding is also provided for adults who receive care in an institutional setting and for adult foster care programs. A proposal-based diabetes initiative is also available through home care services. The Assisted Living program was originally designed to address care needs for adults. Children were not eligible for supports through the Assisted Living program until 2003, at which time they were included without additional dedicated funding. The program itself was under the federal 2% cap on expenditure for First Nations programs from 1996-2015. Due to on-going funding issues the assisted living program currently cannot meet the increasing needs of First Nation people living on-reserve.[cccxxxiv,cccxxxv] Currently the program operates at a deficit and gaps remain for weekend services, transit and out-of-home assistance, respite services, supports to address high needs associated with substance use or traumatic brain injury, and funding for palliative care. The lack of culturally relevant services has also been identified as a limitation of the program and limited information sharing with Nations has presented barriers to fully implementing available funding.[cccxxxvi,cccxxxvii]

On-reserve, the federal government also funds the First Nations and Inuit Home and Community Care Program. Home Care is typically provided by a nurse or personal care worker and includes services such as assessment, respite, and referrals. Self-determination in programming creates variation across Nations, with specialised services such as rehabilitation, at-home mental health services, and adult day programs being offered based on the Nations' programming. Funding has been stable for the Home Care program, yet concerns have been raised that increasing demand, increasing complexity of needs, challenges in recruitment and training of staff, and the lack of funding to address social determinants of health will present access barriers in the coming years.[cccxxxviii] Jurisdictional complexity also creates barriers for Nations that develop their own programming and builds in delays in implementing self-determined services. Examples of barriers to implementing self-determined services on-reserve include a lack of coordination between the three levels of government and inadequate federal funding for on-reserve services.[cccxxxix]

Tax benefits can also provide limited financial relief to the families of on-reserve children living with disabilities, if they choose to file federal taxes and are able to navigate multiple barriers to accessing benefits. These barriers include ineligibility for families who do not owe taxes and limited information about the benefits that are available or the process for applying for these benefits.[cccxl,cccxli,cccxlii,cccxliii] The minimal availability of on-reserve supports can force the families of children and youth with disabilities to leave their Nations to seek services in urban areas. In addition, as a result of barriers to accessing on-reserve services and benefits, giving up custody of a child and placing them in the care of CPS through a VPA is sometimes the only option for accessing needed services.[cccxliv]

Figure three: System of services for children living with different abilities[cccxlv]



Case study two: Services available in Pinaymootang in March 2016[cccxlvi]

This case study provides a detailed, descriptive overview of on-reserve services in one Nation prior to Jordan's Principle implementation. In March 2016, before Jordan's Principle was implemented, the Pinaymootang Health Centre was only funded to administer education and awareness programs.[cccxlvii] There were no physicians or nurse practitioners on staff, but the health centre employed a team of registered nurses that provided medical services including basic checkup and immunization services, administration of medication, and assistance with regular treatments. The centre's staff also coordinated services with healthcare providers in other communities, advocated for patients to be placed on physicians' waiting lists, and coordinated travel arrangements for medical visits outside of the First Nation. Pinaymootang's rural geographic location created further barriers to accessing services.[10]

There were no early intervention services for children between the ages of zero and five available in Pinaymootang, and difficulties in obtaining assessment services further prevented most children in this age group from accessing early intervention allied health services outside of their First Nation. A partnership with MFNERC allowed the school to: fund limited allied health services, including assessment services roughly twice a year; sponsor the training of educational assistants (EAs) and parents in Winnipeg; and provide assistive devices for students with communication impairments. The school also provided limited support for the development of Individualized Education Programs and one-on-one support from EAs. School staff were not equipped to ensure individualized programs were followed, monitored, or adapted to children's evolving needs. Other services, like PT and counselling or other mental health supports, were not provided at all due to a lack of funding. See figure four for a summary of available services.

The context of health services in Pinaymootang First Nation, was also shaped by the management of and provision of services through the Interlake Eastern Regional Health Authority (IERHA), which is part of the provincial health system. IERHA suffered from an acute shortage of mental health services. There were no designated acute care psychiatric units in the regional hospitals and the Pinaymootang health centre director indicated that the entire region was served by a mental health professional employed for a total of only 2 days per week.[cccxlviii,cccxlix] Further, provincial health services in the region were plagued by staffing shortages, communication failures, and limitations in the availability of emergency care and specialized health services.[cccl,cccli,ccclii,cccliii,ccccliv,ccclvccclvi,ccclvii,ccclviii] For families in Pinaymootang, these problems within the IERHA system were compounded by a history of discrimination that was acknowledged by the nearby Ashern hospital.[ccclix] These factors negatively impacted the willingness of families in Pinaymootang to access hospital based services.

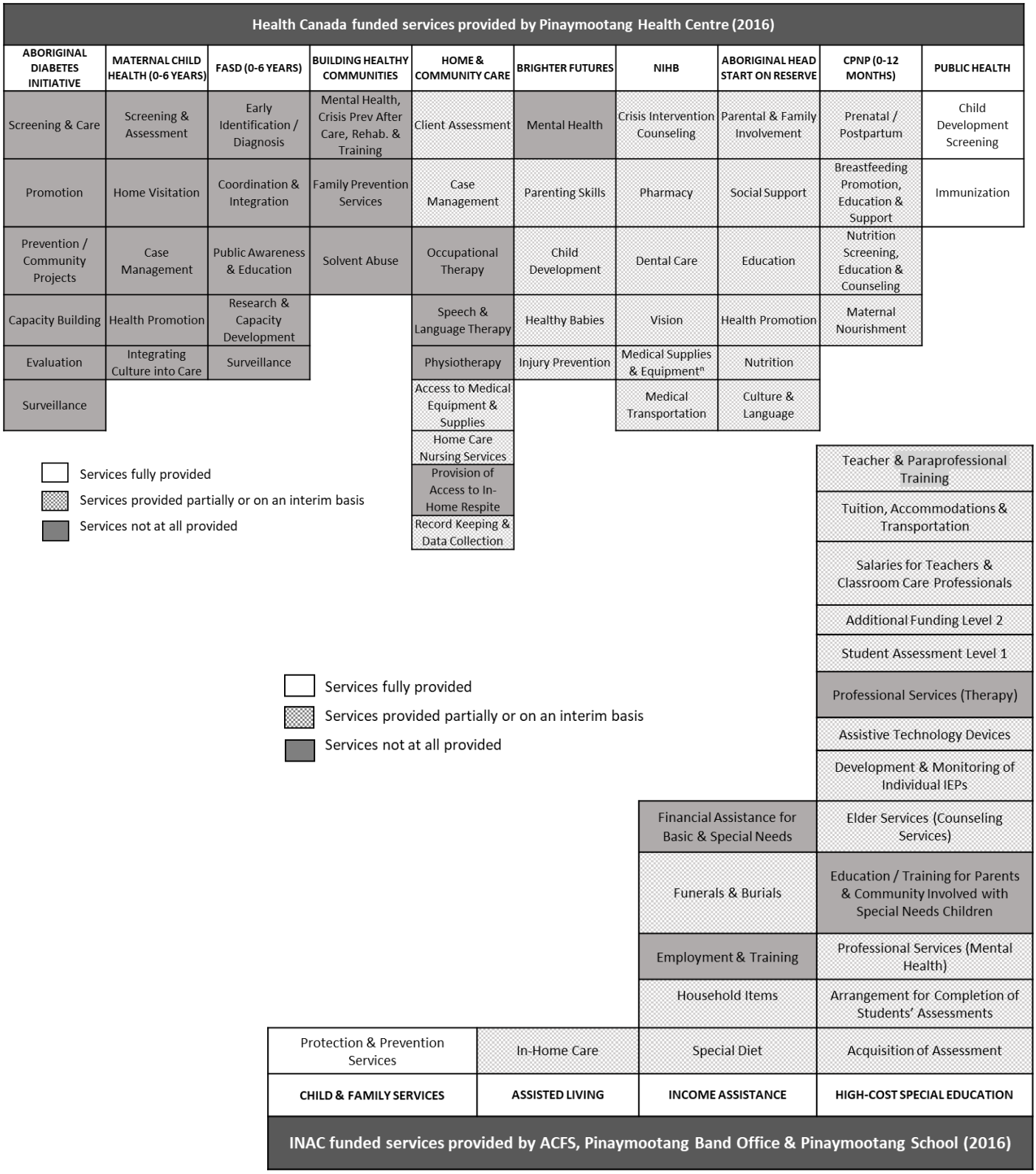
The generalized problems with health services in the region also had potential mental health impacts. For example, for the caregivers of Pinaymootang children with special healthcare needs, the lack of

[10] Pinaymootang is located 250km north from Winnipeg with access to well-maintained roads; Nations that are reliant on ice roads, fly-in access, or dirt roads faced increased barriers to providing on-reserve services and additional costs in accessing urban service centres.

health services in the region compounded the gaps in services available in Pinaymootang, which significantly increased their stress. Some families chose to relocate in order to access services. In doing so, they sacrificed close connections to family and community support networks, and to the land. Families who chose to remain in Pinaymootang were faced with difficult choices of constantly travelling to access services or seeing their children go without the services they needed.[cccix]

As a result of the lack of services within Pinaymootang and in the surrounding region, researchers found that caregivers were exhausted. Some were sleep deprived and all worried about the care of their children once they transitioned into adulthood. The burdens of ensuring their children's wellbeing meant that caregivers became socially isolated. They also found themselves under significant financial pressure; at least one parent had to give up their job to take care of their child at a time when families faced increased expenses to provide for their child's needs.[ccclxi] Similar challenges have been described by families of children with special healthcare needs living in First Nations throughout the province; these strains impacted their overall health and wellbeing.[ccclxii]

Figure four: Health Canada and INAC funded services in Pinaymootang (2016)[ccclxiii]



2 THE EMERGENCE OF THE CURRENT STRUCTURE OF JORDAN'S PRINCIPLE IN MANITOBA

Case study three: Jordan's Story[ccclxiv]

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

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

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

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

Jordan's Principle was initially conceived as a child-first principle designed to ensure that First Nation children did not experience denials, delays, or disruptions of needed services as a result of jurisdictional disputes between governments or government departments.[cccLxv] These disputes emerge around services for First Nation children because of the complex structure of services described in chapter one. Jordan's Principle was created in recognition of Jordan River Anderson's life and of the fact that Jordan's case was not an isolated incident. Despite strong support for Jordan's Principle, the federal government did not meaningfully implement Jordan's Principle until after a series of CHRT decisions which, starting in 2016, dramatically expanded the interpretation of Jordan's Principle and mandated full implementation by the federal government.[cccLxvi,cccLxvii]

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

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

The implementation of Jordan's Principle in Manitoba has, in important ways, defied the federally imposed pattern of a demand driven, individualized approach to services. Instead, it has laid the foundation for a new, systemic approach to services for First Nation children. In doing so, the implementation of Jordan's Principle has simultaneously addressed some persistent First Nations demands *and* strained the capacities and mandates of existing structures to support the realization of a self-determined system of services. First Nations have identified the process of developing the capacity to build and manage a First Nations system of service as "complex" and requiring "time and care."[cccLxviii] However, the resources to support the complex process of negotiating and developing a First Nations led system of services have not yet been made available.

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

First Nations in Manitoba have long advocated for a self-determined approach to ensuring the physical, mental, social, emotional, and spiritual wellbeing of First Nation children. First Nations' advocacy for self-determination continues to prioritize the development of systems of services rather than a case-by-case approach to addressing the needs of specific children.[cccLxix, cccLxx, cccLxxi, cccLxxii] The current implementation of Jordan's Principle in Manitoba reflects ongoing advocacy by First Nations. Though a thorough historical accounting is beyond the scope of this report, we briefly describe a small sample of case studies of First Nations' efforts and advocacy in this section. We start with examples from the mid 1990s and offer case studies that extend up to 2016. The examples in case studies four through six demonstrate the persistent efforts of First Nations, and regional First Nations

organizations, within Manitoba to achieve a systemic approach to services as well as the consistency in governmental response over time and across projects.

Table three summarizes AMC resolutions, passed between 2001 and 2014, that endorsed a systemic approach to services. Advocacy for the full implementation and the meaningful participation of First Nations in the implementation of Jordan's Principle was central to the ongoing efforts to achieve a systemic approach to addressing the needs of First Nation children in Manitoba. Jordan's Principle, as it was initially articulated, stated that when a First Nations child required services, the government or department to which the request was originally made should pay for or provide the needed services without delay.[cccLxxiii] Since its inception in 2005, Jordan's Principle has been championed by Jordan's family, community, and First Nations in Manitoba as well as other First Nations organizations, such as the First Nations Child and Family Caring Society (the Caring Society). In 2007, the House of Commons unanimously endorsed a resolution in support of Jordan's Principle; the Principle also received strong support from First Nation, Canadian, and international bodies.[cccLxxiv,cccLxxv, cccLxxvi,cccLxxvii,cccLxxviii]

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

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

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

The implementation of Jordan's Principle in Manitoba was shaped by the narrow federal approach to Jordan's Principle.[cccLxxxv] An outline of key events in the implementation of Jordan's Principle in Manitoba, between 2007 and 2016, is presented in table four. Table four overviews both actions by the federal and provincial governments to implement the narrow federal approach to Joran's Principle and First Nations efforts to expand that approach. Attempts to facilitate the broader implementation of Jordan's Principle also included the drafting of provincial legislation designed to counteract the narrow approach advanced by the federal government. In 2008, concern over slow and informal implementation of Jordan's Principle led to the proposal of the *Jordan's Principle Implementation Act*.[cccLxxxvi] The bill would have affirmed the right of First Nation children to receive the best health care and social services, on a timely basis, in their homes or

communities. The bill was introduced three times between 2008 and 2010, but never proceeded beyond a first reading in the legislature.[cccLxxxvii,cccLxxxviii]

Accordingly, the implementation of Jordan's Principle continued within the narrow parameters outlined by the federal government. A Canadian Paediatric Society report card published in 2016 summarized the implementation of Jordan's Principle in Manitoba this way: "First province to announce an agreement to implement Jordan's Principle (September 2008), although no resources have been dedicated to the process. [The province] Reports that 'informal case conferencing' has minimized impact of jurisdictional disputes, but did not provide the number of cases addressed in this manner."[cccLxxxix]

Case study four: The Niniijaanis Nide (My Child, My Heart) Program in Pinaymootang First Nation[cccxc]

In 2010, the Sumner-Pruden family from Pinaymootang First Nation filed complaints with the Manitoba and Canadian Human Rights Commissions because the services required to address the complex healthcare needs of their son, Dewey, were not available in their Nation. The case led Health Canada to contact the Pinaymootang Health Centre, to enquire about the costs of additional services to meet Dewey's needs. The Pinaymootang Health Director responded with a proposal for funding to address the unmet needs of 11 Pinaymootang families. She stated that it would be "unconscionable to advocate and provide services to one child, when there are numerous children and families within the community that are entitled to health care services and supports."[cccxci]

Throughout 2014 and 2015, the health centre was directed by FNIHB/ISC officials to submit proposals for the a program to meet the needs of children in Pinaymootang to three separate funding opportunities: two unsuccessful applications were submitted to Health Canada's First Nations and Inuit Health Branch's Home and Community Care Program and First Nations Chronic Disease Prevention and Management Framework, and a successful application was made to the federal Health Service Integration Fund. The health centre received no news for several months after submitting a grant application and did not have a direct line of communication to Health Canada staff. Different representatives from Health Canada made sporadic contact with the health centre and it was unclear if each representative was aware of the other communications taking place between the Ministry and local service providers.

Pinaymootang eventually received temporary Health Service Integration Fund funding for the My Child, My Heart program. Initial funding was granted for four months (December 2015 to April 2016). The health centre set about building a new program, with no specialized services providers to support them and limited time to demonstrate program effectiveness in order to secure additional funding. The services provided through the My Child, My Heart program combined assessment and care practices from several different disciplines that were each normally the responsibility of a specialist. This placed enormous pressure on the program's child development workers, Case Manager, and health centre director, who were responsible for meeting the needs of the children and their families, following best practices, and ensuring safe and appropriate service delivery.

The burdens of service delivery were amplified by a short-term funding model. The My Child, My Heart was granted an additional year of funding through the newly established Jordan's Principle program, and funding has subsequently been renewed annually.[cccxcii] Annual funding allocation meant that the program's sustainability was not guaranteed; it depended on unilateral funding renewal decisions made by FNIHB/ISC. Accordingly, needed services could be discontinued if budget priorities changed. Gaining the trust of families in need, only to become the bearers of bad news if funding was not renewed, had the potential to damage ongoing relationships between service providers and community members. Child development workers hired for the program risked being left jobless if funding was discontinued. For families, establishing new routines and getting used to a new standard of care only to see it taken away posed a huge risk to the health and wellbeing of their vulnerable children.

Currently the My Child My Heart program offers a broad range of supports to the families of 151 children. The services provided include respite care, support groups, land based activities, an early childhood development program run through a local preschool, rehabilitation assistance, and American Sign Language training and supports.[cccxciii,cccxciv]

Case study five: Awasis Agency – Children with lifelong complex, medical needs

In 1996, MKO requested the formation of a tripartite working group to examine 16 cases in which children from MKO member Nations were placed in the care of Awasis CFS Agency, and in specialized care situations, away from their home Nations, because of complex health care needs that required extensive care. The committee found that 11 of the 16 children required services similar to those provided through the provincial Children Special Services program, which served off-reserve children across the province. The committee concluded that, "many of these children could remain in their home communities with their family" if Children Special Services were available on-reserve.[cccxcv] Based on the working group's recommendations, Awasis Agency secured funding for an 18-month pilot project to support the repatriation of children who were residing outside their home Nations due to lifelong complex medical needs. Project funding was subsequently extended for an additional year.

An evaluation of the pilot program found promising results, including: the extension of specialized services to First Nation children and families who would not otherwise have had them, the repatriation of some medically complex children within their Nations, the development of multidisciplinary service teams at the Nation level, and increased family and community engagement with medically complex children. However, it also identified significant weaknesses and subsequently made multiple recommendations for expansion of the program and for policies to better serve First Nations children. The recommendations included the following:

- Address historical gaps in the Nation-level services for First Nation children with complex medical and/or special needs.
- Resolve ongoing jurisdictional debates over which government/government department is fiscally responsible for required medical and therapeutic services to on-reserve children and families.
- Expand the target group beyond children in care to include all children with multiple medical and special needs residing in First Nations.
- Expand the project mandate to include: a mobile, interdisciplinary therapy team; education for families, community service providers and Nation members regarding children with complex and special medical needs; extended case management to serve a larger number of children.
- Provide additional funding to First Nations CFS agencies to support services to children with complex medical and special needs.
- Partner with educational and accreditation units to address the need for trained and experienced First Nations rehabilitation therapists and para-professionals at the Nation level.[cccxcvi]

Despite these findings and recommendations, FNIHB only funded the pilot project between 1999 and 2001. Awasis Agency was informed that negotiations for a new program would be required in order for the pilot project to continue. Continued funding for the individual children involved in the pilot project

was provided on a case-by-case basis.[cccxcvii] Based on the pilot project experience and the evaluation results, Awasis Agency proposed a more comprehensive program in 2007.[cccxcviii] This proposal was never funded. The Awasis Agency 2012-13 annual report noted that the last two children who participated in the pilot program would turn 18 in 2014 and 2015, bringing the follow-up funding for participants to an end. A 2016 AMC resolution on Jordan's Principle called for re-establishment of the Awasis Agency program.[cccxcix,cd]

Case study six: AMC proposal for a region-wide service delivery model

A 2007 AMC proposal outlined a service delivery model that would address gaps in services for First Nation children with disabilities and their families.[cdi] The proposal emerged from the work of the Manitoba First Nations Disability Multi-Sectoral Working Group, which included federal and provincial representatives and was established by AMC and the MFNERC in 2006.[cdii] The proposal outlined a flexible, evolving First Nations service delivery system that would be coordinated by a central service centre. The central service centre would work in close partnership with regional centres charged with coordinating mobile therapy units. These therapy units would provide allied health services as well as community-based vision and hearing supports. The proposal outlined guiding principles that were central to the service delivery system. These included:

- First Nations jurisdiction and control – A focus on promoting leadership, control, ownership, and participation at the community level.
- A holistic approach – A focus on the relationship between physical, emotional, mental, and spiritual wellbeing as well as family and community relationships.
- A community-based service delivery structure – A focus on delivering services at the community level whenever possible.
- A shift out of assessment phase into implementation phase – A focus on ensuring action to implement services and supports that address children's long-term needs in addition to providing short-term diagnosis and assessment.
- First Nations capacity and leadership in service delivery – A focus on supporting the training and study needed to develop a system that engages First Nations professionals, volunteers, and service providers.

None of the participants in or contributors to this study were able to definitively confirm the outcome of this proposal and we found no evidence that the proposed service delivery model was ever implemented.

Table three: A partial list of AMC resolutions on services for children and Jordan's Principle

Date	AMC Resolution
March 5-9, 2001	Confirmed AMC support for the First Nations Disability Association's initiatives to operate as the central service delivery agency for First Nations persons living with disabilities, and the liaison between existing disability service organizations and First Nations and their members, required regular progress reports to AMC.
March 5-9, 2001	Mandated the AMC Disability Program to undertake a comprehensive review of the system of services for First Nation people with disabilities and use the findings to develop a comprehensive strategy for program and policy change.
January 24-25, 2006	Called for the naming of Jordan's Principle in honour of the memory of Jordan River Anderson and with respect to his family and community. Called for the implementation of Jordan's Principle, and called for AMC, federal, and provincial governments to establish a jurisdictional dispute resolution table with "fair and effective First Nation representation."
May 30-June 1, 2006	Endorsed the terms of reference and partnership approach of a Multi-Sectoral Working Group, involving AMC, MFNERC, INAC, Health Canada, and provincial ministries. The group was to develop a strategic plan to address the needs of on-and off-reserve persons with disabilities.
January 18-19, 2011	Endorsed a five-point plan for implementation of Jordan's Principle, including federal and provincial advocacy, engagement with the Assembly of First Nations (AFN), and a public awareness campaign to be undertaken with other supporters of Jordan's Principle.
June 19-21 2012	Called on the Prime Minister of Canada to set a target date, no later than 2015, to end inequalities experienced by First Nation children and young people and resolved that First Nations should do the same and report publicly on progress.
March 4-6 2014	Supported the AMC Secretariat's request to intervene in *Maurina Beadle & Pictou Landing v. Canada*, and endorsed the development of a public campaign and communication strategy to increase support for and understanding of Jordan's Principle, as well as continued advocacy around Jordan's Principle.

Table four: Timeline of Jordan's Principle implementation in Manitoba 2008-14

Year	Jordan's Principle developments
2008	Manitoba became the first province to reach a bilateral agreement, with the federal government, to implement a Jordan's Principle, jurisdictional dispute resolution process.[cdiii,cdiv] A Joint Committee composed of federal and provincial representatives was established to develop case conferencing and dispute resolution processes.[cdv] The AMC Secretariat requested inclusion in the Joint Committee, but no First Nations representatives were included.[cdvi]
2009	A Terms of Reference Official Working Group (TOROWG) established by the Joint Committee drafted a report that: articulated the narrow federal application of Jordan's Principle, outlined the spectrum of cases that would fall under Jordan's Principle, and described potential processes for determining the level of government and government department with primary responsibility for funding services. The report also described potential case conferencing mechanisms, dispute resolution processes, and appeal processes.[cdvii] The report enumerated a number of situations in which federally funded, on-reserve services were not equal to provincially funded off-reserve services. However, it described these as falling outside the scope of Jordan's Principle because "these examples of service disparities are not the result of a dispute between the Federal and Provincial jurisdictions over responsibility for the provision or funding of services. As such, these differences do not relate to Jordan's Principle, as there is no jurisdictional dispute."[cdviii] The report suggested that out-of-home child welfare placement was one way for on-reserve children to access services in keeping with normative provincial standards.[cdix]
2011	An AMC resolution criticized the approach to Jordan's Principle in Manitoba, renewed the call for implementation of Jordan's Principle, and laid out a five-point plan for AMC advocacy and action.[cdx]
2012	An AMC representative was invited to join the Joint Committee and included, as an observer, in the TOROWG. Notes from an October 2013 Joint Committee meeting indicated that the Jordan's Principle process had been tested in only two cases; one was resolved through the provision of funding by a private donor.[cdxi]
2014	The federal government and the provincial government circulated a letter announcing that a Jordan's Principle case conferencing process had been formalized.[cdxii] In the same year, an affidavit from the acting director of the AMC Secretariat, which accompanied the AMC Secretariat's motion to intervene in *Canada v. PLBC & Maurina Beadle*, indicated that the AMC Secretariat knew of many cases in which First Nation children were not receiving equitable services but were denied access to Jordan's Principle because of the federal government's narrow interpretation.[cdxiii] The affidavit also asserted that, "to the AMC Secretariat's knowledge the only way First Nation children in Manitoba are able to access comparable services is if they are put into the child welfare system."[cdxiv] These assertions were echoed in a process evaluation, commissioned by AMC, that began in 2014. The study examined the case conferencing and case resolution process in five cases that were determined ineligible for Jordan's Principle, but which, nonetheless, proceeded through case conferencing and dispute resolution. In at least two cases, families moved outside of their First Nation in order to access services and, in at least one case, the family entered into a VPA to place their child in out of home care in order to access services.[cdxv]

2.2 JORDAN'S PRINCIPLE AS INTERPRETED BY THE CHRT– 2016-PRESENT

The federal approach to implementing Jordan's Principle in Manitoba began to shift as a result of a series of CHRT decisions. These decisions were issued in response to a human rights complaint filed by the Caring Society and the AFN in 2007. The complaint alleged that the underfunding and poor administration of on-reserve child welfare services constituted systemic discrimination against First Nation children.[cdxvi] The failure to implement Jordan's Principle was identified as one component of the ongoing discrimination against First Nation children in child welfare services.[cdxvii] The federal government fought the case on technical grounds until 2013, and the first decision in the case was released in 2016.[cdxviii,cdxix,cdxx,cdxxi]

In 2016, the CHRT ruled that Canada discriminated against First Nation children through its funding and administration of child welfare services. Between April of 2016 and February of 2021, the CHRT issued thirteen additional orders responding to Canada's continued failure to comply with the Tribunal's orders.[cdxxii] These orders required Canada to develop revised child welfare funding and administration policies. The orders also required Canada to provide funding that corresponded to the "real needs of First Nations [CFS] agencies" including, but not limited to: infrastructure repair, prevention services, assessment, service gaps, and costs associated with remoteness.[cdxxiii,cdxxiv,cdxxv]

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

- Applies to *all* First Nation children, regardless of ability, disability, or their residence on or off reserve.[cdxxvii,cdxxviii]
- Requires the federal government to provide funding in cases of emergency involving First Nation children, living off reserve, without status, including children who are ineligible for First Nations status.[cdxxix]
- Requires that the federal government address the needs of First Nation children by ensuring there are no gaps in the government services provided to them.[cdxxx,cdxxxi]
- Applies to a broad range of health, education, and social services including, but not limited to "mental health, special education, dental, physical therapy, speech therapy, medical equipment and physiotherapy."[cdxxxii,cdxxxiii]
- Requires the government department of first contact to pay for a government service or assessment that is "available to all other children" and do so "without engaging in **administrative case** … **conferencing,** policy review, service navigation or any other similar administrative procedure before **the recommended service is approved and** funding is provided." [cdxxxiv]
- Requires the government department of first contact to pay for a government service or assessment that is "not necessarily available to all other children or is beyond the normative standard of care." Further requiring that "the government department of first contact will still evaluate the individual needs of the child to determine if the requested service should be provided to ensure substantive equality

in the provision of services to the child, to ensure culturally appropriate services to the child and/or to safeguard the best interests of the child." Provincial and federal government officials may engage in administrative case conferencing, policy review, service navigation or other administrative procedures only after services are approved and funding provided.[cdxxxv]

- Applies to a broad group of First Nation children including: (1) children, residing on or off reserve, who are recognized by a First Nation as belonging to their community; (2) children who neither have nor are eligible for *Indian Act* status, but have a parent who has or is eligible for *Indian Act* status; and (3) children residing off reserve, who have lost their connection to their First Nation due to colonial policies.[cdxxxvi] The Federal government has sought judicial review of this decision, and the matter is before the Federal Court.[cdxxxvii]

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

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

In addition, a September 2019 ruling ordered compensation to the children, parents, and grandparents impacted by Canada's discriminatory First Nations Child and Family services. The basic terms and the process for compensation have yet to be agreed to by the federal government, the Caring Society, the Chiefs of Ontario, and the Nishnawbe Aski Nation.[cdxlvii] While the CHRT is providing guidance surrounding the terms of compensation, the federal government has expressed the intention to settle the

compensation through a civil lawsuit to mitigate expenditure.[cdxlviii,cdxlix,cdl] Two class actions are currently before the federal courts with the federal government expressing intent to settle one brought forward on behalf of Xavier Moushoom and Jeremy Meawasige.[cdli,cdlii] There continue to be significant discrepancies between the parties' interpretations of compensation eligibility.[cdliii,cdliv]

Textbox two: Questions for assessing substantive equality[cdlv]

The following questions are utilized by the federal government in assessing group and individual requests for services that exceed normative standards, based on the substantive equality standard delineated by the CHRT. Adequately answering these questions requires both knowledge of historical events and an ability to connect complex processes of discrimination and trauma to a child's individual experience or to the needs of a group of children. This approach to substantive equality is broad, time consuming, and places undue burden on families and their service providers.

