Docket: T1340/7008

CANADIAN HUMAN RIGHTS TRIBUNAL

B E T W E E N:

FIRST NATIONS CHILD AND FAMILY CARING SOCIETY OF CANADA and ASSEMBLY OF FIRST NATIONS

Complainants

- and -

CANADIAN HUMAN RIGHTS COMMISSION

Commission

- and -

ATTORNEY GENERAL OF CANADA
(Representing the Minister of Indigenous Services Canada)

Respondent

- and -

CHIEFS OF ONTARIO,
AMNESTY INTERNATIONAL and
NISHNAWBE ASKI NATION

Interested Parties

AFFIDAVIT OF CINDY BLACKSTOCK

I, Cindy Blackstock, of the City of Ottawa, in the Province of Ontario, **SOLEMNLY AFFIRM THAT:**

1. I am a member of the Gitxsan First Nation, a professor at McGill University's School of Social Work, and the Executive Director of the complainant, the First Nations Child and Family Caring Society of Canada ("**the Caring Society**"). As such, I have personal knowledge of the matters hereinafter deposed to save and except for those matters stated to be on information and belief and where so stated, I believe them to be true.

Recognition of This Sacred Moment

2. Words, especially legal words cannot fully embrace the sacred love parents have for their children. This case has shone a bright light on the parents and families who have fought endlessly for their children, to protect them from harm and keep them safe in their homes. I honour those parents and families – particularly those who have passed away waiting for this day. Their love now echoes past their last wish of making sure their children are loved and looked after when they are gone.

3. Maurina Beadle is one of the best teachers of how to love children in life and beyond.

4. In every conversation I had with Maurina Beadle, she said how blessed she was to be the mother of Jonavon and Jeremy. She beamed every time she talked about them and it was her love for all children that inspired her courageous challenge of Canada's refusal to implement Jordan's Principle by providing her son Jeremy with the care he needed while she recovered from a stroke. In filing the case, Maurina told me that she was doing it for Jeremy and every other child who needed help under Jordan's Principle.

5. In making his decision in favour of Maurina and Pictou Landing Band Council, the Honourable Justice Mandamin recognized Jonavon's support for Jeremy's care. His decision captures Maurina's loving mothering:

> […] The family providers are Ms. Beadle, to the degree she has recovered from her stroke and Jeremy's older brother, Jonav[o]n, who attends to assist.
>
> Ms. Beadle and her son Jeremy have a deep bond with each other. His mother is often the only person who can understand his communication and needs. She spent many hours training him to walk and helping him with special exercises. She discovered his love of music and sings to him when he is upset or does not want to cooperate. Her voice calms him and can make him desist in self-abusive behaviour. She takes him on the pow-wow trail, travelling to communities where pow-wows are held She says Jeremey is happiest when he is dancing with other First Nations people and singing to traditional music.

6. This Federal Court decision was the first legal precedent for Jordan's Principle and was cited in the Canadian Human Rights Tribunal's landmark 2016 Decision on the Merits and subsequent orders that have now yielded over 2 million services to First Nations children.

7. Maurina Beadle passed to the Spirit World November 13, 2019. It is a blessing that she was able to see the children she loved so much receiving the help they deserved under Jordan's Principle and knew about the Tribunal's compensation order 2019 CHRT 39 released on September 6, 2019. She knew justice for her boys, the other children she loved so much and for her was coming. In the last few months of her life, as the strokes became more frequent and her body weakened, her spirit strengthened, and she fought even harder to ensure her sons and all children had lots of TLC (tender loving care).

8. After Maurina's passing, I was pleased to see Jonavon continued Maurina's quest for justice for Jeremy and other kids like him. Maurina told me very many times how much she loved both of her sons, and that she stood against these injustices not just for them, but also for Jordan River Anderson, his family and other First Nations kids.

9. I honour all of the children and youth who were separated from their families owing to Canada's repeated discriminatory conduct. The multi-generational trauma from Canada's residential schools and other colonial pursuits was exponentially worsened by Canada's choice to discriminate in the provision of the very services these families needed to stay safely together. The result of Canada's discrimination was that more children were separated from their families than at the height of residential schools. Put simply, in the wake of the cultural genocide inflicted by the residential schools, Canada became more efficient at separating First Nations families. This injustice is only partially recognized by the compensation – true justice will come when Canada takes meaningful and adequate measures to ensure it never happens again.

10. This consent motion on compensation honours all the victims including the sacred children, youth, and families who have passed on to the Spirit World. The most tragic of deaths are when children and young people pass into the Spirit World in what George Tuccaro of the Mikisew Cree First Nation teaches us that when a young person dies it is a "Death out of Season."

11. I am so grateful that in these proceedings, the children and young people who passed away before seeing the compensation awarded will not be forgotten. The children in unmarked graves near residential schools received no such justice as the Indian Residential Schools Agreement only compensated the living. I hope that the Spirits of those children are uplifted knowing that their injustice informed justice for deceased children and young people in this proceeding.

12. The magnitude of this moment causes me great sorrow: many lives have been lost and others forever changed in the shadow of discrimination. In reflecting on the voices heard throughout this case, I am struck by the words of Derald Dubois, a Residential School Survivor and then Director of Touchwood Child and Family Services who lost his son: "meeting Frankie for the first time, I guess you can say I fell in love".

13. As I sign this affidavit, I honour the teachings of the late Elder Elmer Courchene who urged us all to pursue "Loving Justice" for every child, youth, family both past and present and to ensure the discrimination never happens again.

My Background

14. I have been the Caring Society's Executive Director since 2002. I have worked in the field of child and family services for over 35 years.

15. I obtained a doctorate in social work from the University of Toronto in 2009. I received a Master of Jurisprudence in children's law and policy from Loyola University Chicago in 2016. I also hold a Master of Management degree from McGill University and a Bachelor of Arts in Psychology from the University of British Columbia.

16. I have received Honourary Doctorates from Blue Quills First Nations University, the University of Western Ontario, the University of Saskatchewan, Waterloo University, Thompson Rivers University, the University of Northern British Columbia, Mount St. Vincent University, the University of Winnipeg, Ryerson University, Osgoode Hall Law School, St John's College, University of Manitoba, University of Toronto, Memorial University, the University of Ottawa, Dalhousie University, University of Victoria, McMaster University, Trent University, the University of Lethbridge, Laurentian University and University of Calgary. In 2022, I was named Chancellor of NOSM University (Northern Ontario School of Medicine).

17. I am an officer of the Order of Canada. In 2017, I received Amnesty International's Ambassador of Conscience Award, the Law Society of Upper Canada's Human Rights Award, and was awarded the Janusz Korczak Medal for Children's Rights Advocacy. In 2018, I was the inaugural recipient of the Children's Aid Foundation of Canada's Lynn Factor Stand Up for Kids National Award. In 2019, I was also awarded the Canadian Public Health Association's National

Public Health Hero Award and, in 2020, I was admitted as an Honorary Member to the Canadian Paediatric Society and received the National Indian Child Welfare Association (U.S.A.) Champion for Native Children Award. In 2021, I received the Canadian Psychological Association's Humanitarian Award. In 2022, I received the Social Sciences and Humanities Research Council's Impact Awards Gold Medal and in 2023 was named one of three finalists for the 2023 World Children's Prize. A copy of my curriculum vitae is attached hereto as **Exhibit "A"**.

18. I affirm this affidavit in support of the consent motion brought by the Caring Society, the Assembly of First Nations (the "**AFN**") and the Respondent, the Attorney General of Canada (on behalf of the Minister of Indigenous Services Canada) ("**Canada**") for orders confirming that the revised Final Settlement Agreement (the "**Revised Agreement**") respecting three Federal Court class actions (regarding the federal government's discrimination in implementing the FNCFS Program and Jordan's Principle) satisfies the problematic derogations identified by the Tribunal in the December 20, 2022 order (2022 CHRT 41) and that this $23,343,900,000 settlement will serve to implement the Tribunal's orders on compensation (2019 CHRT 39, 2020 CHRT 7, 2020 CHRT 15, 2021 CHRT 6, 2021 CHRT 7 and 2022 CHRT 41).

Pathway to this Consent Motion

19. As set out in detail in the proceedings leading up to the Tribunal's order in 2022 CHRT 41, denying the AFN and Canada's joint motion to approve the 2022 FSA, the Caring Society did not support that agreement as it denied, or provided a lesser value of compensation, to a troubling number of victims (including children) who were already entitled to $40,000 plus interest pursuant to the Tribunal's compensation orders. The Tribunal had found that these victims experienced the worst-case scenario of discrimination, and the 2022 FSA adversely affected them even though Canada and the class action parties brought no evidence justifying the denial or reduction of their compensation amounts. The 2022 FSA also created uncertainty for other victims who have already been deemed eligible to receive $40,000 plus interest in compensation under the Tribunal's orders.

20. I was also concerned that the AFN and Canada's joint motion was vague and did not identify the specific changes they were seeking to the Tribunal's compensation orders and was devoid of any serious consideration of the adverse consequences for some victims. I was also concerned about the lack of accessibility of some material related to the 2022 FSA. For instance,

in or about September of 2022, I looked for the Short Form of Notice in the class action on the fnchildcompnesation.ca website, but was unable to find it. After some searching, I ultimately found that document on a website maintained by Sotos LLP, sotosclassactions.com.

21. Concerns regarding the 2022 FSA were also expressed by resolutions from the Federation of Sovereign Indigenous Nations' Health and Social Development Commission, the First Nations Summit, the BC Assembly of First Nations, the Union of B.C. Indian Chiefs, and a letter from the Class Action Clinic at Windsor Law.

22. I participated in the AFN's Special Chiefs Assembly held in Ottawa from December 6 to 8, 2022, where resolutions regarding compensation and long-term reform were being considered. This meeting happened after the Tribunal's October 24, 2022, letter decision, but in advance of the Tribunal's full reasons in 2022 CHRT 41 which were released on December 20, 2022. As a result of discussions among First Nations Chiefs, AFN Resolution no. 28/2022 was adopted by consensus, supporting the minimum $40,000 plus interest in compensation already ordered by the Tribunal and providing parameters for future discussions in view of the Tribunal's ruling. AFN Resolution no. 28/2022 is attached to the June 30, 2023 affidavit of Craig Gideon at Exhibit D.

23. AFN Resolution no. 28/2022 and the release of 2022 CHRT 41 were landmark moments in negotiations leading to the Revised Agreement on compensation. The Tribunal's clear commitment in 2022 CHRT 41 to the victims' *quasi*-constitutional rights under the *Canadian Human Rights Act* set well-defined parameters to fix the 2022 FSA to ensure all eligible victims received the full benefit of the Tribunal's ground-breaking orders.

24. From January 2023 to March 2023, the Caring Society, Canada, and the class action plaintiffs negotiated an increase of $3.34 billion in compensation and modified the terms of the 2022 FSA to ensure the implementation of the Tribunal's orders.

25. These negotiations resulted in the Revised Agreement, which was approved by the First Nations-in-Assembly at the AFN Special Chiefs' Assembly, held from April 3-6, 2023. Throughout the history of this complaint, the First Nations-in-Assembly have adopted resolutions providing direction at many key decision-making points affecting their children, young persons and families in their Nations.

26. Specifically, AFN Resolution no. 04/2023 supported the Revised Agreement and supported the AFN seeking an order from the Tribunal confirming that the Revised Agreement fully satisfied the Tribunal's compensation orders. AFN Resolution no. 04/2023 is attached to Craig Gideon's June 30, 2023, affidavit as Exhibit E.

27. The First Nations-in-Assembly's approval of the Revised Agreement was a vital precondition to the Caring Society's agreement to sign the Minutes of Settlement. Given the concerns expressed by many First Nations regarding the 2022 FSA and the vast reach and impact of the Revised Agreement on First Nations children, youth and family in First Nations, it was important that First Nations leadership have their questions answered and to decide for themselves whether or not to support the Revised Agreement.

28. After AFN Resolution no. 04/2023 was passed, the Caring Society, AFN, and Canada separately executed Minutes of Settlement. As set out in the Minutes of Settlement, the Caring Society is of the view that the Revised Agreement satisfies the Tribunal's orders. It also makes clear that the Caring Society's involvement in reviewing and commenting on the Revised Agreement was focused on the victims identified by the Tribunal for compensation in this proceeding. The Minutes of Settlement are attached hereto as **Exhibit "B".**

Commitment to an Evidence-Informed Settlement

29. The Caring Society is committed to evidence informed approaches to public policy that benefits First Nations children, youth, and families. Data on the number of children and adults being compensated under the settlement was necessary to calculate the sufficiency of the compensation budgets required to satisfy the Tribunal's compensation orders.

30. As the Tribunal has previously found, data on First Nations children, youth and families affected by child and family services and Jordan's Principle is not robust. However, the Caring Society relied on available data sources to estimate budgets for each class of victims. These key sources were:

a. The Parliamentary Budget Officer's April 2, 2020 report *First Nations Child Welfare: Compensation for Removals* ("PBO Report" a true copy of which is attached hereto as **Exhibit "C"**);

b. Part G "Class Size Estimates" in the January 18, 2021 expert report prepared by Peter Gorham, Dr. Nico Trocmé and Marie Saint-Girons and titled *Report on the Estimated Class Size – First Nations Children in Care 1991 to 2019: Xavier Moushoom v Attorney General of Canada* ("Gorham/Trocmé/Saint-Girons Report" a true copy of which is attached hereto as **Exhibit "D"**, the full version of this report is attached to the July 22, 2022 affidavit of Janice Ciavaglia as Exhibit "C"); and

c. The February 7, 2022 letter from Peter Gorham to class counsel, setting out a revised estimate of First Nations children entering care between April 1, 1991 and March 31, 2022 ("Supplementary Gorham Letter") a true copy of which is attached hereto as **Exhibit "E"**, and which is also attached to the July 22, 2022 affidavit of Janice Ciavaglia as Exhibit "H").

31. These sources provided the Caring Society with the following key assumptions:

a. There were 8,500 First Nations children already in care on January 1, 2006 (see PBO Report at page 3);

b. 49,600 First Nations children entered care between February 24, 2006 and March 31, 2019 (see Gorham/Trocmé/Saint-Girons Report at Table 103b);

c. 9,100 First Nations children entered care between April 1, 2019 and March 31, 2022 (calculated based on the Supplementary Gorham Letter and Table 102 in the Gorham/Trocmé/Saint-Girons Report);

d. Roughly three-quarters of First Nations children removed under the FNCFS Program were removed from their homes, families, and communities (calculated based on Tables 2-1 and 2-2 of the PBO Report);

e. Over the group of claimants, there are roughly 1.5 parents per child (see PBO Report at page 7); and

f. It would be possible to substantiate physical, psychological, or sexual abuse in roughly 10% of claims made by parents (this assumption is addressed below).

32. The PBO Report estimates that roughly one third of First Nations children removed from their homes, families, and communities under the FNCFS Program were removed for reasons primarily related to abuse (see PBO Report at Table 2-3). The *First Nations/Canadian Incidence Study of Reported Child Abuse and Neglect-2019* ("2019 FN-CIS") found that physical abuse, emotional maltreatment, and sexual abuse were the primary categories of maltreatment for roughly 30% of removals. However, Dr. Fallon and Dr. Trocmé expressed concerns regarding the ability to substantiate these cases in their February 2022 report *Review of Data and Process Considerations for Compensation Under 2019 CHRT 39*, which is attached as Exhibit "J" to the July 22, 2022 affidavit of Janice Ciavaglia (see Fallon/Trocmé report at pp 7, 52, 69, and 91). Given the commitment by all parties to ensuring that child victims are not subjected to interviews as part of the claims process, these data limitations may result in under-identification of parent claimants whose children were removed from their homes, families, and communities because of physical, psychological, and sexual abuse. Given this uncertainty, the Caring Society's estimates assume that only one third of parents falling in this category would be identified through the claims process (i.e.: 10% of total parents).

Eligibility of children for compensation resulting from Jordan's Principle discrimination

33. At the time that the AFN and Canada brought their joint motion seeking the Tribunal's approval of the 2022 FSA, the Caring Society had serious concerns regarding the eligibility criteria for victims who were eligible for compensation via the Tribunal's orders for discrimination related to Jordan's Principle. More specifically, we noted ambiguity in the 2022 FSA, leaving open the possibility that individuals who would have been eligible for compensation under the Tribunal's orders would not be eligible for compensation, or would receive lesser compensation, under the 2022 FSA. This concern was compounded by the Canada/AFN request that the Tribunal cede administration of the compensation process to the Federal Court, leaving the Caring Society without an avenue to make submissions to an independent decision-maker regarding any future limitations on compensation eligibility and supports for victims.

34. As a result, the Caring Society had two priorities in discussions to redress the former settlement agreement's derogations from the Tribunal's orders: (1) clarifying that the Tribunal's orders were the floor for compensation; and (2) ensuring that, if the Federal Court were to assume administration of a compensation regime that would implement the Tribunal's orders, that the

Caring Society would have standing in Federal Court to make submissions on elements of the compensation process that have not yet been defined.

35. The Caring Society is satisfied that the Revised Agreement achieves these objectives. The definition of the "Jordan's Principle class" has now been amended to specifically state that "[t]he Parties intend that the way that the highest level of impact is defined, and the associated threshold set for membership in the Jordan's Principle Class, fully overlap with the First Nations children entitled to compensation under the Compensation Orders." The presumption that the delay is unreasonable when it exceeds the Tribunal-mandated 12-hour (for urgent cases), and 48-hour (for non-urgent cases) has also been added to the Revised Agreement on compensation.

36. The parties to the Revised Agreement have also agreed that the Caring Society will be entitled to notice of proceedings before the Federal Court related to issues impacting the rights of the beneficiaries of the Tribunal's compensation order, and will have standing to make submissions on any applications pertaining to the administration and implementation of the Revised Agreement as it relates to those matters.

Eligibility of parents for compensation resulting from Jordan's Principle discrimination

37. The Revised Agreement sets out a process to pilot a framework for determining which parents of children eligible for compensation based on discrimination related to Jordan's Principle themselves experienced the "worst case scenario" of discrimination. This is an element that was missing from the 2022 FSA.

38. The Caring Society accepts that not every parent of a child who is eligible for compensation based on discrimination related to Jordan's Principle necessarily experienced the same level of impact. Certainly, many parents experienced extreme negative impacts related to denials, unreasonable delays, and gaps in essential services that their children ought to have received, including removal of their child to receive services, other serious irremediable harms, or the tragic death of their child. However, unlike the removal of First Nations children from their homes, families, and communities, in which there is an undeniable rupture of the parent-child relationship, not all discrimination related to essential services for First Nations children has the same impact on their parents.

39. The Caring Society accepts that clear eligibility criteria are an essential part of a fair compensation process that implements the Tribunal's orders. None of the Tribunal's orders, nor any provision of the Compensation Framework, addressed eligibility criteria for parents whose children experienced discrimination related to Jordan's Principle. The piloting contemplated in the Revised Agreement on compensation will provide useful guidance.

Children removed from their homes, families and communities to placements not funded by Canada.

40. The 2022 FSA settlement amount of $20,000,000,000 did not include a budget to compensate First Nations children removed from their homes, families and communities who were placed in placements not funded by Canada ("**Non-ISC Funded Placements**"). The Caring Society reviewed existing data from the Canadian Incidence Study on Reported Child Abuse and Neglect (2019 FN-CIS) to extrapolate the number of First Nations children in Non-ISC Funded Placements.

41. The starting point of the Caring Society's estimate of the number of children removed from their homes, families, and communities to Non-ISC Funded Placements was data from Table 16 of the 2019 FN-CIS, a true copy of which is attached hereto **Exhibit "F"**.

42. Table 16 of the 2019 FN-CIS notes that 2,365 First Nations children were removed to placements not funded by Canada in 2019. This amounted to roughly 40% of all placements made in 2019.

43. The Caring Society also verified the proportion of placements not funded by Canada in the 2003 report *Understanding Overrepresentation of First Nations Children in Canada's Child Welfare System: An Analysis of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2003)* (also known as *Mesnmimk Wasatek: catching a drop of light*) ("2003 FN-CIS"), which estimated 1,554 First Nations children being removed to placements not funded by Canada in 2003. This amounted to roughly 45% of all placements made in 2003. A true copy of Table 7-6 from the 2003 FN-CIS is attached hereto as **Exhibit "G"**.

44. Using these two figures, the Caring Society assessed that the estimated number of children removed to placements funded by ISC under the FNCFS Program from January 1, 2006 to March

31, 2022 (including children already in care on January 1, 2006) would represent roughly 57.5% of all First Nations children living on-reserve who had been removed from their homes.

45. The Caring Society also received analysis of the 2019 FN-CIS data from Dr. Fallon regarding the proportion of First Nations children resident on-reserve who were removed in 2019 and placed in Non-ISC Funded Placements located more than a 30-minute drive from their residence. A true copy of this analysis is attached hereto **Exhibit "H"**. This data was used to serve as a proxy for children placed outside of their communities.

46. Data regarding unfunded placements with "kith" (adults who do not have a blood relationship to the child, also referred to as "fictive kin") as opposed to "kin" (a child's relatives) are unclear.

47. A 2017 Policy Brief from the Children's Advocacy Alliance in Nevada estimated that 20-30% of children in "kinship" places are placed with "fictive kin" (i.e., individuals to whom the child is not related, but with whom there is a relationship of trust with the family). A true copy of the Children's Advocacy Alliance Policy Brief is attached hereto as **Exhibit "I"**.

48. Data in a 2017 report produced by researchers at the University of Melbourne noted that 17.5% of children in statutory kinship care in Australia were placed with non-relatives. A true copy of Table 2 from this report is attached hereto as **Exhibit "J"**.

Eligibility of estates of parents for compensation

49. Parental estates are now included in the Revised Agreement. The Caring Society set out to extrapolate, based on existing data, the number of parents whose children were removed from their homes, families, and communities, who would not have survived to the date of settlement approval.

50. The Caring Society selected April 1, 2006 to March 31, 2023 as the date range over which it would estimate the number of parents whose children were removed from their homes, families and communities who passed away prior to the date of settlement approval. The Caring Society selected this period, as the First Nations-specific mortality information that it had access to was

based on annualized statistics, making it difficult to select "partial year" periods to reflect deaths between January 1, 2006, and March 31, 2006, or from April 1, 2023 to settlement approval.

51. More specifically, the Caring Society's estimation of the number of parents of First Nations children removed from their homes, families and communities who passed away between January 1, 2006 and March 31, 2023 was based on a 2018 paper authored by Randall Akee, of the University of California, Los Angeles' Department of Public Policy and by Donna Feir, of the University of Victoria's Department of Economics, titled *First People Lost: Determining the State of Status First Nations Mortality in Canada Using Administrative Data*. A copy of Professor Akee and Professor Feir's paper is attached hereto as **Exhibit "K"**.

52. The Caring Society did not conduct similar estimates for parents of children who experienced discrimination related to Jordan's Principle who themselves experienced a "worst case scenario" of compensation. Given that the piloting exercise has not yet been conducted, there is insufficient information to establish the "cohort" of parents from which to calculate the number of parents who would not have passed away prior to settlement approval. However, the Caring Society's view is that mortality within this cohort can be considered by the Federal Court, on submissions from all parties including the Caring Society, as one of the factors in determining the reasonableness of the claims process proposed to distribute the $2,000,000,000 budget established for compensation to the parents of victims falling within the Jordan's Principle and Trout Classes.

53. For the Caring Society, an important aspect of the Revised Agreement (which we acknowledge is a deviation from the Tribunal's order in 2020 CHRT 7) includes the provision that compensation that would otherwise be paid to the estates of deceased parents will be paid directly to the children of those deceased parents.

54. In my view, privileging children as beneficiaries of parental estates is an important and sacred component of the Revised Agreement.

55. The children in this case who have lost a parent are facing compounded harms: the harm inflicted by Canada's discriminatory conduct and the harm of losing a parent.

56. During the National Inquiry into Missing and Murdered Indigenous Women and Girls (the "**MMIW Inquiry**"), where I served as an Expert Witness, evidence was shared regarding the harmful impacts on First Nations children who lose a parent, particularly when that loss is the result of a violent death. Experiencing loss of a parent or caregiver, particularly to violence, can result in children and youth harbouring intense feelings of loss and anger, unresolved trauma, depression and, at times, suicide.

57. The MMIW Inquiry also noted these children can face an increased risk of experiencing mental health challenges, substance misuse, involvement in the criminal justice system, becoming a young parent, and dying while young. Additional harmful impacts include weakened or permanently ruptured ties with siblings, extended family, and home communities; loss of culture, language, and sense of identity; risks of abuse of neglect; and an increased risk of homeless and poverty. The relevant sections of the MMIW Inquiry Report are attached hereto as **Exhibit "L"**.

58. Academic literature also demonstrates that bereaved children face significant challenges. Evidence suggests that bereaved children are vulnerable for increased risk for social impairment – not only during the immediate post bereavement period but extending into adulthood. They also face educational challenges, social challenges, and mental health challenges. Moreover, depending on the family's circumstances at the time of the death, children and youth may face housing instability, family instability and a significant loss of love and nurturing required for healthy development. A selection of academic literature on this topic is attached hereto as **Exhibit "M"**.

59. Throughout this case, the Caring Society's primary focus has been on supporting and advocating for the rights of First Nations children, youth and families harmed by Canada's discrimination. The Revised Agreement provides a unique opportunity to provide additional compensation to First Nations children and youth who have lost a parent – a traumatic experience for all children but an experience compounded by their experiences of discrimination in this case. In my view, taking a child centered approach to directly compensating these children aligns with the spirit of the Tribunal's work and honours the memories of the children and youth who went to the Spirit World.

60. Most children and youth who died during the long history of this case were surrounded by loving families and the child's estate ought to benefit those left behind.

Compensation for parents who had multiple children removed from their homes, families and communities.

61. As noted above, the Caring Society accepts the PBO's estimate that, within the group eligible for compensation under the Tribunal's orders, there are roughly 1.5 parents per child.

62. Using this figure, the Caring Society multiplied the budget required to provide compensation to all First Nations children removed from their homes, families, and communities by a factor of 1.5 to determine the full budget required to fully compensate First Nations parents for all instances in which their children were removed from their homes, families, and communities.

Interest on compensation awards

63. Pursuant to the Tribunal's order in 2019 CHRT 39 at paragraph 275, the Caring Society based its interest calculations on the Bank of Canada interest rate as it stood on September 6, 2019, being 1.75%. A true copy of the Bank of Canada's September 4, 2019, press release announcing its decision to maintain its target overnight rate at 1.75% is attached hereto as **Exhibit "N"**.

64. Given the lack of information on the years in which First Nations children were removed from their homes, families and communities for the first time, or experienced Jordan's Principle discrimination for the first time, the Caring Society broke its total estimate of children eligible for compensation under the Tribunal's orders into annualized cohorts (with a quarter-year cohort to reflect children removed from their homes, families and communities between January 1, 2022 and March 31, 2022). The Caring Society then calculated the simple interest that would have accrued at 1.75% from January 1 of each year to January 1, 2023.

Jordan's Principle post-majority cy-près trust fund

65. Supports for victims pursuant to the Compensation Framework approved by the Tribunal in February 2021 were to be developed as part of the process of implementing the Tribunal's compensation orders. One particular area of concern for the Caring Society related to the ability

of victims of Jordan's Principle discrimination with significant needs to benefit from compensation after they reached the age of majority and until sufficient supports were in place to meet their needs as young adults.

66. To date, Canada has not extended Jordan's Principle past the age of majority. The consent order made in 2022 CHRT 8 requires Canada to "assess the resources required to provide assistances to families/or young adults in identifying supports for needed services of high needs Jordan's Principle recipients past the age of majority". The Tribunal went on to order that Canada shall consult with the parties in order to discuss the scope and scale of these transition supports and how such funding capacity can be incorporated into the long-term reform of Jordan's Principle. As set out in the Caring Society's May 10, 2023 update letter to the Tribunal, little progress has been made on this issue. The Caring Society has repeatedly urged ISC to provide funding on an actuals basis for young people requiring Jordan's Principle after the age of majority to ensure they are not discriminated against on the basis of race, national or ethnic origin, disability, or other prohibited grounds. Canada has refused to do so and has not tabled an alternative that would achieve the goal of non-discrimination.

67. For First Nations young adults with significant needs, there is a very real prospect that they will be unable to enjoy the compensation they have been afforded under the Tribunal's orders on reaching the age of majority, as these funds would be required to redress gaps in services that are no longer filled by Jordan's Principle. The same concern does not arise for First Nations youth in care eligible for compensation under the Tribunal's orders, given the relief ordered by the Tribunal related to post-majority supports in March 2022.

68. The Revised Agreement provides some relief for these young adults by establishing a $90,000,000 cy-près trust fund to provide supports to Jordan's Principle victims with high needs during the period in which they are young adults. All interest and growth associated with the $90,000,000 will be allocated back to this fund to provide further benefits for eligible young adults. The National Advisory Committee (NAC) will be consulted in the development of eligibility criteria for this fund and the Caring Society will be directly involved in the selection of the trust entity and its terms and conditions for operations.

The Caring Society's participation in the Federal Court process

69. As noted above, a key objective for the Caring Society's participation in the negotiations was to redress the derogations identified in the Tribunal's October 2022 letter decision and in 2022 CHRT 41 and to ensure that it would be able to provide its views to a neutral decision-maker in the event of disagreement regarding the manner of implementing the Tribunal's compensation orders under the Federal Court's supervision.

70. This concern is satisfied by the provisions in the Revised Agreement providing for notice to, and standing for, the Caring Society regarding applications to Federal Court addressing the interests of victims who are beneficiaries of the Tribunal's compensation order. The Minutes of Settlement signed between Canada, the AFN and the Caring Society related to Tribunal approval of the Revised Agreement also provide for $5,000,000 in capacity funding to the Caring Society to participate in these proceedings over the anticipated 18-year term of the claims process.

71. Payment of compensation is a recognition of the serious harms experienced by tens of thousands of First Nations children, youth, and families when Canada fails to implement solutions to its discriminatory conduct. However, the heartbreaking harms evidenced in this case make the payment of compensation a mixed blessing. I am glad the victims, many of whom are still children, will receive compensation for the harms they experienced but I am sad there were any victims at all. Had Canada acted on the recommendations of the multiple reports documenting the discrimination before this case was filed, there would be no compensation payable because there would have been no victims.