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

2.3 Emergence of the current approach to Jordan's principle in Manitoba

Following multiple orders and on-going CHRT monitoring, the federal government slowly began incorporating the CHRT's criteria for Jordan's Principle eligibility and timelines in its implementation of Jordan's Principle. [cdlvi] In July of 2016, the federal government announced the creation of the Jordan's Principle Child-First Initiative (CFI), and initially allocated $382.5 million to support the initiative between 2016-19.[cdlvii] The CFI included funding for a Service Access Resolution Fund, which was to pay for services for individual children approved under Jordan's Principle and for Jordan's Principle group requests, for funding to address service gaps affecting large numbers of children.[cdlviii,cdlix] The CFI also included federal funding for an "Enhanced Service Coordination model of care," under which organizations in each province and territory would receive funding for Service Coordinators who helped families to navigate existing federal and provincial services.[cdlx,cdlxi,cdlxii] The initial announcement of the CFI reflected a continued, narrow approach to Jordan's Principle which focused on ensuring that "children with a disability or interim critical condition living on reserve have access to needed health and social services within the normative standard of care in their province/territory of residence."[cdlxiii]

Building on the initial announcement of the three-year CFI, the federal government described their plans for the long-term implementation of Jordan's Principle as a "phased approach."[cdlxiv] The first, transitional phase involved continued funding of Enhanced Service Coordination, First Nations service delivery, and innovation in service delivery. The first phase also involved seeking a mandate and funding from Cabinet for consultation with First Nations. The goal of the second phase has been described as the "implementation of a First Nation vision for Jordan's Principle based on the results of First Nations-led dialogue sessions, including funding needed to fill persistent gaps in service."[cdlxv]

In line with phase one, the 2019 federal budget included allocated $1.2 billion over three years for Jordan's Principle, and Jordan's Principle funded organizations had their funding renewed for the 2019–20 fiscal year.[cdlxvi] However, federal projections taking into account the tripling of Jordan's Principle requests during the 2017–18 year estimated $840.5 million would be required to adequately fund nationwide Jordan's Principle requests in 2019–20 alone, concluding that if demand continued to grow as estimated, an additional $1.3 billion would be required over three years.[cdlxvii] Publicly available budget information indicates expenditures of $392 million in 2018-19, including administrative and operational costs, and $561 million in 2019-20; planned spending projections indicated a reduction in funding in 2020-21, with projected spending at $436 million, rising only slightly to $446 million in 2021-22 and $494 million in 2022-23.[cdlxviii] Requests for Jordan's Principle funding increased quickly with the costs of services and products extending beyond the funds originally allocated in year three of the CFI. As shown in figure five, both funding and the number of services and supports provided through Jordan's Principle nationally grew from year to year, with over 350,000 products and services approved for funding in 2019-20.[cdlxix] We could find no public information about funding beyond 2022-23, nor any public

documentation of the progress towards phase two of the implementation of Jordan's Principle.

In Manitoba, response to the federal announcement of the Jordan's Principle CFI proceeded along two streams. One stream of action was centred in the regional FNIHB office. FNIHB efforts were led by a Jordan's Principle Regional Coordinator whose approach was influenced both by his own experience as a Home Care director in a First Nation and by his work with Pinaymootang First Nation as they sought funding for and established the My Child My Heart program. During initial consultations between FNHIB and AMC, AMC advocated for an encompassing approach in which Jordan's Principle funding would address the education, health, housing, and social service needs of children and their families.[cdlxx] After initial consultations with AMC, the regional FNIHB office acted quickly to ensure that First Nations in the Manitoba region could take advantage of the time-limited funds dedicated to the CFI. In July and August of 2016, as details of the national strategy for funding Jordan's Principle were still emerging, First Nations in Manitoba were asked to identify children with special needs who could benefit from additional supports. The emphasis on children with special needs was in keeping with the federal definition of CFI eligibility at the time and with the approach taken in Pinaymootang. Eight million dollars in Jordan's Principle funding was initially approved for Manitoba, with $1.3 million to be spent during the 2016-17 fiscal year.[cdlxxi]

FNIHB representatives described an initial approach in which they would respond to First Nations requests on a first come first serve basis.[cdlxxii] In July of 2016, the Jordan's Principle Regional Coordinator began expanding beyond this initial strategy, commencing a prolonged series of engagement meetings with individual First Nations and First Nations organizations, such as Tribal Councils, to provide additional information about Jordan's Principle. During these meetings, First Nations leaders and FNIHB discussed the potential for utilizing Jordan's Principle funding within their Nations. Nations and organizations providing services within the Nations were asked to propose their "dream projects", which were reviewed in follow up meetings.[cdlxxiii] By the beginning of November, FNIHB reported it already received 11 requests for respite care funding and 426 requests for services for individual children with assessed needs.[cdlxxiv] Engagements with First Nations and First Nations organizations continued through to October of 2017.

The FNHIB Regional Jordan's Principle Coordinator also began to take stock of existing organizations that might be able to provide allied and mental health and wellness services in First Nations. He explained the process this way:

> We felt that special services needed to be centralized … I wanted us to use a lean process where you pool for the service that you need. You don't ask – you don't – a community doesn't ask for more. But all First Nations receive equal support and equal opportunity to receive those services. And by doing that I want – we also wanted to reduce the expense it could have been if the professionals are the ones who were determining the costs for delivering services. So we centralized services like occupational therapy, speech language pathology, audiology, mental health, and we entered into contribution agreements

> with a few non-profit agencies here in Winnipeg who are already providing those services through the Province of Manitoba but they were not going on reserve.[cdlxxv]

In September of 2016, an initial discussion around the extension of services was held with the Rehabilitation Centre for Children (RCC) and an agreement that RCC would extend services to First Nations was reached shortly afterwards.[cdlxxvi] Over the course of 2017, FNIHB representatives met with and engaged an additional four Specialized Service Providers (SSP).[cdlxxvii] Four SSPs (St.Amant, the Manitoba Adolescent Treatment Centre, the Rehabilitation Centre for Children and Frontier School Division) are non-First Nations organizations, operating as part of, or in partnership with, the provincial system. The other SSP, MFNERC, is a First Nations run organization founded by AMC (see chapter three for extended descriptions of these SSPs).[cdlxxviii,cdlxxix,cdlxxx]

In addition to the implementation measures led by the FNIHB regional office, a parallel stream of action was centred in regional First Nations organizations, which continued to advocate for a First Nations led, systematic approach to provision of services. In September of 2016, as FNIHB was pursuing initial implementation of the Jordan's Principle CFI, AMC issued two resolutions related to Jordan's Principle. The first, again, called for the immediate implementation of the full scope of Jordan's Principle, both on and off reserve.[cdlxxxi] As outlined in table five, the second put forward four recommendations for Jordan's Principle implementation in Manitoba.[cdlxxxii] One of these recommendations was restructuring of the Terms of Reference Official Working Group (TOROWG) which was established by the federal and provincial governments in 2009, to oversee implementation of Jordan's Principle in 2009 (see table four for additional discussion of the TOROWG). Subsequent resolutions outlined a Jordan's Principle governance structure and called for further collaboration in order to create shared understanding and formally establish authorities, policies, and standards for the implementation of Jordan's Principle.

AMC proposed and received Jordan's Principle funding to support First Nations engagement around Jordan's Principle. AMC worked in partnership with the First Nations Family Advocate Office to undertake a series of engagement sessions and meetings between December 2016 and June 2017.[cdlxxxiii] Through these engagements, feedback and priorities for Jordan's Principle implementation were gathered from 20 First Nations. The engagements yielded the broad set of recommendations that are summarized in textbox three, and reaffirmed the long-standing commitment of First Nations in Manitoba to a systemic approach to service provision. As summarized in figure six, participants reiterated the commitments—to First Nations leadership, a holistic approach, local access to services, and long-term funding—that were articulated in proposals dating back to the 1990s.[cdlxxxiv]

In keeping with the emphasis on self-determination and First Nations decision making, and with the September 2016 call for restructuring of the TOROWG, the structure for coordination and collaboration around Jordan's Principle evolved over time. The TOROWG continued to function through 2016, with First Nations participants in these meetings calling for restructuring to promote greater First

Nations leadership and more meaningful engagement with First Nations across Manitoba. They also called for an approach that more systematically responded to needs identified by all First Nations and for the development of a sustainable First Nations service delivery model.[cdlxxxv,cdlxxxvi] At an April 2017 meeting of the TOROWG, the AMC, in collaboration with representatives from the MKO, SCO, MFNERC and FNHSSM, proposed that the TOROWG be restructured. Representatives from INAC (now ISC) and FNIHB agreed.[cdlxxxvii]

A group known as the Jordan's Principle Technical Advisory Group (TAG), including AMC, MKO, SCO and FNHSSM began meeting regularly in place of the TOROWG until a new, formal governance structure could be put in place. In July of 2019 an AMC resolution called for replacing the TOROWG with the Jordan's Principle Equity Roundtable, which is summarized in figure seven. The Roundtable was intended to:

- Oversee Jordan's Principle case conferences,
- Identify and advocate for the resources needed for the full implementation of Jordan's Principle,
- Identify federal funding policies that should be changed in order to align with Jordan's Principle,
- Liaise with the national level Jordan's Principle Action Table (JPAT) and Jordan's Principle Operating Committee (JPOC),[11]
- Establish a strategy for Jordan's Principle funded prevention services in order to end the practice of placing children in CFS care in order to access services, and
- Oversee ongoing evaluation of the implementation of Jordan's Principle in Manitoba.[cdlxxxviii]

The Roundtable was to incorporate multiple, distinct but interconnected forums. These included a Service Delivery Specialists Group, which could focus on addressing challenges in day-to-day service provision and development, and multiple other forums in which key stakeholders could consider the long-term and political questions involved in the implementation of Jordan's Principle. Through these activities, the Equity Roundtable would seek to ensure that First Nations were involved in and maintained control of Jordan's Principle in Manitoba. Alongside development of plans for a new governance structure, the AMC Jordan's Principle Service Coordination team developed a work plan designed to follow up on the recommendations in the Keewaywin Engagement and, receiving approval from the Women's Council, began to implement the plan and establish the Equity Roundtable.[cdlxxxix]

AMC progress was slowed by staff turnover and, in the interim, a parallel group that initially brought together Jordan's Principle Service Coordinators employed by Tribal Councils (Tribal Council Service Coordinators; TSCs) and representatives from the FNIHB regional office (on behalf of ISC) began informally meeting. SSP and independent Nation representatives were also invited to join this group, which began work on a regional agenda similar to that

[11] The JPAT and JPOC both provide policy development guidance surrounding Jordan's Principle.

outlined in the AMC Jordan's Principle service coordination work plan.[cdxc,cdxci,12]

AMC's development and implementation of the Equity Roundtable experienced continued delays. By spring of 2019, the AMC Secretariat drafted a proposal entitled *Support for a Manitoba First Nations Capacity Enhancement Centre (CEC)* for submission to ISC.[cdxcii] The proposal sought resources for completion of the Jordan's Principle service coordination work plan, and for the development of the knowledge and capacity needed to transition to a truly First Nations led system of services for First Nations in Manitoba. The details of this proposal are outlined in textbox four.[cdxciii]

The national Jordan's Principle office declined to fund the proposal and, in April 2020, AMC again submitted a proposal to support the development of an alternative service delivery system. Similar to the initial submission, this proposal focused on:

1. The development of enhanced First Nations' capacity to implement Jordan's Principle,
2. The development of an alternative, First Nations led service delivery mechanism,
3. The development of research and policy to help ensure access to services on and off reserve,
4. Ensuring appropriate funding for Jordan's Principle,
5. Supporting the Equity Roundtable,
6. Enhancing communication about Jordan's Principle to First Nations,
7. Project management, and
8. Strengthening and maintaining the relationships needed to ensure effective implementation of Jordan's Principle.

Funding for this proposal was also denied.[cdxciv] In September of 2020 the Executive Director of Jordan's Principle provided the following feedback:

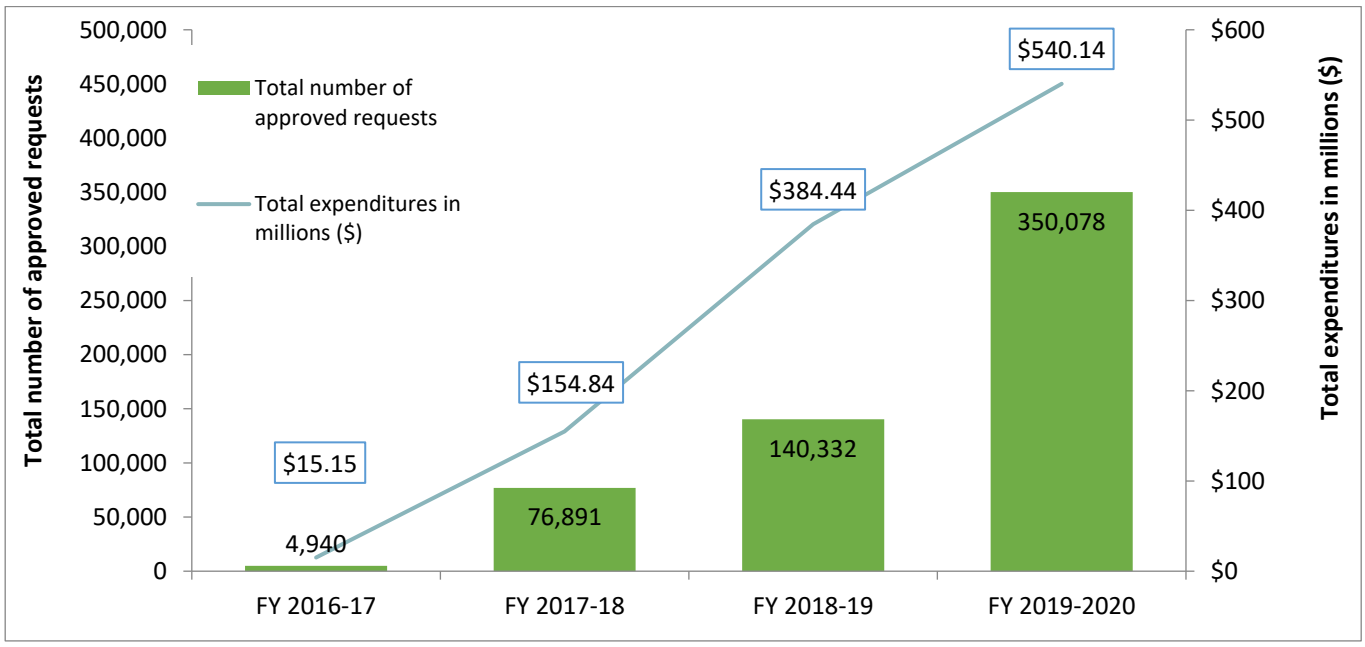
> In terms of next steps regarding your proposal, and to support a phased approach, we are recommending that we support AMC to develop a Case Management model. This would require working in partnerships with agencies that are currently offering case management, and engagement with First Nations and Tribal Councils, but it will be a concrete step in increased First Nation control over the Jordan's Principle service delivery model in Manitoba. We are hopeful that it could lead to expansion to further functions in the future.[cdxcv]

In response, AMC began work to understand First Nations developed case management model should do and look like, while also continuing to pursue the items on the Jordan's Principle service coordination work plan and potential development of a CEC. The Senior Tripartite Table and the First Nations Advisory Table that are central to the planned Equity Roundtable have not yet officially met because of time and human resource issues related to

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

the COVID-19 pandemic.[cdxcvi] The TAG has continued to meet but, during the period of COVID-19 related restrictions, expanded to include service delivery specialists. During this period the TAG has transformed into a forum in which Jordan's Principle Case Managers meet to discuss developments and concerns, share information, and make collective progress towards addressing policy issues of shared interests.[cdxcvii,cdxcviii] The TSC/ISC/SSP group also continued to meet and to discuss parallel concerns.[cdxcix] The group briefly expanded its meetings to include AMC and FNHSSM representatives in the fall of 2020 before suspending meetings in December of 2020 because of COVID-19 related time and workload issues.[d]

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



*Approved Inuit individual requests and community managed requests from Nunavut are not included in the number of approved requests.
FY 2016-17 includes November 1, 2016 (when the first contribution payment for Jordan's Principle was paid out) to March 31, 2017.

Table five: Partial list of AMC resolutions related to Jordan's Principle 2016 to present

Date	AMC Resolutions
September 20-22, 2016	Expressed support for the September 2016 CHRT decision. Called for full implementation of Jordan's Principle and advocacy by the Grand Chief and AMC members.
September 20-22, 2016	Outlined a four-point plan for Jordan's Principle implementation. Called for: • Restructuring of the TOROWG; • Eagle Urban Transition Centre (EUTC) Special Needs Advocate Office to take the lead on enhanced service coordination and receive core operational funding for this work and three additional Service Coordinators to serve northern First Nations. • The revival of the Awasis Agency/Norway House Cree Nation Children's Special Services Program and the implementation of this program across Manitoba. • An intergovernmental task force to define ethical, moral and legal authorities for Jordan's Principle including legislation and First Nations governance standards.
September 20-22, 2016	Supported the AMC Secretariat's proposal, to INAC, to carry out regional engagement, based on the Touchstones of Hope, working together with MKO, the SCO, and the Technical Advisory Group on Children and Families (identified in the Bringing our Children Home report).
April 25-27, 2017	Declared continued endorsement and support for the AMC Secretariat's work to ensure the full implementation of Jordan's Principle.
July 18-19, 2018	Called for replacement of the TOROWG by the Jordan's Principle Equity Roundtable, with full participation of MKO, SCO, FNHSSM and MFNERC. Membership to include: First Nations, federal, and Manitoba technicians and ministers; representatives from the First Nations Women's Council; and the AFN Manitoba Regional Chief. The roundtable would ensure the First Nations involvement in and control over the full implementation of Jordan's Principle.
October 23-25, 2018	Notes that some First Nations have shared that monies allocated for Jordan's Principle were used to offset budgets from other departments in First Nations, reaffirms AMC's full support for Jordan's Principle and calls for Jordan's Principle funds to be used only for the provision of services for First Nation children.
May 29, 2019	Supports the use of Jordan's Principle funds for infrastructure and capital costs.
October 29-30, 2019	Notes a 2019 AFN resolution to review the JPOC and Jordan's Principle Action Table (JPAT) to ensure and ensure First Nation representatives are appointed to the JPOC. Calls on the Women's Council to present nominations to the AFN.
April 24-25, 2019	Mandated the AMC Secretariat to work with the AMC Chiefs Committee on Governance Renewal to draft a conflict of interest policy that would apply to AMC appointees to the Jordan's Principle focused bodies.

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

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

Figure six: Manitoba First Nations approach to Jordan's Principle implementation[diii]

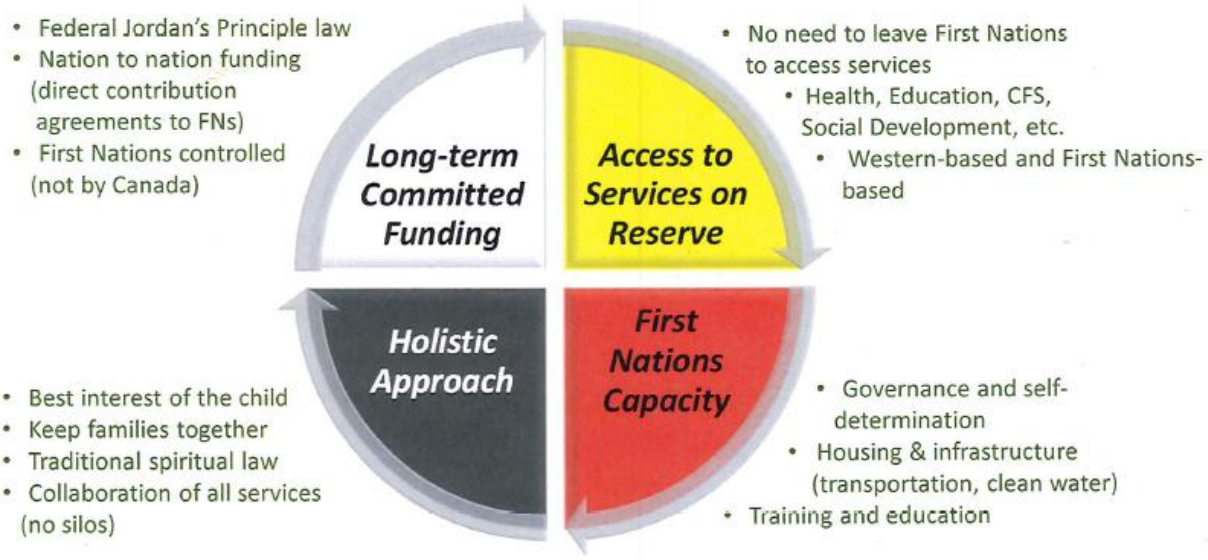
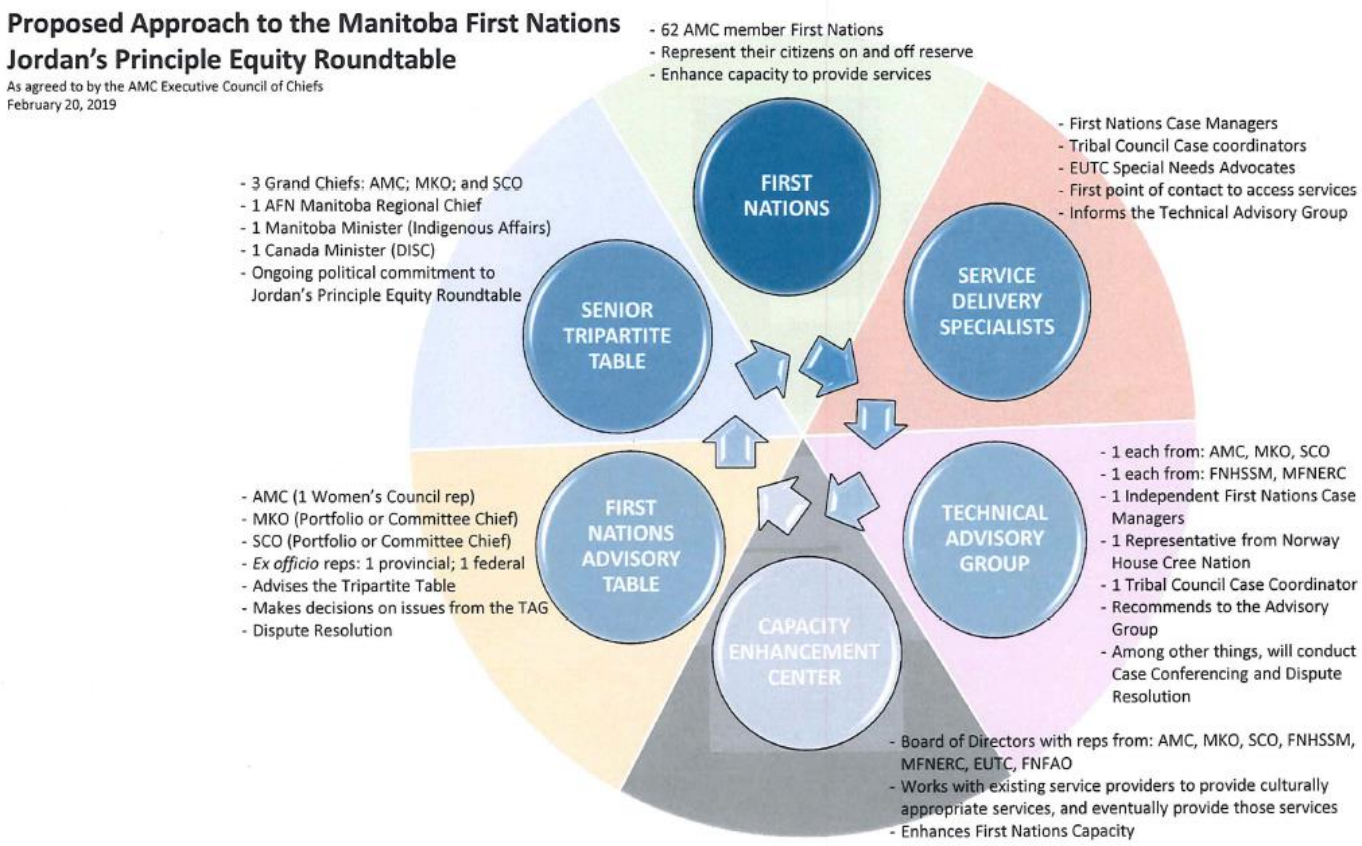


Figure seven: Proposed approach to the Manitoba First Nations Jordan's Principle Equity Roundtable[div]



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

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

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

3 CURRENT STRUCTURE OF JORDAN'S PRINCIPLE IN MANITOBA

The current structure of Jordan's Principle in Manitoba emerged through the parallel FNIHB/ISC and First Nations led processes described in the prior chapter. The services and supports provided through Jordan's Principle are layered on top of the services and service structure described in chapter one. There may be substantial collaboration between individual staff members or between organizations providing services through Jordan's Principle and service providers within the pre-existing structure for health, education, and social services (see chapter four). However, as described in chapter two the implementation of Jordan's Principle in Manitoba has been carried out primarily through the actions of FNIHB and First Nations, independent of the pre-existing systems of services described in chapter one.[13]

The First Nations and regional level programs[14] and services that are funded through Jordan's Principle include:

- First Nations developed programs implemented at the First Nations level,
- A system of region-wide allied health and mental health/wellness supports provided by Specialized Service Providers located in Winnipeg,
- Coordination of services for First Nation families living or accessing services off-reserve, including support in accessing Jordan's Principle funds to address the needs of individual children, and
- Additional, regional initiatives that focus on addressing specific gaps in services (such as the need for pediatricians and child psychologists in northern communities) and support First Nations engagement with Jordan's Principle.

This purely descriptive chapter offers a portrait of the Jordan's Principle funded services that supplement, complement, and interact with the system of services described in chapter one. The description provided here lays the foundation for the analysis presented in chapters four and five.

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

[14] In order to address the needs of First Nation children and families, and in keeping with the CHRT's delineation of Jordan's Principle as a legal obligation that must be continually upheld, First Nations are working to establish long-term, sustainable service programs. Accordingly, we use the term 'program' to describe Jordan's Principle funded services throughout the remainder this report. However, we note that, because of its initial classification as an initiative, Jordan's Principle continues to be funded in a way that is more commonly used to support short-term 'projects'. See section 4.1.2. for additional detail and discussion.

The current structure of Jordan's Principle in Manitoba features multiple components designed to move beyond a case-by-case approach to service provision and systematically extend delivery of needed services to First Nation children and families, living both on and off reserve. The current Jordan's Principle structure also incorporates support and capacity building resources at both the regional and Tribal Council levels. Figure eight presents a summary of the different components of Jordan's Principle in Manitoba. This figure was originally produced by ISC/FNIHB. It has been simplified (to complement the longer service descriptions that follow) and updated based on interviews, review of service provider websites, and review of documents shared by service providers.

In addition to the services and supports identified in figure eight, the current structure of Jordan's Principle includes the possibility for Nations or organizations serving First Nation children to make *group* requests for Jordan's Principle to address gaps in services that affect groups of First Nation children. *Individual requests* may also be made for Jordan's Principle funds to support the provision of products/services to individual First Nation children whose needs are not met through existing programs.[dvii] The CHRT has mandated that responses to individual requests must reflect consideration of the principle of substantive equality and be rendered within strict timelines (12-48 hours).[dviii] Nationally, individual requests for Jordan's Principle funding are typically administered by government representatives (focal points) charged with facilitating the review and approval of requests for services.[dix] In the Manitoba context, the first line of support and response is from Tribal Council and Off-Reserve Service Coordinators, who either support the preparation of a request to be assessed by regional focal points or, in many cases, assess and respond to the request directly.[dx]

3.1 First Nations (on-reserve)

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

Figure eight: Jordan's Principle services in Manitoba[dxx]

First Nations

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

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

Specialized Service Providers (SSPs)

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

Manitoba First Nations Education Resource Centre (MFNERC): Provides a broad range of services to 58 First Nations schools in 49 Nations with a combined student population of more than 15,500 children from nursery school go Grade 12.

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

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

Frontier School Division (FSD): Seven wellness workers address mental health needs across 15 on-reserve schools.

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

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

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

Eagle Urban Transition Center (AMC)

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

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

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

Tribal Councils

Seven TCs are funded for two positions each.

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

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

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

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

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

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

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

ISC/FNIHB beyond Jordan's Principle

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

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

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

Based on the work and leadership of Case Managers, each First Nation developed a Jordan's Principle program that could also receive funding for child development workers, respite workers, and administrative assistants.[dxxi,dxxii] Federal funding was subsequently made available for land-based healing, EAs, rehabilitation assistants, wellness workers, and assistant case coordinators.[dxxiii,dxxiv,dxxv] First Nations can also request additional funds that can be flexibly allocated to enhance available services.[dxxvi]

In keeping with the federal government's initial focus on children with disabilities and special needs, most First Nations Jordan's Principle initiatives are housed within health services. However, some First Nations have developed Jordan's Principle within education, and Jordan's Principle Case Managers may also work independently of either pre-existing service structure.[dxxvii,dxxviii,dxxix] Each First Nation developed their own approach to Jordan's Principle, prioritizing needs identified within the Nation and building up on existing strengths and available resources. As will be discussed in more detail in chapter four, the Nation–level services developed with Jordan's Principle funding cover a broad spectrum that includes, but is not limited to, education supports (including EAs and tutors), land based education and healing, language and cultural supports, recreational activities, supports for children and youth with disabilities, after school and early childhood activities, parent and caregiver supports, activities to support health lifestyles, and supports for basic needs.[dxxx] Data provided by FNIHB regional office in 2018 indicated that the number of full time staff supported by Jordan's Principle funding ranged from a minimum of five per First Nation to a maximum of 43 in a larger First Nation in Manitoba. [dxxxi]

3.2 First Nation Centres

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

3.2.1 Mino Bimaadiziwin (The Good Life)

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

3.2.2 Ndinawemaaganag Endaawaad (Tina's Safe Haven)

Tina's Safe Haven provides 24-hour drop-in services to roughly 50 youth on a daily basis. The service began in November of 2018 in memory of Tina Fontaine, who was murdered in 2014 at the age of 15. Since that time, Tina's family, with the support of the Ndinawe drop-in centre, advocated for funding to provide an accessible 24-hour service for youth.[dxxxiii] Tina's Safe Haven provides 24-hour access to services such as on-site laundry, computer and phone services, and a gaming room. Recreational activities, camping, celebratory dinners and dances, referrals, employment and housing supports are also provided.[dxxxiv,dxxxv] Ndinawe also provides a training program to support youth seeking to enter careers in community based care work.[dxxxvi]

3.3 Service coordination

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

In addition to the services funded at the First Nation level, each of the seven Tribal Councils receive funding for one **Service Coordinator** who "supports and coordinates development-training, design, implementation, and evaluation at the community level."[dxxxvii] TSCs strive to build the relationships needed to properly support families and to identify and address family needs. Their work may include some level of support for both on- and off-reserve families spread across vast geographic regions. Their roles also extend to coordinating access to existing services, including things like arranging medical transportation and child care supports and facilitating access to SSP services. Further, they provide education around Jordan's Principle for both on- and off-reserve families and support Case Managers by coordinating group meetings and trainings for, making regular visits to communities (in some cases, this may require extensive travel), and supporting proposal/group request writing.

Tribal Councils also receive funding for Off-Reserve Case Managers who support the development and submission of individual Jordan's Principle requests for First Nation families living off reserve, in the smaller urban centres, outside of Winnipeg. They assess, process, and respond to requests involving low cost and Nation based services within CHRT mandated guidelines and timelines.[dxxxviii,dxxxix] They forward requests for other types of services to FNIHB for assessment, the requests assessed by FNIHB include those involving dental care, medical equipment, educational supports, or housing.[dxl,dxli] They may also coordinate with the EUTC and off reserve service providers to facilitate continuity of care for families and children.

3.3.2 Service coordination and respite care in Winnipeg (Eagle Urban Transition Centre)

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

The EUTC receives federal Jordan's Principle funding for six **Off-Reserve Service Coordinators** who support First Nation families and special needs individuals (children and adults) in accessing needed services and advocating to ensure their rights are met. EUTC also receives federal funding for a **Respite Short Term Service Coordinator** charged with "supporting children and families when they are living off-reserve for short periods of time."[dxliv] EUTC's approach to respite care supports families in identifying caregivers that are known to and trusted by the family/child and supporting the family in formalizing the relationship with that caregiver. EUTC also maintains its own list of respite care workers and can facilitate introduction to those workers when families are not able to identify a caregiver from within their own networks.[dxlv]

The Off-Reserve Service Coordinators work in conjunction with Jordan's Principle Service Coordinators, Case Managers, and Specialized Service Providers to help ensure a culturally

based continuum of care both on and off reserve. EUTC advocates for and supports families in navigating health, education, child and family services, employment and income assistance, and housing policies and systems in Winnipeg.[dxlvi,dxlvii,dxlviii,dxlix,dl] EUTC also supports families through the status registration processes.[dli,dlii] In addition to connecting families with existing services, EUTC Service Coordinators support preparation of Jordan's Principle requests, and directly assess and process payments for requests for low-cost services/supports and services/supports that cannot be easily covered under rigid federal government administrative guidelines.[15] Processing requests from children and families occurs within the CHRT mandated timelines with urgent individual requests fulfilled within 12 hours and non-urgent individual requests fulfilled within 48 hours; should administrative documentation become a barrier EUTC prioritizes resolving the child's needs as quickly as possible.[dliii]

The range of supports provided by EUTC includes, but is not limited to: accompanying families to meetings with service providers, facilitating coordination between service providers, advocating for families to receive needed services, advancing requests for Jordan's Principle funding, supporting families through complaint and legal processes, linking families to community resources, and providing necessary instrumental support to meet family needs.[dliv,16] EUTC also provides interested children, youth, and families with support in connecting with and reclaiming cultural identity through monthly sweats, weekly Elder visits, use of a smudge room, and other culturally-based services.[dlv,dlvi]

3.4 Specialized Service Providers (SSPs)

SSPs are pre-existing organizations that have received federal Jordan's Principle funding to support the extension of services to First Nation children (aged zero-18) and their families. Across interviews, administrators of these Winnipeg-based organizations indicated they were approached about service provision in the first half of 2017 and began providing and coordinating services later that year. SSPs provide services to diverse First Nations, with complex service structures, across vast geographies. In addition to the services described below, SSPs have been regularly meeting together with TSCs and regional FNIHB representatives to share information and better coordinate services.

3.4.1 Rehabilitation Centre for Children (RCC)

The RCC's mission is to support "excellence in children's rehabilitation and developmental pediatrics through innovative clinical service, education, research and technologies."[dlvii] RCC's strategic plan is built around three main themes: Theme one: Children, Youth, and Families – Family Centered / Culturally Safe

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

[16] For a detailed description of a similar service-coordination effort in Alberta, see Larlee et al (2018) The Enhanced Service Coordination Model in the Alberta Region. In Sinha, V., Vives, L. and Gerlach, A. (eds.) Implementing Jordan's Principle Service Coordination in the Alberta Region: The First Nations Health Consortium. Calgary/Edmonton, AB: The First Nations Health Consortium. Retrieved from: https://static1.squarespace.com/static/57320457ab48dea767e5e69f/t/5c97103eeef1a1538c20022e/1553403977185/2019-FNHC_InterimReport-WEB.pdf

Integrated Services; Theme two: Service Excellence – Knowledge Generation & Evidence Informed Practice; and Theme three: Organizational Effectiveness.[dlviii] The organization's board of directors is appointed by the Department of Health and it operates on a diversified funding base, combining provincial funding with private foundation funding and fee-for-service revenues.[dlix]

Located in the Specialized Services for Children and Youth Centre in Winnipeg, RCC has three departments that provide clinical services. Neurodevelopmental services incorporate child development and fetal alcohol spectrum disorders (FASD) clinics as well as neonatal newborn follow up. Clinical and Rehabilitation Services provide prosthetics, orthotics, and mechanical design services as well as multidisciplinary clinics —such as feeding, orthopedics, muscular dystrophy, and others— and complementary therapy services for children from birth to school entry at its Winnipeg centre. The Outreach Therapy Department provides OT and PT services to off-reserve children across Manitoba, through its school therapy services and children's therapy initiative, and to on-reserve children through Jordan's Principle.[dlx,dlxi,dlxii]

RCC first received provincial funding to provide outreach services to rural Manitoba communities in 1987. It has long served First Nation children accessing services off reserve, in rural Manitoba communities, and in its Winnipeg office. Federal Jordan's Principle funding allowed RCC to extend its services directly in First Nations.[dlxiii] RCC currently delivers services in 63 First Nations in partnership with other agencies. RCC provides home and community-based OT, PT, SLP and audiology services for children from birth to school entry. The organization also provides child development, FASD and assistive technology clinics in First Nations.[dlxiv,dlxv,dlxvi] Through its collaborations with MFNERC, RCC supports school transition for both the child and family during the kindergarten year.[dlxvii]

3.4.2 St.Amant

Located in Winnipeg, St.Amant is an independent not-for-profit that receives funding from the Manitoba Departments of Health and Families and Health Canada. It provides a wide range of programs and services to adults and children with intellectual or developmental disabilities, acquired brain injury, or other conditions necessitating similar supports; it also provides supports for their families.[dlxviii] St.Amant operates a large residence for complex-care, more than 100 community sites and homes, a research centre, a school, and two child-care centres.[dlxix]

St.Amant's core values are collaboration, hospitality, excellence and respect. Their vision is one of freeing the spirit and fulfilling potential together. The organization's strategic plan is organized around a human rights and advocacy framework, which also focuses on creating an accessible environment. St.Amant takes a holistic approach to services and provides services to support people's spiritual, physical, emotional, and mental health. St.Amant clinical services include OT, PT, SLP, spiritual health, dietician services, social work, counselling, community nurse consultants, and music therapy.[dlxx]

St.Amant takes a lifespan approach to providing disability services. Through its preschool outreach therapy services, the organization provides OT, PT, and SLP services to infants and young children; it also has a program that

supports preschool and school-age children with autism. St.Amant also has a school that provides short-term residential support for children who have complex and challenging behavioural and/or other needs. It provides interim supports to children until they can be reintegrated into their on-reserve schools. St.Amant has an intensive and voluntary social work program called the Family Care Program, designed to prevent families with a child or an adult with disability, from experiencing breakdown and crisis.[dlxxi] In addition, St.Amant has clinicians supporting adults with disabilities, in a range of environments, to comprehensively address end of life care and diverse needs surrounding dementia. St.Amant currently supports an estimated 170 First Nations adults with health transition services, providing short-term access to behaviour stabilization supports and medical assistance prior to return to their Nations. In addition, St.Amant has supported independent living for adults who need some day-to-day assistance in their lives.[dlxxii]

St.Amant has supported individual First Nation people accessing clinical services *off reserve* for decades. Federal Jordan's Principle funding has allowed St.Amant to extend a broad range of services on reserve.[dlxxiii] The organization was first approached by the federal government in 2017 and asked to submit a proposal to provide services on reserve. Administrators felt a responsibility, and accepted the opportunity, to help because there was an unmet need and no other organization – Indigenous or government sponsored – was in a position to provide the services offered through St.Amant. The organization started taking on-reserve referrals in the summer of 2017, extending some of the key services offered through their provincially funded programs.[dlxxiv] Since the first pilot year, they have been constantly expanding. The staff increased from six in 2017, to over 40 in 2020; these staff members support nearly 600 children in 52 First Nations, often providing multiple services to a child.[dlxxv,dlxxvi]

On reserve, St.Amant provides services for children and youth with challenging behaviors, as defined by the family and care givers. These services aim to increase positive behaviors; promote independence, inclusion, and participation; improve quality of life for children/youth and caregivers; and reduce stigma.[dlxxvii] The services offered in First Nations include psychological supports to address behavioural challenges identified by family members or care givers and clinical counselling focused on the impact of disability on a child or family. St.Amant also offers: a family care program that supports the families of children with disabilities in meeting self-identified goals, support from dieticians specializing in needs of children with developmental disabilities, and consultation with nurses experienced in working with children with complex needs. In addition, it provides psychometric testing to youth in care in order to assess eligibility for provincially funded adult disability services.[dlxxviii,dlxxix] St.Amant strives to support other service providers in leaning about adults and children with disabilities. It has provided close to 200 workshops to families and staff of Jordan's Principle, schools, daycares, and CFS. Common workshop topics include understanding autism, understanding the impact of intellectual disability on daily life, coping strategies for caregivers, and supporting children who have challenging behaviours in a dignified and positive way.[dlxxx]

3.4.3 Manitoba First Nations Education Resource Centre (MFNERC)

The AMC founded MFNERC in 1988 to provide "education, administration, technology, language, and culture services to First Nations schools in Manitoba."[dlxxxi] MFNERC now provides services to 58 First Nations schools in 49 First Nations, with a combined student population of more than 15, 500 children and adolescents.[dlxxxii,dlxxxiii] The organization offers a broad range of programs and services, spanning from the domains of early learning to high school, First Nations language and culture, numeracy and literacy, physical education and health, science and education technology, student learning assessments, and special education.[dlxxxiv] A collaborative approach is taken to service delivery in which extensive consultation and coordination with First Nations leadership, Elders, schools, and children and families guides the identification of needs and the implementation of services.[dlxxxv] MFNERC has also developed partnerships with universities in order to support the development of First Nations capacity to provide clinical services for First Nation children.[dlxxxvi]

Federal Jordan's Principle funding, combined with other increases in federal funding, has enabled MFNERC to expand and enhance the special education services it provides to First Nations schools across Manitoba. MFNERC's funding for special education increased dramatically in 2016, when the federal government increased investment in ISC's High Cost Special Education program.[dlxxxvii] Jordan's Principle funding added to MFNERC's special education funding. Jordan's Principle funding supports provision of clinical services in all schools supported by MFNERC. These services are provided by a team of 80 staff across 10 disciplines, including OT, PT, SLP, school psychology, mental health and wellness, deaf and hard of hearing and American Sign Language instruction, intergenerational trauma supports, respiratory therapy, and nursing services.[dlxxxviii,dlxxxix,dxc]

The organization has prioritised hiring First Nation people, which allows services to be provided in Nethetho/Ininew (Cree), Denesuline (Dene), Anishininew (Oji-Cree), and English.[dxci] MFNERC has also utilised a grant provided by ISC funding to support the implementation of training programs for First Nations resource teachers, rehabilitation assistants, and school psychologists in order to support First Nations capacity to implement clinical programming.[dxcii] Focusing resources on capacity building as identified as a long-term organizational objective that supported on-reserve provision of specialised services, retention of staff, and the implementation of culturally relevant services guided by the self-identified needs of First Nations.[dxciii] A long-term goal of MFNERC is to support First Nations self-determination in service delivery, which can entail stepping back as Nations develop their respective capacities for specialised service provision.[dxciv]

3.4.4 Manitoba Adolescent Treatment Centre (MATC)

MATC is governed by a provincially appointed board of directors and falls under the jurisdiction of the Winnipeg Regional Health Authority Mental Health Program.[dxcv] MATC first opened in 1984; the organization provides mental health services to children and adolescents, aged three-18, using hospital and community based programs. Long-term and brief interventions are provided to address the psychiatric and emotional needs of people in

services.[dxcvi] Services include assessment, consultation, inpatient treatment, individual and group therapy, family therapy, pharmacological therapy, psycho-educational supports, and consultation and referrals for substance use.[dxcvii] Training services are also offered through MATC to support the professional development of mental health professionals across Manitoba.[dxcviii] On-site and telehealth services are provided by a diverse inter-professional team that emphasizes accessible cross-cultural services, relationship building, trust, and accessibility for children and families.[dxcix]

Federal Jordan's Principle funding allowed MATC to extend and expand on a pre-existing psychiatric telehealth service, which was designed to fill gaps in services by providing consultation with child and adolescent psychiatrists through rural health authorities. The telehealth service originated as a provincially funded service; people living in First Nations could only access the service through off-reserve community mental health workers. In 2010, the Manitoba Department of Families began providing limited Youth Suicide Prevention Strategy funding for MATC to extend the telehealth service to some First Nations. The program began with five First Nations in 2010 and expanded to 15 First Nations, with strategic provision of services to Nations that were overrepresented in emergency room visits. The service moved beyond a tele-psychiatry model to include ongoing therapeutic support from child and adolescent mental health clinicians.[dc] The program won a Manitoba award for its innovative partnership between First Nations, and provincial and federal governments.[dci]

A significant portion of MATC's work is geared towards ensuring complex mental health needs are addressed through long-term supports. Cases can include, but are not limited to, addressing complex trauma, providing on-going supports for mental health diagnosis such as schizophrenia and developmental delays, and offering crisis and long-term support for youth experiencing suicidality.[dcii] MATC workers also travel to First Nations, effectively converting the telehealth program to a hybrid model that incorporates visits to meet with children and youth in First Nations in order to establish a connection. Provision of follow-up and ongoing therapy through telehealth ensures cost effective accessibility and continuity of care. In addition, the presence of Jordan's Principle Case Managers and respite workers in First Nations has allowed MATC to establish more consistent and active partnerships that support the identification of children with psychiatric needs. At the start of 2017 three MATC clinicians provided services in 15 First Nations. With the support of Jordan's Principle funding, services have expanded to a team of 12 clinicians, with diverse professional specialties, providing services to 63 First Nations across Manitoba.[dciii,dciv,dcv]

Since receiving Jordan's Principle funding MATC has observed a significant increase in demand for services which has required hiring additional staff to meet the needs of First Nation children and adolescents.[dcvi] MATC currently provides services with an awareness that First Nations capacity to design, implement, and provide mental health services for children and adolescents is developing. A long-term aim of MATC is to provide services up until First Nations programs can independently meet the mental health needs of children and adolescents.[dcvii]

3.4.5 Frontier School Division (FSD)

FSD was created by a Ministerial order, in 1965, with a mandate of providing educational services to Métis and northern students based on the provincial curriculum. FSD currently administers services in 41 schools and has education agreements with 15 First Nations for administration of on-reserve schools. The geographic area of service provision is organized within five "areas" extending across a northern region that includes 75% of the landmass in Manitoba.[dcviii,dcix] These schools serve 6,305 students from kindergarten to grade 12, many of whom are First Nations.[dcx,dcxi,dcxii] For example area four schools provides services to an estimated 1,200 students, 83% of whom are First Nations or Métis. Within area four Frontier Mosakahikan School has a student population that is 100% First Nations or Métis for its kindergarten to grade 12 programming. In addition, 78% of students attending the Frontier Collegiate Institute, which provides education services for grades nine-12, are First Nation or Métis.[dcxiii] In the 2019-20 school year FSD received 60% of its funding from Indigenous Services Canada, 35% of funding from the province of Manitoba, and roughly 2% of its funding from municipal sources.[dcxiv] Over time, the programs and services offered by FSD have been tailored and expanded to include programs like: Career Education, Fine Arts, Character Education and First Nations Languages.[dcxv]

FSD sought Jordan's Principle funding in order to serve a high percentage of First Nation children who were identified as having at least "one languishing mental health factor" in a study conducted by FSD. In cooperation with clinical psychologists and psychiatrists, FSD designed and delivered a mental health diagnostic assessment for children in their schools. In the schools within area one, about 22% of the student were identified as having at least one "languishing mental health factors", which the report identified as including self-harm, suicide ideation, trauma, rape, sexual abuse, physical violence. FSD requested Jordan's Principle funding in order to meet mental health needs, among its First Nations students, that were more significant than its regular in school counsellors could support. Jordan's Principle provided funding for seven wellness workers to address these mental health needs.[dcxvi,dcxvii]

FSD outlined four main objectives for services funded through Jordan's Principle: a wellness portfolio, telehealth services, an Elder's program, and wellness activities. The established wellness portfolio includes seven wellness workers; one for each area within Frontier School Division, and an additional worker, based on need, in two areas. The second objective of developing a telehealth service was to address the challenges that FSD faces in serving one of the largest geographic areas of any school board in Canada. Telehealth would facilitate provision of immediate supports to students in crisis, even when travel and weather conditions slow the provision of in-person services. Out of 15 sites identified as having a priority need for telehealth, 11 have all the hardware and software in place to begin telehealth services. The third goal was to develop an Elder's program that includes Elders in the therapy plans of children in crisis. Development of this program requires recognition of the diversity of traditions within the Nations served by FSD and incorporation of the flexibility to serve both those families that follow traditional teachings and those that embrace Christianity, while also supporting

revival of a Nations' Indigenous languages and cultures. Implementation of the Elder's program has been delayed due to lack of funding and coordination. Finally, as wellness workers are able to expand beyond responding to immediate crises, FSD seeks to develop an expanded range of wellness activities that create spaces for children and youth to share their concerns openly, in order to prevent crisis.[dcxviii]

3.5 Regional support

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

The MKO is a non-profit, founded in 1981, that provides political advocacy to support 26 northern Nations in Treaties 4, 5, 6, and 10.[dcxix] KIM is a self-governing, First Nations led health organization that was created, in 2020, by the MKO Chiefs Task Force on Health to serve as a First Nations-led aggregate health transformation entity. KIM aims to "achieve health related services that are reflective of the needs and priorities of First Nations people" by working with First Nations to "transform health and wellness services and improve health outcomes for First Nations people."[dcxx] KIM currently coordinates and provides on-reserve pediatric and clinical psychology services in 13 northern Nations, through both in-person and telehealth platforms.[dcxxi,dcxxii]

A liaison at KIM works with Jordan's Principle Case Managers and Health Directors, provides presentations at Chiefs Assembly and national conferences, and has attended the TAG meetings. Through these outreach initiatives, which focus on Jordan's Principle Case Managers, health directors and others in First Nations, KIM identified Nations which had on-going gaps in pediatric and clinical psychology services. The KIM liaison works to build relationships with Nation-based service providers through virtual meetings, in order to understand the unique needs of the Nations and facilitate the introduction and work of pediatricians and psychologists. Advocacy with remote northern Nations to ensure gaps in physician and psychiatric services can be filled is on-going work for KIM.[dcxxiii]

3.5.2 Southern Chiefs Organization (SCO)

The SCO coordinates discharge and client care for First Nation children at the Health Sciences Centre Children's Hospital (in Winnipeg) and through the Specialized Services for Children and Youth.[dcxxiv,dcxxv] Implementation of this service is just beginning.