72. To truly honour the victims, Canada must take further effective and positive measures to ensure the discrimination stops and does not recur. AFN Chiefs-in-Assembly Resolution 40/2022 affirms the principle that "Every Child Matters" and this is reflected in the deep gratitude I have witnessed from First Nations children, youth and families for the prevention, post-majority and Jordan's Principle supports ordered by the Tribunal. Our shared goal is to ensure this is the last generation of First Nations children who have to bear the burden of Canada's discrimination.

AFFIRMED BEFORE ME over video teleconference on this **30th day** of June 2023, in accordance with O. Reg. 431/20, *Administering Oath or Declaration Remotely*. The Commissioner was in Bracebridge, Ontario and the affiant was in Prince George, British Columbia

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Commissioner for taking affidavits
Sarah Clarke LSO # 57377M

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CINDY BLACKSTOCK

This is **Exhibit "A"**
to the affidavit of
Cindy Blackstock
sworn before me this
30th day of June, 2023

Commissioner for Taking Affidavits
(or as may be)
Sarah Clarke LSO # 57377M

Cindy Blackstock (Gitxsan First Nation)

Executive Director, First Nations Child and Family Caring Society of Canada
Professor, School of Social Work, McGill University

ACADEMIC RECORD *(4 Academic degrees; 21 Honorary Doctorates)*

PhD (Social Work)	University of Toronto, Toronto, Ontario (2009)
Master Degree (Jurisprudence)	Loyola University (Faculty of Law) Chicago, Illinois (2016)
Master Degree (Management)	McGill University Montreal, Quebec (2003)
Bachelor of Arts (Psychology)	University of British Columbia Vancouver, British Columbia (1987)
Doctor of Laws (Honorary)	University of Northern British Columbia Prince George, BC (2012)
Doctor of Letters (Honorary)	Thompson Rivers University, Kamloops, BC (2015)
Doctor of Laws (Honorary)	University of Saskatchewan (2016)
Doctor of Iyiniw Kiskeyihtamowinq Asonamakew (Passing Knowledge on)	Blue Quills First Nations University (2016)
Doctor of Laws (Honorary)	Western University (2016)
Doctor of Laws (Honorary)	Waterloo University (2016)
Doctor of Letters (Honorary)	Mount Saint Vincent University (2016)
Doctor of Laws (Honorary)	University of Winnipeg (2017)
Doctor of Laws (Honorary)	Ryerson University (2017)
Doctor of Laws (Honorary)	Osgoode Law School (2017)
Doctor of Cannon Law (Honorary)	St. John's College (November 2017)
Doctor of Laws (Honorary)	University of Manitoba (May 2018)
Doctor of Laws (Honorary)	University of Toronto (June 2018)
Doctor of Laws (Honorary)	Memorial University (June 2018)
Doctor of Laws (Honorary)	University of Ottawa (June 2018)
Doctor of Laws (Honorary)	Dalhousie University (May 2018)
Doctor of Laws (Honorary)	University of Victoria (2018)
Doctor of Laws (Honorary)	McMaster University (2018)
Doctor of Laws (Honorary)	Trent University (2019)
Doctor of Laws (Honorary)	University of Lethbridge (2019)
Doctor of Laws (Honorary)	University of Calgary (2020)

AWARDS AND HONORS *(92)*

2021	BC General Employees' Union Spirit of Leadership Award
2021	Canadian Psychological Association Humanitarian Award
2021	BCGEU Leadership Award
2021	Because Mothers Matter Award
2021	Macleans Magazine: The Power List: 50 Canadians who are shaping how we think and live
2020	Fraser Mustard Lecture
2020	CSWE Lecture
2020	Canadian Paediatric Society, Honorary Life Membership
2020	National Indian Child Welfare Association of the USA: Champion for Native Children
2020	Child Welfare League of Canada, COVIDCARING recognition
2020	Federation of Saskatchewan Indigenous Nations: Star blanket Honouring
2019	Unreserved: Class of 2019
2019	Officer of the Order of Canada: Investiture
2019	American Society of Pediatric Otolaryngology Kerschner Lecture
2019	National Public Health Hero Award: Canadian Public Health Association
2019	Human Concern International: Canadian Women Making a Positive Difference
2019	Chatelaine Magazine: Women of the Year
2018	TD Spotlight on Achievement, Family Physicians Assoc. of Canada
2018	Mahatma Gandhi Peace Prize, Mahatma Gandhi Assoc. of Canada
2018	Officer, Order of Canada
2018	Women Making an Impact: Status of Women Canada
2018	Indspire: Promising Practice: Spirit Bear and children make history
2018	Stand Up for Kids Inaugural Award
2018	Profile, The Lancet (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30429-X/abstract)
2017	Newsmaker of 2018 (CBC)
2017	Chiefs of Ontario Honouring
2017	Gitksan First Nation Honouring
2017	Treaty 8 Honouring for work on Jordan's Principle and the CHRT
2017	Senior Fellow, Raoul Wallenberg Centre for Human Rights
2017	Fellow, Broadbent Institute
2017	Presbyterian Church of Canada, Dr. E. H. Johnson Memorial Award
2017	United Church of Canada, Human Rights Award
2017	Amnesty International, Ambassador of Conscience Award
2017	Canadian Labour Congress, Award for Outstanding Service to Humanity
2017	Janusz Korczak Medal for Children's Rights Advocacy
2017	Jack Layton Progress Prize, Broadbent Institute
2017	Law Society of Upper Canada, Human Rights Award
2017	150 Great Canadians @Canadians150
2016	Canadian Institute of Child Health Award
2016	Ontario Association of Social Workers: Social Change and Human Rights Champion award
2016	Assembly of Manitoba Chiefs Honoring

2016	Neil Reimer Award: UNIFOR
2016	Jordan's Principle Honoring: Norway House Cree Nation
2016	Champion for Children: Defense for Children International
2016	Honorary Recipient, Peter Henderson Bryce Award
2016	Honoring: BC First Nations Leadership Forum on Child Welfare
2016	Golden Whistleblower Award: Canadians for Accountability
2016	Liberty Award (individual): BC Civil Liberties Association
2016	Honouring, Assembly of First Nations
2016	Order of the Buffalo Hunt, Government of Manitoba
2015	Assembly of First Nations Honoring for work on Canadian Human Rights Tribunal
2015	Courage in Law Award, UBC Indigenous Law Students
2015	Distinguished Patron, Defense for Children International
2014	Canadian Society for Training and Development, President's Award
2014	Canadian Civil Liberties Association, Community Award
2014	University of Alberta, Community Scholar Award
2014	Honorary Witness, Truth and Reconciliation Commission
2014	The Federation of Community Social Services of BC Award of Excellence
2013	Human Rights Activist, 16 Days of Activism, Nobel Women's Initiative
2013	Human Rights Defender, Frontline Defenders (Dublin, Ireland)
2013	Friend of Child and Youth Award, North American Council on Adoptable Children
2013	Distinguished Person endorsing the Joint Statement against the Physical Discipline of Children
2013	Champion of Child and Youth Rights Award, First Call (BC)
2012	Recognition, Canadian Journalists for Free Expression
2012	Honorary Lifetime Member, Indigenous Bar Association
2012	Essential Piece Award: Kasohkowew Child Wellness Society
2012	Trudeau Foundation Mentor
2011	National Aboriginal Achievement Award (Public Policy)
2011	Ashoka Fellow (announced 2010 and formally inducted in 2011)
2010	J.W. McConnell Family Foundation Social Innovation Generation Fellows
2010	Canadian Association of Social Workers Outstanding National Service Award
2010	Ontario Municipal Social Services Association, Outstanding Human Services Award
2009	Manitoba First Nation Child Welfare Gala Leadership Award
2009	Yellowhead Tribal Services Recognition Award
2009	Atkinson Foundation Economic and Social Justice Fellowship
2009	Defense for Children International, Canada: Champion for Children Award
2008	University of Western Australia, Healthway Indigenous Scholar Fellowship
2008	Leader in Social Work, National Social Work Week, Ontario Association of Social Workers
2008	Adel Sedra Distinguished Scholar Award, University of Toronto
2008	Inclusion in the United Nations database on Indigenous experts and professionals, United Nations Permanent Forum on Indigenous Issues
2007	Assembly of Manitoba Chiefs Recognition Award, Jordan's Principle
2007	Perry Shawana Aboriginal Child Care Advocacy and Leadership Award
2007	Norway House Cree Nation Recognition Award for Jordan's Principle

2007	Canada Graduate Scholarship (PhD), Social Science and Humanities Council
2006	Wi Chi Ti Zon Group Home Recognition Award
2006	Victor Marchessault Advocacy Award, Canadian Paediatric Society.
2005	Honorary Foster Parent, Aboriginal Foster Doll Project, BC Youth in Care Network; Aboriginal Foster Parents Association and the BC Federation of Foster Parents
2003	Sarah Berman Memorial Award for Public Speaking, North American Council on Adoptable Children
2003	Queen's Golden Jubilee Medal
2003	Yellowhead Tribal Services Child and Family Services Recognition Award
2002	Caring for First Nations Children Society Recognition Award
2001	Province of British Columbia Ministry for Child and Family Development, Instructor Recognition Award
1998	Sto:lo Nation recognition for Instruction of the Aboriginal Social Worker Training Program

ACADEMIC APPOINTMENTS *(7)*

2018-Present	University of Alberta, Adjunct Professor, Faculty of Education
2014–2015	OISE, University of Toronto, External Scholar, Faculty of Graduate Studies
2013	Dalhousie University, External Scholar, Faculty of Graduate Studies
2011–2015	University of Ottawa, Faculty of Women's Studies and Graduate Studies
2005	University of Toronto, Senior Instructor
2005	University of Victoria, Adjunct Professor
2000	University of Manitoba, Professional Affiliate

PROFESSIONAL APPOINTMENTS *(7)*

2016–Present	Professor, McGill University, School of Social Work
2011–2016	Associate Professor (tenured), University of Alberta, Faculty of Extension
2003–Present	Executive Director First Nations Child and Family Caring Society www.fncaringsociety.com
1999–2003	Executive Director Caring for First Nations Children Society *www.cfncs.com*
1995–1999	Assistant to the Social Development Director The Squamish First Nation
1987-1995	Senior Social Worker Province of British Columbia

RESEARCH *(15)*

2019	SSHRC Aid to Scholarly Journals Grant Supplement: 2018–2021 – 5K per annum for 3 years (15K).

2018-2021	SSHRC Insight Research Grant: Just because we are small doesn't mean we can't stand tall (teacher's perceptions of children's direct engagement in reconciliation based social justice). Principle Investigator: Cindy Blackstock
2018-2021	SSHRC Aid to Scholarly Journals Grant for First Peoples Child and Family Review (2019–2022): Principle Investigator: Cindy Blackstock 26.5 per annum for 3 years (79.5)
2015-2019	SSHRC Journal Grant for First Peoples Child and Family Review (2015–2018): Principal Investigator: Cindy Blackstock.
2015	Advisor, New Zealand Royal Society Marsden Fund Research Program "Children visiting a museum: information gathering or creative capacity building?"
2012	Building Capacity with First Nations and mainstream Youth Protection services in Quebec. Collaborator: Principal Investigator: Nico Trocmé.
2011	SSHRC grant for First Peoples Child and Family Review. Principal Investigator: Cindy Blackstock
2007-2009	Nova Scotia Department of Community Services and Mi'kmaw Family and Children's Services. *When Everything Matters: Comparing the factors contributing to the reunification or continuance in child welfare care for First Nations and non-Aboriginal children in Nova Scotia*.
2007	National Collaborating Centre on Aboriginal Health. *Development of the Scientific Vision for NCCAH.* 2007. Public Health Agency of Canada and the United Nations Committee on the Rights of the Child. *Supporting the development of the UNCRC general comment on Indigenous child rights.*
2005	Department of Indian Affairs and Northern Development. *Wen:de: The Journey Continues*. Available on line at www.fncaringsociety.com
2005	Department of Indian Affairs and Northern Development. *Wen:de: We are coming to the light of day.* Available on line at www.fncaringsociety.com
2004	Department of Indian Affairs and Northern Development. *Bridging Econometrics with First Nations child and family service practice.* Available on line at www.fncaringsociety.com
2004	Department of Indian Affairs and Northern Development. *Staying at Home: Least Disruptive Measures*
2004	Health Canada. *Keeping the Promise: The United Nations Convention on the Rights of the Child and the Lived Experience of First Nations Children and Young People*
2003–2004	Voluntary Sector Initiative, Government of Canada. *Caring Across the Boundaries: Exploring the Nature and Extent of Engagement of the Voluntary Sector with First Nations Children and Families*.

SERVICES RELATED TO RESEARCH *(19)*

2020	Co-convenor, Working group on COVID-19.

2017-2019	Research Steering Group Member, Global Child CIHR project to develop compliance indicators for the UN Convention on the Rights of the Child.
2016	Co-convenor, Reimaging Child Welfare Symposium. Partnership with Osgoode Law School, TAG, African Canadian Legal Centre and the Caring Society
2016	Moderator: Big Thinking Lecture by Noaimi Klein; Federation of the Humanities and Social Sciences
2015	Moderator: Big Thinking Lecture by Justice Murray Sinclair: Federation of Humanities and Social Sciences.
2015	Symposium participant, Neocolonialism and Indigenous children's rights: University of Technology, Sydney: AU
2014	Moderator, Big Thinking Lecture by Dr. Jim Miller, House of Commons, Federation of Humanities and Social Sciences.
2014	Board Member, Federation of the Humanities and Social Sciences
2013–Present	Director, First Nations Children's Action Research and Education Centre (FNCARES), University of Alberta
2010	Reviewer, Research Grants for the Social Science and Humanities Council
2009	Advisor, Centre of Excellence for Child and Youth Mental Health at CHEO
2006–2009	Facilitating consultation with the Indigenous Sub Group for the United Nations Committee on the Rights of the Child in the development of the General Comment on Indigenous Child Rights
2006	Reviewer, Harvard University John F. Kennedy School of Government, American Indian Program evaluation of the Longitudinal Survey on Aboriginal Health
2006–2008	Expert Panel on Health Literacy, Canadian Public Health Association
2004–2008	Canadian Incident Study on Reported Child Abuse and Neglect, research team member.
2003–2009	Co-director, Centre of Excellence for Child Welfare
2001	Grant Reviewer, Centre of Excellence for Child Welfare.
1997–2002	Advisory Committee Member, Joint National Policy Review of First Nations Child and Family Services, the Assembly of First Nations and Department of Indian Affairs and Northern Development.
2000–2002	Advisory Committee Member, Centre of Excellence for Child Welfare.

ADVISORY BOARDS/EXPERT ADVISOR/EXPERT WITNESS *(14)*

2021	Advisor, Alaskan Native child welfare collective
2020	Witness, Laurent Commission: First Nations children.

2018	Witness, Commission d'enquete sur les relations entre les Autochones et certain services publics au Quebec.
2018	Expert Witness, Murdered and Missing Indigenous Women's Inquiry
2016–Present	Commissioner, Pan American Health Organization, Review of Health Inequities and Inequalities in the Americas.
2017–Present	Advisory, Hand to Hold Campaign to ensure children who are medically transported in Quebec can travel with a guardian/other caring adult.
2014	Reviewer, Indigenous Ethics of Predictive Risk Modeling for Maori Children and Families
2011–2013	Expert Advisor, UNICEF on UN Declaration on the Rights of Indigenous Peoples
2010–2011	Advisor to Microsoft Corporation Canada, First Nations education initiative
2010–2012	Ashoka Changemaker's First Nations, Metis and Inuit Changemaker's Competition Advisory Committee
2010–2012	Mount Royal University, Continuing Education Department. Child and Youth Human Rights Extension Certificate Advisory Committee
2010	Member, Audit Advisory Committee, Auditor General of Canada
2010	Expert Child Welfare Committee, Northwest Territory Government
2010	Expert Panelist, United Nations Permanent Forum on Indigenous Issues

EXECUTIVE PRODUCER OF FILMS AND PHOTOGRAPHY EXHIBIT CURATOR

2021	*For Love***,** Production of Carrier-Sekani Family Services and Walk Tall Productions, Inc. Shania Twain (Narrator), Matt Smiley (Director), Mary Teegee Producer, Warner Adam and **Cindy Blackstock, Executive Producers.**
2020	*Spirit Bear and Children Make History*. Film adaptation of book by the same name. **Cindy Blackstock –** co-book author, co-wrote screen play, voice actor and executive producer. Presented by The First Nations Child and Family Caring Society of Canada and Spotted Fawn Productions.
2016	*(Dis)placed: indigenous youth and the child welfare system.* **Cindy Blackstock**, co-producer. Melisa Brittain, Director and film maker.
2013	*Fighting for Shannen and all the kids too!* **Cindy Blackstock**, Executive Producer. Andree Cazabon: Director and film maker.
2013	*Letters to Canada.* **Cindy Blackstock**, Executive Producer. Andree Cazabon: Director.
2012	*I am a witness: A short film*. **Cindy Blackstock,** Executive Producer. Andree Cazabon: Director.
2009	Caring Across Boundaries: Reconciliation in a child's world. **Cindy Blackstock**, Curator, with photography by Liam Sharp. Premiered at First Canadian Place (Bank of

Montreal headquarters) in Toronto. Since toured to the AFN Special Chiefs Assembly, New Brunswick First Nations, University of Ottawa and the Canadian Labour Congress National Conference.

REFEREED JOURNAL EDITORIAL BOARDS/REVIEWS *(22)*

2021	Reviewer, *Canadian Journal of Family Law*
2020	Reviewer, *Canadian Journal of Family Law*
2020	Reviewer, *Paediatrics & Child Health*
2020	Reviewer, *Canadian Journal of Family Law*
2019	Reviewer, *Canadian Journal of Family* Law
2017	Reviewer, *Lancet*
2015	Reviewer, Fernwood Publications
2014	Editor in Chief, *First Peoples Child and Family Review*
2014	Reviewer, *International Indigenous Policy Journal*
2013	Reviewer, *Canadian Medical Association Journal*
2012	Reviewer, *Child Abuse and Neglect*
2012	Reviewer, *Child Abuse and Neglect*
2012	Reviewer, *First Peoples Child and Family Review*
2011	Reviewer, *Violence Against Women*
2011	Reviewer, *Child Abuse Review*
2009–Present	Reviewer, *First Peoples Child and Family Review*
2007	Co-wrote editorial, *First Peoples Child and Family Review*
2007	Reviewer, *Violence Against Women*
2006	Reviewer, *Violence Against Women*
2005	Guest Editor, *Pediatrics and Child Health*
2004–Present	Founding Editorial Board Member, *First Peoples Child and Family Review*
2003	Guest Editor, *Journal on Developmental Disabilities*

PUBLICATIONS IN REFEREED JOURNALS *(47)*

Asmundson, G., **Blackstock, C**., Bourque, M., Bimacombe, G., Crawford, A., Deacon, S., McMullen, K., McGrath, P., (2020). Easing the disruption of COVID-19: supporting the mental health of people of Canada- October 2020- an RSC Policy Briefing. FACETS, 5(1), 22 December 2020.

Blackstock, C., Bamblett, M. & Black, C. (2020). Indigenous ontology, international law and the application of the Convention to the over-representation of Indigenous children in out of home care in Canada and Australia. *Child Abuse & Neglect.*

Hay, T., Kirlew, M. & **Blackstock, C.** (2020). Dr. Peter Bryce (1832-1932): whistleblower on residential schools. *Canadian Medical Association Journal* (CMAJ), 192 (9) E2223-E2224.

Blackstock, C. (2019). Revisiting the breath of life theory. *British Journal of Social Work*, 2019 (49), 854-859.

Blackstock, C. (2019). Indigenous child welfare legislation: A historical change or another paper tiger? *First Peoples Child and Family Review*, 14(1). Retrieved May 5, 2019 at http://journals.sfu.ca/fpcfr/index.php/FPCFR/article/view/367/299

Blackstock, C. (2019). Learning to babble: Why children are essential to social justice and reconciliation. *Every Child Australia,* 25 *(1), 4-7.*

Blackstock, C. (2017). The United Nations Committee on the Rights of the Child: Does its structure and working methods optimize efficacy and promote child participation? *Canadian Journal of Children's Rights*, 4(1), 116-126.

Blackstock, C. (2016). The Complainant: The Canadian Human Rights Tribunal on First Nations Child Welfare. *McGill Law Journal*, 62:2, 285-328.

King, J., Wattam, J. & **Blackstock, C.** (2016). Reconciliation: the kids are here! *Canadian Journal of Children's Rights,* 3 (10), 32-45.

Blackstock, C. (2016). Toward the full and proper implementation of Jordan's Principle: An elusive goal to date. *Paediatric Child Health* 21(5), 245-246.

Blackstock, C. (2016). Social movements and the law: addressing engrained government-based discrimination against Indigenous children. *Australian Indigenous Law Review.* 19 (1),*5-19.*

Levesque, A., Clarke S. & **Blackstock, C.** (2016). La plainte de discrimination devant le Tribunal des droits de la personne canadien de portant sur les services d'aide a l'enfance aux enfants des Premiere Nations Principe et le de Jordan. *Journal enfance, famille, generations*, 16 (25).

Cross, T., **Blackstock, C.,** Formsma, J., George, J. & Brown, I. (2015). Touchstones of hope: still the best guide to Indigenous child welfare. *First Peoples Child and Family Review* 10(2), 6-11.

Fallon, B., Chabot, M., Fluke, J., **Blackstock, C.** & Sinha, V. (2015). Exploring alternate specification to explain agency-level effects in placement decisions regarding Aboriginal children: Part C. *Child Abuse & Neglect* (May, 2015), 97-106.

Blackstock, C. (2015). Should governments be above the law? The Canadian Human Rights Tribunal on First Nations child welfare. *Children Australia*, 40 (2), 95-104.

Blackstock, C. (2013). Opening statement of the First Nations Child and Family Caring Society of Canada: Canadian Human Rights Tribunal. *Kanata*, 6 (Winter, 2013), 16-21.

Blackstock, C. & Auger, A. (2013). Pursuing human rights for community level resilience: the Jordan's Principle case, process and initiative as resilient community action. *International Journal of Child and Journal Resilience*, 1 (1).

Fallon, B., Chabot, M., Fluke, J., **Blackstock, C.,** Maclaurin, B., & Tonmyr, L. (2013). Placement decisions and disparities among Aboriginal children: further analysis of the Canadian Incidence Study on Reported Child Abuse and Neglect part A: comparisons of the 1998 and 2003 surveys. *Child Abuse and Neglect*, 37 (1), 47-60.

Blackstock, C. (2012). Aboriginal child welfare self-government and the rights of Indigenous children: A book review. *Children and Youth Services Review,* 34(12), 2504-2506.

Blackstock, C. (2012). Jordan's Principle: Canada's broken promise to First Nations children? *Paediatrics and Child Health, 17(7), 368-370.*

Cross, T. & **Blackstock, C.** (2012). We are the manifestations of our ancestor's prayers. *Child Welfare*, 91 (3), 9-14.

Blackstock, C. (2011). Wanted moral courage in child welfare. First Peoples Child and Family Review, 6 (2), 36-47.

Blackstock, C. (2011). The emergence of the breath of life theory. Journal of Social Work Values and Ethics, 8(1), 1-16. Retrieve at http://www.socialworker.com/jswve/content/view/143/73/

Blackstock, C. (2011). Why if Canada wins, Canadians lose: The Canadian Human Rights Tribunal on First Nations child welfare. Children and Youth Services Review, 33 (2011), 187-194.

Tommyr, L. & **Blackstock, C.** (2010). Commentary: public health approach in First Nations communities. International Journal on Mental Health and Addictions, 8(2), 135-144.

Fluke, J., Chabot, M., Fallon, B., MacLaurin, B., & **Blackstock, C.** (2010). Placement decisions and disparities among aboriginal groups: an application of the decision making ecology through multi-level analysis. Child Abuse and Neglect, 34(1), 57-69.

Chabot, M., Fallon, B., Tonmyr, L., Maclaurin, B., Fluke, J. & **Blackstock, C.** (2010). Exploring alternate specifications to explain agency level effects in placement decisions regarding Aboriginal children: further analysis of the Canadian Incidence Study on Reported Child Abuse and Neglect. Child Abuse and Neglect, 37 (1), 61-76.

Blackstock, C. (2009). First Nations children count: enveloping quantitative research in an Indigenous envelope. First Peoples Child and Family Review, 4(2), 135-144.

Blackstock, C. (2009). Why addressing the over-representation of First Nations children in care requires a new theoretical approach. *Journal of Social Work Values and Ethics*, 6(3).

Blackstock, C. (2009). The occasional evil of angels: learning from the experiences of Aboriginal peoples with social work. *First Peoples Child and Family Review,* 4(1), 28-37.

Blackstock, C. (2009). After the apology: why are so many First Nations children still in foster care? *Children Australia*, 34 (1), 22-31.

Trocmé, Maclaurin, Fallon & **Blackstock, C.** (2008). *Mesnmik Wasatek. World perspective, 8th edition*. Chicago: International Society for the Prevention of Child Abuse and Neglect.

Blackstock, C. (2008). Rooting mental health in an Aboriginal world view inspired by Many Hands One Dream. *Paper prepared for the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO.*

Blackstock, C. (2008). *Jordan's Principle: editorial update*. Paediatrics and Child Health, 13 (7), 589-590.

Blackstock, C. & Cross, T. (2007). Indigenous child rights. *Encyclopedia on violence against children.* California: Sage Publications.

Blackstock, C. (2007). If reindeer could fly: dreams and real solutions for Aboriginal children. *Education Canada*, 7(1), 4-8.

Blackstock, C. (2007). The breath of life versus the embodiment of life: Indigenous knowledge and western research. *World Indigenous Nations Higher Education Consortium Journal, 2007*. Porirua, New Zealand.

Blackstock, C. (2007). Are residential schools closed or have they just morphed into child welfare? *Indigenous law journal* 6(1), 71-78.

Wien, F., **Blackstock, C.,** Loxley, J. and Trocmé, N. (2007). Keeping First Nations children safely at home: how a few federal policy changes could make a big difference. *First Peoples Child and Family Review, 3(1), 10-15.*

Blackstock, C. & Alderman, J. (2005). The untouchable guardian: the state and Aboriginal children in the child welfare system in Canada. *Early childhood matters, December 2005, No. 105*, 19-23.

Blackstock, C. (2005). The occasional evil of angels: Learning from the experiences of Aboriginal Peoples with social work. *World Indigenous Nations Higher Education Consortium Journal, Vol. 2.* New Zealand.

Saylor, K. & **Blackstock, C.** (2005). Many hands one dream: healthy Aboriginal children and youth. *Paediatrics and child health, 10 (9), 533-534.*

Blackstock C. (2005). Voices from the field - First Nations children in care. *Encyclopedia on Early Childhood Development*. Centre of Excellence for Early Childhood Development Website, http://www.excellence-earlychildhood.ca/liste_theme.asp?lang=EN&act=32

Blackstock, C. (2005). Same Country: Same Lands; 78 Countries Away: An exploration of the nature and extent of collaboration between the voluntary sector and First Nations Child and Family Service Agencies. *First Peoples Child Welfare Review, 2 (1)*, 130-157.

Trocmé, N., Knoke, D. and **Blackstock, C.** (2004). Pathways to the over-representation of Aboriginal children in the child welfare system. *Social Services Review, Volume 78, (4),* 577-600.

Blackstock, C., Trocmé, N. and Bennett, M. (2004). Child welfare response to Aboriginal and Non Aboriginal Children in Canada; a Comparative Analysis*. Violence Against Women*, 10(8), 901-917.

Blackstock, C. (2004). Embracing our Distinct Humanity in *Journal of Developmental Disabilities, 10(2),* vii-1.

BOOKS (4):

Blackstock, C. (2020*).* *Spirit Bear: Echoes of the pas*t. Ottawa: First Nations Child and Family Caring Society of Canada.

Blackstock, C. (2019). Spirit Bear: Honouring memories; planting dreams. Ottawa: First Nations Child and Family Caring Society of Canada.

Blackstock, C. (2018). *Spirit Bear: fishing for knowledge; catching dreams*. Ottawa: First Nations Child and Family Caring Society of Canada.

Blackstock, C & Robinson, E. (2017). *Spirit Bear and Children make history*. Ottawa, First Nations Child and Family Caring Society of Ottawa. *Note: received recognition as an Indspire Best Practice in Indigenous Education and over* 17,000 copies have been sold/donated since December 2017. Available in Carrier, French and English.

NON-JURIED PERIODICALS AND SUBMISSIONS *(36)*

Blackstock, C. (2021). Screaming into silence, *Maclean's Magazine: August 2021, pp.24-25.*.

Blackstock, C. (2021). The government needs to face up to its role in Indigenous child deaths. *The Guardian,* Opinion, July 8, 2021 11:53 BST.

Blackstock, C. & Palmater, P. **(2021).** The discovery of unmarked children's graves in Canada has Indigenous people asking: how many more? *The Guardian,* Opinion, June 9, 2021 16:05 BST.

Blackstock. C. (2021). *Stealing "Indian" human rights in 2021.* Policy Options, June 2021.

Blackstock, C. (2020). The colonial toxicity of the "be patient" speech. *Hill Times,* Opinion, September 21, 2020.

Blackstock, C. (2020). Reconciling History: Learning from the Past at Beechwood**.** *The Beechwood Way Magazine,* Summer 2020, Vol. 13, p. 4. (also available in French: Reconcilier l'historie: Apprehendre du passe a Beechwood, Ete 20202, Vol. 13, p. 4.

Saint-Girons, M., Joh-Carnella, N., Lefebre, R**., Blackstock, C.,** & Fallon, B. **(2020).** *Equity concerns in the context of COVID-19: A focus on First nations, Inuit and Metis communities in Canada.* Toronto, ON: Child Welfare Research Portal.

Blackstock, C. (2020). COVID-19: Les impacts sociaux: la duplicite du gouvernmement en matiere de racisme. La Press, Opinion, 14 juin 2020.

Blackstock, C. & Day, I. (**2020).** History will repeat itself if First Nations remain underfunded in the fight against COVID 19. *The Globe and Mail,* Opinion, April 8, 2020.