3.5.3 FNHSSM eHealth Support Desk

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

3.5.4 Assembly of Manitoba Chiefs (AMC)

AMC originally received Jordan's Principle funding to support First Nations "engagement" around Jordan's Principle through the Keewaywin Engagement process. In addition, AMC has used Jordan's Principle funding to support multiple Jordan's Principle forums, as well as planning and communication activities.[dcxxvii,dcxxviii] Examples include a Service Coordinator's gathering, Case Management facilitators gathering, and a Jordan's Principle stakeholders gathering and professional development training. All these events brought

together people who were central to the implementation of Jordan's Principle to discuss successes and challenges, future direction, and capacity development. Additional events and activities include a Jordan's Principle focused Chiefs in Assembly, and ongoing Jordan's Principle TAG meetings.[dcxxix,dcxxx,dcxxxi]

Beyond these activities, AMC has defined the role of its Jordan's Principle Services Coordination team as being that of *implementing* the recommendations identified in Jordan's Principle forums and the Keewaywin Engagement Jordan's Principle Implementation report.[dcxxxii] As discussed in chapter two, the full implementation of Jordan's Principle requires the development of new governance structures as well as mechanisms for building capacity and developing policy. To this end, the AMC Jordan's Principle Services Coordination unit developed an expansive work plan that includes, but is not limited to:

- Supporting the development of training tools, shared policy, supports for creation of local laws and by-laws, an information portal, an essential service checklist, and other tools to facilitate full implementation of Jordan's Principle by First Nations.
- Creating templates to support First Nations in completing environmental scans to identify gaps in services, evaluating Jordan's Principle services, and budgeting.
- Supporting the development of a fully developed customary care model as well as policies and programs to facilitate repatriation and reunification of children in care with their families.
- Supporting the development of new legislation, federal and provincial policies, funding models, governance structures, and alternative service delivery systems that ensure the full implementation of Jordan's Principle.
- Facilitating ongoing collaboration though the Jordan's Principle Equity Roundtable as well as ongoing communication about Jordan's Principle with First Nation leadership and citizens, parents and the general public, Jordan's Principle Case Managers and Service Coordinators, and service providers.[dcxxxiii]

4 THE IMPLEMENTATION OF JORDAN'S PRINCIPLE: KEY THEMES

In this chapter, we present key themes related to the current implementation of Jordan's Principle in Manitoba. These themes emerged from our initial analysis of the qualitative and quantitative data collected thus far. We found that:

- There has been a systemic approach to implementing Jordan's Principle, but this approach is undermined by the provision of short-term, demand driven funding.
- First Nations leadership has been both supported and hampered by a discretionary federal approach to the implementation of Jordan's Principle in Manitoba.
- The services available to First Nation children have been greatly expanded through Jordan's Principle, but continue to exclude vulnerable groups. In addition, important gaps and disparities in services persist.
- Jordan's Principle offers important flexibility for Nations to realize self-determination in services, but significant resources and supports are required to ensure both an equitable baseline of services for all First Nations and the opportunity for all Nations to realize self-determination in services.

4.1 A SYSTEMIC APPROACH WITH SHORT-TERM, DEMAND DRIVEN FUNDING

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

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

As will be discussed in the final section of this chapter, a fundamental challenge in the implementation of Jordan's Principle in Manitoba is that of establishing a system that ensures equitable services for all First Nation children while also honouring and supporting First Nations' self-determination in services.

Several elements of the approach to Jordan's Principle in Manitoba are consistent with the basic elements of a systemic approach.

Implementation of Jordan's Principle across Manitoba has prioritized group rather than individual funding, extended funding opportunities across Nations rather than simply responding to individually generated proposals, and prioritized the full-time employment that can help promote employment stability. Systemic approaches that allow for long-term, full-time hiring can also ensure some level of managerial supervision is provided in unregulated professions.[dcxl]

Elements of a systemic approach to Jordan's Principle were incorporated from the outset of implementation: each First Nation was asked to submit a proposal for Jordan's Principle funding and initially received base funding for a full-time Case Manager, accessible vehicle and additional child development or respite workers as requested.[dcxli,dcxlii] The level of funding for these positions also reflected a long-term, systemic approach. One interviewee noted:

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

As a result of extending an initial funding opportunity to each First Nation, rather than waiting for Nations to come forward one-by-one and request funds, Jordan's Principle funding in Manitoba was established quickly and at a relatively high level. Evidence of the rapid action to establish Jordan's Principle in can be seen in figure nine, which presents data comparing expenditures, by jurisdiction, over time. Manitoba, Saskatchewan and Alberta have similar population sizes; the comparison between these three provinces suggests that Manitoba First Nations have been able to leverage a larger proportion of Jordan's Principle funding, relative to population size, than First Nations in nearby provinces.[17]

The initial approach to implementing Jordan's Principle in Manitoba also established, from the outset, an emphasis on funding services through group requests, which support the development of services for multiple children, rather than individual requests, which require a separate funding request for each child in need of services. Figure 10 shows that, in 2019-20 in Manitoba, 99% of Jordan's Principle funded services and products were funded through group, rather than individual, requests. Figure 11 breaks down the services and products funded in Manitoba by service domain. It shows that the vast majority of products and services funded through Jordan's Principle in Manitoba were in four service domains: mental wellness, allied health, respite care and healthy child development. Within these service domains 99-100% of products and services were funded through group requests in 2019-20. A handful of other service domains that, collectively, account for only 1% of Jordan's Principle funded services and products were highly individualized, with 100% of services funded through individual requests. An approach which makes services available to broad groups of children reduces the delays and burdens associated with individualized approaches that require a request must be made – and

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

paperwork compiled and submitted – for each product or service required by an individual child. Research on the implementation of Jordan's Principle in Alberta suggests that this individualized approach can create significant delays and barriers to accessing services.[dcxliv,dcxlv,dcxlvi]

The systemic approach taken in Manitoba has supported a rapid growth in the number of products and services funded through Jordan's Principle and pronounced reductions in per-unit service costs over time. Figure 12 shows the products and services funded through Jordan's Principle from 2017-20, demonstrating a six-fold increase in the number of products and services funded in Manitoba between 2018-19 and 2019-20. The number of products and services funded through Jordan's Principle far exceeded that in any other jurisdiction. This increase is consistent with a combination of developments in the implementation of Jordan's Principle in Manitoba in 2018 and 2019: the funding of land based healing services for all First Nations and Tribal Councils; the introduction of rehabilitation assistants and mental wellness services across First Nations; an increase in child development/respite care workers in some Nations; and the introduction of Off-Reserve Case Managers at the Tribal Council level.[dcxlvii] In addition, it may reflect the ongoing expansion of the range of programs and services being provided at the Nation level, and the growing caseloads reported by SSPs. Another factor that could potentially contribute to this pattern would be growth in cross referrals, with individual children receiving services from multiple programs/providers or multiple members of interdisciplinary teams. Service requests at the Nation level might also be expected to increase over time, as communities and families came to be familiar with and to develop trust in services and service providers that have demonstrated their availability on a consistent basis.

The available administrative data also suggests that the approach to the implementation of Jordan's Principle in Manitoba achieved significant reductions in the average cost of products/services over time. The right-hand side of figure 12 shows a marked decline in the average cost of Jordan's Principle funded products and services between 2017-20. This pattern is consistent with the establishment of an economy of scale: a reduction in the per-unit cost of service occurs when an increase in the number of services results in the fixed costs of service provision being spread across more units.[dcxlviii] For example, the per-unit cost of providing an allied health service to children might fall when a service provider, who flies into a Nation, serves more children during each visit because the cost of the flight gets divided across more children.

As seen in figure 13, across the five service domains that account for 99% of funded products and services in Manitoba, the maximum cost of *individual* Jordan's Principle requests is lower in Manitoba than in other jurisdictions. This pattern is consistent with an approach that has established an economy of scale by attempting to extend services across First Nations. For example, the cost of providing an individual child with allied health services that extend beyond the services that are typically available in their Nation is reduced if some allied health services are already provided through Jordan's Principle group request funding This is because service providers are already travelling to the Nation, have some understanding of the context in the Nation, and have developed relationships needed to support service provision. Thus, the

cost of providing additional services is reduced. Across most systematized service domains, the median cost for individual requests in Manitoba was also comparable to or lower than other provinces. The two exceptions were mental wellness and education, in which median cost of individual requests was higher than in other provinces.

Figure nine: Total Jordan's Principle request expenditures, by region (2017-20)[dcxlix,dcl]

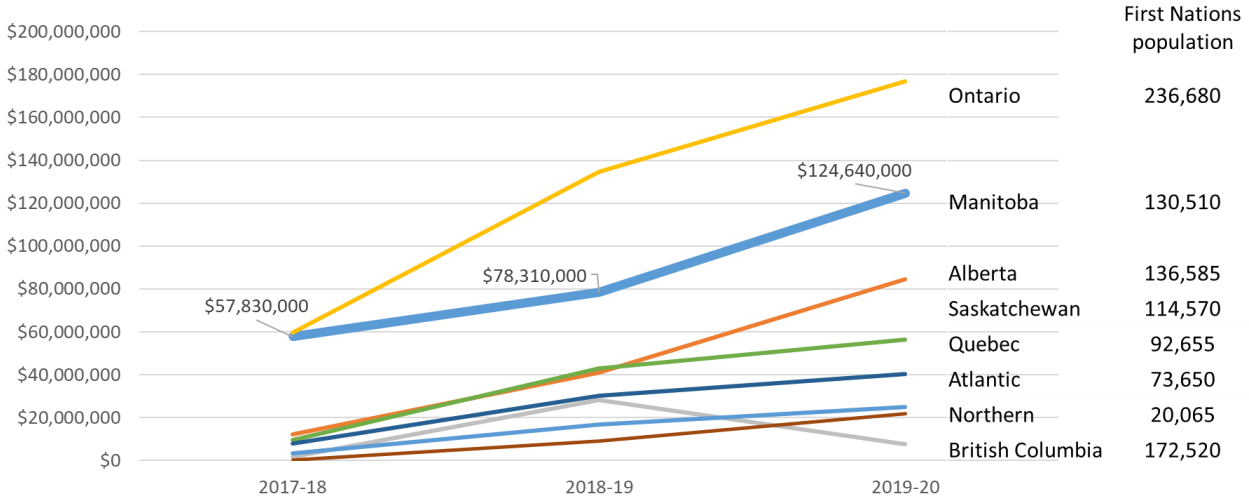


Figure 10: Proportion of Jordan's Principle funded services & products funded through group and individual requests, by region (2019-20)[dcli]

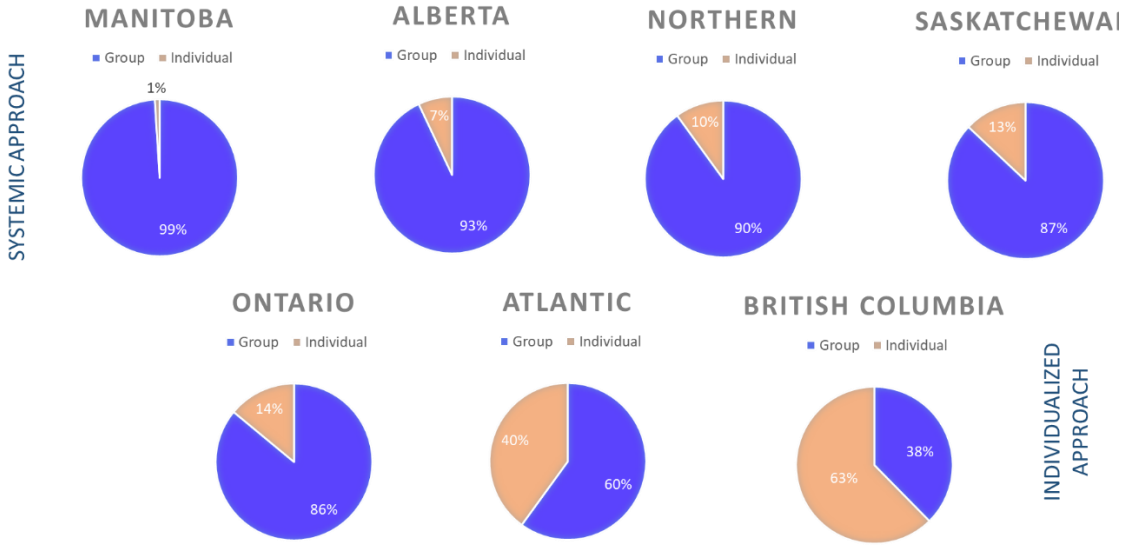
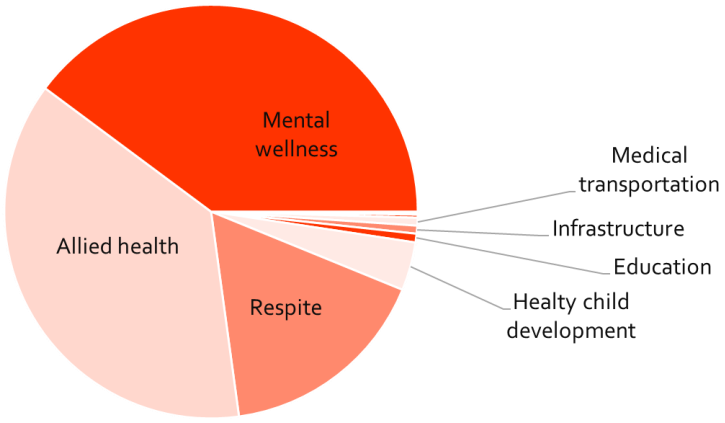


Figure 11: Total number of products/services by service area, and proportion of products services funded through group or individual request by service area[dcli]



100% group request funding
- Mental wellness
- Respite
- Allied health (99.8%)
- Healthy child development (99%)
- Social

90% group request funding
- Education

90% individual request funding
- Infrastructure

100% individual request funding
- Medical transportation
- Medical equipment & supplies
- Medications/nutritional supplements
- Oral health
- Travel

Figure 12: Number and average cost of Jordan's Principle funded services and products, by region (2016-20)[dcliii]

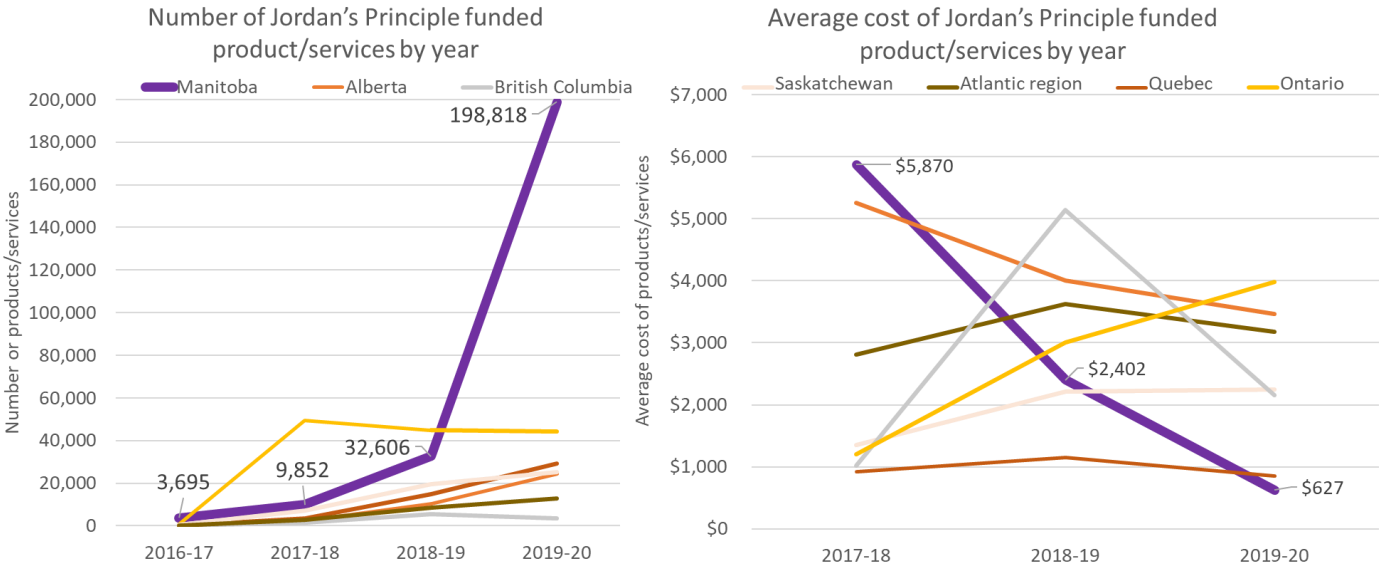
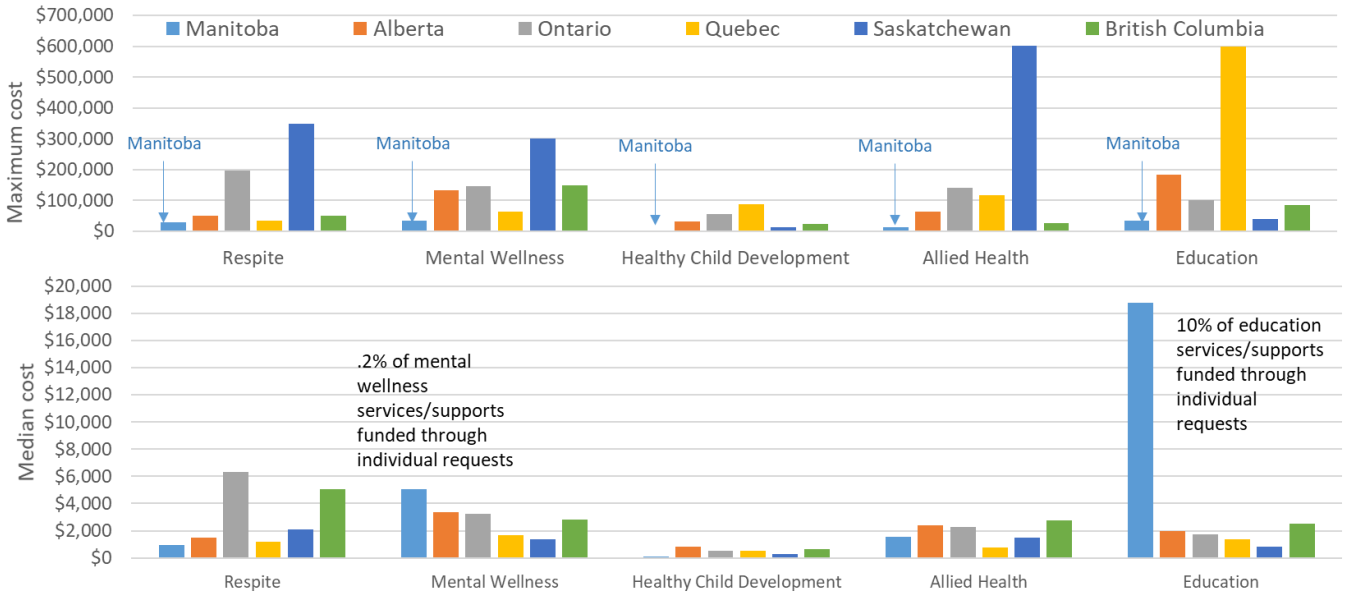


Figure 13: Maximum and median cost of individual Jordan's Principle requests by service domain and region (2019-20) [dcliv,dclv,18]



4.1.1 Demand driven approach

The systemic approach to the implementation of Jordan's Principle is in tension with a demand-driven approach which has sometimes been imposed, by the federal government, on the implementation of Jordan's Principle in Manitoba. In interviews and meetings, people pointed to the events surrounding the development of Jordan's Principle funded land-based healing initiatives as an example of this tension. In 2018, based on discussion with Case Managers who shared the mental health challenges faced by youth in their Nations, the regional FNIHB office extended an invitation to all First Nations in Manitoba to submit requests for funds to support land-based healing initiatives; each was funded at $150,000.[dclvi,dclvii] The approach of circulating a request for land-based funding proposals was consistent with a systemic approach to extending services across First Nations. After a 2019 audit of Jordan's Principle in Manitoba, however, the regional office was informed by the national Jordan's Principle office that it was not in keeping with national policy to reach out to First Nations to invite group requests. Rather, the regional office was instructed to wait for First Nations to initiate requests, then identify needs, and fund accordingly.[dclviii,dclix] Discussion in interviews and meetings indicated that the instruction to wait for each individual First Nation to demand funding was also accompanied by a shift in decision making: after the 2019 audit, group requests for funding over $100,000, which were previously assessed at the regional level, were sent to the national Jordan's Principle office (in Ottawa) for assessment.[dclx] Many of the requests assessed at the national office were denied.[dclxi]

This same pattern was subsequently replicated in interactions between the regional FNIHB

[18] Data for Northern and Atlantic regions not available.

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

4.1.2 Short-term funding

A systemic approach is also in tension with the federal provision of short-term funding for Jordan's Principle. Funding for Jordan's Principle was initially designated for three years (2016-19) and then extended for an additional three years (2019-22).[dclxiii,dclxiv,dclxv] Interviewees were notified annually of their funding, with no guarantee of annual renewal.[dclxvi,dclxvii] This short-term approach to funding is in conflict with the CHRT's recognition of Jordan's Principle as an ongoing "legal requirement." The CHRT has stated:

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

Despite the long-term legal obligation to implement Jordan's Principle, funding is only currently committed through 2021-22 (see figure 14 for funding levels), and First Nations and service organizations continue to receive annual notification of funding renewal.[dclxix,dclxx] An interviewee explained that the short-term funding was tied to the designation of Jordan's Principle as an initiative rather than a program, noting that:

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

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

In light of the CHRT orders and federal efforts at compliance, interviewee's expressed optimism about the continuity of Jordan's Principle funding. However, they also saw the short-term nature of the funding as problematic, noting that annual funding renewal creates uncertainty and risk around funding stability.[dclxxiii,dclxxiv] One of the Case Managers explained:

> So I know that after next year we're not sure if the funding will continue, right? There hasn't been an announcement or anything made in regards to … what's going to happen after 2022. So, like, I know that we're not a program. And – what we're hoping for is that it will continue, but we – it's still that

> unknown, that uncertainty of not knowing what's going to happen. I think that's the scary part is what are these families going to have … if Jordan's Principle should [not] continue. And I'm pretty sure that if they try and stop it there'll be a big noise. But I've always thought about that when we first started because we were on yearly contracts, like we were only given yearly contracts at a time … because there was no guarantee that this program would continue. So, that's the other thing. Like that's always at the back of my mind is what's going to happen after 2022?[dclxxv]

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

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

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

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

Reports from Alberta, which suggest a sharp decline in funding approved in 2020-21, serve as a cautionary tale about the range of fluctuation that is possible in an annual approach to funding renewal.[dclxxxi] Figure 15 shows funding for Jordan's Principle group requests in Alberta, by year. The data presented in this graph extends through the first five months of the 2020-21 fiscal year. It

shows a steep decline in Jordan's Principle funding in 2020-21. Data for the final months of the 2020-21 fiscal year is not yet available and it is possible that a large number of second-half funding approvals could have significantly reduced the overall gap between 2019-20 and 2020-21 funding. However, if funding approval for the end of the fiscal year mirrored that of the first five months, then funding for Jordan's Principle group funding in Alberta dropped precipitously, to less than 1/2 of the funding provided in 2019-20. In addition, the small amount of funding approved during the first five months of the fiscal year could only be accomplished by cutting or delaying the approval of funding for existing programs and positions. Even those organizations that eventually had their funding renewed would experience burden, uncertainty and risk as they sought to plan for the continuation of services without new funds or indication of funding renewal. Thus, the annual renewal of funding conflicts with a systemic approach to developing service for First Nation children and families, and imposes uncertainty and risks on First Nations and service providers working towards the long-term transformation of services to ensure the health and wellbeing of First Nation children.

Figure 14: National Jordan's Principle budget (2018-23; in millions of dollars)[dclxxxii]

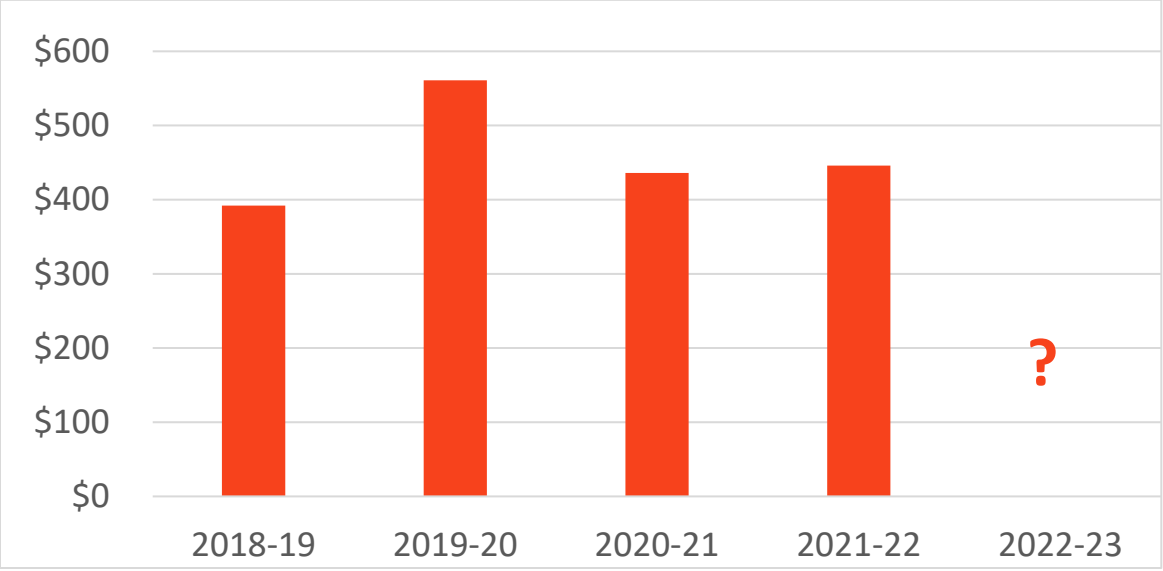
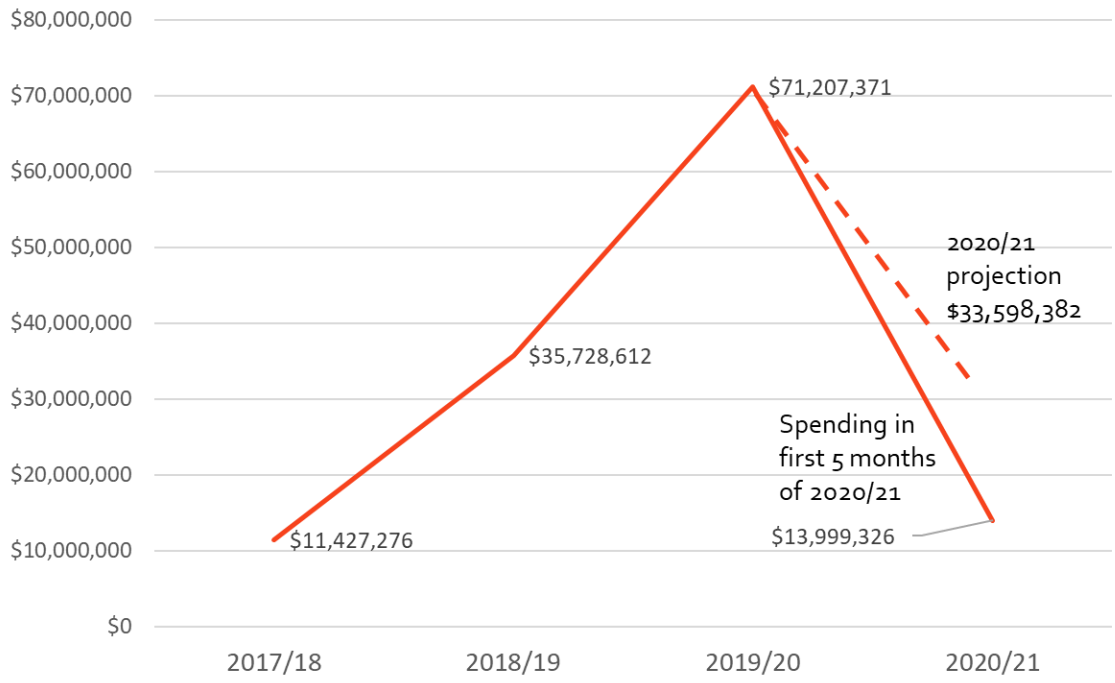


Figure 15: Jordan's Principle group funding in Alberta, by year[dclxxxiii]



4.2 A DISCRETIONARY APPROACH TO JORDAN'S PRINCIPLE

Another theme that was frequently observed in the data for this study had to do with governmental use of administrative discretion in the implementation of Jordan's Principle. Administrative discretion refers to the flexibility that civil servants and service providers have in the interpretation and application of rules in complex situations.[dclxxxiv] Interviewees raised the issue of administrative discretion, highlighting a context in which the outcome of Jordan's Principle requests and other decisions around funding seemed dependent on the person or organizational unit making the decision. Within the Manitoba context, this administrative discretion was largely understood as supporting and empowering First Nation leadership. However, interviewees also discussed situations in which a discretionary approach led to confusion, and even conflict, complicating understanding of roles and responsibilities in relation to Jordan's Principle and hampering efforts to establish a true, First Nations led approach to the implementation of Jordan's Principle in Manitoba.

A discretionary approach to the implementation of Jordan's Principle is evident in the comparison of group request and individual request trajectories across jurisdictions. Figure 16, which shows the trajectory of group requests (2019-20) by region suggests there is broad leeway in decision making at the regional level. The trajectory of group requests differs dramatically across jurisdictions. In Ontario and Quebec, for example, over 90% of submitted requests were deemed to have sufficient information and over 85% were approved within the fiscal year. In the

Northern Region, the Atlantic Region and Manitoba, a much lower proportion of submitted requests (65-80%) were deemed to have sufficient information, but most of these requests were approved, the final approval rate in these provinces was between 55-70%. In Saskatchewan, British Columbia and Alberta, a large proportion of submitted requests were not deemed to have sufficient information *and* only a small portion of those requests were approved; the final approval rate in these provinces ranged between 20-30%. Though the variation across jurisdictions was not as pronounced the trajectory of individual requests, which is depicted in figure 17, also suggests a similar pattern of discretion across jurisdictions. For example, less than 50% of submitted requests were eventually approved in Saskatchewan, Alberta and British Columbia, while over 80% were approved in Quebec.

Within Manitoba, discretion in Jordan's Principle decision making has largely been portrayed and understood as being used to support and empower First Nations. This focus is evident in the approach to the implementation of Jordan's Principle that was described in chapter two. The Jordan's Principle Regional Coordinator acted on strong support for the systemic approach for which First Nations had long advocated. The initial approach to Jordan's Principle, in which each Nation was invited to submit a proposal and encouraged to outline their dream program, as well as the extension of a request for proposals for land-based healing proposals, exemplified this supportive use of administrative discretion. Similarly, the development of a system in which Services Coordinators have a primary role in assessing and making decisions on individual Jordan's Principle requests, reflects the concerted efforts to support First Nations decision making around Jordan's Principle in Manitoba.

The Regional Jordan's Principle Coordinator summarized the perspective this way:

> Anything to do with community-based needs, we are able monitor community activities with the support of the Tribal Council for affiliated communities, and we only get involved when it is a critical situation. When it is not critical, the Case Managers and Service Coordinators know what to do. And that helps us, especially in the future, or for the future of Jordan's Principle – that our First Nations will be the drivers of where they want to go, and the government, who will be there as a support, will be more as facilitators but we are not the ones who are the drivers. We are not the agents.[dclxxxv]

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

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

A SSP also discussed the important role the Regional Jordan's Principle Coordinator, along with other regional FNIHB and ISC employees, have played in the implementation of Jordan's Principle in Manitoba.

> If [they] hadn't been in their key positions and … hadn't have supported [the Regional Coordinator], we would have – I don't think we would have been able to build what we built. They, as bureaucrats, didn't follow that approach and kind of bucked the trend. Look at the benefit in Manitoba now because of that.[dclxxxvii]

Despite the strong emphasis on using discretion to support and empower First Nations, interviewees also shared examples of situations in which the federal government's discretionary approach to the implementation of Jordan's Principle created new challenges. Key among these were situations in which significant policy changes were enacted without discussion with First Nations and announced without advance notice or explanation. Communication around policy shifts was often cursory, transmitted without the benefit of backgrounders or other explanatory policy documents, and last minute. Case Managers sometimes received notice that additional funding was available (to support home modification, rehabilitation assistants, wellness workers, assistant case coordinators or EAs), effective immediately, with as little as a paragraph of accompanying explanation, a template for new position descriptions, and instructions that funds were to be spent within a fixed time period. Thus, even in the case of policy announcements that responded to needs identified by First Nations, the limited information provided and short timelines for implementing policy changes meant that Case Managers and service providers were left to figure out the details of how to spend the funds and meet expectations on their own.[dclxxxviii,dclxxxix,dcxc] As will be discussed in the final section of this chapter, the challenge of building new services with little guidance contributed to a context in which it was difficult to ensure a consistent baseline of services across Nations.

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

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

A shift in policy relating to the use of Jordan's Principle funding for children in care was also mentioned by several interviewees; this policy change is summarized in case study seven.

In some cases, such as the change in age eligibility, policy changes explicitly and directly prevented services providers from meeting the

needs of children and youth who had previously been supported through Jordan's Principle. Other shifts in policy, such as those involving the transfer of decision making to the national office, brought delays and, from the perspective of those in Manitoba, increased denials in response to requests. In each case, a shift in policy created confusion about how decisions relating to Jordan's Principle were made and uncertainty about the shape of Jordan's Principle moving forward.

In each case, the policy shifts were consistent with a pattern that is well documented in the existing literature on administrative discretion: the use of administrative discretion establishes a conflictual relationship between managers and "street level" decision makers, who directly engage with clients. Street level workers seek to address the needs of their individual clients through the use of administrative discretion, while management seeks ways to curtail discretion in order to assure the standardization of processes and decision making, to address budget concerns and to conform to other organizational priorities.[dcxci,dcxcii,dcxciii,dcxciv,dcxcv,dcxcvi]

People involved in service coordination also suggested that the federal government's discretionary approach to the implementation of Jordan's Principle was reproduced in decisions about Jordan's Principle individual requests. Interviewees highlighted ways in which a discretionary approach produced inconsistencies in decision making and undermined service coordinators' decision making authority. Some interviewees noted that standards and approaches to decision making were not consistent.[dcxcvii,dcxcviii,dcxcix] For example, two interviewees highlighted a meeting in which it was suggested that Jordan's Principle eligibility criteria could be "stretched" in order to extend funds to children and families for example, by justifying recreational expenses with the argument that they would prevent future gang involvement.[dcc,dcci]

While the use of discretion to stretch standards benefitted the individual families and children receiving services, it wasn't universally used in preparing or assessing requests. Accordingly, discretion could lead to situations in which one family received a product or service while another, with seemingly similar needs, did not. This in turn could create tensions between Service Coordinators who assessed cases with less flexibility and families, whose expectations were built on the knowledge of families who received services and supports because eligibility criteria were stretched. Some interviewees also indicated that families had learned that appealing a Service Coordinator's decision to a focal point could result in the provision of services that had been denied, and Service Coordinators noted that the reversal of decisions upon informal appeal to a focal point made them less confident in assessing requests, and others noted that this might also be perceived as undermining First Nation leadership.[dccii,dcciii,dcciv]

Tensions and challenges associated with a discretionary approach were most pronounced when it came to decisions around programs that did not clearly align with pre-existing structures and mandates for services to First Nation people. The implementation of Jordan's Principle has challenged the pre-existing service, administrative and political structures because it crosses:

- First Nations, regional and national levels of decision making,
- The domains of both direct services and governance, and

- Multiple service domains (e.g. health, education, and social services).

Thus, for example, the AMC Secretariat considered the implications of the mismatch between Jordan's Principle and existing structures when exploring the options for a systemic approach to the provision of services to First Nation children in 2017 and noted that:

- "The mandate of the AMC Secretariat does not include delivery of Jordan's Principle services or programs, or to be a funding flow through."
- "The existing mandates of FNHSSM and MFNERC do not contemplate the implementation of Jordan's Principle as a service provider/funding flow through. The definition of Jordan's Principle is broader than taking a singular Health or Education approach," and
- "The development of another AMC mandated entity would take time to development."[dccv]

It recommended "that the AMC Secretariat continue to explore options on how to implement Jordan's Principle together with the MKO and SCO, FNHSSM and MFNERC."[dccvi]

Administrative discretion within a system of Jordan's Principle funded services is necessary to ensure decision making is flexible enough to consider and address the unique needs and contexts of First Nations as well as First Nation children and families. However, a federal approach which relies on administrative discretion when it comes to decisions around the basic structure and infrastructure of Jordan's Principle may bypass the collaborative and, sometimes time-consuming or contentious, consensus building measures that are needed to align, or realign, existing structures with Jordan's Principle. For example, interviewees noted that the Interlake Reserves Tribal Council was funded to develop Jordan's Principle policies and procedures and South East Regional Development Corporation (SERDC) received funding to develop a shared, regional Jordan's Principle database.[dccvii] Both decisions were made by the FNIHB regional office, in discussion with the TSC/ISC/SSP working group.

An interviewee gave more details about this type of discretionary decision making in discussion of the SERDC database funding. She indicated that that SERDC received database funding based on the organization's prior establishment of a database for their member Nations; the hope was to build on that prior experience in order to efficiently establish a Jordan's Principle data system. However, the interviewee noted that, when database plans were presented to Case Managers and others there was "pushback."

> Why did South East get the database contact? Who decided that"? And it wasn't just a political thing, it was competition between other database companies who had their own MOU's in place saying, "Well why did that company get it and yet we're doing a database for another program?"[dccviii]

These responses reflect a disconnection between the processes for database funding/development and region-wide knowledge and processes. No request for proposals was circulated and the development of database plans took place primarily in partnership with a TSC/ISC/SSP working group that did not include representatives from the FNHSSM, AMC or other groups with long-term,

region wide knowledge that might have helped proactively address some of the questions raised. Database development was put on hold due to the tensions around the project and COVID-19 related work and restrictions.[dccix,dccx]

The lack of transparency evident in the details of the database development project are indicative of a larger pattern of disconnections and potential overlaps in work and mandate. After being invited to join TSC/ISC/SSP group meetings in the fall of 2020, the AMC noted that "it appears discussion items identical to objectives the Jordan's Principle Technical Advisory Group (TAG) of the Jordan's Principle Equity Roundtable are working towards."[dccxi] While AMC was developing plans for, and working towards the establishment of, the Equity Roundtable and a CEC under mandate from First Nations leadership, the TSC/ISC/SSP group was pursuing parallel work in partnership with FNIHB. For AMC, the lack of coordination between these efforts raised further tensions and questions about the level of funding being provided to the TSC/ISC/SSP and, by extension, about potential links between that the TSC/ISC/SSP work and the denial of funds to support the development of the capacity enhancement centre proposed by AMC and endorsed by First Nations leadership.[dccxii]

New, informally developed structures like the TSC/ISC/SSP serve a critically important role, supporting the regional coordination and development of Jordan's Principle. However, when new structures are developed and operate, or support allocation of resources, in a discretionary fashion, they can add to pre-existing challenges within the complex, and siloed pre-existing system of services to First Nation children. The pre-existing service structure has been shaped by a fragmented colonial policy framework and Jordan's Principle has quickly layered new services on top of these pre-existing structures. Time and resources are required to support the development of *formal*, new, regional structures to support the implementation of Jordan's Principle. A discretionary approach to decision making when confusion arises may enable the quick progress towards improved implementation. However, in such situations, discretionary decision making may also have the unintended consequence of enflaming tensions or even causing conflict. In contrast, more formalized and transparent decision making processes can offer opportunities to avoid duplication of efforts and other inefficiencies, and to demonstrate that decisions are being made based on the needs and interests of First Nation children rather than governmental and institutional interests or resource control.

Figure 16: Jordan's Principle group request trajectory, by region (2019-20)[dccxiii]

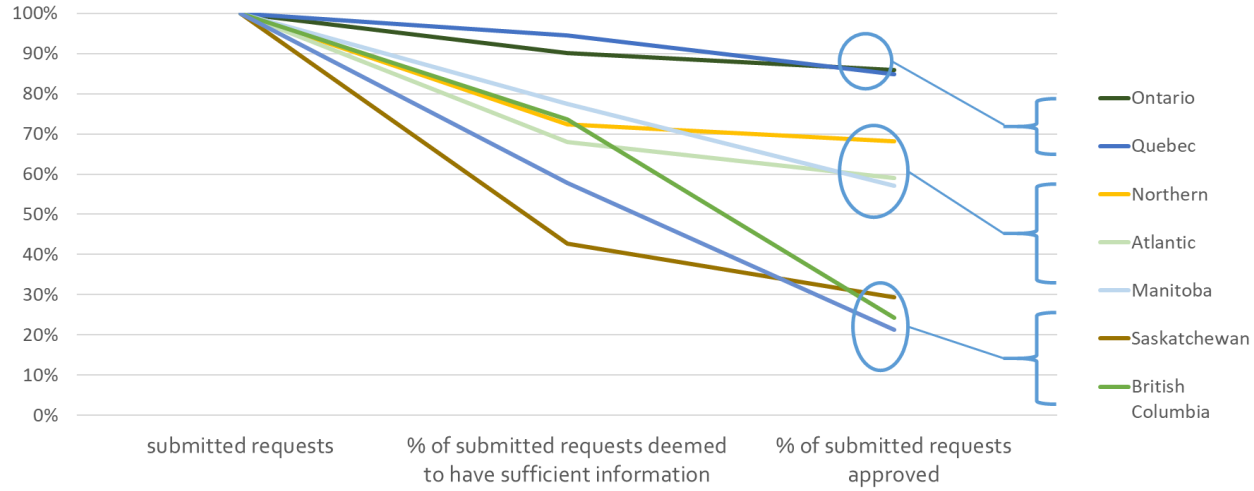
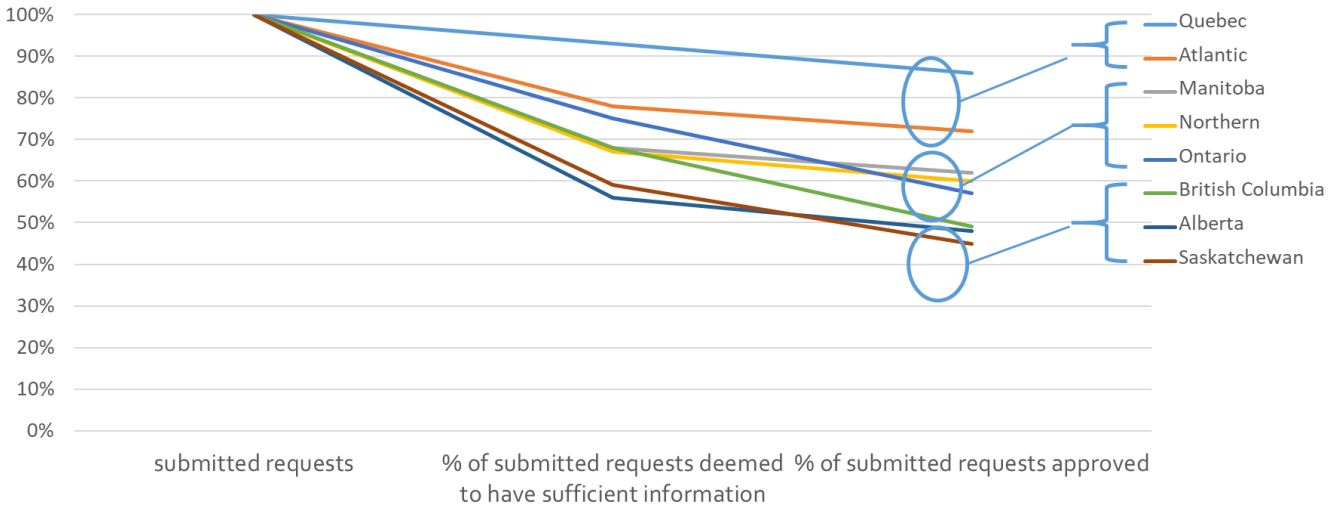


Figure 17: Jordan's Principle individual request trajectory, by region (2019-20)[dccxiv]



Case study seven: Jordan's Principle funding for children in care

First Nations, service providers, and Service Coordinators in Manitoba were initially told that Jordan's Principle funding should not be used to support the needs of children in CFS care. In light of the CHRT ordered increases to First Nations child welfare funding, they were told, services for these children would be covered by CFS. This policy changed abruptly. First Nations, service providers, and Service Coordinators were suddenly informed, without any explanation, that Jordan's Principle funds would be used to support children in care, but were cautioned to avoid duplication of services that were covered by CFS.[dccxv] The sudden shift in policy caused confusion among Service Coordinators and providers who wondered about the reason for the change and worried about a possibility that Jordan's Principle funds were being used to offset shortages that should be addressed through federal and provincial CFS funding.[dccxvi,dccxvii,dccxviii,]

A regional focal point explained that the policy shift came in response to a specific case involving a provincial CFS ward (a child living off-reserve who was to be in CFS care until aging out of the system) who required immediate access to mobility equipment in order to be discharged from hospital. Provincial funding processes are not designed to provide immediate response to such requests. When those involved in the child's couldn't get immediate support from the province, they called a national advocacy organization, the Caring Society, which reached out to the federal government. The regional FNIHB office subsequently received a call from an ISC official asking about the situation. A focal point looked into the situation and approved funding for the mobility equipment so that the child could leave the hospital. In response to that case, a shift in policy was introduced. Requests involving provincial wards are assessed and directly responded to through Jordan's Principle. Requests involving federal wards are sent to federal CFS officials for assessment and payment; only if CFS does not pay are they covered through Jordan's Principle.[dccxix] The details and complexity of this dual stream approach to the treatment of requests involving federal and provincial children in care did not appear to be clear to interviewees at the time that interviews were conducted.

4.3 Expanded services with continuing gaps, disparities, and exclusions

4.3.1 Expanded services

The services available to First Nation children have been greatly expanded through Jordan's Principle, but there continue to be exclusions of vulnerable groups and services, as well as important gaps and disparities in services. As described in chapter three, most Nations now have some access to allied health and mental health services that are provided by Winnipeg based SSPs who travel to deliver services in First Nations. The RCC and MATC provide services in all 63 Nations, St.Amant provides services in 52 Nations, MFNERC serves 58 First Nations schools in 49 Nations, and FSD serves an additional 15 First Nation schools.[dccxx,dccxxi,dccxxii,dccxxiii,dccxxiv]

In addition, Jordan's Principle has also created the opportunity for a broad set of new and enhanced services developed at the Nation level. All First Nations in Manitoba receive funding for a Case Manager and respite care or child development workers; many also receive funding for land-based healing, therapy assistants and wellness workers. A broad range of additional services can be provided at the Nation level – these include diverse programs including classes and supports for culture and language, child and youth recreational activities, educational supports, child care, supports for families and caregivers, community events and group activities, courses and activities focused on healthy living and life skills, and emergency assistance.[dccxxv] Thus Jordan's Principle has dramatically expanded access to services in contexts where there was previously very limited or no service access.[dccxxvi,dccxxvii,dccxxviii,dccxxix]

Some interviewees suggested the new services funded through Jordan's Principle may prevent apprehensions into CFS by responding to the needs of children and families.[dccxxx] In other cases, funding for services through Jordan's Principle has supported the return of First Nation children to their home communities, allowing them to access services that were previously unavailable at the local level and required placement in long-term care. A SSP gave an example of repatriation.

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

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

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

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

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

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

Textbox five: Jordan's Principle success stories

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

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

She continued and described the child's progress.

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

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

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

Speaking of the impact of Jordan's Principle more generally, she said, "it's been amazing seeing the progress of our children." [dccl]

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

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

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

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

4.3.2 Growing caseloads and waitlists

While Jordan's Principle has expanded the range of services available to First Nation children, interviewees indicated that the ability to meet children's needs is increasingly challenged by growing caseloads and waitlists. Figure 18 displays data on the growth in SSP caseloads over time, as well as 2020-21 waitlist totals. It shows that caseloads increased dramatically and extended waitlists developed for three of four SSPs for whom data was available. In some cases, children might wait as long as a year before receiving services through a SSP.[dcclliii]

Some SSPs who reported difficulty meeting the need for services also indicated that they had been funded for far fewer positions than requested or were uncertain about the availability of funding for hiring additional, needed, staff.[dccliv,dcclv,dcclvi] This placed a heavy burden on service providers. One front-line worker noted:

> Between all seven of us there's 2,500 kids that we have to provide programming for. So it's really difficult. And then there's still some more kids waiting, right?[dcclvii]

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

> We have grown, like I said from 91, we are now at 255 children who are in our program, which puts us up around over 1,000 when you include siblings and the family whether they are parents or grandparents or relative or even, you know, a caregiver of, whatever their role is.[dcclix]

Interviewees also noted that there were long waitlists for off-reserve services. For example, one person cited a case in which there was a six month wait for youth with complex trauma and high corresponding needs to see a mental health worker.[dcclx] Long wait times persist even though the need for widespread reforms to mental health services in the province has been highlighted for many years, and the Manitoba Advocate for Children and Youth has linked ongoing gaps in services to child deaths.[dcclxi,dcclxii,dcclxiii]

One SSP succinctly summarized the dilemma of meeting First Nation children's needs.

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

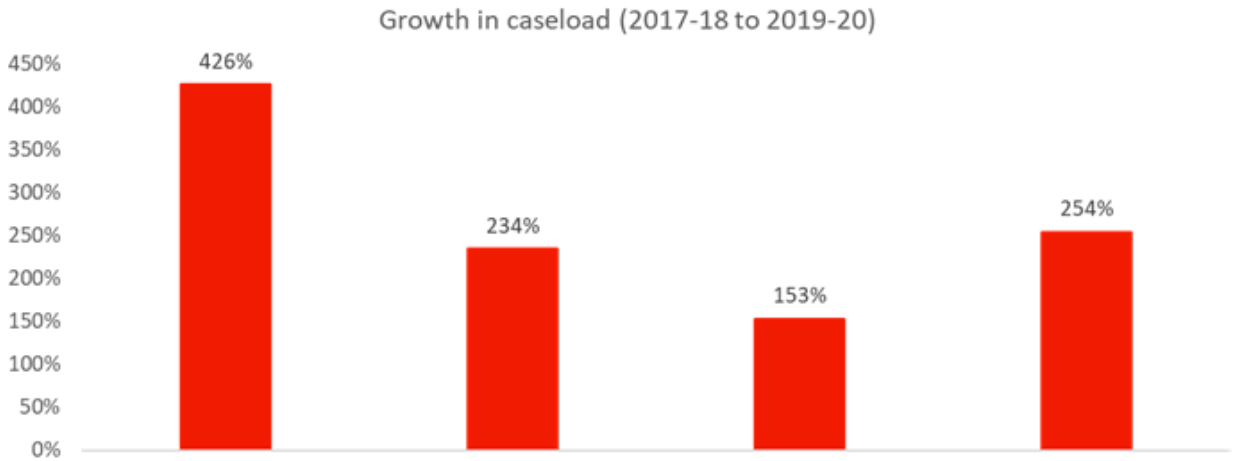
Further reflecting on the situation, the SSP described a current strategy for dealing with caseloads and waitlists.

> We have prioritization systems. And so, you know, where there's a – especially urgent need, we try to respond more quickly … there are some – definitely some ethical trade-offs inherent in this approach. If we have a clinician in a community with a small number of

> children and more referrals come in from the same community, we will prioritize those because we already have someone there.[dcclxv]

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

Figure 18: Percent growth in SSP caseloads between 2017-18 and 2019-20, and 2020 caseloads and waitlists[dcclxvi,dcclxvii,dcclxviii,dcclxix,dcclxx,dcclxxi]



	SSP 1	SSP 2	SSP 3	SSP 4
2020 caseload	721	612	2668	7722
2020 waitlist	375	0	1546	1570

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

4.3.3 Significant gaps in services

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

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

In addition to these specific gaps in service, interviewees and focus group participants spoke of additional, ongoing difficulties accessing services because of factors such as a lack of necessary coordination, lack of sufficient

clinical capacity, insufficient physical and digital infrastructure, and other issues that are discussed in more detail in other sections of this report.

4.3.3.1 Youth over age 18

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

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

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

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

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

Many interviewees noted that disability can extend across the life span and asked what happens when a child reaches the age of 18 and retains the same level of needs without the corresponding services.[dcclxxxvi,dcclxxxvii,dcclxxxviii] They pointed to the Home and Community Care program as the only option on-reserve and noted the inadequacy of this program when it came to the needs of youth with long-term disabilities.[dcclxxxix,dccxc] One Case Manager noted that:

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

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

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

Another described children living in First Nations as being:

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

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

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

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

Another described years of effort to secure funding for a program that would support youth transitioning to adulthood.

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

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

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

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

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

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

4.3.3.2 Safe and adequate housing

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

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

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

> When I came on we did have one kid that needed a lift in his home. He needed a washroom … The mom was carrying him all the way from his room all the way to the end of the hall just to bath him … So those were things that were happening. And the home was not equipped to meet his needs … he was on oxygen and you know, there were times when he'd run low on that right? So the ambulance would have to come and there were all these struggles

> getting the stretcher into the hall because the halls weren't built for stuff like that.

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

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

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

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

A SSP drew attention to the fact that housing modifications through Jordan's Principle were only available to children with disabilities, sharing a story that highlighted the very real and immediate ways in which housing was needed in order to meet the needs of other First Nation children.

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

Service providers also noted the ways in which the poor and limited housing quality curtailed the capacity to deliver services required to meet the needs of children and families. One service provider pointed out the fact that overcrowded housing limited the possibilities for out-of-home respite care, which allowed caregivers to rest and relax within their own homes while their children were cared for elsewhere.[dcccvi] Another drew attention to the challenges of providing housing for service providers who visited the communities for multiple days.

> Availability of accommodations in community was actually a very common reason to have to cancel a visit. Or it impacted the ability of the whole team, if I think of [a multidisciplinary team of three service providers] going in together and working together, impacted their ability to go in together, which is, you know, I think that was challenging.[dcccvii]

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

> There are numerous, numerous communities and homes that their homes are not, not livable, but that's what they have. I know there's a sense of embarrassment that numerous families that I am involved in have stated to me, so they don't want us in their home … So, when a child is having behaviours and especially as generalized to the home and only the home, that makes it difficult for us because we cannot help to distinguish that behaviour or replace that behaviour because of the environment. Of course, we are willing and open to meeting anywhere and everywhere that the family wants to meet, and we do our best to replace that behaviour, to generalize it elsewhere. But it is a barrier.[dcccviii]

Jordan's Principle can, in theory, currently fund the modification of homes to meet the needs of children with disabilities. However, Case Managers noted multiple challenges accessing funds to modify housing. They described a long and extensive application process that requires support letters from the Housing Department, Chief and Council, and the Director of Health. Applications must also include a labor quote and materials quote that cover the costs of the renovation. In addition, an Environmental Health Officer has to do the required assessments. This is another hurdle for communities as Environmental Health Officers only visit three to four times a year, for only two to three days, and doing assessments is not their only responsibility.[dcccix,dcccx,dcccxi]

The complications and delays in approval of housing modifications through Jordan's Principle were further exacerbated by shifts in decision making procedures. Housing requests were initially assessed by the regional FNIHB office. However, at some point, this changed and applications were sent to the national office in Ottawa in order to assess whether housing modifications could be supported through existing housing programs and budgets. Many requests were denied at the national level, with no clear explanation, even though the supporting letters and assessments verified the need for home modification.[dcccxii,dcccxiii,dcccxiv] Case managers noted that, as a result of the restrictive approach to housing modification funding, they know of long lists of families whose housing needs have gone unmet. In addition, they noted that, in some cases, they waited several months or over a year to get a response to housing modification requests.[dcccxv] By early 2021, a regional Jordan's Principle coordinator noted that decision making around housing modification had recently reverted to the regional office and, though there were still restrictions on the range of requests that could be approved, modification requests were once again being approved regionally.[dcccxvi]

4.3.3.3 Remote, northern Nations

Manitoba covers a vast geographic area that encompasses nearly 650,000 square kilometers.[dcccxvii] The geographic remoteness of some First Nations plays a significant factor in the implementation of Jordan's Principle. In Manitoba, there are only four large service centres where supplies, materials, equipment, a skilled or semi-skilled labour pool, financial institutions and provincial health, social, and environmental services are available: Winnipeg, Thompson, Brandon, and the Pas. Only four First Nations are within 50km of, and have year-round road access to a service centre. An additional 39 First Nations have year-round road access, but are 50-350 km away from a service centre. One First Nation is over 350km with year-round road access, and 17 First Nations have no year-round road access.[dcccxviii] These 17 fly-in First Nations are the most remote in Manitoba. However, road conditions, weather, and the distance required to access a service centre can also present challenges for Nations that are less than 350km from a service centre and have year-round road access. Geographic remoteness presents unique barriers to the implementation of services in rural and remote First Nations; Case Managers and service providers indicated that the resources currently available through Jordan's Principle were not sufficient to address these barriers.