Blackstock, C. (2019). Blackface and About Face: Where Canada's Reconciliation Agenda went wrong. *Toronto Star: Opinion,* October 7, 2019.

Blackstock, C. (2019). Ottawa wilfully discriminated against First Nations children. Silence is no longer an option. *Globe and Mail:* Opinion: September 11, 2019

Blackstock, C. (2019). When will Ottawa end its willful neglect of Indigenous children? *Globe and Mail*: Opinion, July 16, 2019.

Blackstock, C. (2019). Will Canada continue to fail Indigenous girls? *Globe and Mail:* Opinion, June 6, 2019.

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RESEARCH REPORTS *(8)*

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Blackstock, C., Prakash, T., Loxley, J., & Wien, F. (2005). *Wen:de: We are Coming to the Light of Day*. Ottawa: First Nations Child and Family Caring Society of Canada.

Trocmé, N., Fallon, B., MacLaurin, B., Daciuk, J., Felstiner, C., Black, T., Tonmyr, L., **Blackstock, C.,** Barter, K., Truscott, D., Cloutier, R. (2005). *Canadian Incidence Study on Reported Child Abuse and Neglect: Major Findings-2003*. Ottawa: Public Health Agency of Canada

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Nadjiwan, S. & **Blackstock, C.** (2003). *Annotated Bibliography on the Nature and Extent of Collaboration Between the Voluntary Sector and First Nations Child and Family Services Agencies in Canada*. Ottawa: First Nations Child and Family Caring Society.

Bennett M. & **Blackstock, C.** (2002). *First Nations Child and Family Services and Indigenous Knowledge as a Framework for Research, Policy and Practice*. Available on line at www.cecw-cecb.ca.

BOOK REVIEWS *(3)*

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Blackstock, C. (2007). The story of Tikinagan Child and Family Services: A book review. *Ontario Association of Children's Aid Societies Journal,* Winter 2007, 51 (1), 27-28.

CURRICULUM WRITING *(11)*

2017	First Peoples Social Work, Bachelor of Social Work, McGill University
2018	Advocacy Course, Master of Social Work, McGill University
2011	Mosquito Advocacy. Master degree level course. Faculty of Extension, University of Alberta
2008	*Touchstones of Hope: Bachelor of Social Work Course.* Centre of Excellence for Child Welfare, University of Toronto.
2005	*Leadership and Followship: the Honor of Both in Effective Indigenous ECD Management*. University of Victoria.
2002	*Negotiations Module, Supervisory Training*, Aboriginal Social Worker Training Project (1/2-day course)
2002	*Ethics Module*, First Nations Partnership Program, University of Victoria
2002	Blackstock, C and Kovach, M. *Social Work 451 Curriculum*. Faculty of Social Work, University of Victoria.
2000	*Aboriginal Child and Family Service Programs*, Aboriginal Social Worker Training Program (1/2-day course)
2000	*Team Assistant Training Curriculum,* Ministry for Children and Families

1999 *Aboriginal Child and Family Services*, Ministry for Children and Families CORE Training (1-day course)

***LITIGATION* (13)**

In the following litigation, I was the instructing client for First Nations Child and Family Caring Society of Canada and also assisted with legal research and writing of legal submissions. I also testified 6 times over the various legal proceedings and have submitted numerous affidavits. According to Government of Canada estimates, this litigation has resulted in an additional $634 million in First Nations child and family services funding in addition to over 777,000 services, products and supports for First Nations children via Jordan's Principle between 2016 and 2020. The litigation is ongoing. I wish to acknowledge the exceptional contributions of Caring Society staff and legal counsel in achieving these results as well as those of the other parties to the proceedings.

2021 *First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2021 CHRT 12. Over $500 million provided in prevention services to First Nations children and families served by federally funded provincial and territorial child welfare providers.

2020 *First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2020 CHRT 36. Non-status First Nations children granted access to Jordan's Principle.

2019 *Attorney General of Canada v. First Nations Child and Family Caring Society of Canada et al.,* 2019 FC 1529. Federal Court dismisses Canada's application to stay the Tribunal's compensation order (2019 CHRT 39).

2019 *First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2019 CHRT 39. Award maximum compensation to victims of Canada's discrimination.

2019 *First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2019 CHRT 7. Interim order ensuring non-status children off reserve can access Jordan's Principle in urgent circumstances.

2019 *First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2019 CHRT 1. Cost award v. Canada for failing to disclose.

2018 *First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2018 CHRT 4. Order to fund First Nations child and family services prevention, legal, building repairs, intake and assessment and band representatives and mental health at actual cost retroactive to January 26, 2016 and on a go forward basis.

2017 *First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2017 CHRT 35. Amendment of 2017 CHRT 14 to allow for some documentation re: Jordan's Principle.

2017	*First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2017 CHRT 14. Order for Canada to fully implement Jordan's Principle.
2016	*First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2016 CHRT 2. Order substantiating the complaint filed by the First Nations Child and Family Caring Society and the Assembly of First Nations in 2007 alleging that Canada's systemic under-funding of First Nations children's services was discriminatory on the prohibited grounds of race and national or ethnic origin.
2016	*First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2016 CHRT 10. Non-compliance order with 2016 CHRT 2.
2016	*First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2016 CHRT 16. Non-compliance order with 2016 CHRT 2.
2013	Attorney General of Canada v. First Nations Child and Family Caring Society et al. 2013 FCA 75. Federal Court of Appeal upholds Federal Court decision to overturn Tribunal decision to dismiss.
2012	*First Nations Child and Family Caring Society et al. v. Attorney General of Canada*, 2012 FC 445. Federal Court overturns Tribunal decision to dismiss the case.

UNITED NATIONS COMMITTEES AND INTERNATIONAL ORGANIZATIONS
(23)

2021	Presenter, UNICEF side event at UN Permanent Forum on Indigenous Issues (Impacts of COVID on First Nations children)
2021	Presenter, Indigenous youth delegation from Canada, UN Permanent Forum on Indigenous Issues (Advocacy and leadership in international human rights law)
2021	Participant, UN Social Development Goals Task Team Frontier Dialogue, Addressing Structural racial and ethnicity-based discrimination in COVID 19 recovery plans.
2019	Presenter: Pan American Health Organization (Health equity and inequity)
2018	Delegate, UN Committee on the Rights of the Child Day of Discussion: Children as Human Rights Defenders
2018	Presenter, Universal Periodic Review: Pre-session for Canada
2018	Presenter, Inter-American Commission on Human Rights
2017	Presenter, United Nations Committee on the Elimination of Racial Discrimination
2016	Presenter, Inter-American Commission on Human Rights
2016	Commissioner, Pan American Health Organization Review of Equity and Health Inequalities in the Americas.
2013	Presenter, Special Rapporteur on Indigenous Issues, Ottawa, Canada
2012	Presenter, United Nations Committee on the Rights of the Child pre-session for review of Canada, Geneva
2012–2013	Expert Advisor, UNICEF New York

2011	Presenter, United Nations Permanent Forum on Indigenous Issues side event on Indigenous children and youth, New York
2010	Expert Member, United Nations Permanent Forum on Indigenous Issues forum on Indigenous children and youth, Vancouver, BC
2009	Presenter, United Nations Permanent Forum on Indigenous Issues. Side Event, New York
2006–2009	Assisted the United Nations Committee on the Rights of the Child in the development of a General Comment on Indigenous child rights.
2007	Presenter, United Nations Permanent Forum on Indigenous Issues, Side Event, New York
2007	Presenter, United Nations Committee on the Rights of the Child, Geneva
2006	Presenter, United Nations Permanent Forum on Indigenous Issues, Side Event. New York
2006	Presenter, United Nations Committee on Economic, Social and Cultural Rights, Geneva
2006	Presenter, NGO Group for the UN Convention on the Rights of the Child, Geneva
2004	Presenter, United Nations Permanent Forum on Indigenous Issues Side Event, New York
2003	Participant, United Nations Committee on the Rights of the Child Day of General Discussion on Indigenous Children

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PRESENTATIONS TO SENATE COMMITTEES AND HOUSE OF COMMONS COMMITTEES *(16)*

2019	Presentation to the House of Commons on Indigenous and Northern Affairs (Bill C-92)
2019	Presentation to the Senate Committee on Indigenous Peoples (Bill C-92)
2017	Presentation to the House of Commons Committee on Heritage (racial discrimination and First Nations children)
2017	Presentation to the House of Commons Committee on Indigenous Affairs (youth suicide)
2016	Presentation to the House of Commons Finance Committee
2016	Presentation to the House of Commons Indigenous Affairs Committee
2016	Presentation to the House of Commons Finance Committee
2014	Presentation to the Special House of Commons Committee on Violence Against Indigenous Women
2011	Presentation to the Standing Committee on Women on First Nations child and family services
2010	Presentation to the Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities on First Nations Adoption
2010	Presentation to the House of Commons Aboriginal Affairs Committee on First Nations child welfare funding
2009	Presentation to the Senate Committee on Human Rights
2007	Presentation to the Senate Committee on Sexual Exploitation

2006	Presentation to the House of Commons Aboriginal Affairs Committee on First Nations child welfare policy
2006	Presentation to the Senate Standing Committee on Human Rights on First Nations child welfare policy
2005	Presentation to the Senate Standing Committee on Aboriginal children off reserves who come into contact with the child welfare system

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PROVINCIAL/TERRITORIAL/JUDICIAL CHILD WELFARE REVIEW SERVICES *(9)*

2017	Presenter, Alberta Ministerial Panel on Child Intervention
2016	Witness, Inquiry into the deaths of 7 First Nations youth, Thunder Bay, ON
2016	Presenter: Government of Manitoba Premier's Council on First Nations Child Welfare
2014	Presenter: Government of Manitoba Premier's Council on First Nations child welfare
2014	Presenter: Government of Alberta on First Nations child welfare
2014	Witness, Canadian Human Rights Tribunal on First Nations Child Welfare
2013	Expert Witness, Phoenix Sinclair Inquiry
2013	Witness, Canadian Human Rights Tribunal on First Nations Child Welfare
2010	Expert Committee Member, Standing Committee of the Legislature, Northwest Territories Review on child welfare
2010	Expert Committee Member, Auditor General of Canada: Audit of Nunavut child and family services
2009	Advisor, New Brunswick Child and Youth Advocate review of First Nations child welfare

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PRESENTATIONS AT JURIED CONFERENCE *(150)*

2021	McGill-wide Department of Medicine Medical Grand Rounds (TRC Calls to Action, Jordan's Principle)
2021	Emergency Department Rounds, Children's Hospital of Eastern Ontario (TRC Calls to Action, Jordan's Principle)
2021	Keynote, International Childhood Trauma Symposium
2021	Keynote, Canadian Psychological Association
2020	Keynote. Fraser Mustard Lecture, Kids Brain Health Network
2020	CSWE Conference: Hokenstad International Lecture
2019	Keynote, Women in Medicine (Jordan's Principle)
2019	Keynote, American Society of Pediatric Otolaryngology (equity and Indigenous child health)
2019	Keynote, College of Alberta School Superintendents (Jordan's Principle)
2018	Keynote, Provincial Court Judges of British Columbia (CHRT)
2018	Grand Rounds, Montreal Children's Hospital (Jordan's Principle)
2018	Keynote: Early Childhood Australia (children's engagement in reconciliation)
2018	Workshop: Early Childhood Australia (mosquito advocacy)

2018 Conversation: Jackson Lecture, OISE U Toronto (First Nations children's rights)
2018 Keynote: International Social Work Conference (children's engagement in reconciliation)
2017 Keynote: Indspire (First Nations children's equity)
2017 Keynote: Yukon Bar Association (Canadian Human Rights Tribunal Case)
2017 Keynote: PSA Super Conference (First Nations children and reconciliation)
2017 Keynote: Ontario Tribunals (Canadian Human Rights Tribunal Rights Case)
2017 Keynote: Yukon Bench Association (Canadian Human Rights Tribunal Case)
2017 Keynote: Federal Family Court of Australia (Indigenous child welfare)
2017 Keynote: University of New South Wales, Bringing them Home 20th Anniversary (Engaging children in reconciliation)
2017 Keynote: City of Ottawa (Reconciliation and Municipalities)
2017 Keynote, Alberta School Superintendents Association (Equity and First Nations children)
2017 Keynote, Expanding Horizons for Early Years (Stigma and effect on First Nations children)
2017 Keynote, Legal Education Action Fund (LEAF), Vancouver
2017 Keynote, Equity and Child Welfare, London, UK (engaging children in equity)
2017 Grand Rounds, Queens University School of Medicine (Jordan's Principle)
2016 Keynote, ISPCAN (First Nations children's equity)
2016 Keynote, Prairie Child Welfare Consortium (First Nations children's equity)
2016 Big Thinking Lecture, Parliament Hill (The Perils of Incremental Equality for First Nations children).
2016 Keynote, 50th Anniversary of Sir Wilfred Laurier Faculty of Social Work
2016 Keynote, Office of the Senior Practitioner, New South Wales, AU (Child participation in reconciliation)
2016 Keynote, Crown Counsel Summer School (Canadian Human Rights Tribunal)
2016 Keynote, Gov't Great Failure: Not Doing Better for First Nations Children when they Knew Better (Congress 2016)
2016 Panel Presentation, Ontario Court of Justice (Reconciliation and Children's Rights)
2016 Keynote, Pathways to Reconciliation (Reconciliation and children)
2016 Keynote, Defense for Children International (Canadian Human Rights Tribunal)
2016 Keynote, Indigenous Health Conference (Equity)
2016 Workshop, Royal Society of Rural and Remote Physicians (Jordan's Principle)
2016 Webinar, Canadian Bar Association (Canadian Human Rights Tribunal)
2016 Keynote, Jack Layton Lecture, Ryerson, ON (Indigenous children's rights)
2016 Keynote, Broadbent Institute Progress Summit, Ottawa, ON (Incremental equality)
2016 Keynote, Upstream, Ottawa, ON (Incremental equality)
2016 Keynote, Better Outcomes, Connexus (Reconciliation)
2015 Panel presentation, SNAICC, Perth, AU (Neocolonialism and child welfare)
2015 Workshop, SNAICC, Perth, AU (Mosquito Advocacy)
2015 Panel presentation, Federation of the Humanities and Social Sciences Congress (Equity and Aboriginal children)
2015 Keynote, C & K Conference, Brisbane, AU: Reconciliation: the children's version
2015 Master class, C & K Conference: Mosquito Advocacy

2015	Panel Presentation, SPUR Festival, Disposable Lives: Murdered and Missing Indigenous Women
2015	Keynote, CIEC Diversity, Equity and Inclusivity Symposium (Equity)
2015	Keynote, Royal Society of Rural and Remote Medicine (Jordan's Principle)
2015	Keynote, MacEwan University: Aboriginal lecture series (Reconciliation)
2015	Expert panel: 6th International Meeting on Indigenous Health (equity)
2015	Keynote: Weld Kernohan Lecture, Dalhousie University
2015	Keynote: Wiichitaakewin Lecture, Confederation College
2015	Keynote: Woodrow Lloyd Lecture, University of Regina
2014	Keynote: Una Ridley Lecture, University of Lethbridge Faculty of Health Sciences: Reconciliation
2014	Keynote: SSHRC Imagining Canada's Future: Reconciliation
2014	Keynote: Mallory Lecture, McGill University: First Nation's Children's Equity
2014	Master class: Childhood Trauma Conference, Melbourne, AU: Mosquito Advocacy
2014	Expert panel: Childhood Trauma, Melbourne, AU
2014	Keynote: Childhood Trauma Conference, Melbourne, AU: Touchstones of Hope
2014	Keynote: Leading Practice Conference, Sydney, AU: Reconciliation and children
2014	Keynote: W.K. Kellogg Foundation American Healing Panel: Addressing Indigenous children at the international level (Indigenous children's rights)
2014	Keynote: Wunusweh Lecture on Aboriginal Law, (First Nations children's rights, University of Saskatchewan.
2013	Keynote: Inaugural Kagedan Lecture on Social Work and Human Rights, (Equity Matters), McGill University
2013	Workshop presenter, (Equity Matters), International Conference and Summit on Violence, Abuse and Trauma, San Diego, USA
2013	Plenary panel presenter, (Prevention- moving from ideas to action across the lifespan), International Conference and Summit on Violence, Abuse and Trauma, San Diego, USA
2013	Keynote speaker, SNAICC (Canadian Human Rights Tribunal and child engagement), Cairns, Australia
2013	Master class presenter, SNAICC (Mosquito Advocacy), Cairns, Australia
2013	Keynote speaker, Mowafaghian Visiting Scholar Lecture, Simon Fraser University (Mosquito advocacy)
2013	Keynote speaker, Rheal Brant Memorial Lecture, Carleton University (First Nations children's rights)
2013	Keynote speaker, Connexus, Ottawa, ON (Children's Voices have Power)
2013	Keynote speaker, *Te Rangi Pūahotanga, Otaki, New Zealand (Children standing in solidarity with First Nations children)*
2013	Keynote speaker, Montreal Women's Canadian Club (Children's Voices have Power)
2013	Carol Harrison Memorial Lecture, Sick Kids Hospital, Toronto
2012	Keynote speaker, British Columbia Association of Social Workers (Moral Courage: Kids have it and adults need it)
2012	Keynote speaker, National Child Maltreatment Symposium (UN Convention on the Rights of the Child and First Nations Children)

2012	Speaker, Montreal Children's Hospital Grand Rounds (First Nations child welfare)
2012	Keynote speaker, New Zealand Public Health Association (Mosquito Advocacy)
2012	Keynote speaker, World Conference on Social Work, Stockholm (First Nations human rights)
2012	Keynote speaker, University of Saskatchewan Indigenous Law Conference (First Nations child welfare case and UNDRIP)
2012	Keynote speaker, Ottawa/Carleton Elementary Teachers Federation (human rights for First Nations children)
2011	Panel presenter, Canadian Association of Health Sciences
2011	Keynote speaker, First Nations Education Steering Committee
2011	Keynote speaker, British Columbia Nurses Union
2011	Presenter, Indigenous Bar Association, Ottawa
2011	Presenter, Canadian Association of School Boards, Ottawa
2011	Presenter, Grand Rounds, Children's Hospital Eastern Ontario
2011	Presenter, Webinar Canadian Association of Social Workers
2011	Keynote speaker, Hidden Legacy Conference
2011	Plenary speaker, US National District Attorneys Association
2010	Keynote speaker, Ontario Association of Social Workers
2010	Keynote speaker, World Indigenous Women's Conference, Darwin, Australia
2010	Keynote speaker, SNAICC conference, Alice Springs, Australia
2010	Workshop presenter, SNAICC conference, Alice Springs, Australia
2010	Keynote speaker, PrevNet conference, McMaster University
2010	Keynote speaker, Canadian Pediatric Society Resident's Seminar
2010	Keynote speaker, Waterloo University, Social Innovation Generation Speakers Series
2010	Panel presenter, Osgoode Law School, Post-Gladue Conference
2010	Keynote speaker, National Indian Child Welfare Conference, Portland, Oregon
2010	Workshop presenter, National Indian Child Welfare Conference, Portland, Oregon
2010	Keynote speaker, Alberta Association of Social Workers Conference, Edmonton
2010	Keynote speaker, Early Childhood Conference, Victoria
2009	Keynote speaker, Indigenous Child Welfare Research, Victoria
2009	Keynote speaker, Canadian Council on Social Development, Calgary
2009	Keynote speaker, Towards 2020 Conference, Ottawa
2009	Presenter, Aboriginal Health Conference, Taipei
2009	Keynote speaker, Compassion International Conference on Child Welfare, Taipei
2009	Keynote speaker, Aboriginal Head Start, Edmonton
2009	Keynote speaker, Ontario Children's Mental Health Organization conference, Toronto
2008	Keynote speaker, Department of Community Services, Sydney, Australia
2008	Keynote speaker, World Conference for Women's Shelters, Edmonton
2008	Keynote speaker, Legal Services Society, Vancouver
2008	Keynote speaker, Association of Child Welfare Agencies, Sydney, Australia
2008	Presenter, Association of Child Welfare Agencies, Sydney, Australia
2008	Keynote speaker, North American Council on Adoptable Children, Ottawa
2008	Keynote speaker, Cultural Diversity and Vulnerable Families, Universite du Quebec, Montreal

2008	Presenter, Community of Practice Tele-symposium. American Institute for Research, Washington, DC
2007	Keynote speaker, Canadian Association of Pediatric Health Centers, Annual Conference, Montreal, Quebec
2007	Keynote speaker, Childhoods conference. Hamilton, New Zealand
2007	Keynote speaker, SNAICC conference, Adelaide, Australia
2007	Keynote speaker, Yellowhead Tribal Services National Conference on First Nations child welfare, Edmonton
2007	Keynote speaker, Indigenous Law Conference, Toronto, Ontario
2007	Workshop presenter, National Indian Child Welfare Conference, Oklahoma City, USA
2007	Plenary speaker, National Indian Child Welfare Conference, Oklahoma, USA
2007	Keynote speaker, Third International Conference on Domestic Violence, London, Ontario
2007	Plenary speaker, North American Indigenous Health Conference, Montreal
2007	Workshop presenter, North American Indigenous Health Conference, Montreal
2007	Abstract co-presenter, North American Indigenous Health Conference, Montreal
2006	Keynote speaker, C and K Early Education Conference, Cairns, Australia
2006	Keynote speaker, Forum on Epidemiology, University of Ottawa School of Medicine.
2006	Keynote speaker, Aboriginal Health Symposium, University of Ottawa, School of Medicine.
2006	Keynote speaker, National Indian Child Welfare Association Conference, San Diego, USA.
2005	Keynote speaker, World Indigenous Peoples Conference on Education, Hamilton, New Zealand
2005	Keynote speaker, Many Hands: One Dream Conference on Aboriginal Child Health, Victoria, BC
2005	Keynote speaker, Canadian Association for Community Living, Saskatoon
2005	Keynote speaker, Millennium Scholarship Conference. Ottawa
2005	S*tructural Risks to Aboriginal Children*, Workshop, Childhoods Conference, Oslo, Norway
2005	*Indigenous Children's Rights,* Workshop, United Nations Permanent Forum on Indigenous Peoples, New York, USA.
2005	Plenary speaker, Rethinking Development, Antigonish, NS
2005	Keynote speaker, Resiliency Conference, Halifax, NS
2005	*National Policy Review,* Workshop, Yellowhead Tribal Services National Conference, Victoria, BC
2005	Plenary speaker, Courageous Conversations, Harvard University
2005	Keynote speaker: Sparrow Lake Alliance Conference, Sparrow Lake, ON
2005	Keynote speaker: Walking in Both Worlds, Winnipeg, MB
2004	Keynote speaker, What Works in Social Policy, New Zealand
2004	Keynote speaker, Pacific Islander Indigenous Research Fono, New Zealand.
2004	Plenary speaker, ISPCAN Conference, Brisbane, Australia
2004	*Caring Across the Boundaries,* ISPCAN Conference, Brisbane, Australia
2004	Plenary speaker, International Conference Promoting Resiliency for Children Receiving Care. Ottawa, ON

2004	*Making Child Welfare Research Accessible: Workshop for Young People,* International Conference Promoting Resiliency for Children Receiving Care. Ottawa, ON
2004	Keynote speaker, Rheal Brant-Hall Memorial Lecture, Carleton University. Ottawa, ON
2003	Keynote speaker, International Promises into Practice Conference
2003	Keynote speaker, North American Council on Adoptable Children, Vancouver, BC
2003	Keynote speaker, Association of Native Child Welfare Agencies conference. Sault St. Marie, ON
2002	Keynote speaker, Canada's Children: Canada's Future. Toronto, ON
2000	Keynote speaker, Child Welfare Symposium. Cornwall, ON

PRESENTATIONS AT COMMUNITY EVENTS/CONFERENCES *(327)*

2021	Virtual Presentation: Merkur Lecture Series (TRC)
2021	Virtual Presentation: First Nations Children's Action Research and Education Service Fall Panel (CHRT)
2021	Virtual Presentation: BC Public Interest Disclosure Conference (Dr. Bryce)
2021	Virtual Presentation: Night for Rights by Society for Children and Youth of BC (2019 FN/CIS, CHRT)
2021	Presentation: Canadian Institute for the Administration of Justice (C-92)
2021	Virtual Lecture: University of British Columbia Dean's Distinguished Lecture (Colonialism, CHRT, 2019 FN/CIS)
2021	Virtual Presentation: The Early Childhood Development Association of Prince Edward Island Fall Conference (Dr. Bryce, 2019 FN/CIS, CHRT)
2021	Virtual Presentation: North Shore Tribal Council Technical Committee (CHRT, 2019 FN/CIS)
2021	Virtual Presentation: Federation of Sovereign Indigenous Nations (CHRT and C-92 funding)
2021	Virtual Presentation: Directors of Child Welfare (2019 FN/CIS)
2021	Virtual Presentation: Directors of Child Welfare (Caring Society Updates)
2021	Virtual Lecture: McGill Faculty of Medicine Annual Osler Lecture (Colonialism, Dr. Bryce, CHRT)
2021	Presentation: MoveUP Convention (historic and continuing inequity, CHRT)
2021	Virtual Presentation: Carrier-Sekani Family Services Annual General Assembly (CHRT, C-92)
2021	Virtual Presentation: The Law Society of Manitoba Access to Justice Week Panel (TRC, CHRT)
2021	Virtual Presentation: The Law Society of Manitoba Annual Child Protection Program (Jordan's Principle, CHRT)
2021`	Virtual Presentation: McGill University 4th International Congress on Whole Person Care (Dr. Bryce, 2019 FN/CIS, CHRT)
2021	Presentation: City of Victoria Reconciliation Dialogue No. 4 (Spirit Bear: Echoes of the Past)
2021	Virtual Presentation: Manitoba College of Social Workers Annual General Meeting & Education Event (historic and continuing inequity, CHRT)

2021	Presentation: Child Welfare Legislation Updates to Gitxsan Child and Family Services (CHRT, C-92)
2021	Presentation: CHRT and C-92 Funding Consideration to Grand Council Treaty 3
2021	Virtual Presentation: BC Aboriginal Child Care Society Conference (Dr. Bryce, Jordan's Principle, CHRT)
2021	Virtual Presentation: Law Class 272 – Queen's University for Professor Sarah Clarke (historic and continuing injustice, CHRT)
2021	Virtual Presentation: Loyola University Coffee Talk (residential schools, Dr. Bryce, CHRT)
2021	Virtual Presentation: Kings University College Veritas Lecture Series (Dr. Bryce, CHRT)
2021	Virtual Presentation: UN Committee on the Rights of the Child Day of General Discussion on Children's Rights in Alternative Care
2021	Virtual Keynote: British Columbia Teachers' Federation (Dr. Bryce, TRC, CHRT)
2021	Virtual Presentation: Royal College of Physicians (Dr. Bryce, CHRT)
2021	Virtual Presentation: University of British Columbia EDST 565 (Dr. Bryce, CHRT)
2021	Virtual Panel: Spirit Bear Teacher Professional Summer Retreat (TRC, historic and continuing inequity)
2021	Virtual Presentation: McGill University Law/Arts Faculty At-Home Homecoming (historic and continuing inequity)
2021	Virtual Presentation: Ottawa Community Pediatricians (Spirit Bear, Dr. Bryce)
2021	Virtual Presentation: Easter Seals Social Justice Speaker Series (youth activism)
2021	Virtual Presentation: Canadian Women's Initiative & Deloitte Indigenous (current and past litigation with the government)
2021	Virtual Presentation: Dodem Kanonhsa' Indigenous Education and Culture Facility (Spirit Bear)
2021	Virtual Presentation: Ontario's Children Advancement Coalition (systemic racism
2021	Virtual Presentation: Canadian Psychological Association Annual General Meeting Convention Address (Spirit Bear)
2021	Virtual Presentation: BC Aboriginal Child Care Society Directors Forum (CHRT and Jordan's Principle update)
2021	Virtual Presentation: Canadian Society for the History of Medicine Annual Conference (colonialism)
2021	Virtual Presentation: Australia Childhood Foundation International Childhood Trauma Symposium (trauma of colonization)
2021	Virtual Lecture: McGill Indigenous Field Course (2019 FN/CIS, C-92)
2021	Virtual Presentation: Saskatchewan Association of Social Workers Annual General Meeting (C-92)
2021	Virtual Presentation: Chiefs of Ontario C-92 Forum
2021	Virtual Presentation: Commentary for OCAC Child and Youth Day (Jordan's Principle)
2021	Virtual Presentation: Wabano Bear Witness Day (Spirit Bear and Jordan's Principle)
2021	Virtual Keynote: Diversity, Equity and Inclusion Conference at Appleby College

2021	Virtual Panel: AFN Quebec and Labrador: Systemic discrimination and Joyce's Principle
2021	Virtual Panel: National Indian Child Welfare Association and First Nations Child and Family Caring Society (Touchstones of Hope: Non-discrimination).
2021	Virtual Presentation: First Nations Leadership Council (Jordan's Principle judicial review)
2021	Virtual Presentation: In Path (Arts as advocacy)
2021	Juniper Elementary School: Spirit Bear
2020	Keynote, Okanagan Nation Child Wellbeing Event
2020	Virtual Keynote: Person's Day: University of Windsor: Invisible colonialism
2020	Virtual Keynote: BC Women's Transition Houses: Inequity
2020	Virtual Keynote: Kempe Centre, Denver, Colorado: Systemic racism
2020	Panel: book launch: Fighting for a Hand to Hold
2020	Virtual Panel: UNICEF Canada: UNICEF report card 16
2020	Virtual Keynote: Youth in Care Canada and the Child Welfare League of Canada (advocacy)
2020	Virtual Keynote: Together Ensemble: Moral Courage and Reconciliation
2020	Virtual Keynote: ISPCAN Webinar: First Nations Children's Equity
2020	Keynote: Council of Yukon First Nations: CHRT and C-92
2020	Keynote: BC Indigenous Heath: First Nations Children's Equity
2019	Keynote: QATSICPP Conference, Brisbane, AU (Child Engagement)
2019	Master Class: QATSICPP, Brisbane, AU (Mosquito Advocacy)
2019	Panel: University of Ottawa IFSD: Democracies: Non-violent struggles for recognition
2019	Panel: Young Public Servants Conference (How does Government learn?)
2019	Keynote: Early Childhood Education BC (Jordan's Principle)
2019	Keynote: Aboriginal Child Welfare Conference, MCFD (Jordan's Principle and CHRT)
2019	Keynote: Walpole Island First Nation (Jordan's Principle)
2019	Presentation: Walpole Island Elementary School (Spirit Bear)
2018	Keynote: Ontario School Counsellors Association (Child engagement in reconciliation)
2018	Keynote: Seven Oaks School Division (Child engagement in reconciliation)
2018	Keynote: Vision Institute (Jordan's Principle)
2018	Keynote: Indigenous Bar Association (Child rights litigation)
2018	Keynote: Mahatma Gandhi Assoc./U Manitoba (CHRT)
2018	Keynote: Mi'kmaw Confederacy of PEI
2018	Keynote: AFN Jordan's Principle Conference (Jordan's Principle)
2018	Keynote: Prince George Friendship Center (CHRT)
2018	Keynote: Mozilla Foundation (Reconciliation)
2018	Panel: Finding Peter Bryce (Peter Henderson Bryce)
2018	Keynote Speaker: Elementary Teacher's Federation of Ontario
2018	Keynote Speaker: CUPE (Reconciliation)
2018	Keynote Speaker: City of Ottawa International Women's Day (human rights)
2018	Panel: McGill University Have a Heart Day
2018	Keynote: Dawson College Montreal (First Nations children and reconciliation)
2017	Presentation: Rotaract Ottawa