Extensive travel demands prior to the COVID 19 pandemic limited the time that service providers could spend in remote First Nations and highlighted the urgent need for capacity building to develop a cadre service providers, who live and work in First Nations, in order to ensure continuity of care.[dcccxix] SSPs indicated that building relationships with children and families in remote First Nations was challenging due to limited time spent in the Nations.[dcccxx] Organizations also struggle with expanding waitlists and limited additional staff to meet needs, which sometimes results in Nations with more referrals receiving services more rapidly than small, remote communities with fewer referrals.[dcccxxi] One of the SSPs described the challenge of serving small, remote Nations this way:

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

The challenge of having limited time in remote communities was related to challenges in travelling to remote First Nations. The logistics of arranging appointments are complicated and dependent on factors like weather and road accessibility, which cannot be controlled. A SSP explained:

> What is often challenging, is the accessibility, the distance to get to

> communities and then you just add that distance, and if it's multiple flights, there's multiple opportunities for weather or whatever [to] interfere.[dcccxxiii]

The difficulties in travelling to communities are compounded by limited access to costly internet services, which present a challenge when attempting to contact Nation based service providers, families, and children.[dcccxxiv]

A SSP explained how the lack of infrastructure interferes with providing services to First Nations and increases their waiting list:

> Our clinicians all carry 25 to 40 cases, which, for social work therapists, would be, you know, considered max. Over 40 becomes overwhelming. And people have bumped up to 45 and we need to help them – and then, the family might not be in agreement, there's lots of logistic problems with communication. Number of homes without telephones, without Wi-Fi or internet, there's all sorts of issues around that. So, we – our waiting list can sometimes be a reflection of that, you know, like, what's the technological resources in the community that allow us to connect.[dcccxxv]

Telehealth services provide some access but burdensome booking processes and limited access to costly internet infrastructure remains a barrier to wide scale implementation.[dcccxxvi]

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

> I think one of the biggest things was when we first started in community, we did have some families that just had trouble getting to appointments. We had one family where she would get the funds to take her child to his appointments, and he has a disability and needs to go at least monthly and he would – she would get the funding for it, but then her ride wouldn't be able to take her. So she would miss the trip to go to the appointment. So they – the clinic where she was taking her child phoned Child and Family Services and said you need to check on this family, this child is not getting in for their appointments and needs to be getting in for their appointments. So, Child and Family Services stepped in. I think they helped with transport once or twice and then we started in the community. So, that family has been the longest family I've been working with. They're the first family we started working with. And it's just a young single mom with no driver's license, no vehicle. And very great – like amazing with keeping track of her child's appointments and all of his needs. But we just take them every time they need to go, we book a hotel room, and I book a driver and they go and get to all of his appointments. And she now brings him to see physiotherapy and occupational therapy right in the community, she doesn't have to travel out for that, or not get to those appointments … And

> he's come a long way; he's gotten some great therapy, things for the school, a new bike, different things that are helping him in the classroom.[dcccxxviii]

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

> The system with medical services is just a pain. So, when a child has to go into Winnipeg, we still have some parents that do fly in but require a second escort for the child. But that's been our nightmare. Because they don't – they won't provide a second escort for the child unless there's all this paperwork completed. And … it has to be a severe situation before they approve. So, like the little guy I just talked about, they finally approved him to have two, both his parents to go in with him because the mother can't lift him.[dcccxxx]

Once in the city, it was difficult to get appropriate accommodation or even basic transportation.

> I don't know if you're aware they stick them in these boarding homes and these children can't, especially the autistic children, they can't handle the noise. And they're particular of things and try and get them, you know, accommodations other than the boarding home or their crappy hotels that they have. So that's been the major issue. So we've having to pay … out of our funds to put them in a hotel where we know they're going to be safe. … When these people go in, like they're on hold for about an hour, two hours, you know, just to get a taxi from point A to point B or a flight. You have to call once you arrive in Winnipeg and say I'm in Winnipeg I need to – I'm here so I need a taxi.[dcccxxxi]

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

Another serious challenge for remote communities was the additional expense and complication of acquiring equipment and supplies. A Case Manager speaking during a TAG meeting explained:

> We're limited in our time and if we have the choice to do it by freight or plane, it's costing a fortune, and that's coming out of our budgets that are for our program where that can be going to a lot of other things and we can be doing for the kids. It costs us $4,000 to bring something up that other communities don't have the issue with because they're driving. It's a barrier.[dcccxxxiii]

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

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

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

4.3.3.4 Off-reserve First Nation children

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

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

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

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

It is unknown whether an Off-Reserve Case Manager was involved in the child's case, and might have been able to arrange access to alternate services. However, the SSP's colleague summarized the situation succinctly, noting that all communities – First Nations and non-First Nations – are underserved when it comes to mental health, but the pathways to accessing services now sometimes seem clearer

on reserve.[dcccxl] Other interviewees noted that Off-Reserve Case Managers have not had the resources to do extensive off-reserve education about Jordan's Principle and noted the differences in the way Jordan's Principle funds were allocated on reserve, where the emphasis was on the systemic extension of services, and off reserve, where funding is primarily allocated to address the identified needs of individual children.[dcccxli,dcccxlii]

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

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

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

The challenges that off-reserve First Nation families face in accessing services are compounded by the fact that the provincial government has no special mechanisms for addressing First Nation children's needs through Jordan's Principle. A 2018 statement from the Manitoba Departments of Health and Families noted that the departments generally take a family-centered approach that may allow for provision of supports above normative standards in order to overcome barriers such as those "related to geography/human resource."[dcccxlv] However, the statement also noted that, in cases involving First Nation children living off reserve, "any requests for services or funding are responded to in the same manner as they would for any other child living off reserve."[dcccxlvi] We could find no evidence that this provincial approach to Jordan's Principle has been meaningfully modified.

Cumulatively, observations by study participants raise important questions about whether First Nation children living off reserve are receiving equitable treatment under Jordan's Principle. Some participants pushed this line of inquiry even further and noted the ethical questions they faced around denying

services to non-First Nation children who lacked access to needed services that are available to First Nation children through Jordan's Principle. Some service providers noted that the provision of additional services to First Nation children is in keeping with the goal of achieving equality of outcomes for First Nation children, yet others noted the moral challenge of denying these services to Métis or other children in urgent need of support.[dcccxlvii,dcccxlviii,dcccxlix]

4.3.4 Ensuring equity and self-determination

The services provided through Jordan's Principle vary widely across First Nations. In some cases the variation across Nations reflects purposeful decisions taken to advance self-determination and tailor services to the needs and contexts within a particular Nation. In other instances, however, variation across Nations reflects pre- existing disparities in resources and capacity.

As discussed in chapter two, First Nations in Manitoba have long advocated for self-determination in services. An approach in which First Nations were asked to propose their "dream project" and then extend beyond that initial request has allowed Nations to build on existing strengths and resources. The flexibility at the Nation-level can be seen in variations in the structure of Jordan's Principle. In keeping with a federal interpretation and presentation of Jordan's Principle that was initially limited to "children with a disability or interim critical condition living on reserve" most First Nations in Manitoba established Jordan's Principle programs within the structure of health services.[dcccl] However, some Nations have chosen to house Jordan's Principle operations within education and, in at least one Nation, Jordan's Principle is now a separate department that exists alongside health and education. Textbox six, which compiles the services that 31 Jordan's Principle Case Managers identified as being funded by Jordan's Principle in their Nations highlights additional variation in focus of and approach to the implementation of Jordan's Principle across First Nations. Some Nations incorporate a strong focus on meeting basic needs through services such as emergency assistance, monthly foodbanks, or school lunch programs. Others may build on the expertise and knowledge of Jordan's Principle Case Managers and staff to emphasize, for example, early childhood development.

A TSC discussed variation within the Nations she worked with:

> One community was running out of the nursing station, so it's still health but it's a different – that's through the nurses' station. And then I think one of the communities was kind of off on their own, but they are a really small community. I think they're a community of like 100. So they had a complete different approach to how they're delivering their programs. They had their own building. So … it looked like a daycare but it wasn't. But it was welcoming and warm and they had a lot of equipment for children who may have had disabilities or sensory items that are specialised. You would think they look like a daycare, but it was strictly their Jordan's Principle building.[dcccli]

A SSP working with multiple Nations also spoke about the differences in approach across Nations.

> As I mentioned, what each community does is … very different from community to

> community. A lot of them operate as almost a, I would say a school tutoring service, where children get one-to-one EA time with, you know, a child development worker at the Jordan's Principle setting and then they go back to school. Other times … programs are primarily devoted to land-based teachings and they go out and do community activities, you know, fishing, hunting, all kinds of stuff and that's the primary focus of programs; others are after school programs.[dccclii]

The flexibility in approach to implementing Jordan's Principle allowed First Nations to tailor programs and services for the unique context and needs of their Nations. A SSP worker highlighted the importance of this flexibility, pointing to the ways in which even very basic decisions about the range of services available might be shaped by a Nation's context.

> With ourselves and I think three or four other … provincial agencies, that's like four to five different agencies within even a small community, which I think is overwhelming. … So I feel like that needs to be looked at, and also if you have a very small community … what does the community need? What's better for them in terms of how many outsiders are coming in?[dccliii]

Others discussed the ways in which the flexibility in approach to Jordan's Principle has allowed some Nations to use Jordan's Principle's programming as a way of revitalizing culture and tradition. One Case Manager noted that, within her Nation, Jordan's Principle had a strong focus on language.

> We are revitalizing our language and our culture and our traditions, but with care because a lot of our people do not speak Ojibway– [name of community] is not a predominantly language-speaking community. We've lost our language here, so we're really hoping to reclaim the language.[dcccliv]

Another Case Manager highlighted a focus on tradition.

> Tradition is coming back to the community. We've included every child in the community in our Jordan's Principle program. The younger generation – and I'm talking about the Generation X like between 30 and younger – they're interested in traditional cultures and bringing that back. So I'm glad that we have that avenue within Jordan's Principle to sort of bring that back to the community. They have their traditional things that they do; like they hunt, they trap, they fish.[dcclv]

Reflecting on the impact of Jordan's Principle programming that is tailored to the different needs of diverse Nations, one SSP described Nations as "thriving." She spoke of:

> A proudness throughout the communities that they're able to offer this to each and every child there. I think that that has going really well. It's [Jordan's Principle] promoted employment throughout the community. It's promoted education throughout the community whether it's certain organizations offering workshops. I know that individuals, even parents have attended, and they walk away with that sense of pride just having that extra education.[dcclvi]

Other interviewees and focus group participants noted the success in Jordan's Principle implementation, while also highlighting challenges. One SSP suggested that she saw an evolution over time in the focus of Jordan's Principle at the Nation level, she noted potential gaps in services while Nations were still developing their Jordan's Principle programming.

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

Another interviewee pointed to disparities that can emerge in Nations that have made strong progress towards developing a system of self-determined services. The SSP noted that some Nations with sufficient capacity choose to opt out of shared services, such as those provided through SSPs or school systems. In doing so, the Nations gain greater control over finances and decision making, but lose the economy of scale that is crucial when hiring and retaining clinicians with specialized skills that are required by only a very small number of children in any specific Nation. The SSP's observations posed the question of how Jordan's Principle and/or other federal funding mechanisms could support self-determination in services while also better ensuring equitable access to services for all First Nation children.[dccclviii]

A focus group participant pointed to the need for guidelines and standards to support consistency across Nations, even when Nations were receiving services from the same service provider.

> The way that each community was doing their intakes, and what information would be provided, was very diverse. And so you may get the information that you needed from one community, but the other communities … didn't give the information that you needed.[dccclix]

Another focus group participant reflected specifically on flexibility for Nations to tailor and develop Jordan's Principle to meet unique needs, saying, "I think, it is one of the strongest points of Jordan's Principle, but it's also a bit of the Achilles heel."[dccclx] She gave an example of a Nation that has only recently begun to develop services through Jordan's Principle.

> Their coordinator has been in the position for about a year. She came into the position with almost nothing established as far as Jordan's Principle programming. And she doesn't have the infrastructure; like, she's got an office, she's got one person who's kind of helping her. She's fly in, fly out herself. And COVID … there was no kind of outline of what she was supposed to do. She doesn't know, because she's new to the thing, the community doesn't know, because they've never had it before. So what she's doing is very vague and she herself is just struggling. And the community itself is responding and saying, "Hey, you're not doing anything, why aren't you doing anything? Nobody's helping us." It's a very – you know, a very difficult position to be in as an individual.

> But at the same time, if somebody came in with a template in this community, it wouldn't work either. So … they have to go through these growing pains, they have to figure this out. They have to figure this out for that specific community, but it's a really tough job, right. This is hard, and it's probably going to hit some more bugs. How they're going to work through those relational pieces between Jordan's Principle and the community, takes a lot of work.[dccclxi]

Survey responses from Case Managers in 31 of 63 First Nations in Manitoba also suggest that some First Nations are falling behind when it comes to provision of services through Jordan's Principle: while some Nations reported many as a dozen, distinct types of Nation-level services provided through Jordan's Principle, others reported only a couple. The pronounced variation in the number and range of services provided suggests more than purposeful choices around the approach to or focus of services and points to disparities in the benefits that different Nations have been able to secure through Jordan's Principle.

A Case Manager summarized the ideal balance between self-determination and ensuring consistency, and equity, in services.

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

The challenge of ensuring a consistent baseline is a complicated one because it involves assessing and developing services across health, education, and social domains. As discussed in depth in chapter one and exemplified by figure three (chapter one) depicting disability services, the pre-existing complexity of health, education, and social services presents further barriers to implementing a consistent baseline in Jordan's Principle programs. The complex pre-existing service systems require Case Managers to have extensive knowledge of diverse, and often highly specialized, service structures that respond to equally diverse needs across children and families. Interviewees and focus group participants noted the difficulty of learning about and navigating the complex system of services that could potentially support children and families. They called for additional supports and training for Case Managers and Jordan's Principle staff to help them understand the available resources.[dccclxiii]

Given the relatively short duration of the implementation of Jordan's Principle in Manitoba, many participants focused on the initial challenges to the development of a system of services. However, existing literature that takes a systems approach to understanding services suggests that challenges to developing effective service systems are not confined to the initial development period. This literature outlines the range of "infrastructure/sub-systems" needed to support effective service systems and posits that effective service programs require linked infrastructures to align and coordinate diverse sub-systems including: governance; finance; program quality and standards; assessment;

data and accountability; human capacity; and family and community engagement.[dccclxiv] Weaknesses in, disconnections between or misalignment of any of these sub-systems pose challenges to the equity, quality and sustainability of services.

In the context of services for First Nation children, such weaknesses, disconnections or misalignments might also compromise self-determination in services. The challenges of building effective service systems are pronounced in any context. However, the stakes are higher in the case of Jordan's Principle, in which Case Managers must have the skills and expertise to support the development of services that cross health, educational, and social domains. These challenges may be amplified in a context in which a century of underfunded and discriminatory services have undermined key subsystems – such as those that support the assessment of need, the collection and analysis of data, and the adoption and implementation of policies which help ensure organizational accountability.[dccclxv,dccclxvi,dccclxvii,dccclxviii] Extensive supports are required to ensure that all First Nations in Manitoba are able to realize an effective, self-determined system of services through Jordan's Principle. In chapter five, we examine the types of supports that participants in this study identified as being important, considering both the attempts to provide those supports within the current implementation of Jordan's Principle and the ways in which the supports provided can be improved and expanded.

Textbox six: Range of Jordan's Principle funded services/supports across First Nations[dccclxix]

- Respite care (Group and in home)
- Mental health & wellness supports
- Occupational Therapy (+ assistance)
- Physio Therapy (+ assistance)
- Speech & Language (+ assistance)
- Behavioral Health Clinician
- Rehabilitation services
- ASL supports
- Medical supports (including pediatrician and physicians)
- Dental supports (including braces)
- Vision supports
- Audiology

Pediatrician Education Assistants
Education support (including tutoring)
Land Based Education & Activities
Language classes
Land based healing and one-on-one counselling
Cultural Worker
Traditional teachings
Cultural/spiritual services
Weekly playgroup Outdoor education
One-to-one/group Mentorship

Youth Recreational Services
Youth Leadership Training
Weekly preschool program
Homework club
Child Development Workers (in health & education)
Development centre for children ages 0-4
Supports for families/caregivers
Parent Advisory Group

Advocacy
Training
Screening Clinics
Clinical assessment
Case management
Referrals
Cooking classes
Monthly foodbank
Assistance with healthy foods in school
Emergency assistance
Lunch program for school children

Life skills training/supports
Support for basic needs
Fitness assistance
Medical/other transportation
Medical equipment
Laptops
Community Events
Group activities
Partnerships with school/CPNP

5 MOVING FORWARD: SUPPORTING SELF-DETERMINATION IN SERVICES THROUGH THE IMPLEMENTATION OF JORDAN'S PRINCIPLE IN MANITOBA

In chapter four, we examined key themes in evaluation participants' descriptions and discussions of Jordan's Principle. We learned that, within Manitoba, Jordan's Principle has quickly expanded the services available to First Nation children, by laying the foundation for a system of services in which First Nations have the flexibility to tailor services to the needs and contexts of their Nations. However the systemic approach to Jordan's Principle implementation is undermined by: continued gaps and disparities in services; a demand driven approach to short-term funding; and a discretionary, federal approach to the implementation of Jordan's Principle in Manitoba. The current Jordan's Principle policy framework excludes vulnerable groups of youth from access to Jordan's Principle and under-resources key services. Participants also pointed to disparities in Jordan's Principle services across Nations and highlighted the need to engage with the difficult task of supporting self-determination in services while also ensuring equitable services for all First Nation children.

In chapter five, we build on this final theme, drawing on our analysis of interviews, focus groups, and policy documents to summarize the supports that policy experts, Case Managers, Service Coordinators, and service providers identified as being critical to the further development of Jordan's Principle in Manitoba. We organize participant reflections around five major themes.

- There is a need for increased coordination and collaboration across organizations, First Nations, and at the regional levels of the implementation of Jordan's Principle;
- There is a need for more systematic approaches to data collection, data sharing, and translation of knowledge related to Jordan's Principle in Manitoba;
- There is a need to identify promising practices[19] in the development and provision of services for First Nation children and to support the development of policies that maintain the flexibility of the current approach to Jordan's Principle while also ensuring a consistent baseline of services across Nations and organizations;
- There is a need for the development of physical and digital infrastructure that supports effective and meaningful engagement with children and families with a broad range of needs;
- There is a need for a long-term approach to funding and capacity building that supports First Nations in moving towards a system of services that is truly self-determined.

[19]Promising practices have specific characteristics including: the advancement of First Nations health, inclusion of diverse perspectives and experiences, support by stakeholders, being well known with historic success, adaptation to community context, and (when possible) formal evaluation. Promising practices are developed by the communities they serve, and integrate contextual specificity in terms of culture, community values, and evidence based practices.

5.1 Coordination and collaboration

As described in chapters three and four, the approach to the implementation of Jordan's Principle in Manitoba involves programs and services developed at the Nation level that are complemented and supplemented by a network of regional level organizations which deliver and coordinate access to services. The implementation of Jordan's Principle has greatly expanded access to services for First Nation children, but it has also challenged pre-existing leadership and service provision structures. Tensions tied to the implementation of a new system of services, that cuts across service domains and levels of decision making, have sometimes been amplified by a discretionary, federal approach to decision making that has simultaneously enabled rapid development of a First Nations – led system of services and bypassed consensus building processes.

Within this context, interviewees and focus group participants identified a need for ongoing collaboration and dialogue at the regional, Nation, and child/family case level. Collectively, they called for collaboration that supports and facilitates local leadership while also building consensus around systems of coordination to enable: more consistent information sharing, development of shared standards, and access to the supports needed to realize self-determination in services.

5.1.1 Regional level

At the regional level, several interviewees spoke of competition and lack of collaboration between regional level organizations. They noted that a lack of transparency around funding allocation created tension and perceptions of unfair treatment. Interviewees called for the development of more open working relationships between First Nations, service organizations, the federal government, and the province of Manitoba.[dccclxx,dccclxxi,dccclxxii,dccclxxiii] AMC Chiefs resolutions have clearly outlined mechanisms through which regional collaboration could be embodied. For example, in September 2016, shortly after the announcement of the Jordan's Principle CFI, the AMC General Assembly passed a resolution calling for the formation of an intergovernmental task force to "define the ethical, moral, and legal authorities for implementation of Jordan's Principle including but not limited to: legislation and First Nations governance standards" that "Uphold the implementation of Jordan's Principle to its fullest extent."[dccclxxiv] This task force was never established.

Building on this call for the collaboration, in July 2018, an AMC General Assembly resolution called for the establishment of a Jordan's Principle Equity Roundtable that would facilitate collaboration and coordination around the implementation of Jordan Principle in Manitoba. A structure for this roundtable was approved by the AMC Executive Council of Chiefs in early 2019 (see figure seven in chapter two).[dccclxxv] A key component of this proposed structure was a "service delivery specialists" group that would bring together Case Managers and Service Coordinators from across Manitoba. An interviewee explained the importance of this group.

> Having First Nations that are on the ground, coming together to talk about issues, share information and identify potential regional directions to go forward. I think that, regionally, that's a good thing.[dccclxxvi]

Due to COVID-19 related issues and human resource restrictions, the Jordan's Principle Equity Roundtable has not yet been established. However, AMC has regularly organized meetings of a TAG that, during the period in which COVID restrictions have been in place, has emerged as a forum that brings Case Managers together to share information and address challenges in Jordan's Principle implementation. Specialized service providers and the regional Jordan's Principle coordinator are also invited to share information with this group on a regular basis.[dccclxxvii,dccclxxviii,dccclxxix,dccclxxx]

Alongside the TAG, another group brings together TSCs, SSP staff and representatives of the FNIHB regional office.[dccclxxxi,dccclxxxii,dccclxxxiii] Interviewees indicated that this TSC/ISC/SSP group has also evolved over time. It initially emerged as a forum in which TSCs with in-depth knowledge of the context in First Nations were supporting SSPs in building connections with and adapting their practice for work in First Nations. Over time SSPs gained familiarity with First Nations and the TSCs group experienced significant turnover; group dynamics and focus shifted accordingly. In the fall of 2020, the TSC/ISC/SSP group was expanded to include some Case Managers and representatives of other regional organizations. However, meetings were suspended at the end of 2020 because of COVID-19 related responsibilities and constraints.[dccclxxxiv,dccclxxxv,dccclxxxvi]

Interviewees indicated that a lack of open communication and coordination between the TAG and TSC/ISC/SSP group sometimes created inefficiencies and duplication of efforts.[dccclxxxvii,dccclxxxviii] One interviewee noted:

> There were Tribal [Council] Service Coordinator meetings, but then there were TAG meetings. Sometimes they were speaking on exactly the same stuff that Tribal [Council] Service Coordinators were talking about and meeting and working on … but there was no formal communication between the two.[dccclxxxix]

Both groups were working on the development of tools to support Case Managers in Jordan's Principle implementation. As discussed in section 4.2, the lack of coordination and collaboration between these groups has already led to some instances of inefficiency and discord. Continued disconnection between two groups working along parallel lines risks further inefficiency or duplication of efforts. In addition, there is potential for confusion, if Case Managers are presented with alternate sets of tools or supports that do not align, and for further division moving forward. In the best case scenario a lack of transparency about the roles, goals, and activities of the two groups might result in Case Managers and other service providers missing out on opportunities to contribute to, participate in, or benefit from their efforts.

5.1.2 Nation level

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

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

In addition, Case Managers highlighted the importance of collaborating with other programs and service providers working within the Nation.

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

A SSP discussed the initial steps towards developing similar collaboration in another Nation.

> In one of our communities, we held a, we called it a "systems meeting" and we involved the school, the Jordon's Principle, and every single organization or clinician … within that organization that was involved in the community as a whole. CFS was involved as well in that meeting and we felt if we had everyone at the table and we were able to outline each and everyone's role, and we thought without, of course, acknowledging children or their names at this point in time just because we're all in the community, right. I mean we can't divulge that information on who's working with whom, but we thought if we could just start that way.[dcccxcii]

Because of COVID-19 related restrictions, they have not yet followed up on that initial meeting. However, the SSP framed the simple sharing and clarification of roles as an important first step towards avoiding duplication of efforts and ensuring more efficient services. Another SSP provided a contrasting example.

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

In this situation, collaboration between Jordan's Principle services and the nursing station, to ensure that the needs of children

and families are addressed, might support the extension of existing holistic team services to teens, facilitate the submission of a group request to support expansion of services, or open up other strategies for addressing the identified gap in services.

In some situations, like that of EAs who work within schools but are hired and supervised by health-based Jordan's Principle programs, collaboration is needed to ensure appropriate, day-to-day management and support for Jordan's Principle staff. In these situations, EAs are hired to support children in school, but the effectiveness of their support depends on coordination and collaboration with teachers and other school staff. Those who work alongside an EA, in the school, on a daily basis, are best positioned to provide the EA with feedback based on observation of their work with children. School staff also assume responsibility for ensuring that EAs are incorporated into school activities in a meaningful way, have adequate space to utilize specialized equipment, and have clear channels for communicating and discussing any questions or concerns they have about children's care.[dcccxciv,dcccxcv,dcccxcvi,dcccxcvii]

A SSP reflected on divisions that can exist between services and identified Jordan's Principle Case Managers as integral advocates that support the development of collaboration.

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

Collaboration between organizations and service providers can enable a coordinated approach to care for children and families.

5.1.3 Child and family level

At the level of work to support individual children and families, collaboration was seen as necessary to ensuring well-coordinated services. One SSP discussed the way in which the implementation of Jordan's Principle has helped facilitate contact between service providers working within the same Nation. When discussing the transition between a service provider working with children aged zero to six and a school-based clinician, she stressed the importance of collaboration during transition.