2017	Presentation: Canadian Association of Pediatric Health Centers (Jordan's Principle)
2017	Chiefs of Ontario: (Child Welfare Reform)
2017	Treaty 8 Jordan's Principle Conference (Jordan's Principle)
2017	Presentation: FNCARES (Incremental Equality)
2017	Keynote: Elizabeth Fry Society of the Yukon Territory (First Nations children and reconciliation)
2017	Keynote: Elizabeth Fry Society of Quebec in collaboration with the Universite de Montreal (First Nations children and reconciliation)
2017	Keynote: Presbyterian Women's Organization (Learning from history to engage in reconciliation today)
2017	Panel presentation: Peter Henderson Bryce: Honouring a Man of Conscience (reconciliation)
2017	Presentation: Bringing them Home in University of Technology in Sydney in collaboration with the Jumbunna Indigenous House of Learning (First Nations child welfare tribunal and child engagement).
2017	Keynote: Presbyterian Church of Canada (Reconciling history).
2017	Keynote: Community Foundations of Canada (BELONG), First Nations children's equity)
2017	Presenter: Canadian Labour Congress (First Nations children's equity)
2017	Ottawa Muslim Women's Association (human rights and First Nations children)
2017	Keynote: Manitoba Nurses Association (Jordan's Principle)
2017	Keynote: Representative for Children and Youth BC (CHRT)
2017	Manitoba School Superintendents Conference, Winnipeg (First Nations children's equity and Shannen's Dream)
2017	Panel: TIFF (Foster Child) Panel with Jesse Wente
2017	Master Class: McGill Students Indigenous Solidarity Week (advocacy)
2017	Keynote: Student Nurses Association of Canada
2017	Keynote: McGill Global Nursing Conference
2017	Presentation: McGill Journal on Health and the Law
2016	Keynote: McGill Indigenous Alumni Gathering
2016	Keynote: Rotary Winnipeg
2016	Panel: Ontario Bar Association: 2016 CHRT 2
2016	Keynote: TAG- the action group to access justice, enveloping legal cases in social movements
2016	Keynote: Rotary Clubs Zone 23 and 32 Institute, First Nations children and reconciliation
2016	Question period: Calgary International Film Festival ("We Can't Make the Same Mistake Twice")
2016	Question period: Toronto International Film Festival ("We Can't Make the Same Mistake Twice")
2016	Keynote: QCAIPP, Gold Coast, Australia (Mosquito Advocacy)
2016	Keynote: New Brunswick First Nations CFS (CHRT case)
2016	Keynote: UFCW North American Women's Conference
2016	Keynote: High Risk Youth Conference (First Nations human rights)
2016	Panel: Ontario Court of Justice AGM (Canadian Human Rights Tribunal)
2016	Keynote: Lighting the Fire (First Nations education and Jordan's Principle)
2016	Keynote: BC First Nations Leadership Forum

2016 Keynote: Law Society of Upper Canada (Canadian Human Rights Tribunal)
2016 Keynote: Association of Native Child and Family Service Agencies in Ontario
2016 Panel: Economic Club of Ottawa (Leadership)
2016 Keynote: University of Alberta Alumni Association- Edmonton (Reconciliation and First Nations children)
2016 Keynote: University of Alberta Alumni Association- Calgary (Reconciliation and First Nations children)
2016 Keynote: School Board 57 Aboriginal Education (First Nations children and education).
2016 Keynote: Walpole Island First Nation Special Needs Conference
2016 Keynote: McGill Faculties of Law and Social Work (Canadian Human Rights Tribunal)
2016 Keynote: Aboriginal Nurses Association (Jordan's Principle)
2015 Presentation: Assembly of First Nations Special Chiefs Assembly (Tribunal update).
2015 Keynote: BC Non-Profit Housing Conference (First Nations children's rights)
2015 Keynote: First Nations Education Steering Committee (First Nations education)
2015 Panel: University of Alberta (Reconciliation in Post-Secondary)
2015 Presentation: Indigenous Bar Association (Mosquito Advocacy)
2015 Workshop: Federation for the Humanities and Social Sciences and SSHRC (Touchstones of Hope)
2015 Panel: Assembly of First Nations (First Nations Child Welfare)
2015 Presentation: Voices-Voix Parliamentary Breakfast
2015 Briefing: Union of BC Indian Chiefs (First Nations Child Welfare Tribunal)
2015 Keynote: Toronto Rotary Club (Reconciliation)
2015 Keynote: UNIFOR (Reconciliation)
2015 Briefing: First Nations Summit (First Nations Child Welfare Tribunal)
2015 Presentation: First Nations of Quebec and Labrador (Canadian Human Rights Tribunal and Best Practices in First Nations child welfare)
2015 Master class: First Nations child welfare (Secwepemc Child and Family Services, Kamloops)
2015 Presentation: Union of BC Indians (Canadian Human Rights Tribunal and best practices in First Nations child welfare)
2015 Moderator: Youth Panel, Journey to Reconciliation, Edmonton
2015 Keynote: University of Alberta Indigenous Knowledge Conference
2015 Master class: Independent First Nations of Ontario Youth Gathering (Mosquito advocacy)
2015 Keynote: Independent First Nations of Ontario Youth Gathering (First Nations' children's rights)
2015 Keynote: Wabano Health Center
2015 Workshop: National Indian Child Welfare Association of the USA: Touchstones of Hope
2015 Keynote: Lawyer's Rights Watch (Canadian Human Rights Tribunal case on First Nations child welfare)
2014 Keynote: University of Alberta Gall Lecture on Human Rights
2014 Presentation: Assembly of First Nations (Canadian Human Rights Tribunal on First Nations child welfare)
2014 Presentation: FNCARES (Government surveillance)

2014	Keynote: LEAF Ottawa
2014	Keynote: LEAF Edmonton
2014	Keynote: Wikwemikong First Nation (First Nations children's rights)
2014	Presentation: Whitefish River First Nation (First Nations children's rights)
2014	Keynote: Prairie Child Welfare Consortium, Saskatoon, Sask. (First Nations child welfare human rights tribunal)
2014	Keynote: IAP2 Conference, Winnipeg Manitoba (Reconciliation: the children's version). Collaboration with Fiona Cavanagh, Faculty of Extension U Alberta).
2014	Keynote: British Columbia Teachers' Federation (First Nations children's human rights)
2014	Presentation: Alberta First Nations Child and Family Service Agencies (Canadian Human Rights Tribunal on First Nations child welfare)
2014	Keynote: Catholic Women's Association, Thunder Bay (Reconciliation and children)
2014	Presentation: Sioux Lookout Health Authority (First Nations child rights and the Canadian Human Rights Tribunal)
2014	Keynote: Ontario Association of School Board Trustees (Equity in First Nations education)
2014	Presentation: Federation of Saskatchewan Indian Nations Health and Social Services Forum (Canadian Human Rights Tribunal)
2014	Moderator: Truth and Reconciliation Commission Youth Panel (Toronto Event)
2014	Keynote: Mi'kmaq Confederacy of PEI and Canada World Youth Aboriginal Youth Gathering (Indigenous children's rights)
2014	Presentation: First Nations Child and Family Services Directors' Forum (Canadian Human Rights Tribunal)
2014	Keynote: Justice, Diversity and Inclusion for All (Children's Rights)
2014	Keynote: Central Alberta Social Worker's Association (Mosquito Advocacy)
2014	Plenary Presentation: Privacy Conference hosted by Faculty of Extension of U Alberta (Domestic Government surveillance of Human Rights Defenders)
2014	BC Civil Liberties Association (Domestic Government surveillance of Human Rights Defenders)
2014	Workshop presenter: National Indian Child Welfare Association, Fort Lauderdale (trajectories of First Nations children in care)
2014	Moderator: Truth and Reconciliation Commission Youth Panel (Edmonton Event)
2014	Keynote: Moving forward- building culturally safe organizations (First Nations children's equity)
2014	Keynote: Ontario Association of Social Workers (First Nations children's equity)
2014	Panel Discussion: Hi-Ho Mistahey, FNCARES
2014	Presentation: Aboriginal Youth Advisory Circle, Alta. Child and Youth Advocate (Mosquito advocacy)
2014	Keynote: Alberta Association of Services for Children and Families (First Nations children's rights)
2013	Keynote: HIPPY Canada, Calgary (First Nations children's rights)
2013	Keynote: Peel Teachers Association, Shannen's Dream
2013	Keynote: (First Nations child welfare tribunal), Best practices in legal representation, Jasper, Alta.

2013	Testimonial: Frontline Defenders, Dublin, Ireland (Civil society and protection against government repression)
2013	Keynote Presenter: Aboriginal Foster Parent's Federation of BC, Penticton (equity and First Nations children)
2013	Keynote Presenter: Prevention Matters, Saskatoon, Saskatchewan (children's rights and child welfare)
2013	Keynote Presenter: Waving the Magic Wand, Enoch Cree Nation, Alberta (structural risks and responses)
2013	Presenter: Pacific Business and Law Institute (First Nations child welfare human rights tribunal)
2013	Keynote Presenter: Algonquin College Aboriginal Graduation
2013	Keynote Presentation: Alberta Aboriginal Child Welfare Forum (Structural risks and solutions)
2013	Keynote Presenter: Walkers of Nishiyuu Youth Forum (First Nations human rights)
2013	Keynote Presenter: Elementary Teachers Federation of Ontario (First Nations children's rights)
2013	Keynote Presenter: University of Ottawa Education Student's Forum (First Nations children's rights)
2013	Keynote Presenter: First Call (First Nations children's rights)
2013	Keynote Presenter: Indigenous Physicians Association of Canada (First Nations children's rights and Jordan's Principle)
2013	Ontario University Students Association
2012	Plenary Presenter: Assembly of First Nations Special Chiefs Assembly
2012	Keynote Presenter: West Region CFS (First Nations child rights)
2012	Keynote Presenter: Advocate's Society (First Nations child rights)
2012	Keynote Presenter: Atlantic Policy Congress Health Conference (Canadian Human Rights Tribunal on FN Child Welfare and Jordan's Principle)
2012	Human Concern International and Youth for Northern Communities (First Nations children's rights)
2012	Keynote Presenter: West Region CFS Women's Gathering (First Nations Child Rights)
2012	Keynote Presenter: BC Association of Social Workers (Moral Courage
2012	Keynote Presenter: Manitoba First Nations (First Nations child welfare)
2012	Keynote Presenter: KAIROS (Mosquito advocacy)
2012	Presenter: Assembly of First Nations education forum (First Nations children's human rights)
2012	Keynote: Temagami First Nation (Children's voices have power)
2012	CUP Annual General Meeting (Children's voices have power)
2012	Presentation: Directors of Child Welfare (First Nations child welfare)
2012	Keynote presentation: QCAIPP, Brisbane, Australia (Voices of children in human rights)
2012	Presentation: Yirkalla Community, Australia (First Nations children human rights)
2012	Keynote presentation: Supporting Aboriginal Children Together, Darwin, Australia (Children have voices)
2012	Keynote presentation: United Church of Canada General Council, Ottawa (Residential school and First Nations children today)

2012	Panel presentation: Assembly of First Nations Annual General Assembly
2012	University of Ottawa, Forum on Reconciliation (Reconciliation: implications for the current generation of FN children)
2012	Keynote presentation: Wabano Health Centre (Structural issues for FN children and Touchstones of Hope)
2012	Keynote presentation: Westboro Church, Ottawa (Equity and Social Justice for FN children)
2012	Keynote presentation: University of Ottawa Bachelor of Education Conference (Shannen's Dream)
2012	Plenary presentation: BC Government (Touchstones of Hope)
2012	Keynote presentation: Ottawa/Carleton Native Studies Teachers Conference (Shannen's Dream)
2012	Keynote presentation: Best Start Conference, Ontario (First Nations children's rights)
2012	Keynote presentation: Chiefs of Ontario ECD conference (structural risks and human rights)
2012	Presentation: Canadian Council of Child Advocates (structural risks and human rights)
2011	Presentation: Sir Wilfrid Laurier Secondary School. (Shannen's Dream, Jordan's Principle and I am a witness campaigns)
2011	Panel presentation: Assembly of First Nations Special Chiefs Assembly (First Nations children's rights)
2011	Keynote presentation: Indian Child Welfare Forum in Saskatoon (First Nations children's rights)
2011	Workshop: Assembly of First Nations Health Forum (Mosquito Advocacy)
2011	Panel presentation: Assembly of First Nations Health Forum (Jordan's Principle)
2011	Keynote: Cowichan Tribes Child Welfare Forum (7 ways to make a difference)
2011	Northern BC Chiefs Forum (First Nations children's rights)
2011	Keynote, KAIROS Women of Courage Tour (Social Justice)
2011	Keynote, Whitefish River First Nation (Touchstones of Hope)
2011	Keynote, Manitoba FN CFS (Touchstones of Hope)
2011	Keynote, Native Women's Association AGM (First Nations children's rights)
2011	Presentation, Combined Voices, Brisbane, Australia
2011	Keynote, Victoria Council of Social Services, Melbourne, Australia
2011	Keynote, Queensland Council of Social Services, Brisbane, Australia
2011	Keynote, Victoria Leadership Forum, Adelaide, Australia
2011	Master Class: Berry Street Family Services, Melbourne, Australia
2011	Panel Presentation, Queensland Council of Social Services, Brisbane, Australia
2011	Panel Presentation, Two Ways Together, Melbourne, Australia
2011	Presentation, Assembly of First Nations Social Development Forum
2011	Presentation, Assembly of First Nations Education Forum
2011	Keynote Presentation CAPDHHE Conference, Edmonton
2011	Presentation, KAIROS Banner March, Ottawa, ON
2011	Presenter: Building Bridges, Carleton Place
2011	Keynote Presentation, OASIS
2011	Presentation: Anglican Church Conference
2011	Keynote Presentation, Building Bridges Partnership

2011 Keynote Presentation, UBC Aboriginal Social Work Gathering
2011 Keynote Presenter, Guelph Children's Aid Society Aboriginal Conference
2011 Panel Presenter, Manitoba School Board's Association
2011 Keynote speaker, Ontario Aboriginal Child Welfare Conference
2011 Keynote speaker, Wesley Prankard's Camp out, Niagara Falls
2011 Workshop, Attawapiskat First Nation
2011 Catholic High school, Ottawa
2011 Presenter, UCFW Human Rights Committee
2011 Keynote speaker, Payukotayno CFS, Moose Factory FN
2011 Plenary speaker, International Indigenous Health Conference
2011 Keynote speaker, Early Childhood Development Support Services, Edmonton
2011 Keynote speaker, National Aboriginal Health Survey Conference
2011 Keynote speaker, Chiefs of Ontario Health Forum
2011 Keynote speaker, Wabano Health Center Youth Forum
2011 Presenter, Public Service Alliance of Canada, Aboriginal Forum
2011 National Women's Legal Association Forum
2010 Workshop presenter, Rise up for Rights, Canadian Labour Congress
2010 Keynote speaker, National Youth in Care Network 25th anniversary
2010 Keynote speaker, Native Women's Centre of Hamilton
2010 Workshop presenter, Rise up for Rights, Ottawa
2010 Workshop presenter, Covenant Chain Aboriginal Conference
2010 Keynote speaker, Assembly of First Nations Youth Gathering
2010 Workshop presenter, Yellowhead Tribal Services National Conference
2010 Keynote speaker, Saskatchewan Association of Social Workers
2010 Keynote speaker, the Charter and You, Ontario Bar Association
2010 Plenary speaker, Post-Gladue, Osgoode Law School
2010 Keynote speaker, Carrier-Sekani Northern Chiefs Summit on Child Welfare
2010 Keynote speaker, BC Provincial Touchstones of Hope Forum
2010 Keynote speaker, Treaty 6, 7 and 8 Chiefs Health Forum
2010 Keynote speaker, Carleton University Aboriginal Awareness Week
2009 Keynote speaker, CECW International Prevention of Child Abuse Event, Toronto
2009 Keynote speaker, Manitoba First Nations CFS Gala
2009 Keynote speaker, New Brunswick Ombudsman's Expert Panel
2009 Keynote speaker, Northern Social Workers Conference, Whitehorse
2009 Keynote speaker, George Hull Centre, Toronto
2009 Keynote speaker, Uniting Care, Australia
2009 Keynote speaker, SNAICC, Australia
2009 Keynote speaker, Department of Communities, Australia
2009 Keynote speaker, Allied Iroquois and Algonquin Indians Health Retreat, Niagara Falls, Ontario
2009 Keynote speaker, Nicola Valley Institute of Technology, Burnaby, BC
2009 Keynote speaker, Nurturing Families, Prince George, BC
2009 Keynote speaker, Southern First Nations Network of Care, Winnipeg
2009 Touchstones of Hope Conference, Toronto, Ontario
2009 Keynote speaker, Ktunaxa Kinbasket Child and Family Services Conference, Cranbrook, BC
2008 Keynote speaker, Treaty 7 Child and Family Service Conference, Calgary, AB

2008 Keynote speaker, Northern Social Workers Association, Yellowknife, NWT
2008 Keynote speaker, University of Western Australia Rural and Indigenous Health, Geraldton, Australia
2008 Keynote speaker, Vancouver Island Chiefs Forum, Vancouver, BC
2008 Keynote speaker, Benevolent Society, Orange, Australia
2008 Presentation, Government of Australia FACSIA, Canberra, Australia
2008 Keynote speaker, Indigenous Child at the Centre 2, Vancouver, BC
2008 Keynote speaker, Vancouver Island Chiefs Forum, Duncan, BC
2004 Keynote speaker, Indigenous Research Symposium, University of Victoria, BC
2005 Keynote speaker, Canadian Association of Social Workers Conference, Toronto, ON
2008 Keynote speaker, Quebec First Nations, Quebec City, PQ
2008 Keynote speaker, University of Alberta Medical School, Edmonton, AB
2008 Keynote speaker, Indigenous Child at the Centre Forum, Vancouver
2007 Speaker, Alberta Ministry for Children's Services Native Unit, Calgary AB.
2007 Keynote speaker, 50th Anniversary of the New Brunswick Community Living Association Conference, Fredericton, NB
2007 Keynote speaker. North Peace School Board
2007 Keynote speaker, Wee-chi-te-win CFS
2007 Keynote speaker, Ontario Association of Municipal Social Services
2007 Keynote speaker, Federation of Saskatchewan Indian Nations
2007 Keynote speaker, Many Hands One Dream, Ottawa
2007 Keynote speaker, Council of Health and Social Development, First Nations of Quebec
2007 Workshop presenter, National Children's Alliance, Middle Childhood Forum, Ottawa.
2007 Keynote speaker, Superintendents of Schools, Regina
2006 Keynote speaker, Superintendents of Schools Association, Winnipeg
2006 Keynote speaker, Wi Ci Ti Zon Child Welfare Conference, Saskatoon
2006 Keynote speaker, Awasis FNCFS Annual General Meeting, Prince Albert
2006 Presenter, Assembly of First Nations Executive Council, Rama First Nation.
2006 Keynote speaker, Métis Nation of Ontario, Annual General Assembly. Garden River First Nation, Sault St. Marie.
2006 Keynote speaker, National Association of Friendship Centers National Youth Forum, Saskatoon
2006 Keynote speaker, Boys and Girls Clubs of Canada
2006 Keynote speaker, Canadian Political Science Students Association
2005 Presentation, Amnesty International
2005 Presenter, Joining Hands Across the World for Indigenous Children, Toronto
2005 Keynote speaker, Annual General Meeting of Superintendents of Schools, Winnipeg, Manitoba
2005 Keynote speaker, Nog da win da min Child and Family Services Annual General Meeting.
2005 Plenary speaker, Rethinking Development Conference, St. Francis Xavier University, Nova Scotia.
2005 Keynote speaker, Resiliency Conference, Halifax, Nova Scotia
2005 Keynote speaker, Heart of the Matter, Malaspina University College

2005	Workshop, *Caring Across the Boundaries,* Heart of the Matter, Malaspina University College.
2005	Workshop, *Community Development and First Nations Child Welfare,* Heart of the Matter, Malaspina University College
2004	Plenary speaker, International Indigenous Child Rights Symposium, University of Victoria.
2004	Keynote speaker, Policy Link Conference, New Brunswick
2004	Plenary speaker, Assembly of First Nations General Assembly
2004	Keynote speaker, Saskatchewan Adoptive Parents Association
2004	Plenary speaker, National Indian Child Welfare Association Conference
2004	Presenter, Big Brothers Big Sisters of Canada Annual Meeting
2004	Keynote speaker, Family Resource Programs of Canada Annual General Meeting
2004	Keynote speaker, First Nations Youth at Risk Conference
2004	Keynote speaker, Yellowhead Tribal Services Agency, National Conference
2004	Panel presentation, National Children's Alliance Annual Meeting
2003	Keynote speaker, Winnipeg Planning Council, AGM
2003	Keynote speaker, Prairie Child Welfare Consortium Conference
2003	Presenter, FNCFCS Indigenous Research Workshop, Halifax
2003	Presenter, Malaspina College Conference

ACADEMIC PLACEMENT SUPERVISION/PhD COMMITTEE SERVICE *(32)*

2021	PhD External, Tania Tautari-Clife, University of Auckland (underway)
2020/21	Hannah Crawford, Laurier MSW
2018	PhD External, La Trobe University (Misha McMahon)
2017	MSW Thesis Supervisor (Tyson Kensall), McGill University
2017	PhD Internal, McGill University (Amal El Sana), McGill University
2016	MSW Placement Supervisor, Carleton University
2015	BSW Placement Supervisor, Carleton University
2015–Present	PhD Committee Member: York University (Farihah Ali)
2015	MSW Placement Supervisor, Carleton University
2015	External Examiner, Australian Catholic University, AU (Bindi Bennett) "Developing identity as a light-skinned Aboriginal person with little or no community and/or kinship ties."
2015	BSW Placement Supervisor, Carleton University
2014	BSW Placement Supervisor, University of Calgary
2014	External Examiner, UTS, Sydney, AU (Susan Green) "The History of Aboriginal Welfare in the Colony of NSW"
2014	BSW Placement Supervisor, Carleton University
2014	External Examiner, University of Toronto OISE
2014	BSW Placement Supervisor, Carleton University
2013	MSW Placement Supervisor, Carleton University
2013	MSW Placement Supervisor, Laurentian University
2013	MSW Placement Supervisor, Carleton University
2012–2015	Doctoral Committee Member, McGill University, School of Social Work (student withdrew from program)

2012–2020	Doctoral Committee Member, Dalhousie University, School of Social Work (candidate: Nancy MacDonald)
2012	BSW Placement Supervisor, Carleton University
2012	BSW Placement Supervisor, Sir Wilfred Laurier University
2011	Placement Supervisor, University of Ottawa
2011	BSW Placement Supervisor, Carleton University
2011	MSW Placement Supervisor, University of Victoria
2010-2011	BSW Placement Supervisor, Carleton University
2010-2016	Doctoral Committee Member, University of Ottawa (candidate: Cynthia Stirbys)
2010	Lauren Scholar Supervisor, McGill University
2009	Lauren Scholar Supervisor, University of British Columbia
2007	MSW Social Work Placement Supervisor, Carleton University and the University of Lapland, Finland
2005	MSW Social Work Student Placement Supervisor, Carleton University
2004	MSW Social Work Student Placement Supervisor, Carleton University
2003	BSW Social Work Placement Supervisor, Carleton University
1999	BSW Social Work Placement Supervisor, University of British Columbia

SELECTED INVITED TEACHING *(140)*

2021	Selkirk College: invisible colonialism and systemic racism
2020	University of Dublin: International Social Work
2020	Lougheed College: Public Policy and Inequity
2020	McGill School of Social Work: Child Protection
2020	McGill School of Social Work: Anti-oppressive Practice
2020	University of Windsor: Invisible colonialism
2020	Brock University, School of Child and Youth Care: Systemic Discrimination
2020	CHEO/University of Ottawa Faculty of Medicine: Reconciliation
2020	University of Toronto Faculty of Social Work: Research Methods
2020	UBC Faculty of Law: CHRT
2019	Mount Allison University: Is it Genocide?
2019	First Nations University: Is it Genocide?
2019	Dalhousie University, Policy Matters: Equity
2019	Monmouth University, Greta Singer Memorial Lecture: Moral Courage
2019	Monmouth University, Bachelor of Social Work: Indigenous Peoples
2019	Queens University, Thomas Courchene Lecture: Equity and Reconciliation
2019	McGill Debating Team, Equity and Reconciliation
2019	Dalhousie University, Kawaskimhon National Law Moot
2019	Dalhousie University, Faculty of Law (Mosquito Advocacy)
2019	Thompson Rivers University, Faculty of Law (CHRT)
2019	Thompson Rivers University, School of Nursing (Jordan's Principle)
2018	Harvard University, Faculty of Law (CHRT)
2018	University of Victoria, Faculties of Social Work and Indigenous Studies (First Nation's children's equity)
2018	McMaster University, Faculties of Social Work and Indigenous Studies (CHRT, ethics, etc.)

2018 Charles Sturt University, Australia (Breath of Life theory)
2018 Charles Sturt University, Australia (Moral Courage)
2018 Yale University, Faculty of Law, USA (CHRT case and Social Movements)
2018 McGill University, School of Social Work (Advocacy)
2018 University of Alberta, Faculty of Education (Child Engagement)
2017 St. Thomas University, School of Social Work (First Nations human rights)
2017 McGill University, Indigenous Student's Assoc. (Mosquito Advocacy)
2017 Thompson Rivers University Faculty of Global Studies (Equity)
2017 Thompson Rivers University Faculties of Social Work/Nursing (CHRT)
2017 University of Ottawa, Faculty of Education (Equity and reconciliation)
2016 University of Ottawa, Faculty of Education (Equity and Reconciliation)
2016 University of Alberta, School of Public Health (Mosquito Advocacy)
2015 University of Toronto, Faculty of Social Work (Breath of Life Theory)
2015 University of Toronto, Faculty of Social Work (Mosquito Advocacy)
2015 University of Toronto, Faculty of Social Work (Reconciliation)
2015 Charles Sturt University, Bathurst AU (Breath of Life Theory)
2015 Charles Sturt University, Bathurst AU (Mosquito Advocacy)
2015 University of Alberta, Sociology (Privacy)
2015 University of Alberta, Human Ecology (Mosquito Advocacy)
2015 University of Ottawa, Faculty of Management (Communications)
2015 University of Ottawa, Faculty of Education (First Nations education)
2015 University of Ottawa, Faculty of Law (Mosquito Advocacy)
2015 University of Regina, Indigenous Students Association (Leadership)
2015 University of British Columbia, Faculty of Law (First Nations children's rights)
2014 University of Alberta, Public Health (Mosquito Advocacy)
2014 University of Calgary, Faculty of Social Work (First Nations children's rights)
2014 University of British Columbia Okanagan, Faculty of Social Work (First Nations children's equity)
2014 University of Saskatchewan, Faculty of Law (First Nations child welfare tribunal and Jordan's Principle)
2014 University of Alberta, Human Ecology (Mosquito Advocacy)
2014 University of Ottawa, Faculty of Education (First Nations Education)
2014 University of Toronto, Faculty of Social Work (Quantitative methods)
2013 University of Alberta, Public Health, (Mosquito Advocacy)
2013 Vanier College, Social Sciences, (Children's voices have power)
2013 University of Ottawa, Political Science, Indigenous Peoples
2013 University of Alberta, Human Ecology (First Nations children's human rights)
2013 University of Alberta, Sociology (First Nations children's human rights)
2013 University of Alberta, Extension (Breath of Life Theory)
2013 University of Ottawa, Indigenous Studies (Mosquito Advocacy)
2013 McGill University, Indigenous Studies (First Nations children's rights)
2013 Kew Beach Public School, Toronto (Shannen's Dream)
2013 University of Toronto, Faculty of Social Work (Evidence based advocacy)
2013 University of Toronto, Social Work
2012 University of Alberta, Faculty of Public Health (Mosquito Advocacy)
2012 Sacred Heart Secondary School (Children's Voices have Power)
2012 University of Ottawa, Faculty of Law (First Nations child welfare tribunal)

2012	McGill University Faculty of Social Work and Faculty of Law (First Nations child welfare tribunal)
2012	Georgian Bay College (First Nations children's human rights)
2012	University of Moncton (First Nations children's human rights)
2012	University of Manitoba (First Nations children's human rights)
2012	Red River College (First Nations children's human rights)
2012	University of Ottawa, Graduate Students Association (Shannen's Dream and Jordan's Principle)
2012	Dalhousie University, Faculty of Political Science, (structural risks)
2012	Workshop, Milne Valley Middle School, Toronto (Equity for FN children)
2012	McGill University, School of Social Work (structural risks and human rights)
2012	Carleton University, Bachelor of Social Work (Breath of Life Theory)
2012	University of Alberta, Human Ecology (structural risks and human rights)
2012	Pierre Elliott Trudeau Elementary School (Have a Heart for First Nations Children Day)
2012	University of Alberta Aboriginal Student's Association (structural risk and human rights)
2012	University of Ottawa, Faculty of Law (human rights case)
2012	University of Toronto, The case for courage in quantitative research for First Nations children
2012	University of Ottawa, Faculty of Law
2012	University of Ottawa, Faculty of Law
2012	York University, Children and Youth Studies
2012	University of Ottawa, Faculty of Law
2011	University of Alberta (CUP), Evidence base for advocacy
2011	Carleton University, Aboriginal Students Association (First Nations Human Rights)
2011	University of Ottawa Law School (Human Rights Case)
2011	University of Northern British Columbia (Breath of Life Theory)
2011	Dalhousie University, School of Social Work (First Nations children's rights)
2011	University of Alberta, Faculty of Nursing (First Nations children's rights)
2011	University of British Columbia, Aboriginal Forum (Breath of Life Theory)
2011	NVIT, Social Work
2011	Carleton University, Social Work
2011	St. Pius X Catholic High School, Ottawa
2010	St. Paul University, Social Work
2010	University of Toronto, Faculty of Law
2010	Ryerson University, Faculty of Social Work
2010	University of Ottawa, International Development
2010	University of Toronto, Research Methods, Faculty of Social Work
2009	University of Toronto, Faculty of Social Work
2009	Queensland University of Technology, Australia
2009	University of Queensland, Australia
2009	James Cook University, Australia
2009	Nicola Valley Institute of Technology, Faculty of Social Work
2009	University of Toronto, Faculty of Social Work
2009	University of Manitoba, School of Social Work
2009	Ryerson University, School of Social Work

2009	Carleton University, School of Social Work
2008	Faculty of Social Work, University of Toronto
2008	University of Ottawa Law School
2008	School of Graduate Studies, University of Toronto
2008	Faculty of Social Work, University of Toronto
2008	Symposium, University of New South Wales, Australia
2008	Symposium, Murdoch University, Australia
2008	Symposium, University of Western Australia
2008	Faculty of Social Work, University of Victoria
2008	Faculty of Social Work, University of Toronto
2007	Faculty of Social Work, University of Toronto
2006	Human Rights, Carleton University
2006	Faculty of Social Work, University of Toronto,
2006	Department of Aboriginal Health, University of Western Australia.
2005	Master of Social Work program, University of Toronto
2005	American Indian Program, Harvard University
2005	Human Rights, Carleton University.
2004	MSW program, Carleton University
2004	PhD. and MSW programs, University of Toronto
2003	MSW program, Carleton University
2003	School of Social Work, University College of the Caribou

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INSTRUCTION *(15)*

2021	Instructor, First Peoples Social Work, McGill University
2020	Instructor, Evidence Informed Advocacy, McGill University
2020	Instructor, First Peoples Social Work, McGill University
2019	Instructor, Evidence Based Advocacy, McGill University
2019	Instructor, First Peoples Social Work, McGill University
2018	Instructor, Community Organization: Advocacy, McGill University
2018	Instructor, First Peoples Social Work, McGill University
2014	Instructor, Mosquito Advocacy, University of Alberta
2012	Instructor, Mosquito Advocacy, University of Alberta
2006	Instructor, Aboriginal Early Childhood Development Program, University of Victoria
2002	Instructor, Aboriginal Social Work module, Provincial Social Worker Training Program, Justice Institute of British Columbia
2002	Instructor, Aboriginal Social Worker Training Program
2001	Instructor, Aboriginal Social Worker Module, Provincial Social Worker Training Program, Justice Institute of British Columbia
1998–2001	Instructor, Aboriginal Social Worker Module, Provincial Social Worker Training Program, Province of British Columbia
1998	Instructor, Pilot Program of the Aboriginal Social Worker Training Program.