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

Another SSP pointed to the challenge of initiating services for a child in the absence of this type of collaboration.

> We try to talk to the families and figure out, you know, how come these students aren't coming to school? And then we find out that some of these kids are … not able to come to school, you know, because they have some profound difficulties, or they have some physical disabilities. So we're not told that right away; sometimes the plan itself that they have at Jordan's

> Principle, where they are working with the school involves mental health support, but they have a contracted mental health worker so it's almost like the work is duplicated, which … I don't think that's beneficial for our families and for students.[cm]

In cases like this, establishment of an appropriate service plan for a child is delayed as independent service providers work to understand and make sense of the alternate supports and services that the child is receiving. In the interim the child may potentially be asked to provide duplicate intake information, undergo assessments or diagnoses already completed, or even receive services based on conflicting or misaligned intervention strategies.

Another SSP highlighted the extent of missed opportunities for collaboration and communication when discussing the case of a large family that her organization had been working with closely.

> A really good example was, I had referred seven children to the Jordan's Principle in a community. I'd been working with one of the siblings, and other clinicians have been working with other siblings, and three months later Jordan's Principle referred them all to us. And I'm like, yeah, no, we've already been there for five years, we're waiting on you. [Laughs] So just things like that.[cmi]

The collaboration that study participants highlighted as being important to Jordan's Principle is essential to establishing continuity and coordination of care, which existing research identifies as a key to effective services. Continuity of care refers to the development and maintenance of trusting, ongoing, positive relationships with service providers and coordination of care is a "proactive" approach to collaboration between involved professionals to ensure child and family needs are resolved through "integrated, person-focused" care across organizations.[cmii] While the concepts of continuity of care and care coordination emerge from the health field, both terms highlight a child-centric approach to services that can be extended to other sectors, such as education and social services. Factors that inform continuity of care and care coordination in First Nations context include geographic remoteness, social determinants of health, racism, lack of service providers who speak Indigenous languages, and a lack of culturally relevant services.[cmiii,cmiv]

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

> We are separate from the provincial system, but some fluidity or willingness again about sharing new information to the school [is needed to ensure] … appropriate education for First Nations students, so that occurs anywhere in the province of Manitoba, especially if they're moving into a provincial school division and they've received clinical services from us. So that school psychologist may be unknowingly

> redoing an assessment that was just done.[cmvi]

Another interviewee working with schools highlighted the ways in which decisions about participation in school divisions and systems could also impact continuity of care. The interviewee raised the example of children who were hearing impaired losing access to American Sign Language teachers and other services when their Nations opted out of regional educational supports, noting the negative impacts on the children and their families. This example and others– such as the case described in section 4.3.3.4 of this report, involving an off reserve First Nations child who was not able to access services provided in a nearby Nation and instead had to travel further for less appropriate services – point to the need for more than just informal collaboration between organizations and service providers. Formal protocols and flexible funding mechanisms that support the extension of services across the jurisdictional boundaries that continue to shape services for First Nation children are also needed.[cmvii,cmviii,cmix,cmx]

5.2 Shared case data

In interviews and focus groups, participants highlighted systems to facilitate the sharing of case files and information as being an essential component of meaningful collaboration between service providers. A Case Manager discussed the difficulty of trying to provide case management in the absence of shared case information.

> The unfortunate thing about that is that I don't have access to the information as to which children were receiving services. And the parents themselves, they may have signed consents, but they don't know what's going on and who is receiving what.[cmxi]

The Case Manager indicated that the lack of clear information negatively impacted her ability to provide information to other service providers who might be involved with a child.

> It helps with duplication of services, but it also helps with assessment purposes as well … I want to get my pediatrician to have access to that too because what's happening is, things get lost in translation.[cmxii]

One SSP who felt his organization had been fairly successful in facilitating the sharing of case information noted that Manitoba guidelines make it relatively easy to share information with caregivers' consent.

> In Manitoba we have the ability to, as long as we have consent, to reach out and to make sure that there's a lack of … overlap in service. We want to make sure that we're not just inundating families with services that, first of all, are being duplicated or maybe that they don't even need. And so, it's been pretty easy to communicate with families, but also across service providers to try to make sure that's not happening while making sure that families aren't getting left behind either. You know, I understand it's maybe not set up the same way in other provinces, so that's been a big plus.[cmxiii]

However, another SSP noted that, even when consent is in place, some organizations may be reluctant to share information that would help eliminate the burden placed on children and families when things like psychological assessments are duplicated.

> We do have difficulty accessing clinical reports, for example [organization name]. They're not very forthcoming with sharing, even clinician-to-clinician, reports. Even with parental consent, always parental consent, there seems to be this unwillingness to share that with us, information that would help in terms of this. We are being asked to do a psychological assessment, and they've already collected background information.[cmxiv]

Another SSP highlighted the way in which pre-existing collaborations could be the key to facilitating information sharing, and could even help to mediate access to information for those who had not yet built necessary relationships. Reflecting on a case involving a family that had given consent for information sharing between service providers, she noted:

> So I have a meeting at the school, off I go. And I discover they actually have a, the child actually, the young boy has a diagnosis … and they won't share the document with the Jordan's Principle agency. So Jordan's Principle's making referrals for diagnosis … and I've got consent. So I just literally flipped open my file and said here, mom has signed this, please give me – she wants Jordan's Principle to have a copy of it. So I got a copy of it, it wasn't that hard but they weren't going to give it to Jordan's Principle.[cmxv]

Considering solutions to the challenges in information sharing, some stressed the potential for a shared database. For instance, one Case Manager noted:

> I cannot wait … to have a database that is the same for all of us to utilize across the board.[cmxvi]

As discussed in section 4.2, initial efforts to develop a shared database have been slowed, by COVID-19 related restrictions and responsibilities, but also by questions about: data sovereignty, who should lead the database development project, and how to select a database contractor to carry out the technical aspect of database development.[cmxvii] Looking forward to a time when these tensions and questions have been resolved, a participant identified a shared database as being a mechanism for more than just the sharing of case-level information. She envisioned it as a means for First Nations to address the gaps in available information about Jordan's Principle and to continue work toward more systemic approaches to addressing existing gaps in services.

> So I think that could also be a role of First Nations, to determine a way to collect our own data that's meaningful to us, that is housed by us, that's interpreted by us, and shared by us. So that's something that was big, I thought there'd be a lot more information and streamlined data, but it's not. And I think that's also very problematic in terms of there is always one off, the cases are resolved, one at a time.[cmxviii]

Another interviewee expanded on the need for data systems that support regional analysis. She explained that it is difficult and unrealistic to address needs if the extent of the underlying problems are not clear. She called for systems for monitoring both access to services and underlying needs as well as ways of linking data

on underlying need to environmental issues such as the availability of clean water.[cmxix]

In the long term, a shared database could also potentially support the assessment of the distal outcomes of Jordan's Principle that should be the ultimate test of Jordan's Principle implementation. However, time and resources are needed to support the development and effective implementation of such a database. The required resources include not only those to support database construction, but those needed to develop, disseminate and provide ongoing training around data sharing protocols. Resources to develop, disseminate, and provide ongoing training around standards of data entry will also be needed in order to ensure that the data collected is complete and consistent enough to support rigorous analysis.[cmxx,cmxxi,cmxxii]

5.3 Promising practices and policy development

Data sharing protocols are one example of policies, or tools for supporting promising practices, that may foster the development of a baseline of equitable services across service providers and Nations. Data sharing protocols may help to eliminate the possibility of delays and disruptions in service that can occur when service providers have not established strong, informal systems of collaboration and coordination. Study participants who called for the establishment of a baseline of services across all First Nations in Manitoba implicitly pointed to the need for additional policies and/or widely disseminated information about promising practices to support the establishment of equitable services for First Nation children throughout the Manitoba region.[cmxxiii,cmxxiv]

Some participants made this call more explicit, being careful to note that any policies or promising practices should respect the self-determination of Nations. One SSP called for:

> Striking the balance between the sort of very unique Manitoba model that we have, which is very decentralized, maintaining that autonomy community to community to do what it needs to do, but also, have some means of, you know, sharing best practices or even best practices specific to communications, that we're aware of what's happening in this system, you know, with a decentralized system, it's really hard to keep track of what's going on. And so, that's an area, I think, for future focus, as well, is striking that balance between autonomy and … yeah, good communication.[cmxxv]

Another interviewee explicitly noted a preference for dissemination of promising practices, rather than establishment of policy, in order to strike this balance.

> They don't want policies in place right now when it comes to Jordan's Principle, because all our communities are so different. I think it'll be hard to have one overarching policy of Jordan's Principle for all of the programs.[cmxxvi]

The clearest calls for definition of a policy framework were related to respite care.[cmxxvii,cmxxviii, cmxxix] Respite care was a focus of the initial implementation of Jordan's Principle in Manitoba and is currently the Jordan's Principle service most commonly offered across First Nations.[cmxxx, cmxxxi] The development of respite care has been carried out on a Nation-by-Nation basis, but programs share some basic, common elements. Jordan's Principle

Case Managers assess families' and children's needs in order to determine the hours and details of, as well as the compensation for, respite services.[cmxxxii] Some Nations provide respite workers for families, other Nations allow families to choose a trusted caregiver who is already known to the child, and some Nations utilize a hybrid model.[cmxxxiii] Respite services allow primary caregivers a break from their constant caregiving duties. They can also play an important role when a child must travel to an urban centre for services or treatment; a respite worker can provide someone to stay in the Nation with a family's other children while primary caregivers travel to the urban centre and may also provide care to a hospitalised child while the primary caregiver(s) return to their Nation for brief periods of time.[cmxxxiv]

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

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

Without the benefit of recommendations around possible respite care standards to guide program development, allocation of respite care hours varies across Nations. One participant described the variation this way:

> One family gets 80 hours bi-weekly, another gets 100, the next gets 50 – but they all have the same issue.[cmxxxix]

Study participants indicated that the variation in approaches to respite care was a source of tension. Service Coordinators and Case Managers noted that families are aware of the differences across Nations/organizations and will appeal directly to the Regional Coordinator if there is disagreement on the hours or wages provided for respite services.[cmxl,cmxli,cmxlii]

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

approval by the AMC Women's Council.[cmxliv,cmxlv]

Additional initiatives to support promising practices and policy development are also underway. For example, one interviewee indicated that the TSC/ISC/SSP group was working on a promising practices module that could be gifted to communities.[cmxlvi] A focus group member pointed to another initiative that was underway under the auspices of the Jordan's Principle Mental Health Working group formed by the TSC/ISC/SSP group.

> They're trying to develop a toolkit, a mental health toolkit that all communities can use. And it's different, like it's different in every community. It would look different in every community.[cmxlvii]

The emergence of both formal policies, developed in consultation with Case Managers, and flexible tool kits to support promising practices that can be modified and adapted for unique Nation contexts, are important steps forward in the implementation of Jordan's Principle in Manitoba. However, consideration of the ongoing utility of these policies and tools raises many questions that link back to the issues of collaboration and coordination discussed earlier in this chapter. A number of questions surrounding mandated responsibilities remain unclear, including: which organizations have the mandate to ensure that newly hired Case Managers receive best practice manuals and tool kits? Which organization has responsibility for informing new Case Managers about existing policies? Is there a mechanism for monitoring compliance with policies and is such a mechanism necessary? How will new tools and policies link with and build on those already developed? Who will ensure that tools and policies are updated over time?

5.4 Infrastructure development

Another area that interviewees and focus group participants stressed as being essential to the further implementation of Jordan's Principle was the development of both physical and digital infrastructure. As discussed in chapter two, the federal decision to classify Jordan's Principle as an initiative, rather than a program, means that Jordan's Principle funding cannot be used for capital expenses, such as construction or modification of buildings to house Jordan's Principle programs. Across different forms of data collection, participants stressed the urgent need for adequate and appropriate space for Jordan's Principle programming and administration. Twenty-six out of 31 Case Managers responding to a survey indicated that the space for their Jordan's Principle programming was "insufficient."[cmxlviii] In the following explanatory comments, survey respondents expanded on the infrastructure challenges that they faced.

> The space that we currently occupy is not large enough for the current staff.
>
> Lack of space has not allowed for Jordan's Principle Initiative to be implemented sufficiently.
>
> Space is a major issue, staff are in different locations and should be in one building.
>
> [We would be] able to provide more supports if adequate space were available.

> Small community, no appropriate buildings for independent Jordan's Principle space.
>
> The band will be asking us to vacate the building to make way for a training centre.
>
> Jordan's Principle desperately needs their own space for sporting activities, sewing club, Pow wow club, Elder's teaching space and an outdoor rink.
>
> We need sufficient space for our children's programs, *i.e.* sensory room, calming room. Our child development programs also need space.[cmxlix]

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

Some Nations in Manitoba were able to front the costs of constructing a Jordan's Principle building, with the expectation that they could amortize the cost by renting the space to the Jordan's Principle program, or to repurpose existing buildings. Descriptions of the ways that having an independent building impacted Jordan's Principle services point to the existence of significant inequities between those Nations that had dedicated Jordan's Principle space and those that did not. One Case Manager described the new space that her program moved into a year ago.[cmlii]

> It has five offices and a rehab room, a board room. And you know, a comfortable living space, a nice kitchen … And that's the best thing is having our own building because it's so kid friendly. We have, like, a little living room and we have their little furniture out. So they come in there, there's that sense of home when they get to the door. And they come in and they see their little living room with all the stuff that they can sit there and just engage in right away. You know. So we've made it fit, like the colour on the wall is not so white and whatever. It's all – you know, it's all fit to welcome the child into the building, and even the kitchen, like we've had so many of our teenagers just drop in and you know, just come in, heat up a pizza, pop, or say hi.
>
> It has that welcoming effect, and I think that's what makes a difference is they know there's a place that they can go to, even the parents that'll drop by. I need some pampers, and we have those on stock so they know they can come there and get what they need, even wipes. You know, whatever their needs are we have to make sure that we have those things available for them.[cmliii]

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

> One of the things that we've been asking for, for a long time is our own space, our own building. When we first heard about Jordan's Principle, that was my vision as well as the vision of the home care coordinator, is that Jordan's - I have goosebumps, I'm giving myself goosebumps talking about it because it hasn't happened yet. But having our own place where people can go to and they're not pushed out of it, they're not rushed through it. They're not turned away from it. But they can come there with their kids, they can be there if they need to be ...
>
> There's a room for kids to play in. there's a kitchen for us to teach cooking or provide food for families. There's assessment space ... part of our team, got moved to the mall. There's no assessment space in that new space ... that is the one thing that we were asking for the most. There is no way we can take a kid in there that has ADHD, autism, FASD attention issues, sensory issues, there's absolutely no way we can do therapy in that space ... If I had to look five years in the future, that's what we would have. Is we would have assessment space, we would have family space, kitchen, places for child development workers to do their jobs. Families do not want child development workers and therapists coming to their house. There's so much shame about it. There's judgment that they feel. There's - they just don't want it. They want to be able to go somewhere and have the appointment, learn what they need to learn and then take it back to their house. I really think that it could be a community hub for many different places.[cmliv]

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

In addition to the need for physical infrastructure, evaluation participants highlighted a critical need for digital infrastructure. As discussed in section 4.3.3.3, limited access to costly internet services poses a challenge to the provision of services. Interview and focus group participants identified improved digital infrastructure as key to delivering more efficient and consistent services moving forward. One SSP, who expressed a strong desire to return to in-person service delivery, also discussed the potential for remote service provision to play a crucial role, even once in-person services resume.

> I think one of the things that we have learned or had to learn with COVID, is that there is room for technology in the services that we provide and ways that we can incorporate it that can be helpful. You know, a lot of the families that we provide services to ... you know, they don't have access to phone or access to internet or at least reliable

> versions of that. And so, you know, when it comes to doing in person services again, number one, we're going to be able to consistently see those families and those clients again. But also understanding that virtual services can sometimes be faster and more efficient … you know, at the end of the day I think that you do lose out on not doing things in person, but in certain situations if it works then it's there. And now hopefully by the end of the pandemic, communities will be a little bit more open to it and receptive to trying to do those things.[cmlvi]

Another SSP highlighted the potential for remote services to allow for more continuity in services than was possible for service providers who had to travel between multiple communities.

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

Other SSPs noted that digital platforms can mitigate disruptive travel and time away from home by supporting immediate access to specialized supports when crises, such as urgent mental health needs, emerge.[cmlviii]

The long-term failures to support digital infrastructure development across First Nations have amplified the harm caused by the COVID-19 pandemic. For example, a SSP noted that he knew of only a couple schools, out of over 50 served by his organization, that had access to the digital infrastructure needed to support remote schooling and, as a result children in many Nations missed out on an entire year of instruction.[cmlix] In recent months increased awareness and growing pressure has been placed on the provincial government to include First Nations in rural digital infrastructure projects that have been on-going following an August 2020 request for proposals from the provincial government. The province decided to utilize an out of province service provider. First Nations were not consulted/engaged in this decision, which is opposed by AMC.[cmlx,cmlxi] Many unresolved concerns surround the province's plan to extend digital infrastructure, and results remain to be seen. [cmlxii,cmlxiii]

5.5 Capacity Building

In addition to the need for coordination, collaboration, case data, promising practices and policy development, and investment in physical and digital infrastructure, evaluation participants noted a need for ongoing capacity development. Participants discussed a need for diverse educational and training opportunities, they also noted that resources are needed to support development of and participation in capacity building initiatives. Interviewees and focus group participants discussed short-term capacity building efforts that focused on ensuring that Jordan's Principle staff were equipped with the skills and knowledge needed to carry out complex roles and meet the needs of children and families. They also identified a need for intensive, long-term capacity building

efforts in order to develop a cadre of First Nations service specialists equipped with the credentials to lead and staff a First Nations system of specialized services.

As noted in prior studies, Jordan's Principle was rolled out rapidly, with little time for planning or preparation.[cmlxiv] Many Nations and service organizations found themselves simultaneously implementing services, recruiting and training staff, and conducting outreach with children and families. Case managers had diverse educational backgrounds and, at times, hired Nation members with minimal professional experience, with an understanding that they would receive professional development and training, for additional Jordan's Principle roles.[cmlxv,cmlxvi,cmlxvii] Reflecting on the speed of the Jordan's Principle roll-out, a participant who had been involved in developing a Nation-level program *prior* to the implementation of Jordan's Principle, noted that they had more time for:

> Listening to families, listening to their needs, listening to their concerns and then working from there … to sit down with families personally say "What do you need? What are your wants?" … You really need to start from scratch to do all the ground work to ensure that you're meeting the needs of the child.[cmlxviii]

While some Case Managers may have been able to make time for this kind of process under Jordan's Principle, others described feeling rushed, and having minimal guidance. A Case Manager hired almost two years after the beginning of Jordan's Principle implementation described her introduction to her position.

> I wasn't really given any details about it [Jordan's Principle]. I didn't actually really know what it was about when I came into it so I did my own research and discovered it was bridging the gaps for any child, at that time 19 and under. So whether it be in health, education, social, or cultural, bringing all the resources together to help the child get, to like overcome their gap I guess.

When asked how she got started in her work, she laughed.

> Through the internet I guess, through, what Jordan's Principle was about. And then I had the opportunity to go in and meet with [a FNIHB regional office representative] for training, just a brief training on what Jordan's Principle is about and what the expectations are.[cmlxix]

She noted that, in addition to that half-day training in Winnipeg, she was also invited to attend a second half-day workshop, in which participants were walked through the forms in a new 'toolkit' of government produced intake and tracking forms they were asked to use moving forward.[cmlxx]

These one-time trainings were insufficient to support Case Managers in keeping abreast of constantly shifting Jordan's Principle policies and procedures, the implications of new CHRT rulings, and provincial-level developments in health, education, and social services. A SSP pointed to the need for ongoing supports and systems for sharing information with new Case Mangers. She noted that new Case Managers may have access to even fewer supports and information sources then those who were hired earlier, when there was a more concerted effort to disseminate information about the SSP system to Case

Managers and Nation-level Jordan's Principle staff.

> I think part of what people are experiencing now is, when Jordan's Principle was first rolling out, there was a lot of initial training offered for Case Managers and CDWs [child development workers] and coming together with the specialised service providers and helping them understand what each of the different programs could offer and how they could work with their community.
>
> And I think that when Case Managers change, I don't know that the new Case Managers get that information clearly. And so that's why I think a part of it is, not only do they not know what they're supposed to be doing in the community yet, they don't know who's out there on tap to help them, right.[cmlxxi]

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

Study participants also identified a need for capacity building and training activities that extended far beyond the initial goal of becoming familiar with different programs and referral options. Case Managers have complex roles and responsibilities that involve, but are not limited to: developing and administering services across the health, education, and social service domains; building and maintaining relationships with Nation leadership, other service providers, and Jordan's Principle workers and administrators; recruiting, hiring and managing respite workers, child development workers, EAs and other staff; and working directly with children and families whose needs can require extensive knowledge of highly specialised supports and services.[cmlxxiii,cmlxxiv,cmlxxv] In some instances Jordan's Principle Case Managers are also charged with linking Nation based staff to training programs that fit their professional interests and address needs within their Nations.[cmlxxvi,cmlxxvii,cmlxxviii] Thus Case Managers require means of building and extending their expertise across a broad range of inter-sectoral clinical and administrative areas, that span across three levels of government. At the same time, they are, themselves, responsible for facilitating capacity building for staff who also have complex roles.

Take for example, the training and capacity development needs of respite care providers who, in many Nations, may be family members or other trusted people within a family's network. Respite services entail a diverse range of tasks that can include caregiving for children with complex physical and behavioural needs. An understanding of the operation and maintenance of medical equipment, such as feeding tubes, as well as medication regimes can also be important for respite provision. To build the capacities of both respite workers and other caregivers, some Nations have offered trainings in CPR, first aid, and non-violent crisis

intervention, with hopes to implement training around feeding tube use and maintenance when the COVID-19 pandemic is resolved.[cmlxxix,cmlxxx,cmlxxxi]

An internal AMC memo highlighted the broad range of trainings that might be useful for caregivers and service providers at the Nation level. The list included both concrete trainings focused on specific skills, and broad areas of disabilities and mental health within which a facilitator with specialized training would be required to ascertain the specific interests of potential participants and tailor training content accordingly. The training areas included:

- First Aid/CPR
- Applied Behaviour Analysis
- Non-Violent Crisis Intervention
- Working Effectively with Violent and Aggressive States
- Potty Training
- Sign language training
- Augmentative communication device trainings
- Training in child development milestones
- Trauma informed care
- Social Skill development
- Behaviour Challenges
- Triple P
- Circle of Security
- Book mates
- Nutritionist/Dietician
- Autism
- FASD
- ADHD
- Cognitive disabilities
- Learning disabilities
- Down's Syndrome
- Sensory Processing Disorder
- Anxiety
- Depression
- Trauma Eating disorders
- Addictions[cmlxxxii]

SSPs were able to offer training and workshops, for both families and service providers, in some of these areas.[cmlxxxiii,cmlxxxiv,cmlxxxv] TSCs and AMC have also, at different times, provided additional capacity building supports for Case Managers. These included: trainings and support for writing funding proposals, workshops on writing briefing notes to keep leadership informed about Jordan's Principle work, meetings in which SSPs presented about their roles and services, and sharing information about policy changes.[cmlxxxvi,cmlxxxvii, cmlxxxviii,cmlxxxix]

However, the effectiveness and comprehensiveness of such capacity building activities was undermined by the chronic under-resourcing within the Jordan's Principle service system. Reflecting on the uptake of offers for training and facilitation, a SSP summarized the challenges.

> I know with the training and facilitation, that I speak to a lot of Case Managers and [Service] Coordinators, and they want it, but their lives are so busy, and they are so – not overwhelmed, but just really, really busy. To carve out a specific time to do training is really hard.
>
> And I've been in that role myself, where the day-to-day running of the work that needs to be done, can take over. And so finding that time to take off [for] training, and getting a group together also is a challenge.[cmxc]

She recalled looking at a Case Manager job description and thinking, "Wow, this is impossible for one person, this is probably a

three-person job."[cmxci] Another participant in the same focus group mentioned one strategy that helped to slightly reduce the burden and complexity of the Case Manager role.

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

Case Managers were not the only ones struggling to prioritize training and capacity building amidst other complex responsibilities. The role of TSCs, who were charged with facilitating capacity building for Case Managers, was equally complex. In addition to supporting submission of complex Jordan's Principle requests, for things like housing modification, and overseeing the entire Jordan's Principle request process (from intake to assessment and approval) for many other types of requests, TSCs were responsible for many other tasks. One coordinator explained:

> I'm dealing with a lot of administrative tasks as well, identifying training, having that training roll out for our staff, we look at management, management is difficult some days and same days it's rewarding and it's good. We look at advocacy also, not only within our own communities at the grassroots level, but we also look at advocacy at the provincial table as well, and federally.
>
> We also look at community engagement, how are we getting the word out of what we are doing and things change so quickly, that we have to adapt to these changes, pretty much overnight. And then getting that rolled out to the other Case Managers, our child development workers, our mental health workers and saying, this is what we're doing now. And then dealing with their kind of shock going, oh my goodness, it's changed again, so we do that. We also provide services for our proposal writing for our programs and I think that's very time consuming, it's a skill that we honed, we work together and we help one another with that.[cmxciii]

SSPs and other regional organizations that also had a role in Jordan's Principle capacity building faced ballooning caseloads, growing waitlists and expanding professional responsibilities. Many workers reported having administrative or clinical jobs that entailed the work typically assigned to two to three people.[cmxciv,cmxcv] Thus, capacity building potential was constrained by existing capacity, which was further strained by staff turnover as well as COVID-19 related absences and secondments.[cmxcvi,cmxcvii,cmxcviii]

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

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

In the long term, participants identified the development of First Nations capacity to provide and manage clinical services as being essential to the development of a truly First Nations led and run system of services.[mii,miii,miv] SSPs generally portrayed their role in First Nations as being provisional, and committed to supporting the development of and transfer of responsibility to First Nations led and run services.[mv,mvi,mvii] However, they also highlighted the need for substantial capacity development in order to reach a point at which transfer across service domains was possible. One SSP spoke to the complexity of supporting needed capacity development while still following the lead of First Nations.

> We felt that we had a responsibility and an opportunity to help, because there was an unmet need. We also committed very early on to committing to hand over these services when the time was right to a First Nations led and governed organization … in the spirit of reconciliation and self-determination, we need to be ready to engage in those [conversations], but to follow the lead of First Nations stakeholders and, you know, work with them on their timelines.[mviii]

Another SSP stressed the value of a two-eyed way of seeing, which integrates the strengths of both western and First Nations approaches to health and wellness.[mix] In order to access the full strengths of the western approach to mental health, he noted:

> We need an Indigenous person applying for psychiatry fellowship, they need an Indigenous person applying for *child* psychiatry fellowship, then we need Indigenous managers who are going to, you know, help us hire an Indigenous team.[mx]

The development of this type of capacity is a long-term project, which calls for intensive investment in education and mentoring. In Manitoba, the MFNERC has played a leading role in innovating and implementing approaches to long-term development of credentialed, clinical capacity within First Nations. MFNERC's current capacity development efforts focus on training First Nations allied and mental health clinicians, resource teachers, education assistants, special education assistants, and therapy assistants. These capacity building and training opportunities are funded through a complex mix of funding sources that has changed over time; each funder has separate requirements and stipulations around the types of training/services to be provided and the Nations to be supported. These funding sources include Jordan's Principle funding, a five-year ISC training grant, and high cost special education funding.