SELECTED MEDIA COVERAGE *(389)*

2022	Indian Country Today: Agreement in principle
2022	APTN Investigates
2022	Sirius XM Same Six Questions
2022	SiriusXM The Kim Wheeler Show
2022	CTV News: Indigenous youth in foster care
2022	Wall Street Journal Podcast – The journal on the CHRT case
2022	CBC: CHRT case
2022	APTN: CHRT case
2022	The Walrus: CHRT case
2022	CTV News – Realities and Racism Panel: Agreement in principle
2022	BBC World News: CHRT case
2022	CTV Your Morning: CHRT case
2022	CBC Radio The Current: CHRT case
2022	CTV Power Play: CHRT case
2022	CBC Power and Politics: CHRT case
2021	Global News: CHRT case
2021	CTV: Vatican visit for residential school apology
2021	CBC, Canadian Press: CHRT case
2021	CTV News Power Play: CHRT case
2021	Canadian Press: CHRT case
2021	Cable Public Affairs Channel: Child welfare compensation
2021	CBC Power and Politics: Child welfare compensation
2021	CBC Radio: Child welfare compensation
2021	Radio-Canada: Child welfare compensation
2021	CBC News: CHRT case
2021	APTN: Child welfare compensation
2021	Global News: CHRT case
2021	CBC News: Child welfare compensation
2021	SiriusXM Dahlia Kurtz Canada's National Talk Show
2021	CTV Your Morning: Compensation for First Nations schools
2021	CBC Power and Politics: Court ruling and government's decision regarding an appeal
2021	CTV Power Play and National News
2021	APTN
2021	Global News: The Pope's potential apology
2021	CTV News: Appeal ruling
2021	CBC: On Chretien
2021	CBC
2021	APTN: CHRT
2021	Globe and Mail; Response to Prime Minister appeal comments
2021	CBC Power and Politics: Reaction to Prime Minister visit to Tk'emlups
2021	CTV Question Period: Federal court ruling, National Day for Truth and Reconciliation
2021	CBC Pedro Sanchez: PH Bryce and learning from the past
2021	CBC Adrian Harewood: PH Bryce and learning from the past
2021	CBC Radio The Current: Federal court Judicial review

2021 CTV National News
2021 CityNews: Federal court
2021 Global News National: National Day for Truth and Reconciliation
2021 CBC News Power and Politics: Federal Court
2021 CTV Morning Live: Beechwood event
2021 Your Morning - Bell Media: National Day for Truth and Reconciliation
2021 CTV National News: National Day for Truth and Reconciliation
2021 Rogers- Breakfast Television: Residential schools and foster care
2021 Globe and Mail: Beechwood event
2021 SiriusXM Dahlia Kurtz Canada's National Talk Show: What the government needs to do moving forward
2021 CTV National News: Catholic Bishops and Canada's Appeal
2021 Global News: National Day for Truth and Reconciliation
2021 CBC Radio: Federal election and Indigenous peoples
2021 Global News: Election promises and Indigenous kids in care
2021 Swiss Public Broadcaster SRF: Residential schools, intergenerational trauma, and continuing inequity
2021 CTV News: Federal government postponing release of MMIWG action plan
2021 CTV News: Fact-checking the English language debate
2021 Al Jazeera: The election and the rights of Indigenous peoples
2021 Al Jazeera: residential schools and mass graves
2021 Global News: Liberal platform promises
2021 DeutschlandFunk (German Radio): Residential schools and foster care system discrimination
2021 APTN: Federal leader debate questions
2021 CTV: Federal election overshadowing residential school graves
2021 CBC Radio: Federal election
2021 CTV Your Morning: Federal funding to search for residential school graves
2021 Global News: Residential schools and how to charge abusers
2021 Al Jazeera: Residential schools, government funding
2021 CTV: Residential schools, government funding
2021 CBC: Indigenous children in foster care
2021 CBC Radio: Child welfare agreement singing between federal government and Cowessess First nation, new Governor General
2021 CTV: Child welfare agreement signing between federal government and Cowessess First Nation, new Governor General
2021 CTV National News: Kuper Island Residential School
2021 BBC: Indigenous children in foster care
2021 Australia Broadcasting Corporation: Unmarked graves at residential schools
2021 Global News: Cowessess First Nation discovery
2021 CTV Your Morning: Cowessess First Nation discovery
2021 Global National: Cowessess First Nation discovery
2021 CTV National News: Cowessess First Nation discovery
2021 BBC: Cowessess First Nation discovery
2021 Al Jazeera: 215 children in Tk'emlups (panel)
2021 Espaces Autochtones Radio-Canada: Discrimination in education and health services
2021 Rabble Off The Hill: 215 children in Tk'emlups, TRC, reconciliation

2021	Global News: Indigenous children in foster care
2021	KALW Radio (San Francisco): 215 children in Tk'emlups and Canada's litigation v. First Nations Children
2021	IndigiNews: Judicial Review
2021	SiriusXM: Judicial Review
2021	CBC News Canada Tonight: Judicial Review
2021	CTV Power Play: Judicial Review
2021	CBC All in a Day: Judicial Review
2021	CBC Radio As It Happens: Judicial Review
2021	CTV News: Judicial Review
2021	CTV Your Morning: Judicial Review
2021	CTV News: Jordan's Principle court case
2021	CBC Kids: How Canadian children can be better allies to Indigenous communities
2021	The Canadian Press: Canadian Human Rights Tribunal and Jordan's Principle
2021	BBC London: Indigenous children in foster care
2021	SiriusXM National morning show with Dahlia Kurtz
2021	CTV News: Dr. Bryce
2021	CTV Your Morning: 215 children in Tk'emlups
2021	CBC Power and Politics: NDP Motion
2021	CTV Power Play: NDP Motion
2021	Global News National: Indigenous children in foster care
2021	CTV Your Morning: 215 children in Tk'emlups
2021	CTV News Channel (Panel)
2021	National Post: Truth and Reconciliation Commission Calls to Action
2021	CBC: 215 children in Tk'emlups
2021	CityNews National: 215 children in Tk'emlups
2021	Democracy Now: 215 children in Tk'emlups
2021	CBC The National: 215 children in Tk'emlups
2021	Global News: 215 children in Tk'emlups
2021	CBC Radio: Peter Henderson Bryce and Memorials
2021	CTV News: 215 children in Tk'emlups
2021	Al Jazeera: 215 children in Tk'emlups
2021	CBC The National: 215 children and Canada's litigation v. First Nations children
2021	CTV Power Play: 215 children in Tk'emlups
2021	CTV National News: 215 children in Tk'emlups
2021	Rabble: Indigenous rights and reconciliation
2021	CTV National News: MMIWG report
2021	APTN
2021	APTN: Judicial Review Submissions
2021	Global News: Judicial review of Jordan's Principle order
2021	APTN: Nation to Nation: Judicial review of Jordan's Principle order
2021	Maclean's Magazine: Vision for the future
2020	CTV News: Systemic racism
2020	Global News: Reconciling History
2020	CTV News: John A. Macdonald
2020	CBC National News: John A. Macdonald
2020	Chatting with Homies: Shannen's Dream and the AFN protocol on child welfare

2020 CTV: AFN protocol on child welfare
2020 CBC Sunday Edition: Michael Enright's last broadcast (systemic racism)
2020 The West Block, Global News: Systemic racism
2020 Two Crees and a Pod: Breath of Life Theory
2020 CTV National News: MMIWG
2020 APTN in Focus: Shannen Koostachin
2020 APTN In Focus: Peter Henderson Bryce
2020 CTV National News: MMIWG
2020 APTN Nation to Nation: CHRT Compensation
2019 Wall Street Journal: CHRT Compensation
2019 CBC Mainstreet Halifax: CHRT Compensation
2019 CTV Regina: CHRT Compensation
2019 APTN Nation to Nation: CHRT Compensation
2019 CBC the House: CHRT Compensation
2019 CBC National News: CHRT Compensation
2019 CTV Power Play: CHRT Compensation
2019 CBC As it Happens: CHRT Compensation
2019 CBC Radio Winnipeg: CHRT Compensation
2019 CBC: Unreserved: Profile of Cindy Blackstock
2019 BBC5: MMIW
2019 BBC4: MMIW
2019 The Guardian: MMIW
2019 CTV News: MMIW
2019 CBC Metro Morning: MMIW
2019 CBC News: MMIW
2019 New York Times; MMIW
2019 CBC the Current: RCMP sexual assault interview with First Nations youth in care.
2019 CTV Powerplay: CHRT
2019 CBC Power and Politics: Jane Philpott and SNC Lavalin
2019 APTN: Bill C-92
2019 APTN: CHRT compensation
2019 CTV National News: Budget 2019
2019 APTN National News: Budget 2019
2019 CBC World at Six: Budget 2019
2019 CBC The National: Budget 2019
2019 Winnipeg Free Press: Budget 2019
2018 CBC the House: CHRT and Indigenous child welfare legislation
2018 APTN: Indigenous child welfare legislation
2018 CTV: Child Welfare and Spirit Bear
2018 Globe and Mail: MMIW and child welfare
2018 CTV: Stand Up for Kids Award
2018 Australian Broadcasting Corporation (radio): early childhood involvement in reconciliation
2018 Australian Broadcasting Corporation: Indigenous theory and children's rights
2018 Gamechangers with Tom Parkin (change leadership)
2018 TVO: Reconciliation in education in Ontario
2018 CBC the Current: Removal of John A. MacDonald's statue

2018 CBC News: Budget 2018
2018 APTN News: Budget 2018
2018 CBC the House: Emergency Meeting on First Nations Child Welfare
2018 CBC National News: CHRT non-compliance order
2018 APTN Nation to Nation: CHRT non-compliance and budget 2018
2018 CTV PowerPlay: CHRT non-compliance order
2017 CBC the House: Jordan's Principle Judicial Review
2017 CTV PowerPlay, Census data on Indigenous children
2017 Globe and Mail: Census data on Indigenous children
2017 CTV Winnipeg: Caring Society Gala and Spirit Bear
2017 The Guardian, First Nations youth suicide
2017 CBC, First Nations youth suicide and equity
2017 CBC, PM Trudeau's statements about Indigenous Peoples in Rolling Stone Magazine
2017 APTN Face to Face, CHRT and Jordan's Principle
2017 Global Television, Jordan's Principle
2017 Chatelaine Magazine http://www.chatelaine.com/news/first-nations-kids-cindy-blackstock/
2017 CBC: As it Happens (Budget 2017- CHRT Non-Compliance Hearings)
2017 CBC the National (Budget 2017- First Nations children)
2017 APTN: Canadian Human Rights Tribunal non -Compliance Hearings
2017 CPAC: Budget 2017 and CHRT Non-Compliance Hearings
2017 Toronto Star: Canada's non-compliance with Jordan's Principle
2017 APTN Nation to Nation: Jordan's Principle
2016 Global News: Canada's non-compliance with CHRT orders
2016 Canadian Press: Canada's non-compliance with CHRT orders
2016 Aljazeera, Canadian Human Rights Tribunal
2016 CCTV America, The Heat (Inequity for First Nations children)
2016 McGill Reporter (Cindy Blackstock joins Faculty of Social Work)
2016 The National, Attawapiskat Suicide Crisis
2016 CBC Peter Mansbridge One on One: Systemic discrimination
2016 CTV Canada AM: Canadian Human Rights Tribunal
2016 CBC: The National: Canadian Human Rights Tribunal
2016 Sunday Edition: Cultural Diversity?
2016 Global National News: Canadian Human Rights Tribunal
2016 APTN National News: Canadian Human Rights Tribunal
2015 APTN National News: Federal election
2015 CBC National News: First Nations water
2015 Sunday Edition: Canadian Values?
2015 CBC Radio: Dr. Peter Henderson Bryce
2015 APTN: Dr. Peter Henderson Bryce
2015 CTV: Truth and Reconciliation Commission Report
2015 CBC National News: Truth and Reconciliation Commission Report
2015 APTN National News: Truth and Reconciliation Commission Report
2015 CBC Winnipeg: Connection between childhood inequity and MMIW
2015 CTV National News: Child in care assault in Manitoba
2015 APTN Nation to Nation: Access to Information
2015 APTN In Focus: Jordan's Principle

2015 CBC Halifax: First Nations child welfare tribunal
2015 CBC Regina: First Nations children's equity
2015 Global TV Regina: Woodrow Lloyd Lecture
2015 CTV Regina: First Nations children's equity
2015 Georgia Straight: Equity for First Nations children
2015 APTN In Focus: Jordan's Principle
2014 CBC Ottawa: Big Thinking Lecture with Jim Miller
2014 CBC Thunder Bay, Jordan's Principle
2014 CBC Edmonton AM: Truth and Reconciliation Commission
2014 APTN Nation to Nation: First Nations child welfare tribunal
2014 CTV Powerplay: First Nations education announcement
2014 CBC As it Happens: First Nations education announcement
2014 CBC National News: Phoenix Sinclair Inquiry
2014 APTN National News: Run away children in foster care
2013 CBC Sunday Edition: What do we owe the future?
2013 CBC radio, Edmonton (Over-representation of Aboriginal children in child welfare care)
2013 APTN, Canadian Human Rights Tribunal
2013 Irish Medical Times: First Nations children's equity
2013 CTV National News: Nutrition Experiments on Indigenous children
2013 ABC Life Matters: Children's rights in Indigenous communities
2013 Koorie Radio: Canadian Human Rights Tribunal
2013 CTV Powerplay, Privacy Commissioner's report
2013 Maclean's magazine, Privacy Commissioner's report
2013 CBC Power and Politics, Privacy Commissioner's report
2013 Toronto Star, Privacy Commissioner's report
2013 APTN National News, Privacy Commissioner's report
2013 CBC As it Happens: Privacy Commissioner's report
2013 Globe and Mail, Canada withholding documents in Indigenous human rights case.
2013 Aboriginal Peoples Television Network: Canada withholding documents in FN child welfare case.
2013 CTV National News: Federal Budget 2013
2013 CBC radio, Yukon: Federal Court of Appeal
2013 CBC radio, Saskatchewan: Federal Court of Appeal
2013 APTN National News: First Nations child welfare tribunal
2013 CBC radio, Ottawa: First Nations child welfare tribunal
2013 Nationtalk, First Nations child welfare tribunal
2013 CBC radio, Saskatoon: First Nations child welfare tribunal
2013 CBC radio, Northern BC: First Nations child welfare tribunal
2013 Metro News, First Nations youth employment
2013 CBC Sunday Edition: Idle no More
2013 CTV National News: Idle no More
2012 Toronto Star: Retaliation complaint CHRT
2012 CBC Radio: As it Happens: Retaliation complaint CHRT
2012 APTN: UNCRC concluding observations for Canada
2012 Canadian Press: Federal government spending millions on advertising while cutting social programs

2012 CTV Powerplay: Canada spending millions to avoid hearing on FN child welfare case
2012 Globe and Mail: Canada spending millions to avoid hearing on FN child welfare case
2012 Toronto Star: Canada spending millions to avoid hearing on FN child welfare case
2012 CBC radio: Canada spending millions to avoid hearing on FN child welfare case
2012 APTN National News: Dates set for FN child welfare case
2012 CTV National News: Assembly of First Nations AGA
2012 Aboriginal Peoples Television Network: Assembly of First Nations National Chief Election
2012 CTV Newshour: Assembly of First Nations National Chief Election
2012 Prince George Citizen: Cindy Blackstock to receive Honorary doctorate degree from UNBC
2012 National Maori Radio, New Zealand: First Nations children's health
2012 CTV National News: First Nations health
2012 CTV National News: Federal budget and First Nations education
2012 CBC BC Region: Federal budget and First Nations education
2012 CBC the Current: UN attention to First Nations child rights
2012 APTN: First Nations Child Welfare Federal Court Case
2012 Ottawa Citizen: Have a Heart for First Nations Children's Day
2012 CBC: First Nations Child Welfare Federal Court Case
2012 Toronto Star: First Nations Youth Ambassadors
2012 CTV: First Nations Child Welfare Federal Court Case
2012 Edmonton Journal: First Nations Child Welfare Case
2012 CTV Powerplay: Crown-First Nations gathering
2012 CBC Power and Politics: Crown-First Nations gathering
2012 Aljazeera: Crown- First Nations gathering
2012 CBC National Radio: Trailblazers: Profile of Cindy Blackstock
2012 Guelph Mercury: Canada's native communities deserve justice now
2012 APTN: CHRT Chair Chotalia responsible for harassment of staff
2011 Toronto Star: Three women who fought back against the Conservatives
2011 CTV Powerplay: Monitoring by the Government of Canada
2011 CTV: Sexual abuse and First Nations Communities
2011 CBC, the Current: Government surveillance of Native youth advocate
2011 Midnorth Monitor: From nightmare to dream
2011 Montreal Gazette: FN school conditions
2011 National Post: Residential school memorial and education inequities
2011 Vancouver Sun: UNCRC report with KAIROS
2011 Winnipeg Free Press: UNCRC report with KAIROS
2011 CBC NWT: UN CRC report with KAIROS
2011 CBC Atlantic: UN CRC report with KAIROS
2011 CTV: UN CRC report with KAIROS
2011 Rutherford Show, Alberta: UNCRC report
2011 CBC Yukon: UN CRC report with KAIROS
2011 Toronto Star: UN CRC report with KAIROS
2011 Australian Broadcasting Company: Indigenous child welfare
2011 Aboriginal Peoples Television Network: Jordan's Principle

2011 Canada AM: Shannen's Dream
2011 Reuters: Our Dreams Matter Too
2011 Silobreaker: Our Dreams Matter Too
2011 India Times: Our Dreams Matter Too
2011 CNBC: Our Dreams Matter Too
2011 Money Magazine (on line): Our Dreams Matter Too
2011 La Press Canadien Ottawa négligerait les jeunes autochtones dans le domaine de l'éducation
2011 Frankfurter Rundschau: Our Dreams Matter Too
2011 Toronto Star: Atkinson Fellowship
2011 CTV: First Nations Child Welfare and Education (AFN)
2011 The Globe and Mail: First Nations Child Welfare and Education (AFN)
2011 Toronto Star: Risks to First Nations Students Attending School Away from Home
2011 CBC the Current: Shannen's Dream
2011 CKVU radio: Shannen's Dream
2011 Toronto Star: Aboriginal Child Welfare Summit
2011 National Post: letter to the Editor on Child Welfare
2011 CBC Radio: Child Welfare Northwest Territory
2011 CBC Radio: FN children's equity as an election issue
2011 Global Television and APTN: Aboriginal Achievement Awards
2011 APTN: Child Welfare Tribunal Rules
2011 APTN Investigates: Child Welfare Tribunal
2011 APTN In Focus: Jordan's Principle
2010 CBC Radio: Shannen's Dream
2010 CTV Powerplay: Shannen's Dream
2010 Aboriginal Peoples Television Network: *Sisters in Spirit*
2010 Aboriginal Peoples Television Network, In Focus: *Child Welfare*
2010 Caama Radio, Alice Springs, Australia: *Human Rights Tribunal*
2010 CBC Sunday Edition: *Human Rights Tribunal*
2010 CBC The Current: *Native Child Welfare*
2010 Aboriginal Peoples Television Network: *First Nations Child Welfare Tribunal*
2010 CBC radio, Yukon Territory: *First Nations Child Welfare Tribunal*
2009 Toronto Star: *Caring Across Boundaries Photography Exhibit*
2009 CBC The Current: *Jordan's Principle*
2009 Toronto Star: *Atkinson Social Justice Fellowship*
2009 Toronto Star: Shortage of Funds: Surplus of Suffering
2009 CBC radio: Yukon Territory: *First Nations Child Welfare Tribunal*
2009 Aboriginal Peoples Television Network: *First Nations Gala*
2009 CHOU radio: *Canadian Human Rights Tribunal*
2009 The Aboriginal Peoples Television Network: *Canadian Human Rights Tribunal*
2009 The Devoir: *First Nations Child Welfare*
2009 The Courier Mail, Queensland: *First Nations Child Welfare*
2009 Contact, Aboriginal Peoples Television Network-*Child and Family Services*
2009 Globe and Mail: *Federal Budget*
2009 Aboriginal Peoples Television Network: Is this our Canada? project
2008 CBC radio: *First Nations Child Welfare Tribunal*
2008 CBC radio: *Dr. PH Bryce and Cindy Blackstock*

2008 Aboriginal Peoples Television Network: *Canadian Human Rights Complaint*
2008 Globe and Mail: *Child Welfare in BC*
2008 The Australian: ACWA Conference
2008 Indigenous radio-Northern Territory, Australia
2008 APTN: *Human Rights Case in Child Welfare*
2008 CBC news: *Attawapiskat School*
2008 APTN: Nomination for International Children's Peace Prize
2008 Maclean's Magazine: *First Nations child welfare*
2008 Victoria Times Colonist: *Jordan's Principle*
2008 Aboriginal Peoples Television Network: *Jordan's Principle*
2007 Australian Broadcasting Network (ABC): *Jordan's Principle*
2007 Te Ao Hou: The Maori Magazine: *Human Rights Complaint and Jordan's Principle*
2007 CBC news: *Manitoba Child Welfare*
2007 CBC news: *Jordan's Principle CMAJ editorial*
2007 Globe and Mail: *Jordan's Principle CMAJ editorial*
2007 Edmonton Sun: *Jordan's Principle CMAJ editorial*
2007 Belleville Intelligencer Newspaper: *First Nations child welfare*
2007 Press conference: Launch of the First Nations family and community institute in Saskatchewan, Saskatoon
2007 CTV news: *Launch of First Nations family and community institute in Saskatchewan*
2007 CBC radio: *Many Hands One Dream*
2007 Aboriginal Peoples Television Network: *Jordan's Principle tabled in the House of Commons*
2007 News conference- House of Commons, Canada: *Jordan's Principle*
2007 Aboriginal Peoples Television Network: *Norway House Cree Nation and Jordan's Principle*
2007 CBC radio, Winnipeg: *Norway House Cree Nation and Jordan's Principle*
2007 News conference, House of Commons, Canada: *Human Rights Complaint*
2007 CBC radio, Montreal: *Human Rights Complaint*
2007 Aboriginal Peoples Television Network: *Human Rights Complaint*
2006 Aboriginal Peoples Television Network:
Contact: Aboriginal child welfare
2005 CBC Television:
Adoption of Aboriginal children
2005 CBC Radio:
Reconciliation in Child Welfare
2005 Global Television Network:
Reconciliation in Child Welfare
2005 Aboriginal Peoples Television Network:
Reconciliation in Child Welfare

COMMUNITY WORK AND PROFESSIONAL MEMBERSHIPS *(22)*

2020-Present	Member, Leadership Council of Global Systemic Racism Working Group
2020-Present	Member, First Nations Leadership Council, funding technical table
2018-2020	interim Board Member: 60's scoop Foundation
2015–Present	Chair of Reconciliation Historical Plaque Working Group, Beechwood Cemetery
2016–2017	Juror, Samara Everyday Political Citizen Youth Awards
2016–Present	Member, IAM Committee, McGill School of Social Work
2015–2017	Advisory Board Member, Canadian Difference
2015–2018	Member, City of Winnipeg, Indigenous Advisory Circle
2014–Present	Registered Social Worker, Alberta Association of Social Workers
2009–Present	Member, Ontario Association of Social Workers
2014–2018	Board Member, Federation of the Humanities and Social Sciences
2014–2018	Chairperson, Equity Committee, Federation of the Humanities and Social Sciences
2011–Present	Member, Indigenous Bar Association
2014–Present	Member, BC Civil Liberties Association
2014–Present	Member, International Commission of Jurists Canada
2009–2014	Member, NGO Group on the United Nations Convention on the Rights of the Child Indigenous Sub Group
2005–2009	Co-convener, NGO Group on the United Nations Convention on the Rights of the Child Indigenous Sub Group
2006–2008	Board Member, Canadian Education Association
2005–2008	Board Member, Boys and Girls Clubs of Canada
2005–2006	Member, Youth Engagement Ethical Guidelines Sub Group
2004– 2005	Board Member, Canadian Coalition of the Rights of the Child
2004–2014	Member, NGO Group, Convention on the United Nations Rights of the Child

This is **Exhibit "B"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)
Sarah Clarke LSO # 57377M

Tribunal File No: T1340/7008

CANADIAN HUMAN RIGHTS TRIBUNAL

B E T W E E N:

FIRST NATIONS CHILD AND FAMILY CARING SOCIETY OF CANADA and ASSEMBLY OF FIRST NATIONS

Complainants

- and –

CANADIAN HUMAN RIGHTS COMMISSION

Commission

- and –

ATTORNEY GENERAL OF CANADA (Representing the Minister of Indigenous Services Canada)

Respondent

- and -

CHIEFS OF ONTARIO, AMNESTY INTERNATIONAL CANADA and NISHNAWBE ASKI NATION

Interested Parties

Honouring First Nations Children, Youth and Families

We honour all the children, youth and families affected by Canada's discriminatory conduct in child and family services and Jordan's Principle. We acknowledge the emotional, mental, physical, spiritual, and yet to be known harms that this discrimination had on you and your loved ones. We stand with you and admire your courage and perseverance while recognizing that your struggle for justice often brings back difficult memories. We pay tribute to those who have passed on to the Spirit World before seeing their experiences recognized in this Agreement.

We are so grateful to Residential School Survivors, Sixties Scoop Survivors, the families of Murdered and Missing Women and Girls and 2SLGBTQQIA persons, First Nations leadership, and the many allies, particularly the children and youth who called for the full implementation of Jordan's Principle, substantively equal child welfare supports and fair compensation for those who were harmed. We thank you for continuing to stand with First Nations children, youth, and families to ensure the egregious discrimination stops and does not recur.

We honour and give thanks to Jordan River Anderson, founder of Jordan's Principle, and his family along with the representative plaintiffs, including Ashley Dawn Bach, Karen Osachoff, Melissa Walterson, Noah Buffalo-Jackson, Carolyn Buffalo, Richard Jackson, Xavier Moushoom, Jeremy Meawasige, Jonavon Meawasige, the late Maurina Beadle, and Zacheus Trout and his two late children, Sanaye and Jacob. We also recognize Youth in and from care, Residential School and Sixties Scoop Survivors who shared their truths to ensure funding for culturally competent and trauma informed supports are available to all affected by this Agreement.

To all the First Nations children, youth and families reading this - remember that you belong. You are children of Chiefs, leaders, matriarchs, and knowledge keepers, and you have the right to your culture, language, and land.

MINUTES OF SETTLEMENT

A. These Minutes of Settlement are intended to resolve the Canadian Human Rights Tribunal Compensation Decisions. The Assembly of First Nations (the "**AFN**"), Canada and the First Nations Child and Family Caring Society (the "**Caring Society**") have collaborated to revise the Final Settlement Agreement in line with the Tribunal's decisions.

B. In 2007, the Caring Society and the AFN commenced this human rights complaint, alleging that Canada discriminated against First Nations children and families on the prohibited grounds of race and national or ethnic origin in the provision of child and family services and in Canada's failure to fully implement Jordan's Principle. The AFN, the Caring Society and Canada are collectively referred to herein as the Parties.

C. In 2016 CHRT 2, the Canadian Human Rights Tribunal (the "**Tribunal**") found that Canada discriminated against First Nations children on reserve and in the Yukon in a systemic way on the prohibited grounds of race and national or ethnic origin, by underfunding the First Nations Child and Family Services Program ("**FNCFS Program**"), and through its design, management, and control. Canada's wilful and reckless discrimination was linked to the unnecessary separation of First Nations children from their families. With respect to Jordan's Principle, the Tribunal found that Canada wilfully and recklessly discriminated against First Nations children on the prohibited grounds of race and national or ethnic origin pursuant to its narrow definition and inadequate implementation of Jordan's Principle, resulting in adverse service gaps, delays, and denials for First Nations children. The Tribunal established Canada's liability for systemic discrimination on the prohibited grounds of race and national or ethnic origin and ordered Canada to cease the discriminatory practices, take measures to redress and prevent discrimination from reoccurring, reform the FNCFS Program, and implement the full meaning and scope of Jordan's Principle.

D. Between 2019 and 2021, three class actions were commenced in the Federal Court seeking compensation for discrimination dating back to April 1, 1991, including a class action commenced by the AFN (the "**Consolidated Class Action**"). The AFN is a party to both the class actions and this proceeding. The Caring Society is not a party to the Consolidated Class Action.

E. In 2019 CHRT 39 (the "**Compensation Entitlement Order**") the Tribunal determined that Canada's systemic discrimination on the prohibited grounds of race and national or ethnic origin caused harms of the worst kind to First Nations children and families, ordering compensation to the victims of Canada's systemic racial discrimination. The Tribunal set an end date of 2017 for compensation for the Jordan's Principle child and family victims and an open-end date with respect to removed children and their parents/caregiving

grandparents pending a further order. In 2021 CHRT 7, the Tribunal ordered the implementation of a framework for the distribution of the compensation, (the "**Compensation Framework Order**").

F. On September 29, 2021, Justice Favel of the Federal Court of Canada dismissed Canada's judicial review and upheld the Compensation Entitlement Order. Canada appealed the decision to the Federal Court of Appeal.

G. In 2022 CHRT 8, the Tribunal established March 31, 2022, as the end date for compensation payable to removed children and their parents/caregiving grandparents under the Compensation Entitlement Order.

H. In June 2022, the class action parties, to the Consolidated Class Action (including Canada and AFN) signed a final settlement agreement (the "**2022 FSA**"). In September 2022, the AFN and Canada brought a motion to the Tribunal seeking a declaration that the 2022 FSA is fair, reasonable and satisfies the Compensation Entitlement Order and all related clarifying orders and in the alternative, an order varying the Compensation Entitlement Order, Compensation Framework Order and other compensation orders, to conform to the 2022 FSA.

I. The Tribunal dismissed the Canada and AFN motion in October 2022, with full reasons at 2022 CHRT 41. The Tribunal found that the 2022 FSA substantially satisfied the Compensation Entitlement Order. However, it failed to fully satisfy the Compensation Entitlement Order as the 2022 FSA disentitled, or reduced entitlements, for certain victims/survivors already entitled to compensation awarded by the Tribunal under the Compensation Entitlement Order and made entitlements for other victims unclear.

J. Following the release of 2022 CHRT 41, the First Nations-in-Assembly unanimously adopted Resolution No. 28/2022. On April 4, 2023, the First Nations-in-Assembly unanimously adopted Resolution No. 04/2023, fully supporting the revised settlement agreement. First Nations- In-Assembly Resolutions No. 28/2022 and No. 04/2023 are attached hereto as Schedule "A".

K. The Parties to this proceeding and the parties to the Consolidated Class Action engaged in negotiations resulting in a revised final settlement agreement drafted to account for the direction in First Nations-in-Assembly Resolution No. 28/2022 and to satisfy the Tribunal's 2022 CHRT 41 decision (the "**Agreement**") attached hereto as Schedule "B".

NOW THEREFORE in consideration of the mutual agreements, covenants, and undertakings set out herein, the Parties agree as follows:

1. As the Caring Society is not a party to the Consolidated Class Action, the Caring Society's involvement in reviewing and commenting on the Agreement is focused on the victims identified by the Tribunal for compensation pursuant to the *Canadian Human Rights Act* within this proceeding.

2. In the opinion of the Parties, the Agreement, as revised by the Parties, now satisfies the Compensation Entitlement Order, the Compensation Framework Order, and all other Tribunal orders related to compensation such that the victims of Canada's discriminatory conduct shall be compensated pursuant to the direction of the Tribunal and in satisfaction of the Tribunal's orders, including the Tribunal's direction and guidance set out in 2022 CHRT 41.

3. As directed by the First Nations-in-Assembly Resolution 04/2023, the Parties shall cooperate to bring a consent motion to the Tribunal seeking its approval of the Agreement in full satisfaction of the Compensation Entitlement Order and the Compensation Framework Order (the "**Joint Compensation Motion**"). Each Party shall file affidavit evidence in support of the Joint Compensation Motion.

4. The Parties commit to supporting the Agreement as it relates to the victims identified by the Tribunal and to make no submissions to the Tribunal suggesting that the balance of the Agreement ought not to be approved.

5. As part of the relief sought on the Joint Compensation Motion, the Parties shall request that the Tribunal retain jurisdiction on compensation until the Federal Court approves the Agreement and the appeal period has expired or until any appeals are resolved. The Parties shall further request that upon approval of the Agreement by the Federal Court on a final basis, the Tribunal's jurisdiction in this proceeding in relation to compensation shall come to an end and that the Federal Court shall supervise the implementation of the Agreement. Should the Tribunal approve the Joint Compensation Motion but the Federal Court reject all or part the Agreement at the Settlement Approval Hearing, or if the Federal Court order approving the Agreement is overturned on appeal, Canada and the AFN shall support the Caring Society's participation in any further steps at the Federal Court / Federal Court of Appeal and, if needed, at the Supreme Court of Canada in relation to seeking approval of the Agreement.

6. The Parties agree that the funds payable by Canada in the amount of $23,343,940,000 and any other commitments and safeguards specifically set out in the Agreement satisfy Canada's obligations with respect to payments associated with the Tribunal's Compensation Entitlement Order, the Compensation Framework Order and all other Tribunal orders related to compensation.

7. As part of the $23,343,940,000 funds payable under the Agreement, $90,000,000 will be transferred to a trust entity for the purposes of providing additional supports to high needs members of the Approved Jordan's Principle Class between the Age of Majority and the Class Member's 26th birthday necessary to ensure their personal dignity and well-being (the "**Jordan's Principle Post-Majority Fund**"). The terms of the Jordan's Principle Post-Majority Fund are set out in the Agreement and include the following:

    a. In cooperation with the Jordan's Principle trust entity, the Caring Society will have the following responsibilities in relation to the Jordan's Principle Post-Majority Fund:

        i. Designing the trust agreement reflecting the purpose of the Jordan's Principle Post-Majority Fund and the terms and conditions of same;

        ii. Determining the eligibility criteria and process for accessing benefits under the Jordan's Principle Post-Majority Fund; and

        iii. Receive and review an accounting from the Jordan's Principle trust entity on a quarterly basis.

    b. Jordan's Principle Post Majority Beneficiaries may access benefits under the Jordan's Principle Post-Majority Fund by making a request to the trust entity. If a Jordan's Principle Approved Class Member who is approaching or is past the Age of Majority contacts Indigenous Services Canada, or its successor, through mechanisms for accessing Jordan's Principle, Indigenous Services Canada will refer the Class Member to the trust entity. Indigenous Services Canada will collaborate with the Caring Society and the plaintiffs to the Consolidated Class Action regarding public information that can be provided by Indigenous Services Canada regarding the Jordan's Principle Post-Majority Fund.

    c. Any income generated on the Jordan's Principle Post Majority Fund which is not distributed to the Jordan's Principle Post Majority Beneficiaries in any year will be accumulated in the Jordan's Principle Post Majority Fund.

8. Canada will pay $5 million to the Caring Society to facilitate the Caring Society's participation in the implementation and administration of the Agreement over the approximately twenty (20) year term of the Agreement on a non-profit basis.

9. As part of the approval of the Agreement at the Federal Court, Canada and the AFN will seek a further extension of the Opt-Out Deadline to October 6, 2023.

10. By signing these Minutes of Settlement, each Party confirms that in their opinion the Agreement satisfies the Tribunal's Compensation Entitlement Order, the Compensation Framework Order and all other Tribunal orders related to compensation.

11. No Party will judicially review the Tribunal's order should it determine that the Agreement satisfies its compensation orders and grant the relief sought on the Joint Compensation Motion.

12. Nothing in these Minutes of Settlement impacts any commentary with respect to the administration of the Agreement following its implementation.

13. Upon approval of the Agreement by the Tribunal and the Federal Court, and the resolution of any judicial reviews and appeals, no further orders for compensation shall be sought by any Party to this proceeding relating to the victims subject to the Tribunal's compensation orders or the Consolidated Class Action.

14. Upon approval of the Agreement by the Tribunal, each Party agrees that it shall not engage in the Federal Court proceeding to oppose or promote others to oppose the terms of the Agreement at the Settlement Approval Hearing.

15. Within five (5) business days of the later of the following dates, Canada and the AFN shall file a Notice of Discontinuance in relation to their respective judicial review applications of 2022 CHRT 41, with the Federal Court on a without costs basis:

    (a) the day following the last day on which an individual may appeal or seek leave to appeal the decision of the Federal Court, approving the Agreement ("**Federal Court Settlement Approval Order**"); or

    (b) the date on which the last of any appeals of the Federal Court Settlement Approval Order are finally determined.

16. Within five (5) business days of the expiry of the appeal period or the date on which the last of any appeals of the Federal Court Settlement Approval Order are finally determined, Canada shall file a Notice of Discontinuance with the Federal Court of Appeal for Court File No. A-290-21 on a without costs basis.

17. In consideration of the agreement by Canada to assume the obligations and pay the amounts referred to in the Agreement in order to enable its implementation, the Caring Society and the AFN, "the Releasors," hereby release, remise and forever discharge Canada and its servants, agents, officers and employees,

predecessors, successors, and assigns (hereinafter collectively the "**Releasees**"), from any claim for compensation arising from this proceeding and all actions, causes of action, claims, and demands of every nature or kind available, whether or not known or anticipated, which the Releasors had, now have or may in the future have against the Releasees, in any capacity, whether personal or representative, in respect of the claims asserted or capable of being asserted with regard to compensation for the discrimination found to have occurred by the Tribunal in this proceeding or asserted and all claims asserted or capable of being asserted in the Consolidated Class Action. For clarity, this release in no way affects the ongoing long-term reform issues in the Tribunal proceeding in Tribunal File No. T1340/7008.

18. If the Tribunal dismisses the Joint Compensation Motion these Minutes of Settlement, including any releases given thereunder to the Releasees, shall be null and void.

Dated this 19th day of April, 2023.

CANADA, as represented by the Ministers of Indigenous Services and Crown-Indigenous Relations

The Honourable Patty Hajdu, P.C., M.P.
Minister of Indigenous Services

The Honourable Marc Miller, P.C., M.P.
Minister of Crown-Indigenous Relations

THE ASSEMBLY OF FIRST NATIONS

Cindy Woodhouse
Regional Chief

THE FIRST NATIONS CHILD AND FAMILY CARING SOCIETY OF CANADA

Cindy Blackstock, PhD
Executive Director

This is **Exhibit "C"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)

Sarah Clarke LSO # 57377M

April 02, 2020

FIRST NATIONS CHILD WELFARE: COMPENSATION FOR REMOVALS

OFFICE OF THE PARLIAMENTARY BUDGET OFFICER
BUREAU DU DIRECTEUR PARLEMENTAIRE DU BUDGET

The Parliamentary Budget Officer (PBO) supports Parliament by providing economic and financial analysis for the purposes of raising the quality of parliamentary debate and promoting greater budget transparency and accountability.

This report estimates the financial cost of complying with a Canadian Human Rights Tribunal decision (2019 CHRT 39) as it relates to First Nations children taken into care. It was prepared at the request of Mr. Charlie Angus, Member of Parliament for Timmins-James Bay.

Some data used in this publication came from the First Nations Component of the 2008 Canadian Incidence Study of Reported Child Abuse and Neglect (FNCIS 2008). These data were used with the permission of the First Nations Child Welfare Research Committee. The study was funded by the federal, provincial, and territorial governments of Canada, the Social Sciences and Humanities Research Council of Canada, and the Canadian Foundation for Innovation.

The PBO thanks the First Nations Child and Family Caring Society, the First Nations Child Welfare Research Committee and Indigenous Services Canada for the information and explanations they provided to assist with this analysis. The analyses and interpretations presented in this report are those of the PBO and do not necessarily reflect the opinions of the above-mentioned organizations.

For readability, all counts have been rounded to hundreds of persons.

Lead Analyst:
Ben Segel-Brown, Financial Analyst

Contributors:
Salma Mohamed Ahmed, Research Assistant

This report was prepared under the direction of:
Mark Mahabir, Director of Costing and General Counsel

Nancy Beauchamp, Jocelyne Scrim, and Rémy Vanherweghem assisted with the preparation of the report for publication.

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Yves Giroux
Parliamentary Budget Officer

RP-2021-001-M_e

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Executive Summary

In September 2019, the Canadian Human Rights Tribunal (CHRT) ordered Canada to pay compensation to First Nations children and caregivers who were affected by the on-reserve child welfare system.

The Government of Canada has applied for judicial review of the CHRT decision, which could result in the compensation order being dramatically narrowed or voided entirely. This report estimates the cost of complying with the decision as it relates to children taken into care.

The preliminary estimate of Indigenous Services Canada (ISC) was that 125,600 people are eligible for compensation totalling $5.4 billion. Based on the PBO's assumed legal interpretation, the PBO estimates that 19,000 to 65,100 people are eligible for compensation in a range of $0.9 billion to $2.9 billion. Both estimates assume compensation is paid by the end of 2020.

Summary Table 1

High-level comparison of estimates

	ISC	PBO
# Eligible	125,600	19,000 to 65,100
Cost to compensate ($ billions)	$5.4	$0.9 to $2.9

The PBO expects fewer people to be eligible primarily because we assume that children placed within their extended family or community are not eligible for compensation.

Our estimate is presented as a range, as it is unclear what proportion of children will be excluded, either because the CHRT deems that their removal was necessary, or that their family benefited from prevention services. This report examines a number of scenarios under which these two eligibility criteria might be applied, and their possible impact on eligibility for compensation.

The Government of Canada has indicated that it intends to compensate those harmed by removals through the settlement of a class action. There may be significant barriers to a successful class action, which could result in fewer families receiving compensation. In addition, compensation for each removed child would not necessarily be more than the amount awarded by the CHRT.

1. Introduction

In September 2019, the Canadian Human Rights Tribunal (CHRT) ordered Canada to pay compensation to certain First Nations children and caregivers who were harmed by racial discrimination in federal funding for child and family services on-reserve and in Yukon.[1]

The decision included orders of compensation related to the removal of children from their family and related to delays and denials of essential services to children. This report focuses solely on compensation for removals. It includes compensation for removals to receive services but excludes compensation for delays and denials of services to children who remained in their homes.

The preliminary estimate of Indigenous Services Canada (ISC) was that 125,600 people are eligible for compensation totalling $5.4 billion, including interest. Based on the PBO's assumed legal interpretation, we estimate that 19,000 to 65,100 individuals are eligible for compensation that would range from $0.9 billion to $2.9 billion, including interest.

The PBO assumes that the CHRT decision requires Canada to pay $40,000 to all First Nations children ordinarily resident on-reserve or in Yukon at the time of their removal who were:

1. Unnecessarily removed from their home, family, and community after 1 January 2006 due to poverty, poor housing, neglect, or substance abuse and did not benefit from prevention services that would have permitted them to remain safely in their home, family and community;

2. Removed from their homes after 1 January 2006 due to abuse and placed outside their family and community; or

3. Were deprived of essential services within the scope of Jordan's Principle[2] and placed in care outside their homes, families and communities in order to receive those services between 12 December 2007 and 2 November 2017.

For each eligible child removed for reasons other than abuse, the parent(s) or grandparents of that removed child are also entitled to $40,000 in compensation.[3]

All the major parties to the CHRT proceedings have varying legal interpretations that differ from each other and from the PBO's assumptions set out above.[4] The PBO's assumed legal interpretation is an objective assessment of what the CHRT order requires; it is not a normative position regarding what compensation should have been ordered. The CHRT may

revise its order as parties seek clarification, as the CHRT did through a letter dated 16 March 2020.[5]

The Government of Canada has applied for judicial review of the decision, which could dramatically reduce or entirely void this compensation order.[6] The Tribunal's orders are also suspended pending a decision by the Tribunal regarding the process to be used to identify those eligible for compensation. Ongoing discussions or future CHRT orders could change the scope of who is entitled to compensation relative to what is required by the September CHRT order.

The PBO's estimate reflects the cost of paying the compensation ordered by the CHRT; it is not discounted for the probability of that order being reduced or voided through judicial review.

2. Cost of complying with the CHRT order

2.1. Placements by type

Based on data supplied by ISC from their financial records, the PBO estimates that 53,700 children will have been removed from their home - either on-reserve or in Yukon[7] - and placed in ISC-funded placements from 1 January 2006 to the end of 2020. This includes 8,500 children already in care in 2006.

Because this figure is based on ISC's financial records, it excludes unfunded placements of First Nations children with family, family friends or community members, where no federal expenditure would be recorded.

ISC classifies funded placements into four types: kinship care, foster care, institutional care, and group homes. The estimated breakdown of placements is shown in Table 2-1.

Table 2-1 Number of children taken into funded care for the first time by care type (2006-2020)

	#
Kinship[8]	12,500
Foster[9]	36,700
Institutional	2,100
Group Homes	2,400
Total	***53,700***

Source: PBO based on data derived from ISC's Child and Family Services Information Management System (CFS IMS).

Notes: This represents an estimate of the number of unique children who will have been taken into care for the first time at some point from 2006 up to the end of 2020. Removals prior to 2014 were estimated based on indexing to point-in-time counts.[10] The type of care is based on the child's first placement.

2.2. Placements outside family and community

According to the CHRT decision, compensation is awarded in relation to children placed in care outside of their homes, families and communities.[11] Thus, children removed from their home and placed within their extended family or community are not eligible for compensation.

By definition, children placed in informal or formal kinship foster care remain within their families or their communities for that placement. In addition, some children placed in non-kinship foster care and group homes remain within their communities. The estimated proportion and number of children in each type of care who were removed from their family and from their community is shown in Table 2-2.

Table 2-2 **Share and number of children removed from their family and from their community by care type (2006-2020)**

Share removed from their family and from their community	%	#
Kinship[12]	8%	1,000
Foster[13]	76%	27,900
Institutional and Group Homes[14]	84%	3,900
Total removed from their home, family and community		***32,700***

Source: PBO based on 2016 Census and 2011 Census and ISC's CFS IMS
Note: See endnotes for assumptions and calculations. For foster care, institutional care and group homes, these proportions reflect the share of children placed off-reserve, either in their initial placement or in a subsequent placement. Some First Nations may consider some off-reserve placements with families sharing the same Aboriginal identity to be placements within the child's community. In the 2011 National Household Survey, 21 per cent of First Nations foster children living off-reserve lived with at least one First Nations foster parent.[15]

2.3. Reason for removal

Of those children who were removed from their home, family, and community, the estimated breakdown of reasons for removal is shown in Table 2-3 below. Two-thirds of children, roughly 22,000, were removed for reasons other than abuse. They are analyzed together because they cannot be distinguished based on caseworker-reported reasons for removal; both children and parents would be eligible for compensation in almost all cases.[16]

Table 2-3 **Share and number of children removed from home, family and community by primary reason for removal (2006-2020)**

Primary reason for removal	%	#
Abuse	33%	10,700
Reasons Other than Abuse	67%	22,000
Total		***32,700***

Source: PBO based on custom analysis of First Nations Component of the 2008 Canadian Incidence Study of Reported Child Abuse and Neglect (FNCIS 2008).

Note: The breakdown was based on the primary reason for removal as recorded in the FNCIS 2008. Exposure to intimate partner violence (the primary reason for removal in 8 per cent of removals)[17] and emotional maltreatment (3 per cent) were classified as removals due to abuse. Multiple factors are often present in a removal. For example, poverty and substance abuse may be factors in a removal due to abuse. This breakdown is based on caseworker's primary classification of the reason for removal which focused on the type of maltreatment rather than underlying causes.

2.4. Necessity and prevention services

Families with children removed for reasons other than abuse are entitled to compensation only if:

- The child was "unnecessarily apprehended"; and
- The family "especially in regards to substance abuse, did not benefit from prevention services in the form of least disruptive measures or other prevention services permitting them to remain safely in their homes, families and communities." [18]

The PBO considered seven possible scenarios for how these criteria might be applied. (The scenarios are outlined in Appendix A.) Under these possible scenarios, the proportion of otherwise eligible families who would be excluded from compensation would range from 0 per cent to 85 per cent. In other words, at the upper bound, all 22,000 eligible children removed for reasons other than abuse would receive compensation, compared with only 3,300 at the lower bound.

2.5. Parents

Parents of children removed due to abuse are not entitled to compensation; however, parents who had a child removed for reasons other than abuse are entitled to compensation.[19] To be eligible for compensation, the parent must have been caring for the child at the time of the child's removal.

Grandparents are eligible for compensation only if the parents were absent and the children were in their care.[20] The term parent was not defined by the Tribunal. However, the PBO assumes that it includes step-parents and adoptive parents, including parents under customary adoptions not formalized by court order.

Children who were removed from their homes have a second in-home caregiver in 47 per cent of cases.[21] So, it is assumed that there are 1.47 eligible caregivers per child. No limitation was applied with respect to the relationship between the in-home caregiver(s) and child, so this includes adoptive parents and step-parents acting as in-home caregivers.

The number of parents who are eligible depends on the number of children who are eligible for reasons other than abuse. This number of children is affected by the extent to which children are excluded because their removal was necessary or their family received preventative services.

If none are excluded, 22,000 children would be removed for reasons other than abuse. This implies that 32,400 parents would be eligible for compensation.

If 85 per cent are excluded, 3,300 children would be removed for reasons other than abuse. This implies that 4,900 parents would be eligible for compensation.

2.6. Compensation

According to the CHRT ruling, each eligible parent and child would receive $40,000 plus applicable interest.[22]

Again, compensation depends on the extent to which children are excluded because their removal was necessary or their family received preventative services.

If no children are excluded, this would result in $1,309 million in pre-interest compensation for the 32,700 eligible children, and $1,295 million in pre-interest compensation for the 32,400 eligible parents.

If 85 per cent are excluded, this would result in $564 million in pre-interest compensation for the 14,100 eligible children. For the 4,900 eligible parents, the pre-interest compensation would amount to $194 million.

The range of estimated compensation is shown in Table 2-4.

Table 2-4 **Summary of the number of children and parents eligible and associated compensation costs**

	Upper Bound		Lower Bound	
	Children	**Parents**	**Children**	**Parents**
# Eligible	32,700	32,400	14,100	4,900
Pre-interest compensation per eligible person	40,000	40,000	40,000	40,000
Pre-interest compensation ($ millions)	$1,309	$1,295	$564	$194
Interest on compensation ($ millions)	$340		$99	
Total cost of compensation ($ millions)	$2,944		$857	

All figures represent the costs up to the end of 2020. Additional costs will continue to accumulate after that time, including interest and compensation in relation to ongoing removals. By the end of 2025, the expected cost would reach $3.7 billion under the 0% scenario.

2.7. Differences in assumptions

The PBO's estimate relies on factual and legal assumptions that differ substantially from those used in ISC's preliminary cost estimate and eligibility criteria proposed by other parties.

Children already in care in 2006

About 8,500 children were in care as of 1 January 2006. The PBO assumes these children are eligible.[23] ISC's preliminary estimate assumes they are not eligible.

Adjustment factor

ISC's preliminary estimate of 48,200 children coming into care for the first time up to the end of 2017-18 is significantly higher than the PBO's estimate of 36,400 children. This is due to an adjustment factor ISC applied in projecting backwards children in care prior to 2014. ISC found that indexing to point-in-time counts underestimated the number of children coming into care relative to administrative data kept by three regions and grossed up its backwards projections accordingly. The PBO chose not to apply a similar

adjustment factor because we could not verify the methodology used by those regions and ISC could not provide us with the regional data.

Children off-reserve

The Chiefs of Ontario argued in recent submissions that "in Ontario, the Compensation Entitlement Order should apply equally to First Nations persons on or off reserve."[24]

The PBO did not adopt this approach because the Tribunal's order is explicitly limited to "First Nations children living on reserve and in the Yukon Territory." Ontario has 182,890 off-reserve individuals who identify as First Nations, just under half of the 380,355 persons on-reserve in all of Canada.[25]

Children placed within their extended family or community

In its written representations on its application for judicial review, ISC defines the eligible group as "every child removed from their home, temporarily or long-term, and every caregiving parent or grandparent to that child, unless they abused the child or children."[26]

Under this interpretation, all children removed from their homes are entitled to compensation, even if they were placed with family or within their community. This is the approach taken in ISC's preliminary estimate. If these children who were placed within their extended family or community were included, it would roughly double the number of eligible children.

Children placed in informal care

ISC's preliminary estimate is based on its child expenditure records. Thus, it implicitly excludes compensation for children removed from their homes and placed in unfunded kinship care where no expenditure would be recorded. Children in unfunded care are not relevant to the PBO's estimate because these children are all placed within their family or community and are thus ineligible for compensation.

However, under the definition set out in ISC's written representations, these children placed in unfunded care would appear to be eligible, even though they are not included in ISC's preliminary estimate. Since 49 per cent of all children removed from their homes are placed in informal kinship care, including these children would roughly double the cost of complying with the order.[27]

Prevalence of abuse

ISC's preliminary estimate assumes that 40 per cent of parents are ineligible because they abused their child. This assumption was made on the basis that 40 per cent of aboriginal respondents reported experiencing childhood physical and/or sexual abuse in a 2015 survey. (An alternative scenario showed 20 per cent of parents ineligible due to abuse.)[28]

The PBO obtained access to the First Nations Component of the Canadian Incidence Study of Reported Child Abuse and Neglect 2008; it showed that 33 per cent of children taken into care on-reserve were the result of abuse. As noted above, the PBO assumes that parents of children removed due to abuse are not eligible even if they did not abuse their child.

Unnecessary removal and non-benefit from prevention services
ISC's preliminary estimate does not incorporate any further inquiry into whether a child's removal was unnecessary or whether their family benefited from preventative services allowing the child to remain in the home.

Number of parents and eligibility of grandparents
With respect to factual assumptions, ISC's preliminary estimate assumes that each child has two eligible caregivers. Based on the First Nations Component of the Canadian Incidence Study of Reported Child Abuse and Neglect 2008, the PBO estimates that removed children have an average of 1.47 in-home caregivers.

It is not clear whether ISC's interpretation of the Tribunal's decision requires the parents to be absent for grandparents to receive compensation. If caregiving grandparents are eligible irrespective of whether the parents of the child are absent, the number of eligible grandparents could be much higher.

The Chiefs of Ontario argued in recent submissions that "the reality of families in First Nations communities means that aunties, uncles and other family members may well have been caring for children at the time of removal, and submits that such people should not be precluded from entitlement to compensation."[29]

The Tribunal rejected this approach, stating: "While the Panel does not want to diminish the pain experienced by other family members such as other grand-parents not caring for the child, siblings, aunts and uncles and the community, the Panel decided in light of the record before it to limit compensation to First Nations children and their parents or if there are no parents caring for the child or children, their grand-parents."

The PBO's estimate is based on compensation for up to two in-home caregivers irrespective of their relationship with their child, so it is not strictly limited to biological parents. However, it would exclude the broader family and community providing care and companionship to a removed child.

Interest calculation
ISC's estimate includes compound interest at the Bank of Canada Policy Rate with unspecified adjustments, whereas the PBO estimate includes simple interest at the Bank of Canada's Bank Rate consistent with the default under section 9(12) of the CHRT *Rules of Procedure*.[30]

The decision nominally awards compensation at the Bank of Canada Rate. However, given the absence of any rationale for deviating from the Tribunal's rules of procedure, the PBO assumes the Tribunal intended to award compensation at the slightly higher Bank of Canada Bank Rate.

Resolution date

ISC's estimates also explore the implications of it taking until 2025-26 to resolve the claim. Under that scenario, ISC's preliminary cost estimate rises to $6.7 billion. The PBO's estimate rises to $3.7 billion under the scenario where all children removed from their home, family, and community for reason other than abuse are eligible.

Impact of assumptions

It seems reasonably clear that ISC's interpretation as set out in court filings deems children placed within their extended family or community to be eligible. It does not incorporate any further inquiry into whether a child's removal was unnecessary or whether their family benefited from preventative services allowing the child to remain in the home.

However, ISC's interpretation is unclear with respect to two of the other most consequential differences in assumptions, specifically:

1. The eligibility of children placed in unfunded care, and
2. The eligibility of caregiving grandparents where the parents are not absent.

If children placed in unfunded care are excluded and the grandparents of children in the care of their parents are excluded, the cost under ISC's interpretation is estimated to be $4.8 billion. Including children placed in unfunded care and four caregiving grandparents per child, the cost under ISC's interpretation would be $22.8 billion.

If proposals to compensate children off-reserve in Ontario were accepted by the Tribunal, the cost would increase by about 50 per cent. Compensating all relatives of a child who provided care to a removed child would result in an indeterminable, but likely large, increase in the cost.

3. Comparative cost of settling a class action

The Government of Canada (hereafter referred to as "Canada") has publicly indicated that it intends to compensate families entitled to compensation under the CHRT order through a settlement of a class action. This could be *Xavier Moushoom and Jeremy Meawasige v. The Attorney General of Canada* or a similar class action recently filed by the Assembly of First Nations.