MFNERC utilizes a broad range of strategies for training, including the development of specialized programs in partnership with universities, offering scholarships for First Nation students to attend existing programs,

and developing cohort-based educational offerings.[mxi,mxii] So, for example, in partnership with the University of Manitoba and an expert working group, MFNERC developed a Master's of Inclusion in Language and Literacy degree that meets the criteria for provincial certification and takes a land-based pedagogical approach, including content focusing on topics such as spiritual literacy and land-based literacy.[mxiii] A similar program in partnership with the University of Calgary School of Education is training school psychologists. In exchange for tuition supports, participants agree to work for MFNERC for a set period of time post-graduation. This capacity building effort not only ensures increased human resources in communities with historic challenges in retaining specialized service providers but also ensures the providers are First Nations, and possibly even from the Nations they work in or from neighboring communities.[mxiv]

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

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

She noted that the principle at her school "forced" her to apply for the program, which funded her master's degree in exchange for a commitments to come back and work for the Nation for five years. She credited MFNERC staff with helping her to realize her current position.

> It was [the Manager of Clinical Services] that always told me, "We have to do this, we have to do this." It was his vision. I couldn't have those dreams, because I never knew such things existed, right? so I always look at it like [his] dream as well. I could have never had those dreams as a community member, because I didn't know. This is really nice to see that it's actually coming to life.[mxviii]

Through this type of program, the makeup of MFNERC's clinical staff has been transformed. Five years ago the organization employed a single First Nation clinician: a speech therapist. Today 52 of 82 full time staff are First Nation people. An interviewee working at MFNERC, described the large number of First Nations staff as being responsible for a shift in the organization's approach to services.

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

Long-term capacity building processes can increase the numbers of First Nations service

providers and, as a result, promote the development of organizational mandates and reforms that support service approaches that are grounded in First Nations world views and contexts. Diverse training programs across levels of education, staff positions, and service domains are essential to facilitating these changes, and are integral to the long-term success of Jordan's Principle.

However, the strain on existing capacity can limit the effectiveness, reach and stability of existing training mechanisms. In addition, the complexity of and limitations on funding further complicate capacity building. For example, depending on the funding sources, MFNERC may be able to open participation to all First Nations in Manitoba, but they might alternatively be required to restrict training to: Nations that are members of the MFNSS, Nations in which MFNERC is supporting special education services; or Nations that have not entered into educational agreements with the province or FSD. The complexities of these differing eligibility criteria are not necessarily clear to Nations or other First Nations organizations. Explaining and clarifying the restrictions becomes an additional responsibility that MFNERC must fulfill on an ongoing basis. The complexity of current funding for capacity development thus further emphasizes the need for mechanisms to ensure equity and transparency in long-term funding across Nations.

6 CONCLUSION

We began work on this study just as COVID-19 was declared a global pandemic and its first impacts were beginning to be felt in North America. Data for the study was collected and analyzed during a period in which the rhythms of daily life, interactions with key sources of social and emotional support, and access to services were severely disrupted for First Nation children and families. Schools were closed and Nations were on lock down. In many cases, pandemic measures also limited individual access to food and other basic necessities usually purchased outside of a First Nation. The challenge of keeping people safe and healthy during a pandemic was further complicated by long-term failures to support development of the infrastructure required to meet the basic needs of children and families. These include, but are not limited to, federal government failures to ensure:

- Safe and suitable housing,
- Consistent access to clean water,
- Reliable year-round access to service centres, and
- The digital access that is now essential to full participation in Canadian society.

As we were working on this interim report, with the pandemic still raging, the discovery of a mass grave containing the remains of 215 children on the site of the Kamloops Indian Residential School in British Columbia dominated the news.[mxx] Less than a month later, 751 unmarked graves were discovered on the site of the Marieval Indian Residential School in Saskatchewan.[mxxi] In meetings with the study Advisory Committee and with study participants, the weight of these discoveries was palpable. The discoveries were not experienced as news of something that happened long ago and far away, but as events that were very current and present. They evoked anew grief over the experiences of family and loved ones who experienced residential schools, as well as questions and concerns over the impact on young people presented with new evidence of a tragic and shameful history of cultural genocide.

Thus, we write about the implementation of Jordan's Principle at a time in which current events shine a light on the serious, ongoing impacts of both past policies of cultural genocide and of the failure to redress untenable structural conditions resulting from past and current policy decisions. This is a context in which both the promise of and challenges to implementing Jordan's Principle, in a way that meets the true needs and best interest of First Nation children, are heightened.

FINDINGS IN THIS REPORT

In this report, we examined the implementation of Jordan's Principle in Manitoba and found that a diverse range of Jordan's Principle funded services have been layered on top of a fragmented and complex pre-existing service structure in which First Nation families must navigate between services funded or delivered by provincial, federal, and First Nations governments. Prior to Jordan's Principle, First Nation children accessed a patchwork of different programs and services. The seams of this patchwork have long been strained by funding, policies, and service priorities that do not align, which create persistent gaps in services. In addition, the rules and focus of any of the service systems in this patchwork may

shift at any time, creating new gaps and disconnections in services.

In Manitoba, the services and supports funded through Jordan's Principle include:

- First Nations developed programs implemented at the Nation level, including respite care, child development, land based healing, educational and therapy assistance, as well as a broad range of other services adapted to the needs, resources, and contexts within each First Nation;
- A system of region-wide allied health and mental health/wellness supports provided by Specialized Service Providers based in Winnipeg;
- Coordination of services for First Nation families living or accessing services on or off reserve, including support in accessing Jordan's Principle funds to address the needs of individual children; and
- Additional, regional initiatives that focus on addressing specific gaps in services (such as the need for pediatricians and child psychologists in northern communities) and support First Nations engagement with Jordan's Principle.

These services are intended to address gaps and disparities in pre-existing services, but do not fundamentally alter the pre-existing structure of services. Jordan's Principle has, in essence, layered a second patchwork of services on top of the first.

In Manitoba, Jordan's Principle has quickly increased services available to First Nation children. The new patchwork of Jordan's Principle services is expansive enough to stretch across all First Nations and cover many key gaps in services. Emphasis has been placed on making this new patchwork durable; it features full time positions and flexibility for First Nations to tailor services to the needs and contexts of their Nations. Thus, the implementation of Jordan's Principle in Manitoba has, in important ways, defied a long-term pattern in which the federal government imposed demand driven, individualized processes. Instead, Jordan's Principle has laid the foundation for a new, systemic approach to services for First Nation children. Accordingly, Jordan's Principle is poised to have a long-lasting, transformative impact on services for First Nation children, living both on and off reserve, in Manitoba.

However, important gaps in services remain. Some of these gaps are clearly linked to explicit government policies such as: the children and services that the federal government has identified as being eligible for Jordan's Principle, the processes for accessing Jordan's Principle funding, or the amount of funding available. For example, participants spoke of critical gaps in services that are unaddressed by current Jordan's Principle policies including:

- Youth over the age of 18 are no longer supported by Jordan's Principle, even though CFS and other services in Manitoba support youth through age 21.
- A chronic housing crisis directly impacts the health, safety, and wellbeing of First Nation children. The process for accessing Jordan's Principle funding for housing renovations is lengthy and funding is only available for children with disabilities. Jordan's Principle does not provide funding to other First Nation children who lack safe and suitable housing.

- Digital and physical infrastructure in First Nations remains significantly under-resourced and underdeveloped. This impacts the accessibility, effectiveness and efficiency of Jordan's Principle services. Study participants spoke of the need for new buildings to house Jordan's Principle programs, systems for ensuring clean water, and other basic sanitation infrastructure. They also called for improved internet service, an increase in telehealth facilities, and the development of other infrastructure necessary for facilitating remote access to services.
- The real cost of Jordan's Principle implementation is not covered in remote northern communities
- Jordan's Principle services have not yet been equitably extended to First Nation children living off reserve.

Study participants also identified service gaps that are tied to the challenge of creating a sustainable system of self-determined services that can ensure both continuity of care and equity of services for all First Nation children. Jordan's Principle offers important flexibility for Nations to realize self-determination in services, but significant time, resources, and technical supports are required to ensure an equitable baseline of services. Study participants pointed to key areas in which additional funding and resources are required.

- Funding continues to be renewed annually, which creates uncertainty and a lack of stability for Jordan's Principle programming.
- Promising practices in the development and provision of services for First Nation children are emerging, but limited resources have been allocated to support identification of these approaches.
- The flexibility that supports self-determination in services and the development of programs tailored to the contexts and needs in diverse First Nations is important to the continued implementation of Jordan's Principle. However, ensuring a consistent and equitable baseline of services across Nations and organizations has been a challenge because of short term-funding and insufficient resources to support long-term capacity building efforts.
- Increased coordination and collaboration is needed across organizations, First Nations, and at the regional levels of the implementation of Jordan's Principle.

This final point was seen as particularly important, and as essential to realizing a stable system of services. Study participants noted that strong linkages across Nations and organizations were essential to ensuring continuity of care for children and families, and for facilitating progress towards an equitable, First Nations led system of services. Coordination and collaboration were, in essence, portrayed as the threads that bind together the Jordan's Principle service patchwork.

Participants pointed to the need for collaboration and coordination when discussing disparities in the range and level of Jordan's Principle services across Nations. They raised concerns about:

- Challenges in establishing and sustaining informal relationships between Nations, First Nations organizations, and service providers;

- The lack of protocols to structure data and information sharing; and
- An absence of formal policies that support the wide range of service provision agreements needed to ensure equitable services as First Nations take on increasing responsibility for and control over services.

The implementation of Jordan's Principle has strained the capacities and mandates of existing organizations and structures. First Nations have identified the task of developing the capacity to build and manage an equitable First Nations system of services as a complex one that will require time and concerted effort. However, a discretionary approach to federal decision making regarding Jordan's Principle has sometimes sidestepped, rather than supported, necessary processes of building and negotiating the consensus that is required to establish a sustainable and equitable system of services for First Nation children.

MOVING TOWARDS THE FINAL REPORT

In this interim report, our goal was to provide a detailed, regional overview, with a focus on service structures and policies. In the final report we will simplify and condense our findings on service structures and policies by incorporating figures and tables in place of extended text whenever possible. This will allow us to integrate the findings presented in the interim report with additional study findings that focus more on the day-to-day work of providing services through Jordan's Principle. In the final report we will incorporate a small number of Nation level case studies, which illustrate, and expand upon, the interim report findings by providing in-depth portraits of the implementation of Jordan's Principle within First Nations with different contexts. Recommendations will be provided based on our research, and our ongoing collaboration with the study Advisory Committee.

APPENDIX ONE: RESEARCH TEAM BIOS

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

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

Katayoun Arbati is a graduate student at the University of Colorado at Boulder. At the School of Education, she studies Educational Foundation Policy and Practice. Katayoun has a Masters of Social Work from Washington University in St. Louis and a Bachelor's degree in English translation from Tehran's Kharazmi University. As a former teacher, Katayoun taught adolescents and youth in Iran for six years. Katayoun has worked with at-risk adolescents and youth as a volunteer and student social worker in both Iran and the United States. Katayoun is passionate about interdisciplinary education and social work research. She is dedicated to applying her interdisciplinary knowledge and experience to the study of at-risk populations' educational and health-related needs and concerns.

Dr. Alison J. Gerlach is an assistant professor who joined the School of Child and Youth Care at the University of Victoria in August 2018. She holds a research associate position at the Research in Health and Health Care Inequities research unit at the University of British Columbia School of Nursing and a research associate position with the Human Early Learning Partnership research network at the University of British Columbia School of

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

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

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

Jaron Hart, from O-Pipon-Na-Piwin Cree Nation, joined the Assembly of Manitoba

Chiefs Secretariat Inc. in March 2017 as part of the Northern Engagement Team with the Keewaywin: Our Way Home, Manitoba First Nations Engagement on First Nations Child and Family Services and the Implementation of Jordan's Principle. Following the engagement, Jaron joined the AMC as a Policy Analyst with Jordan's Principle Service Coordination.
Prior to his time with the AMC, Jaron studied Political Science and English at the University of Manitoba. Throughout his studies, Jaron participated in a joint-internship between the University of Winnipeg (UW) and the Canadian Museum for Human Rights (CMHR). In the course of his time with UW as a student assistant through the joint-internship Jaron prepared course materials, assisted students with assignments while also coordinated the transition of the former Adventures in Global Citizenship into 'HR-2600 Emerging Issues in Human Rights', and liaised with other post-secondary institutions regarding transfer credit equivalency.
Jaron's time with the CMHR was spent researching and producing an LGBTQ2S* Module for the CMHR for use in their future exhibits. In his spare time, Jaron enjoys giving back to the community through volunteer work and human rights advocacy; this included a two-year appointment to the City of Winnipeg's Human Rights Committee, advising the City of Winnipeg's Mayor and Council on Human Rights, serving as a National Youth Ambassador for Experiences Canada's 150 & Me Project, and extensive board experience with a focus on human rights learning and advocacy.

My name is **Samantha Folster**, a Cree indigenous woman from Norway House, Manitoba. My spirit name is South wind Thunder bird Woman. I am 47 years old and a member of the Norway House Cree Nation. I have a Social Work Degree with the University of Manitoba and a Master's Degree in Public Administration with the University of Manitoba/University of Winnipeg. I have worked in Social work for 20+ years working with families and children in various programs and services. These include Child and Family Services, Education, Social Services, Health, Mediation and Children's Special Services. The opportunity to be a leader in my community for one term in 2014-2018 has expedited my vision in policy development and provided insight in community development as a whole. During my lifetime, career board governance experience provided many decision making opportunities at a community, regional, and national level.
During the conception of Jordan's Principle it was our community that began the process of advocacy for Jordan's Principle as Jordan River Anderson was from Norway House Cree Nation. It was an experiential time in my career to witness the fruition of this program and service for our families and children. As a policy analyst for Jordan's Principle for Assembly of Manitoba Chiefs, it is a role that continues to be a strong voice for children and families in all first Nations across this province.

Dr. Josée G. Lavoie is a professor with the Department of Community Health Sciences, Faculty of Health Sciences, College of Medicine, University of Manitoba, and Director of Ongomiizwin Research at the University of Manitoba. Josée holds a BSc in Dietetics & Nutrition (1986); a MA in Medical Anthropology from McGill University (1993); and a PhD in Health Policy and Financing (2005) from the London School of Hygiene and Tropical Medicine, UK. Before beginning her research career, Josée spent 10 years working in

Indigenous controlled health services in Nunavik, Nunavut and Northern Saskatchewan. She is a member of the board for the Canadian Society for Circumpolar Health. Josée's program of research is located at the interface between policy and Indigenous health services, with a focus on contracting, accountability and responsiveness.

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

APPENDIX TWO: AMC DRAFT RESPITE CARE POLICY

First Nation Home Respite Assessment

Date: _____

Child Name:_____**Childs Date of Birth:**_____

Parent / Guardian:_____ **Band and Treaty Number:**_____

Contact Information: **Cell:**_____**Home:**_____

Work:_____**Other:** _____

Indigenous Respite Care for Jordan's Principle

Respite care will be provided to clients who receive extensive care from family/community members. The goal of respite care is to provide respite time to improve outcomes for families in a balanced model of spiritual, emotional, mental and physical. The role of respite will determine a comprehensive caregiver support initiative and to identify improved access to services. The service provided is to offer families and children a balanced structure which is planned and provided to a child with special needs. The hours for care will depend on the assessed need. Child responsibility will be defined by the family and the respite service will work accordingly to the families care routineand care plan. Respite services that have been identified to provide support include:

- **Group Respite**: this includes the land based support and scheduled events and services in agroup setting
- **Home Respite**: support is provided to the caregivers needs in developing a in home care plandepending on the needs of the family and child
- **Individual Respite**: A one-on-one respite for the child in educational, emotional, mental,spiritual or physical need of the child.
- **Emergency Respite**: a service provided under a crisis situation which requires immediateresponse to fill in the gap of service delivery.

JORDAN'S PRINCIPLE FULLY ACKNOWLEDGE AND SUPPORTCULTURALLY APPROPRIATE SERVICES WHICH INCLUDE LANGUAGE, SPIRITUALITY AND CONNECTION TO THE LAND

Culture

First Nations teaching cannot be truly embraced without a foundational philosophy of First Nations culture and love of the Creator/god. First Nations culture provides a rich essence that is intrinsically woven by the supportive threads of relationship: with one other, with the Great Spirit, and with the Earth. This is the kernel ofFirst Nations wisdom, and the core value from which all expressions of culture evolved - whether ritual, artefact, or ceremonial practice. Relationship, often expressed best (in the English language anyway), as **"All My Relations"** guides the development of all cultural components, including language, oral teachings, prayer from all denominations, music, dance, spiritual and social gatherings, rites of passage, housing, even clothing, adornment, art, tools, and object creation.

Dynamic Culture

It is impossible to describe a common cultural reality for all First Nations people. The various nations traditionally manifested cultural practices, symbols, and belief systems coloured by their unique experiences onthe land and with each other, always conscious and connected with the Spirit world. Still, all First Nations people from all over Mother Earth share the critical tenet of Relationship as central to their expressions of culture.

INTAKE PROCESS: DEVELOPMENT OF CARE PLANS POLICY

1. **Does Special Needs of Family Require:**

Long Term ____	**Short Term ____**	**One time ___**	**Emergency ___**
Time Frame of Service: 3 months ____	**6 months____**	**9 months____**	**12 months____Other_____**

2. **The care plan will specify**:

   a) **the type and frequency of service the client needs and will receive;**

   b) **the client-centered goals of the service with a target date;**

   c) **goals that should be individualized, measurable and achievable;**

   d) **the date that service will commence;**

   e) **referrals to be made;**

   f) **the role of the client in self-care;**

   g) **Services to be carried out by:**
      - **Informal caregivers support network;**
      - **Other organizations or agencies;**

   h) **Service review date.**

3. **The plan should include:**

   a) **Health promotion;**

   b) **Illness prevention;**

   c) **Emotional support and counseling;**

   d) **Education to promote self-care and independence; and,**

   e) **Transition/discharge.**

3. **The care plan must be updated on an ongoing basis to reflect changing needs, met or changed goals,altered service or support.**

DIET			
Child eats age appropriately.No emotional issues related to food/eating. **Caregiver** provides normal care and assistance. 1	Child has difficulty in feeding self or requiresrestrictive diet due to diagnosed medical condition. **Caregiver** provides assistance beyond what isage appropriate. 2	Disability prevents child from consistently self-feeding. **Caregiver** provides feeding assistance with normal feeding utensils and/or requires extensive time to feed child. 3	Disability prevents child from self feeding. **Caregiver** provides total assistance involving medicalprocedure in order to eat. E.g. tube feeding. 4
☐	☐	☐	☐
Spiritual: **Mental:** **Emotional:** **Physical:**			

PERSONAL CARE AND HYGEINE			
Child handles own self-care, but may require routine prompts and guidance. Self care seen as age appropriate. **Caregiver** provides normal monitoring, support and guidance. 1	Child lacks skills to complete age appropriateself-care. **Caregiver** does extra work due to child's inability to compete age appropriate needs. 2	Child requires assistance with activities of daily living due to disability or life long medical condition and/or the child requires total physical care due to condition. **Caregiver** does additional work due to wetting and soiling (3-4 times per week). 3	**Behavior**: Child is unwilling or resistant in completing own self-care. **Caregiver** required to be skilled and patient who can proactively and non-punitively handle the child's care needs. 4
Spiritual: **Emotional:** **Mental:** **Physical:**			

Social Needs			
Child's social and wellnessneeds are met. **Caregiver** provides socialneeds with support and guidance 1	Child social needs are not metand requires supports **Caregiver** does best to meetthe social needs but requiresextra support 2	Child struggles with social andwellness which requires support and experiences socialisolation. Lacks self-esteem and has tendency of self-harm and homelessness. **Caregiver** experiences difficulty in meeting the needsof the child. An identity issue is of concern and does not provide guidance required for child. 3	Child's social needs are at highrisk in social interaction. They put themselves at risk and/or others. Due to cognitive and developmental challenges **Caregiver** does not have the skills to provide support to thechild. Provides best to their ability. Requires support. 4
Comments: **Spiritual:** **Emotional:Mental:** **Physical:**			

MENTAL HEALTH			
Childs mental health has notbeen identified as a concern. **Caregiver** parent does not identify any mental health issuethat is significantly affecting daily living. 1	Child has diagnosed mentalhealth condition/ Mental disability. **Caregiver** follows the recommendation of a mental health professionalbut no medication prescribed. Child needs structure, and supervision. 2	Child has mental health diagnosed condition or amental disability. Child may be on medication prescribed by an MD or Psychiatrist. **Caregiver** has regular consultations with a mental health professional with respectto assisting the child. 3	Child has a mental health diagnosis/disability. Child receives direct therapyfrom a mental health professional. **Caregiver** is directly involved in the implementation of a treatment plan. 4

BOUNDARIES			
Child's behavior is age appropriate. **Caregiver** provides age appropriate direction, monitoring and guidance.	Child puts self or others at risk situation ally. Behavior may also be disruptive and/or aggressive. **Caregiver** provides increased supervision and guidance in these situations.	Child puts others and/or selfat risk on a daily basis or child has no boundaries dueto medical or mental health condition. **Caregiver** provides daily supervision, but there are times during the day whenchild can be left unsupervised for brief periods of time.	Child lacks impulse control and puts self and/or others atrisk constantly. Child is resistant to care (lifestyle). **Caregiver** provides 24-hour supervision in all areas of daily living. Caregiver may require a safety plan due to risky behaviors of child. E.g. gang threats, dangerousbehaviors.
☐	☐	☐	☐
Comments: **Spiritual:** **Mental:** **Emotional:** **Physical:**			

SCHOOL EDUCATION PROGRAMS		**IN SCHOOL SUPPORT REQUIRED**	**Yes** **No**
Child participates in regularschool/ day programs with few difficulties. **Support** provides normalencouragement. 1	Child experiences some difficulties in school/day programs behaviorally oracademically. **Support** provides additionalsupport, daily communication between home and school, homework assistance and weekly or monthly meetings. **School** providing supportsuch as resource support2	Child has behavioral/ academic problems at school/day program. **Support** participates inmulti-system planning processes. **School** receives Level II or III education funding to participate in school programs i.e. special or modified day programs. 3	Child unable or unwilling to participate in regular or modified school/day ☐ ☐ programming. **Support** provides alternative structure for school/day program that involve home schooling with/without educationalassistance. 4
☐	☐	☐	☐
Comments: **Spiritual:** **Mental:** **Emotional:** **Physical:**			

SUMMARY AND EVALUATION

Level 1 , Level 2 , Level 3 , Level 4

NEED	POINTS			
DIET	☐	☐	☐	☐
PERSONAL CARE AND HYGEINE	☐	☐	☐	☐
SOCIAL NEEDS				
MENTAL HEALTH	☐	☐	☐	☐
BOUNDARIES	☐	☐	☐	☐
SCHOOL/DAY PROGRAM	☐	☐	☐	☐

TOTAL SCORE: _____

POINTS CHART AND SUMMARY

25 points	80 hours monthly
20-24 points	80 – 60 hours monthly
15-19 points	60-40 hours monthly
10-14 points	40-20 hours monthly
1-10 points	15-20 hours monthly
*includes ONLY in-home support and one-on-one respite	

RESPITE PLAN:	**Respite submission (breakdown of hours & pay amounts)**

I/We have read, discussed and understand that this is the special rate being recommended and is based on the needs of the child and my/our tasks/responsibilities as detailed in this form.

Parent/Guardian Name	**Signature and Date**
Child Development Worker Name	**Signature and Date**

MEDICAL HEALTH (see Unified Referral Intake System (URIS) to evaluate)			
***ONLY USED BY URIS NURSE IF APPLICABLE TO YOUR FIRST NATION**	Child has a disability and/or a life long medical condition requiring assistance. E.g. basic operation of a wheelchair, administration of pre-measuredoral medications. **URIS C** **Caregiver** assists with medically related equipmentand/or pre-measured medications due to the child'shealth condition.	Child requires health careroutines due to disability and/or life long condition,**URIS B** **Caregiver** is trained in specificcare procedures; including OT/PT, due to the child'shealth condition.	Child's health condition includes complex medical careneeds. **URIS A** **Caregiver** is trained in technology required by child.When primary caregiver is away, professional care is required.
☐	☐	☐	☐
Unified Referral Intake System (URIS): Group A Group B Group C			

Unified Referral Intake System (URIS)		
Group A	**Group B**	**Group C**
Complex Health Care ▪ Complex health care proceduresrequiring the clinical skill and judgment of a registered nurse.	**Health Care Routines** ▪ Health care routines that may be safely delegated to non-health-carepersonnel who receive training and ongoing monitoring by a registerednurse.	**Activities of Daily Living** ▪ Activities of daily living are identifiedto provide a sense of the overall care needs that children may have while participating in programs.
Group A	**Group B**	**Group C**
Procedures ▪ Ventilator care ▪ Tracheotomy care ▪ Suctioning (tracheal/pharyngeal) ▪ Nasogastric tube care and/or feeding ▪ Complex administration of ▪ medication – i.e. via infusion pump,continued ▪ nasogastric tube, or injection (otherthan Auto-injector) ▪ Central or peripheral venous lineintervention ▪ Other clinical interventions requiringjudgments and decision making by a medical or nursing professional.	**Procedures** ▪ Clean intermittent catheterization ▪ Condom application for urinarydrainage ▪ Gastrostomy care and feeding ▪ Emptying an ostomy bag and/or changing an established appliance ▪ Administration of medications by: ▪ oral route (requiring measurement) ▪ instillation (i.e., eye/ear drops) ▪ topical (i.e., ointment, therapeuticdressing) ▪ inhalation (i.e., bronchodilators) ▪ gastrostomy ▪ Suctioning (oral or nasal) ▪ Responding to seizures when specificskills are required ▪ Administration of sublinguallorazepam ▪ Assistance with blood glucose monitoring requiring specific actionbased on results. ▪ Responding to low blood sugaremergencies ▪ Administration of pre-set oxygen ▪ Administration of adrenaline auto-injector	**Procedures** ▪ Passive range of motion/stretchingexercises; ▪ Exercises for strength and mobility; ▪ Application of orthotics andprosthetics; ▪ Oral feeding when specific skills arerequired; (continued) ▪ Assistance with mobility whenspecific skills are required; ▪ Chest pummeling and postural ▪ drainage; ▪ Assistance with: ▪ Oral hygiene and cleanliness ofhands/face, ▪ Dressing, ▪ Toileting and/or diapering, ▪ Oral feeding, ▪ Walking; ▪ Basic operation of a wheelchair; ▪ Assistance with symptoms of common maladies (e.g., coughing,vomiting, diarrhea); and Assistance with administration of pre-measured oral medication.

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