Canada cannot void the CHRT's order simply by settling a class action. So, the framing of a class action settlement as an alternative to complying with the CHRT decision still relies on Canada having that order quashed through judicial review. If the CHRT order was paid out, Canada has argued that any compensation awarded under the CHRT order would be offset against damages awarded in a class action.[31]

It appears that eligibility for compensation under either class action could be broader in terms of three factors: the time period covered; the relatives entitled to compensation; and the eligibility of families of children removed due to abuse.

However, there may be barriers to the success of a class action. Federal funding for child welfare differs dramatically between provinces, between agencies, and over time. Families differ in the prevention services they received, the reasons their child was taken into care, and where their child was placed. Responsibility for removals and the circumstances leading to removals are shared among many parties.

To establish a clear relationship between an action for which the federal government is liable and harm suffered by the plaintiffs, it may be necessary lawyers representing the plaintiffs to dramatically limit the scope of who is eligible for compensation, or the harm for which they are being compensated. For example, in the *Sixties Scoop* class action, the group eligible for compensation was limited to children who were placed in non-aboriginal foster homes, and only included compensation for loss of culture.[32]

In terms of the amount of compensation, previous class action settlements regarding the removal of children from their homes, families and communities suggest that compensation for each removed child would not necessarily be any more than the $40,000 maximum awarded by the CHRT. The amounts awarded in previous similar cases are shown in Table 3-1.

However, individuals who suffered exceptional harm as a result of their removal, such as children who suffered abuse while in a foster home, could potentially receive much more if an individualized assessment process is implemented. An example of that would be the process used for the Indian Residential School Settlement.

The scope of eligibility and amount of compensation are negotiated and are, therefore, difficult to predict.

Table 3-1 Summary of compensation awarded in previous similar cases

	Common experience payments	Individualized compensation	Differences
Indian Residential Schools Settlement (2006)	$10,000 for the first year, $3,000 for subsequent years, averaging $20,457 ($25,900 in 2020 dollars) for emotional abuse, loss of family life, loss of language/culture, etc.	38,178 claims out of 105,530 claimants with awards averaging $111,265	Longer average duration, more abuse
Sixties Scoop Settlement (2017)	Likely <= $25,000, solely for loss of cultural identity	Not settled	Generally permanent

Appendix A – Possible interpretations of further restrictions

Families with children removed for reasons other than abuse are entitled to compensation only if:

- The child was "unnecessarily apprehended" and
- The family "especially in regards to substance abuse, did not benefit from prevention services in the form of least disruptive measures or other prevention services permitting them to remain safely in their homes, families and communities."

The CHRT's decision does not clearly explain how these eligibility criteria are supposed to be applied. Seven possible approaches were considered, including:

- Canada-wide approaches,
- province-year specific approaches,
- group-by-group analysis of the presence of factors or services, and
- group-by-group causal analysis.

The 0 per cent to 85 per cent range reflects the possible exclusions under these interpretations.

Among these possible approaches, the most likely interpretation is that the CHRT's eligibility criteria require a further group-by-group assessment of whether each child was unnecessarily removed. The evidence would be that they did not benefit from prevention services which would have permitted them to remain at home.

The assessment would not be the extent of harm, which the Tribunal rejected as harmful and unnecessary. Rather, it would be whether the harm associated with a child's removal arose from the underfunding of preventative services.

One factor that supports the interpretation that an additional group-by-group assessment is required is that the evidence summarized by the CHRT and the conclusions it drew accept the existence of unnecessary removals, but do not address the prevalence of unnecessary removals.

In summarizing the evidence, the CHRT states that the least disruptive measures to address neglect are underfunded, and that "without funding for [the] provision of preventative services many children […] are unnecessarily removed from their homes and families."[33]

The necessity of a case-by-case assessment is further supported by the reference to substance abuse in the CHRT order. The CHRT appears to be making some attempt to define a population it expects to be found ineligible as a result of a further assessment.

It does so when it restricts eligibility to families who "especially in regards to substance abuse, did not benefit from prevention services in the form of least disruptive measures or other prevention services permitting [the children] to remain safely in their homes, families and communities."[34]

This suggests that removals due to caregiver substance abuse, where the caregiver benefited from prevention services intended to allow the child to remain in the home, do not give rise to compensation. The term "especially" suggests that families benefiting from prevention services may be excluded in other circumstances. Determining whether caregivers benefited from prevention services intended to allow the child to remain in the home requires a case-by-case assessment.

Another important contextual factor is that the order was issued in response to a request by the Assembly of First Nations (AFN) to establish an expert panel to determine appropriate case-by-case compensation. This proposal was not just for a case-by-case assessment of individual damages, which the Tribunal rejected as harmful and unnecessary. It was also to determine whether preventative services would have prevented abuse leading to a child's removal.[35]

Canada-wide approaches

Under these approaches, no children are screened out and no case-by-case assessment is required.

Scenario 1: Reliance on finding of systemic discrimination

A taxonomy of compensation category proposed by the First Nations Child and Family Caring Society (FNCFCS) argues that a prior CHRT ruling "found that First Nations children living on-reserve were discriminated against by the Canadian government in part because they did not receive adequate prevention services." [36] On this basis, the taxonomy appears to accept that all children did not benefit from prevention services. This would result in no cases being screened out.

Scenario 2: Reliance on placement outside of family and community

Alternately, the Tribunal could reason, as it did in relation to cases of abuse, that all First Nations children should have been placed within their family and community. If the Tribunal does not entertain evidence that equitable funding to find and support such placements was in place or that an equitable level of such placements occurred, this would result in no cases being screened out (the PBO's cost estimate already excludes placements with family and community).

Province-year specific approach

Under these approaches, children are screened out depending on the province and year in which they were taken into care.

Scenario 3: Removals in province-years where funding for prevention services was in place

The eligibility criteria ask specifically about whether a family benefited from prevention services. Canada has been incrementally providing funding for prevention services on a province-by-province basis in an attempt to address the systemic discrimination identified by the Tribunal.

For about 85 per cent of removals for which compensation has been ordered, prevention services were funded under a bilateral agreement or the enhanced prevention focused approach. This suggests that if children are screened out in province-years for which the additional funding for prevention services was in place, as much as 85 per cent of cases could be screened out.

Group-by-group and case-by-case analysis of the presence of factors

Under these approaches, the Tribunal or delegated body would determine, or has determined, that children removed in certain circumstance are eligible. Then it would consider whether each case falls within an eligible group.

Scenario 4: Removals related to poverty, housing, or substance abuse

The FNCFCS's taxonomy has an eligibility requirement asking whether the child experienced neglect related to poverty, housing and substance abuse. This is in conflict with the wording of the CHRT order, which includes neglect as a parallel ground. However, in this way, the taxonomy indirectly restricts eligibility to those found to be harmed in the Wen:de reports prepared by the First Nations Child and Family Caring Society of Canada.

Those reports speak of neglect related to poverty, housing and substance abuse as circumstances where removals are potentially preventable.[37] In this way, looking at whether a removal was related to poverty, housing or

substance abuse may be a reasonable proxy for determining the circumstance where removals are potentially preventable in the view of the CHRT.

To assess the impact of this approach, the PBO requested a custom tabulation from the First Nations Component of the 2008 Canadian Incidence Study of Reported Child Abuse and Neglect. That custom tabulation shows that this approach would only slightly restricts eligibility, as poverty, housing and substance abuse were a suspected or confirmed factor in 94 per cent of investigations resulting in placements outside the home.

Table A-1 **Presence of risk factors among investigation resulting in an out-of-home placement for First Nations on-reserve children, as reported by caseworkers**

	%
Unsafe housing conditions	23%
Home overcrowding	10%
Household income only from social assistance, EI, other benefits, or none	54%
Household ran out of money for necessities within the past six months	19%
Suspected or confirmed drug or alcohol abuse by caregiver	84%
Any of above risk factors	94%

Source: PBO based on custom analysis of FNCIS 2008.

Scenario 5: Exclusion of substance abuse cases

The decision indicates that the exclusion related to benefit from prevention services applies especially with regard to cases of substance abuse. The particular emphasis placed on substance abuse in the context of the availability of prevention services mirrors earlier quotes from the Wen:de reports. These quotes express the view that where treatment services were available, continuing substance misuse lies within the personal domain for change.[38]

First Nations addiction treatment centres and community-based prevention programs are offered at various locations across Canada.[39] Without a clear definition and further data, it cannot be determined whether these services were adequate and available in the context of a particular removal. If the

assessment were to screen out all families where caseworkers flagged suspected or confirmed substance abuse, 84 per cent of families could be excluded.

Group-by-group and case-by-case causal analysis

If the CHRT requires evidentiary proof that prevention funding would have averted the removal of a group of children on a balance of probabilities, the outcome will depend on the evidence accepted and the scope of least disruptive measures and prevention services the CHRT believes should have been provided.

Scenario 6: Causal analysis based on ISC definition of preventative services

The types of "prevention services" funded by Canada over most of the relevant period were non-medical services delivered to families, such as education, counselling and intensive in-home supports.[40] Between 2007-08 and 2013-14, Canada increased funding for prevention services under an "Enhanced Prevention Focused Approach" (EPFA).

However, it was not possible to identify a distinct group of children who are no longer coming into care as a result of the EPFA. In the decade since implementation of the EPFA began, the number of children in ISC-funded care has increased in some provinces with EPFA funding, while decreasing in others.

In total, the number of children in care increased 18 per cent in provinces with EPFA funding, whereas the number of children in care decreased 9 per cent in the remaining provinces and single territory (Yukon).

However, excluding kinship care, the number of children in care in EPFA provinces with EPFA funding is estimated to have decreased 25 per cent. Beyond the absence of a clear aggregate impact, it is difficult to identify a causal relationship for a variety of other reasons.[41]

Based on experiences over the last decade with EPFA funding, it would be difficult to prove that the removal of any particular group of children would not have occurred with adequate funding for prevention services.

Academic literature is inconclusive regarding the effectiveness of prevention services. Several types of home visitation programs have been found to reduce child maltreatment or maltreatment risk factors in some cases; but, in other cases the same or similar programs have not been effective or even increased maltreatment.[42] Such results may also not be generalizable to First-Nations on-reserve families and few studies look at impacts on probabilities of being taken into care. Even where effective, these programs only reduce the probability of a child being taken into care. It would still be difficult to say

that any particular family would not have been taken into care if the intervention had been in place. It is difficult to predict what conclusions the CHRT would draw from such a mixed body of research.

Scenario 7: Causal analysis based on broader definition of preventative services

Under a broader definition of preventative services, there do appear to be services which could reduce the number of children removed from their homes, families and communities. Specifically, funding to find and support kinship placements and foster care on-reserve, funding for housing and income assistance could avoid the removal of some children. It might even be possible to show that the removal of a particular family's child could have been prevented if the child was removed from to their home due to poverty, unsafe housing, or if a family member would have been willing and able to take in a child if more support was available.[43] However, for many cases of neglect, it would be difficult to point to any particular program that would have prevented the removal of a child.

Notes

1 *First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada (representing the Minister of Indigenous and Northern Affairs Canada)*, 2019 CHRT 39.

2 As set out in 2017 CHRT 35, Jordan's Principle relates to the approval of and reimbursement for government services for First Nations children. Where a government service is available to all other children, the government department of first contact must pay for the service. Where a service is not necessarily available to all other children, the government department of first contact must evaluate the needs of the child to determine whether the requested services should be provided to ensure substantive equality or culturally appropriate services, or to safeguard the best interests of the child. The CHRT decision orders compensation to be paid to each First Nations child who "was denied services or received services after an unreasonable delay or upon reconsideration ordered by this Tribunal." The parents or grandparents of those children are also eligible for compensation.

3 Compensation will be paid to caregiver grandparents only if the parents were absent. 2019 CHRT 39 at para 185.

4 Written Representations of the Applicant/Moving Party on Motion to Stay at para 9; Affidavit of Cindy Blackstock at p 117 (Page 5 of Exhibit 12) [FNCFCS taxonomy]; Assembly of First Nations (AFN), Compensation Order / Questions and Answer.

5 CHRT, Letter of 16 March 2020.

6 Among other issues, the Application for Judicial Review challenges the Tribunal's decision to award individual compensation in a case of systemic discrimination, its decision to award individual compensation in light of a lack of evidence proper funding could have prevented all removals, and the amount of compensation awarded in the case of short temporary removals. Attorney General of Canada, Written Representations of the Applicant/Moving Party on Motion to Stay.

7 This differs from the approach taken by the FNCFCS's taxonomy, which limits eligibility to children who have, or are eligible, for Indian Status. Eligibility is not expected to be restricted to Status Indian children because:

- The decision refers to First Nations children rather than "Status Indian" children;
- Canada has jurisdiction over lands reserved for Indians; and
- Underfunding of on-reserve prevention services would negatively affect all children on-reserve. irrespective of their status.

The definition of a First Nations child is an open issue being considered by the CHRT.

[8] Because kinship care was not distinguished in ON, MB, and YK for the entire period, point-in-time counts for the number of children in kinship care in ON, MB, and YK were interpolated based on provinces that distinguished kinship care. Interpolated kinship placements were deducted from foster placements.

[9] Quebec and the Atlantic provinces include placements with family within foster placements in some circumstances. This error also effects the result for Ontario and Manitoba due to interpolation for these provinces. In addition, and possibly as a result, the share of children in non-kinship foster care is higher than found in the First Nations Component of the Canadian Incidence Study of Reported Child Abuse and Neglect, where non-kinship foster care accounted for 53 per cent of placements with expenditures. As defined in the FNCIS 2008, kinship foster care includes all formal placements arranged within the family support network, including placements with extended family and in customary care.

[10] Expenditures have only been nationally tracked at the child level since 2013, meaning children entering care for the first time can only be identified for 2014 onwards. The number of children taken into care for the first time prior to 2014 was estimated based on indexing the number of children taken into care for the first time in 2014 by care type to point-in-time counts of the number of children in care by care type. The 2014 base year only excluded children in care in 2013. So this approach may overestimate the number of unique children who were taken into care to the extent there are recurrent placements with a gap of more than one year between placements. If this were common, one would expect to see a decline in unique children coming in care for the first time since 2014, which has not occurred.

[11] This differs from the approach taken by the FNCFCS taxonomy and by Indigenous Services Canada, which both ask whether children were removed from their "homes, families, or communities." That would result in compensation being paid to children placed within their family or community. See: Affidavit of Sony Perron at para 5; Attorney General of Canada, Written Representations of the Applicant/Moving Party on Motion to Stay at para 9; Affidavit of Cindy Blackstock at p 117 (Page 5 of Exhibit 12).

The PBO interprets the decision to only compensate children removed from their family and community because:

- The decision uses the word "and" rather than "or";
- The references to families and communities would be redundant if all children removed from the home qualified;
- The panel's corresponding factual finding is that "removing a child from its family and community is a serious harm" (paras 161, 169, 184);
- Similar wording specifying that compensation is for children "placed in care outside of their extended families and communities" (para 249) is used with respect to abused children. The CHRT had earlier found that

abused children "should have been placed in kinship care with a family member or within a trustworthy family within the community" (para 149). This suggests that the CHRT believes no wrong was done in cases where a child was placed with a family member outside of the child's community or a non-family member within the child's community.

12 Over a 3-year period, a study Perry et al. found 13.6% of children placed in kinship care were moved to another family or group. Gretchen Perry, Martin Daly and Jennifer Kotler, Placement stability in kinship and non-kin foster care: A Canadian study (2011).

It was assumed subsequent placements had an equal probability of being non-kinship placements. Children moved to non-kinship placements were assumed to have an equal probability of being placed off-reserve as a child directly placed in a non-kinship placement.

13 Based on ISC data, the PBO estimated the number of First Nations children in ISC-funded non-kinship foster care in 2016. Based on 2016 Census data, the PBO could determine the number of children in non-kinship foster care on reserve. The probability of any particular placement being on-reserve for each province was assumed to be equal to the percentage of these children ISC funded care who were in care on reserve. The number of subsequent placements for First Nations children was derived from Quebec administrative data. An expected probability of being placed on reserve in any placement was calculated using the Quebec distribution of number of placements and each province's probability of being placed off-reserve for each placement. That probability was weighted based on the provincial distribution of children in care to produce a national probability of being placed on reserve in any placement.

The key assumptions in this approach are:

- All First Nations children placed in foster care on-reserve came from homes on-reserve,
- The duration of time in care for placements on-reserve is similar to the duration of placements off-reserve and,
- The probability of a subsequent placement being off-reserve is independent of the probability of the initial placement being off-reserve.

ISC, Response to PBO IR0437; Statistics Canada, Aboriginal Population Profile, Census 2016. First Nations of Quebec and Labrador Health and Social Services Commission: Trajectories of First Nations youth subject to the Youth Protection Act COMPONENT 3: Analysis of mainstream youth protection agencies administrative data.

14 The estimated share of children placed in group homes is based on the number of Status Indians in residential care facilities (which includes group homes) on-reserve based on the 2016 Census, as a percentage of the number of children who had been in group homes for 6 months or longer as of census day based on ISC's CFS IMS. This assumes that individuals residing in the group home less than six months would have been recorded at their ordinary residence and there is no significant difference in the duration of

group home placements on and off reserve. An expected probability of being placed on reserve in any placement was calculated using Quebec distribution of number of placements for placements in group homes and institutions.

Institutions are generally distinguished from group homes by capacity. Given the low total number of children in residential care facilities in any province, it was deemed unlikely that there were any children in institutional care on reserve. The figure presented represents the weighted average of the two figures.

ISC, Response to PBO IR0437; Statistics Canada, Custom Tabulation based on 2016 Census; Tonino Espositoa, Nico Trocmé et al., The stability of child protection placements in Québec, Canada 42 Children and Youth Services Review (2014) 10-19.

15 Statistics Canada, Living arrangements of Aboriginal children aged 14 and under (2016).

16 There may be rare cases in which a child is removed for reasons other than abuse, poverty, poor housing, neglect, or substance abuse, or in order to receive services. For example, a child could be taken into care because the parents are unable to care for them for other reasons, such as illness, death or incarceration.

17 The order elaborates on abuse as including sexual, physical and psychological abuse (2019 CHRT 39 at para 256). The term psychological abuse is not actually defined in provincial child welfare legislation. But the most comparable definitions of 'emotional injury', 'emotional harm', 'psychological ill-treatment' typically all include exposure to family violence (See Affidavit of Cindy Blackstock at p 196, Page 84 of Exhibit 12). This is not to say that the victim of intimate partner abuse abused their child by exposing their child to intimate partner violence. However, the abused parent is nevertheless not eligible because their child was necessarily removed due to abuse by the perpetrator of intimate partner violence. There is no order of compensation that covers even innocent parents of children removed due to abuse.

The primary reason for removal differs from the prevalence because multiple factors may be present in a particular case. As reported by caseworkers in cases where children were removed, 39 per cent of caregivers were victims of intimate partner violence, while 31 per cent of caregivers were perpetrators of intimate violence. This was the case even though intimate partner violence was the primary reason for removal in only 8 per cent of removals.

18 2019 CHRT 39 at para 245.

The PBO assumes the order for compensation is to be limited to those groups found to be harmed as described within the order. This is the approach taken by the FNCFCS taxonomy, but not the approach taken by ISC. ISC appears to read each order as not limited by the preceding findings of harms. Despite the lack of a demonstrative pronoun indicating this

restriction, the orders are assumed to be limited to those found to be harmed because:

- The explicit purpose of the decision is to compensate children and caregivers harmed by discriminatory underfunding of child protection services, so one would expect compensation to be limited to those found to be harmed;
- The identical orders made in paragraph 245 (regarding neglected children) and 249 (regarding abused children) would be redundant if not limited to the groups found to be harmed;
- Without being restricted to those found to be harmed, the order would include First Nations children residing off-reserve, who receive services funded by provincial governments;
- In further restricting eligibility to children who "especially in regards to substance abuse, did not benefit from prevention services [...] permitting them to remain safely in their homes, families and communities", the Tribunal is excluding a group of households.

The order appears to accept that the fact an abused child was placed in care outside of their extended families and communities is sufficient proof that an abused child did not benefit from prevention services. This flows from the use of the phrase "and therefore, did not benefit from prevention services". This implies that the Tribunal is finding, as a matter of fact, that removed abused children placed outside their families and communities did not benefit from prevention services. The Tribunal made this factual finding explicit earlier in its reasons at paragraph 149. The word 'therefore' was not used in the corresponding order regarding removals for reasons other than abuse.

Although the CHRT uses the term "apprehended" in English, it uses the term "placés" in French and "removed" in the heading and later in the same paragraph. This suggests the term is not being used in a precise legal sense to limit eligibility to children apprehended by children's aid societies to the exclusion of children voluntarily placed in care. Voluntary placements in care account for about 6 per cent of placements in care. Even if excluded on this ground, they would likely be eligible on the basis their child was taken into care in order to receive essential services.

19 As written, the decision would not compensate parents of children removed due to abuse even when the parent was not the perpetrator of the abuse. Specifically, the decision explicitly excludes caregivers who abused their children (para 256). However, the decision also does not include a positive order to compensate the parents of children necessarily removed due to abuse. For physical abuse, the only category for which a sufficient sample size was available, the primary caregiver was the perpetrator in 97 per cent of cases, and a secondary caregiver the perpetrator in 3 per cent.

20 2019 CHRT 39 at para 185.

21 Based on custom analysis of the FNCIS-2008.

[22] The interest on compensation was calculated assuming simple interest at the Bank of Canada's Bank Rate.

[23] CHRT, Letter of 16 March 2020.

[24] Chiefs Of Ontario, Submissions.

[25] 2016 Census, Aboriginal Population Profile.

[26] Attorney General of Canada, Written Representations of the Applicant/Moving Party on Motion to Stay at para 9.

[27] Based on custom analysis of the FNCIS-2008.

[28] Statistics Canada, Family violence in Canada: A statistical profile, 2015.

[29] COO, Submissions.

[30] The Bank of Canada's Bank Rate was the series used in *O'Bomsawin v. Abenakis of Odanak Council*, 2018 CHRT 25 (CanLII), <http://canlii.ca/t/hxsvq>.

[31] 2019 CHRT 39.

[32] Brown v. Canada (Attorney General), 2017 ONSC 251. The final settlement was broader that established in that case, see Sixties Scoop Settlement Agreement (2017).

[33] 2019 CHRT 39 at paras 163-165).

[34] 2019 CHRT 39 at para 245.

[35] AFN, Written Submissions Regarding Compensation returnable April 25-26, 2019 at para 12.

[36] Affidavit of Cindy Blackstock at p 117, Page 5 of Exhibit 12.

[37] 2019 CHRT 39 at para 163.

[38] 2019 CHRT 39 at para 163.

[39] ISC, National Native Alcohol and Drug Abuse Program.

[40] ISC, National Social Programs Manual 2012 at § 4.4.2. ISC, Mid-Term National Review for the Strategic Evaluation of the Implementation of the Enhanced Prevention Focused Approach for the First Nations Child and Family Services Program at § 1.2.1 ["Prevention services may include, but are not limited to, respite care, after-school programs, parent/teen counselling, mediation, in-home supports, mentoring and family education, in accordance with services similarly offered by the province of residence off reserve."];.ISC, Program Directive: Prevention/Least Disruptive Measures (Draft).

[41] Many other changes occurred over the decade. The count of children in care may be affected by expansions in funding eligibility for kinship and customary care placements. In addition, significant prevention funding may have been diverted towards other purposes, including intake services, which can increase the number of children taken into care. ISC does not know how much prevention funding was actually spent on prevention services.

According to a survey of agencies by the IFSD, 12 per cent of federal funding was used for prevention services. IFSD, Enabling Children to Thrive, Figure 36.

42 Anne Blumenthal, Child Neglect II: Prevention and Intervention; Preventing Violence Across the Lifespan Research Network, RESEARCH BRIEF: Interventions to Prevent Child Maltreatment; WHO, Child maltreatment prevention: a systematic review of reviews; Sarah Dufour and Claire Chamberland, The Effectiveness of Child Welfare Interventions: A Systematic Review; Richard P. Barth, Preventing Child Abuse and Neglect with Parent Training: Evidence and Opportunities; Prinz et all, Population-Based Prevention of Child Maltreatment: The U.S. Triple P System Population Trial.

43 Anne Blumenthal, Child Neglect II: Prevention and Intervention; Lyn Morland, Effect Of Safety Net Policies On Child Neglect; Cancian et al, The Effect of Family Income on Risk of Child Maltreatment.

This is **Exhibit "D"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)

Sarah Clarke LSO # 57377M

G. Class Size Estimates

96. Based on the data from 1991 to 2019 regarding adoption and foster care of First Nation Canadians who normally reside on reserve, the number of unique children was estimated using the Duration Model.

97. These estimates are for children who first entered care on or after 1 April 1991. Any child who entered care for the first time prior to 1 April 1991 was excluded from these estimates.

98. Based on the results of our modelling, we estimate that the number of registered Indian children ordinarily resident on reserve[3] who were taken into care from 1 April 1991 to 31 March 2019 is between 90,000 and 120,000.

99. In our opinion, it is likely that the number of such children is between 100,000 and 110,000.

100. These estimates are based on the results produced by the Duration Model. As we change the assumptions, the results change. We noted that the results usually lay between 100,000 and 110,000 under various assumptions.

101. Using the assumptions that we have detailed within this report, the Duration Model estimated a total of 106,200 registered Indian children normally resident on reserve entered care from 1 April 1991 to 31 March 2019.

102. The Duration Model made no distinction between children by the status of care. The following table shows our estimate of registered Indian children normally living on reserve who entered care between 1 April 1991 and 31 March 2019, broken down by the length of time in care. We estimate 106,200 children were in care of whom 43,600 exited care with between 0 and 6-months total time in care and the balance of 62,600 were in care for at least 6 months. Of those, 15,400 exited care with between 6 and 12-months total time in care and the balance of 47,200 were in care for at least 12 months.

[3] Registered Indian children include all First Nation children with status under the Indian Act as well as children with at least one parent who has status under the Indian Act and who normally lives on reserve.

Table 102 – Children in Care – 1 April 1991 to 31 March 2019

Number of Months	Number in Care at Least x Months	Survived to 2019	Deceased by 2019	Number Leaving in Period	Survived to 2019 for Leaving
0 months	106,200	105,100	1,100	43,600	43,200
6 months	62,600	61,900	700	15,400	15,200
12 months	47,200	46,700	500	10,600	10,500
18 months	36,600	36,200	400	6,100	6,000
24 months	30,500	30,200	300	4,400	4,400
30 months	26,100	25,800	300	3,500	3,400
36 months	22,600	22,400	200	3,000	2,900
42 months	19,600	19,500	100	2,300	2,300
48 months	17,300	17,200	100	1,700	1,700
54 months	15,600	15,500	100	1,400	1,400
60 months	14,200	14,100	100	2,400	2,400
72 months	11,800	11,700	100	-	-

103. We were requested to split the above table between those who entered care from 1 April 1991 to 23 February 2006 and those entering care from 24 February 2006 to 31 March 2019.

Table 103a – Children in Care – 1 April 1991 to 23 February 2006

Number of Months	Number in Care at Least x Months	Survived to 2019	Deceased by 2019	Number Leaving in Period	Survived to 2019 for Leaving
0 months	56,600	55,600	1,000	23,800	23,400
6 months	32,800	32,200	600	8,400	8,300
12 months	24,400	23,900	500	5,100	4,900
18 months	19,300	19,000	300	3,600	3,500
24 months	15,700	15,500	200	1,500	1,500
30 months	14,200	14,000	200	1,800	1,800
36 months	12,400	12,200	200	1,000	900
42 months	11,400	11,300	100	1,400	1,400
48 months	10,000	9,900	100	600	600
54 months	9,400	9,300	100	1,000	1,000
60 months	8,400	8,300	100	1,100	1,100
72 months	7,300	7,200	100	-	-

Table 103b – Children in Care – 24 February 2006 to 31 March 2019

Number of Months	Number in Care at Least x Months	Survived to 2019	Deceased by 2019	Number Leaving in Period	Survived to 2019 for Leaving
0 months	49,600	49,500	100	19,800	19,800
6 months	29,800	29,700	100	7,000	6,900
12 months	22,800	22,800	-	5,500	5,600
18 months	17,300	17,200	100	2,500	2,500
24 months	14,800	14,700	100	2,900	2,900
30 months	11,900	11,800	100	1,700	1,600
36 months	10,200	10,200	-	2,000	2,000
42 months	8,200	8,200	-	900	900
48 months	7,300	7,300	-	1,100	1,100
54 months	6,200	6,200	-	400	400
60 months	5,800	5,800	-	1,300	1,300
72 months	4,500	4,500	-	-	-

This is **Exhibit "E"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)

Sarah Clarke LSO # 57377M

7 February 2022

Mr. Robert Kugler
Associé / Partner
Kugler Kandestin LLP
1, Place Ville-Marie, Suite 1170
Montréal QC H3B 2A7

RE: Moushoom/Trout – Removed Children Attaining Age of Majority

Rob:

I have estimated the number of children in the removed child class that will attain the age of majority over future years. I made the following assumptions as part of this work.

1. The number of First Nation children entering care in Canada in each fiscal year 2002-03 to 2018-19 is the number estimated by Nico Trocmé, Marie Saint-Girons and myself in our joint report "Estimated Class Size – First Nations Children in Care 1991 to 2019" dated 18 January 2021 (the "**Joint Report**").

2. The number entering care for fiscal years 2019-20 to 2021-22 were approximately the same as was estimated for the 2018-19 year in the Joint Report – 3,400 per year.

3. In the Joint Report, we estimated the number of children entering care between 1 April 1991 and 31 March 2019 to be 106,000, plus or minus about 15,000. I estimate there are an additional 10,000 First Nation children who entered care from 1 April 2019 to 31 March 2022.

4. The total number of First Nation children who entered care from 1 April 1991 to 31 March 2022 is estimated to be 116,000 plus or minus about 15,000.

5. The age distribution of the children entering care in each year in Canada was similar to the average age distribution of children entering care in Ontario from 2000 to 2012.

6. The age of majority is age 18 in all Canadian jurisdictions with the exception of British Columbia, New Brunswick, Newfoundland and Labrador, Northwest Territories, Nova Scotia, Nunavut and Yukon where it is age 19.

7. I referred to the 2016 census numbers that identify population of First Nations people by band and province/territory and determined that 75% of First Nations people live in a province with an age of majority of 18 and 25% live in a jurisdiction with an age of majority of 19. I assumed that any difference by jurisdiction in the probability of a First Nations child being taken into care is not material to the results and I assumed that 75% of children taken into care attain the age of majority at age 18 and 25% at age 19.

I was advised that children taken into care up to 31 March 2022 are to be included in my analysis. I determined that all children taken into care prior to 1 April 2003 will have attained the age of majority by 31 March 2022 and I have ignored them for purposes of this report.

Based on these assumptions, I determined the number of children that entered care in each of the past 19 years by age of entry and the year in which they will attain the age of majority.

As of 31 March 2022, I estimate that 44,500 of the total 116,000 children are under the age of majority. Consistent with the range provided in the Joint Report, I estimate that number could vary by plus or minus 6,000 – that is the number of children under the age of majority as of 1 April 2022 is likely in the range 38,500 to 50,500.

Based on the single-point estimate of 44,500 under the age of majority, the following table sets out my estimate of the number of First Nations children taken into care from 1 April 1991 to 31 March 2022 who will attain the age of majority in each 12-month period in the future.

Fiscal Year	Number Attaining Age of Majority
Apr 2022 to Mar 2023	3,990
Apr 2023 to Mar 2024	3,910
Apr 2024 to Mar 2025	3,740
Apr 2025 to Mar 2026	3,530
Apr 2026 to Mar 2027	3,420
Apr 2027 to Mar 2028	3,250
Apr 2028 to Mar 2029	3,130
Apr 2029 to Mar 2030	2,890
Apr 2030 to Mar 2031	2,600
Apr 2031 to Mar 2032	2,280
Apr 2032 to Mar 2033	2,120
Apr 2033 to Mar 2034	2,000
Apr 2034 to Mar 2035	1,850
Apr 2035 to Mar 2036	1,640
Apr 2036 to Mar 2037	1,430
Apr 2037 to Mar 2038	1,190
Apr 2038 to Mar 2039	900
Apr 2039 to Mar 2040	530
Apr 2040 to Mar 2041	100
Total	**44,500**

If you have any questions or require additional information, please call me.

Yours truly,
JDM Actuarial Expert Services Inc.

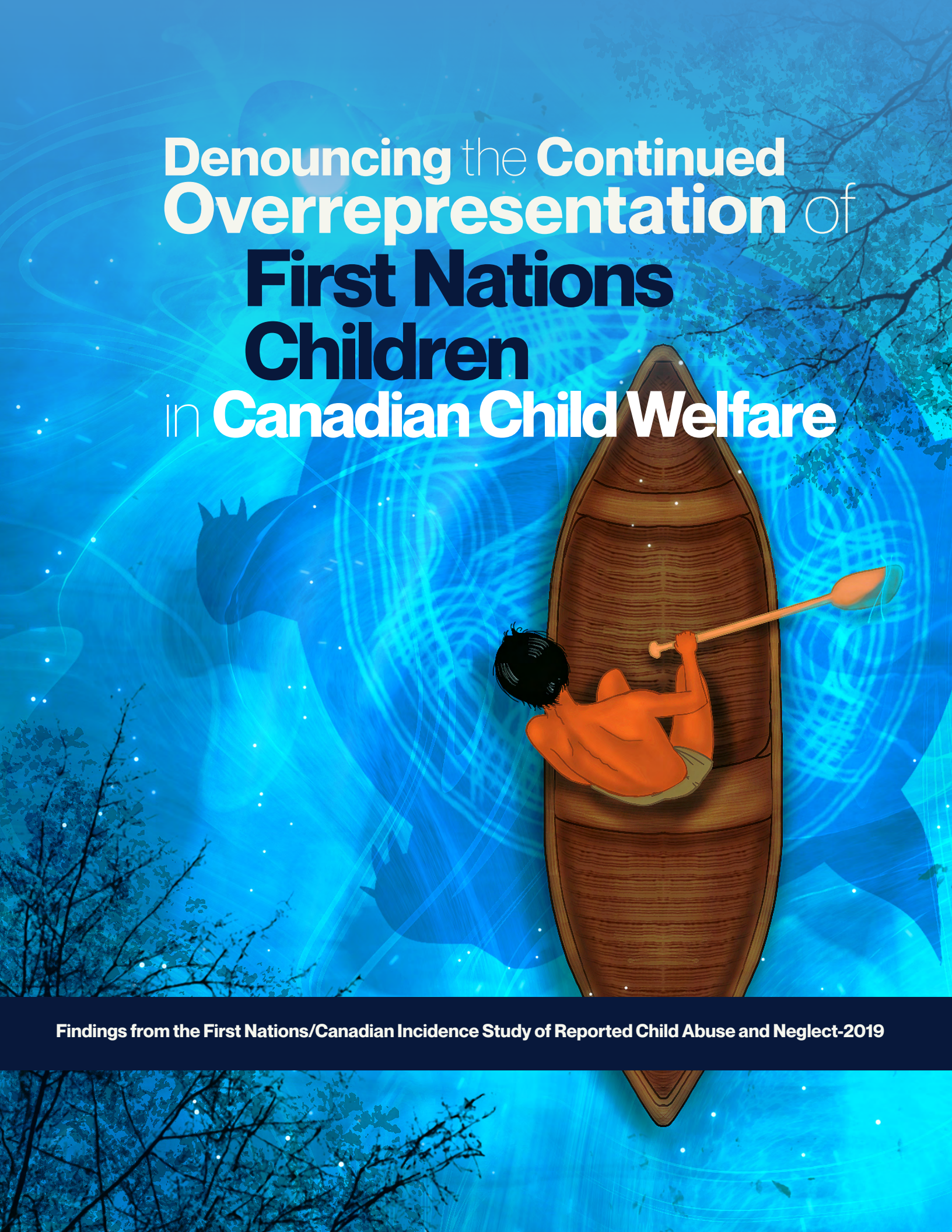
Peter Gorham, F.C.I.A., F.S.A.
President and Actuary

This is **Exhibit "F"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)

Sarah Clarke LSO # 57377M

Denouncing the Continued Overrepresentation of First Nations Children in Canadian Child Welfare



Findings from the First Nations/Canadian Incidence Study of Reported Child Abuse and Neglect-2019

The cover art was gifted by Ziibiikwans, Caitlyn Murphy- Eagleson.

“

This piece is titled "Miskwaadesi" which means "painted turtle" in Ojibwe. This piece has a young indigenous youth at the center, canoeing over large, spiritual turtles in water. This piece evokes a connection with land, spirit and the youth.

Water in my work often represents healing, and this study definitely ties into important research associated with important healing work that needs to be done to address child abuse and neglect.”

- Ziibiikwans, Caitlyn Murphy- Eagleson

Denouncing the Continued Overrepresentation of First Nations Children in Canadian Child Welfare

Findings from the First Nations/ Canadian Incidence Study of Reported Child Abuse and Neglect-2019

Authors

Barbara Fallon, Rachael Lefebvre, Nico Trocmé, Kenn Richard, Sonia Hélie, H. Monty Montgomery, Marlyn Bennett, Nicolette Joh-Carnella, Marie Saint-Girons, Joanne Filippelli, Bruce MacLaurin, Tara Black, Tonino Esposito, Bryn King, Delphine Collin-Vézina*, Rachelle Dallaire, Richard Gray, Judy Levi, Martin Orr, Tara Petti, Shelley Thomas Prokop, & Shannon Soop

*Subsequent authors are listed alphabetically

The FN/CIS-2019 research was directed by the Assembly of First Nations with core funding from the Public Health Agency of Canada. The views expressed in this report are those of the authors and do not necessarily reflect the views of these institutions.

Citation:

Fallon, B., Lefebvre, R., Trocmé, N., Richard, K., Hélie, S., Montgomery, H. M., Bennett, M., Joh-Carnella, N., Saint-Girons, M., Filippelli, J., MacLaurin, B., Black, T., Esposito, T., King, B., Collin- Vézina, D., Dallaire, R., Gray, R., Levi, J., Orr, M., Petti, T., Thomas Prokop, S., & Soop, S. (2021). *Denouncing the continued overrepresentation of First Nations children in Canadian child welfare: Findings from the First Nations/Canadian Incidence Study of Reported Child Abuse and Neglect-2019*. Ontario: Assembly of First Nations.

December 2021

Table 16: Placement Type in Maltreatment-Related Investigations in Canada in 2019 for First Nations and Non-Indigenous Children

	First Nations Child Investigations			Non-Indigenous Child Investigations		
Placement Type	#	Rate per 1,000 children	%	#	Rate per 1,000 children	%
Informal Placement (Kinship Out of Care and Customary Care)	2,365	7.78	5%	4,798	0.84	2%
Kinship in Care	1,589	5.23	3%	545	0.10	<1%
Foster Care (Non-kinship)	1,775	5.84	4%	2,677	0.47	1%
Group Home/Residential or Secure Treatment	207	0.68	<1%	757	0.13	<1%
Other Placement (e.g. places of safety)	205	0.67	<1%	153	0.03	<1%
Subtotal: Placement Made	**6,141**	**20.20**	**13%**	**8,930**	**1.56**	**4%**
No Placement Made	39,776	130.81	87%	232,207	40.55	96%
Total Investigations	**45,917**	**151.00**	**100%**	**241,137**	**42.11**	**100%**

Based on a sample of 27,994 cases extracted from the Quebec administrative system in 2019, 7,007 investigations in Ontario in 2018, and 6,384 investigations in the rest of Canada in 2019. The differences in rates between First Nations and non-Indigenous child investigations must be understood in the context of the ongoing impact of colonialism, discrimination, and poverty.

Table 16 presents out-of-home placements made in child maltreatment-related investigations in Canada in 2019. Thirteen percent of investigations involving First Nations children resulted in an out-of-home placement for the child (an estimated 6,141 investigations) compared to only four percent of investigations involving non-Indigenous children (an estimated 8,930 investigations). When comparing the rates per 1,000 children, the rate of placement for First Nations children (20.20 investigations per 1,000 First Nations children) is **12.9 times** the rate of placement for non-Indigenous children (1.56 investigations per 1,000 non-Indigenous children). The rate of placement in formal out-of-home care (i.e. excluding informal care) for First Nations children (12.42 investigations per 1,000 First Nations children) is **17.2 times** the rate of placement in formal out-of-home care for non-Indigenous children (0.72 investigations per 1,000 non-Indigenous children).

Investigating workers were asked to specify the type of placement that was made when a placement in out-of-home care was noted for the investigated child. Informal placements represented the most frequently noted placement type for both First Nations and non-Indigenous children (noted in five percent of investigations involving First Nations children and two percent of investigations involving non-Indigenous children). The next most frequently noted placement types in investigations involving First Nations children were non-kinship foster care (noted in four percent of investigations) and kinship in care (noted in three percent of investigations).

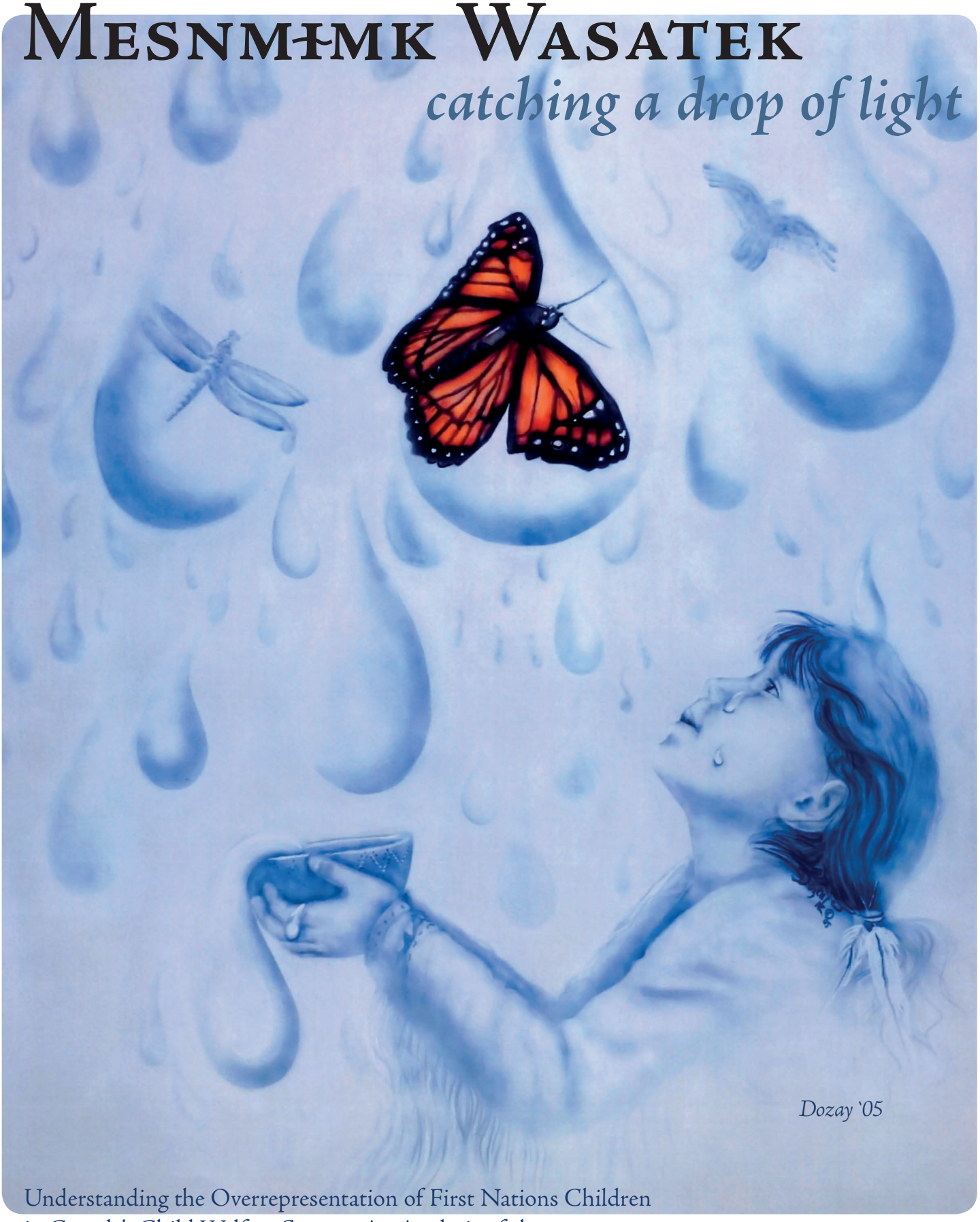
This is **Exhibit "G"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)

Sarah Clarke LSO # 57377M

Mesnmɨmk Wasatek

catching a drop of light



Understanding the Overrepresentation of First Nations Children in Canada's Child Welfare System: An Analysis of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2003)

Nico Trocmé, Bruce MacLaurin, Barbara Fallon, Della Knoke, Lisa Pitman & Megan McCormack

of non-Aboriginal children experienced a change of residence during or at the conclusion of the initial substantiated maltreatment investigation.

Source of Referral

Table 7-7 presents the categories of non-professionals and professionals who referred cases of substantiated maltreatment. Each independent contact with the child welfare office regarding a child/children or family was counted as a separate referral source. The person who actually contacted the child welfare office was identified as the referral source. For example, if a child disclosed an incident of abuse to a schoolteacher, who made a report to child welfare services, the school was counted as a referral source. However, if both the schoolteacher and the child's parent called, both would be counted as referral sources.

The Maltreatment Assessment Form included 18 pre-coded referral source categories and an open "other" category. Referral sources were collapsed into 3 categories reflected in Table 7-7.

Non-Professional Referral Sources: This includes parents (custodial and non custodial), child, relative, and neighbour or friend.

Professional Referral Sources: This includes community agencies, health professionals, school personnel, mental health professionals, other child welfare services and police.

Other referral source: Any other source of referral.

Sixty-four percent (an estimated 7,803) of all referrals substantiated First Nations child maltreatment investigations were made by professionals. Non-professional sources referred 26% (an estimated 3,119) of substantiated First

Table 7-6: Placement Decisions in Primary Substantiated First Nations and Non-Aboriginal Child Maltreatment Investigations in Canada, Excluding Quebec, in 2003

	First Nations Child Investigations		Non-Aboriginal Child Investigations		Total
Out-of-Home Placement***	%	Number of Child Investigations	%	Number of Child Investigations	
No placement required	67	8,147	86	75,747	83,894
Placement considered	4	464	4	3,355	3,819
Informal kinship care	13	1,554	4	3,481	5,035
Any Child Welfare Placement*	16	1,946	7	5,562	7,508
Kinship foster care	5	595	1	592	1,187
Other family foster care	6	764	4	3,743	4,507
Group home	4	449	1	823	1,272
Residential/Secure treatment	1	138	1	404	542
Total Child Investigations	100	1,946	100	5,562	7,508

Canadian Incidence Study of Reported Child Abuse and Neglect, 2003

Analyses are based on a sample of 5,367 substantiated child maltreatment investigations with information about out-of-home placement

*x^2, $p<0.05$ **x^2, $p<0.01$ ***x^2, $p<0.001$

This is **Exhibit "H"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)

Sarah Clarke LSO # 57377M

Table 1: Placement Type (0-17 years of age) for Investigations involving FN children in Canada in 2019

	Frequency	Percent
Kinship out of care	2,180	4.5
Customary care	308	0.6
Kinship in care	1,609	3.3
Foster care (non-kinship)	1,798	3.7
Group home	157	0.3
Residential or secure treatment	58	0.1
Other	219	0.5
Total	6,329	13.1
No placement	42,126	86.9
Total	48,455	100.0

Note: Estimated placement type for all investigations involving FN children (status/non status) in Canada in 2019.

There are an estimated 48,455 child investigations in Canada in 2019 involving First Nations children under 18 years of age. Of these, 13% (an estimated 6,329 child investigations) resulted in an out of home placement. Of the child investigations that resulted in a placement, 4.5% were placed in kinship out of care, 3.7% in foster care, 3.3% in kinship in care, 0.6% in customary care, 0.3 % in a group home.

Table 2: Placement type by estimated travel time (EXCLUDES Quebec & Ontario) for investigations involving FN children 0-17 years of age, in 2019

		to travel between the				Total		
		Under 30 minutes	30 minutes to 1 hour	Between 1 and 2 hours	2 hours of more		>30 Minutes	
	Kinship out of care	1,109	314	167	147	1,737	628	36%
	Customary care	214	0	0	0	214		
	Kinship in care	973	367	42	155	1,537		
	Foster care (non-kinship)	414	559	368	217	1,558		
	Group home	84	0	0	47	131		
	Residential or secure treatment	-	0	31	0	31		
	Other	183	20	0	0	203		
Total		2,977	1,260	608	566	5,411		

Note: Question was not asked for Quebec and Ontario. Investigtions by placement type and travel time estimated. >30 mintues 36% of Kinship out of care.

There are an estimated 5,411 child investigations which resulted in an out of home placement in Canada (excluding Quebec and Ontario) invovling First Nations children. Of these, 32% (an estimated 1,737 child investigations) were placed in kinship out of care. For the child investigations involving a placement in kinship out of care, 36%(an estimated 628 child investigations) were placed more than 30min away from their primary

Table 3: Placement Type (0-17 years of age) for Investigations involving FN children in Canada in 2019 ON RESERVE

		Frequency	Percent	
	Kinship out of care	980	8.4	
	Customary care	303	2.6	
	Kinship in care	858	7.3	
	Foster care (non-kinship)	403	3.4	
	Group home	29	0.2	
	Other	14	0.1	
	Total	2,586	22.1	
	No placement	9,124	77.9	
Total		11,710	100.0	

Note: This is placement type broken down for investigations on reserve.

There are an estimated 11,710 child investigations involving First Nations children on reserve. Of these, 22% (an estimated 2,586 child investigations) resulted in an out of home placement; 8.4% in kinships out of care, 7.3 % in kinship in care, 3.4% in foster care, and 2.6 % in customary care.

Table 4: Placement type by estimated travel time (EXCLUDES Quebec & Ontario) 0-17 years of age in 2019 ON RESERVE

		to travel between the				Total
		Under 30 minutes	30 minutes to 1 hour	Between 1 and 2 hours	2 hours of more	
	Kinship out of care	556	152	70	14	792
	Customary care	214	-	-	-	214
	Kinship in care	544	250	29	30	853
	Foster care (non-kinship)	103	218	14	43	378
	Group home	-	-	-	29	29
	Other	14	-	-	-	14
	Total	1,431	620	113	116	2,280

Note: Placement type by travel time on reserve. Not asked for Quebce and Ontario.

There are an estimated 2,280 child investigations which resulted in an out of home placement in Canada (excluding Quebec and Ontario) invovling First Nations children on reserve. Of these, 34% (an estimated 792 child investigations) were placed in kinship out of care. For the child investigations involving a placement in kinship out of care, 30% (an estimated 236 child investigations) were placed more than 30min away from their

Table 5: Placement Type (0-17 years of age) for Investigations involving FN children in Canada in 2019 OFF RESERVE

	Frequency	Percent
Kinship out of care	1,199	3
Customary care	5	-
Kinship in care	751	2
Foster care (non-kinsh	1,395	4
Group home	128	0
Residential or secure t	58	0
Other	205	1
Total	3,743	10
No placement	33,002	90
Total	36,745	100

Note: placement type off reserve.

There are an estimated 36,745 child investigations involving First Nations children off reserve. Of these, 10% (an estimated 3,743 child investigations) resulted in an out of home placement; 3% in kinship out of care, 2% in kinship in care, 4% in foster care, and 1% in other type of placement.

Table 6: Placement type by estimated travel time (EXCLUDES Quebec & Ontario) 0-17 years of age in 2019 OFF RESERVE

		to travel between the				Total
		Under 30 minutes	30 minutes to 1 hour	Between 1 and 2 hours	2 hours of more	
	Kinship out of care	553	162	96	133	944
	Kinship in care	429	117	13	125	684
	Foster care (non-kinship)	311	341	353	173	1,178
	Group home	84	-	-	18	102
	Residential or secure treatment	-	-	31	-	31
	Other	169	20	-	-	189
	Total	1,546	640	493	449	3,128

>30 Minutes

391 41%

Note: Placement type off reserve by travel time. Question not asked for Ontario and Quebec.

There are an estimated 3,128 child investigations which resulted in an out of home placement in Canada (excluding Quebec and Ontario) invovling First Nations children under the age of 18 years off reserve . Of these, 30% (an estimated 944 child investigations) were placed in kinship out of care. For the child investigations involving a placement in kinship out of care, 41% (an estimated 391 child investigations) were placed more than 30min away from their primary residence.

This is **Exhibit "I"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)

Sarah Clarke LSO # 57377M

Policy Brief SAFETY

TANF for Fictive Kin Providers

2017

When a child is removed from his/her home, the child welfare agency must identify and notify all other adult relatives within the fifth degree of consanguinity of the child.[1] When blood relatives are not willing or able to take the child, the preference for placement is then given to fictive kin – those who have a family-like tie to the child. Relatives and fictive kin caregivers provide kinship care, which allows a child to grow to adulthood in a family environment and maintain connections to their family, community and identity[2].

Kinship caregivers differ from foster parents because they are "unlicensed" when they first accept children into their home, which means they are not entitled to the financial support that non-kin foster parents receive. For most kinship caregivers, having a child placed in their care can become financially burdensome: many of these caregivers are retired and living on fixed incomes; more than one-third are already living at the poverty line[3]; and some may be in poor health[4].

In Nevada, the FY2014 monthly average number of children in Foster Care was 4,955.

- 36% of children in foster care in Nevada live in a kinship placement.
- 68% of foster children living in a kinship placement are in an unlicensed home.
- Between 20-30% of kinship placements are with a fictive kin caregiver.

In Nevada, there are two main sources of financial support for qualified kinship families.

1. **Title IV-E of the Social Security Act** –Relative and fictive kin families may become licensed as foster parents and receive the same foster care reimbursement that foster parents receive. The process is managed by the child welfare agency and can take months, leaving many families struggling to pay the bills while they are working to become licensed while caring for the new children in their home.
2. **Temporary Assistance for Needy Families (TANF)** – During the time relatives are working to become licensed, many families may be eligible for a smaller form of financial support from the TANF grant offered through the Division of Welfare and Supportive Services (DWSS). Child- only TANF, also known as Non-Needy Relative Caregiver TANF[5], is available to individuals caring for dependent children,[6] other than their own biological children, who meet specified conditions. These include:
    I. Providing proof of relation to the child(ren)by birth, marriage or adoption within the 5th degree of consanguinity[7,8].
    II. Proof the biological parents do not reside in the home[9], or if they are in the home, have been declared by the court to be mentally or physically incapable of caring for children[10].

---

[1] Fostering Connections Act, 2008
[2] Child Welfare League of America [CWLA] & Generations United [GU], 2011
[3] Nelson et al., 2010; Alliance for Children's Rights, 2014.
[4] Sakai, Lin, & Flores, 2011; Stein et al, 2014
[5] NV DWSS Manual 1010.2.3 Non-Needy Relative Caregiver A Non-Needy Relative Caregiver (NNRC) is a relative, other than a legal parent, who is not requesting assistance for themself and only requesting assistance for a relative child(ren). Only one non-parent caregiver may be included as a needy caregiver and they must be a relative of specified degree (see manual section A-300). See manual section A-2600 for eligibility requirements and C-140 for payment amounts.
[6] NV DWSS Manual 323 DEPENDENT CHILD
[7] NV DWSS Manual 321 CAREGIVER
[8] NV DWSS Manual RELATIONSHIP
[9] NV DWSS Manual 1010.2 TANF Cash Programs

III. The gross household income must not exceed 275% of the Federal Poverty Guidelines for household size[11].

Due to a lack of coordinated information for families, an application process that can be complicated, and the stigma families may feel is associated with applying for a welfare benefit; few eligible households receive the child-only TANF grants[12]. In addition, there are policies that prevent some kinship families from accessing the TANF grant at all.

- Paternal relatives may find they are unable to receive help if the biological father is not listed on the child's birth certificate[13].
- If the caregiver does not share a blood relationship to all kinship children in their home, the case will be denied for the children with whom there is a blood relationship because the sibling set is considered an assistance unit[14].
- Relatives must also agree to have child support enforcement officers pursue the biological parents for child support to repay the state[15], a requirement that deters some families.
- Due to relationship requirements, fictive kin families are not eligible for any financial support from TANF.
- Finally, even if the family meets all the criteria to apply, some relative families are denied at the welfare office, potentially related to the fact that child-only applications are relatively rare. Relative families would often have to request an appeal to correct the decision.

Recommendations:

The Children's Advocacy Alliance recommends that Nevada:

1. Expand child-only TANF to allow payments to fictive kin caregivers of children in foster care – who meet all other requirements. Based on the number of children per fictive kin placement, the financial impact would be between $127K-$225K per month.[16]

2. Ensure child welfare workers are informed of the child-only TANF program so that relative families are encouraged to apply when they first get placement of a child. Increase the number of TANF training hours for welfare eligibility specialists, with a focus on child-only TANF.

Children's Advocacy
ALLIANCE

702-228-1869

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[10] NV DWSS Manual 330 WHO IS INCLUDED
[11] NV DWSS Manual A 2620.1.1
[12] Mauldon, Speiglman, Sogar,& Stagner, 2012; Nelson, 2010; AECF, 2012
[13] NV DWSS MANUAL 323.3 Children Living With Relatives of the Biological Father
[14] NV DWSS MANUAL A 2630.2
[15] NV DWSS MANUAL 1600 PURPOSE , 1610 ASSIGNMENT OF SUPPORT , 1611 GOOD CAUSE FOR NON-COOPERATION WITH CSEP
16 One child per placement: (Total number of children in foster care* .36 kinship placements)* .3 fictive placements *$417. Two children per placement:[(Total number of children in foster care* .36 kinship placements)*.3 fictive placements]/2 *$476

This is **Exhibit "J"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)

Sarah Clarke LSO # 57377M

Fairy godparents and fake kin: Exploring non-familial kinship care ('kith care')

Diversity in kinship care Research Series Report 1:
Non-familial kinship care

THE UNIVERSITY OF MELBOURNE

COMMISSION FOR CHILDREN AND YOUNG PEOPLE

Contents

"Kinship care may often be called 'family and friends care', but there is as yet little in the literature about care by friends as opposed to family (whether or not 'blood' related) … What kinds of arrangements exist, and how (if at all) are they different?"

(Pitcher, 2014)

Table 1: Administrative datasets explored

Australian Institute of Health & Welfare (AIHW)	Preliminary data about the carer relationship from four Australian jurisdictions appeared in for the first time in the AIHW 2015–2016 Child Protection Report (Australian Institute of Health and Welfare, 2017).
Victorian Department of Health and Human Services (DHHS)	CRIS is the Victorian child protection database that records information about children subject to child protection investigations. The extract of data provided included information about the relationship between children and their kinship carers, and start and end dates of placements.
2011 Australian Census of Population and Housing (ABS)	The Census of Population and Housing conducted by the Australian Bureau of Statistics (http://www.abs.gov.au/websitedbs/D3310114.nsf/Home/Census) includes information about the usual place of residence[a] of every individual on the designated census night. Customised tables provided included proxy data about the prevalence of kinship care arrangements and associated demographic characteristics.
Australian Department of Social Services (DSS) – Centrelink	The extract of de-identified electronic case file data about recipients of Centrelink carer payments regarding the relationship between carers and children in their care was provided. However, DSS analysts commented that the data was not of great clarity, and urged cautioned in drawing conclusions from it. The extract indicated that that the overwhelming majority of carer payments (97%) were provided to identified parents of children. Few carers (1%) were identified as unrelated to children for whom they were providing care[b]. Numbers were too small to derive reliable numbers of payments to kinship carers in Victoria. (DSS data analysts, personal communications October 2014).
Taskforce 1000	A dataset of Aboriginal children in care in Victoria in 2014–2015 not available for perusal.
Household, Income and Labour Dynamics in Australia (HILDA) Survey	The HILDA Survey is a household-based panel study conducted by the Melbourne Institute of Applied Economic and Social Research. This survey collects information about economic and personal well-being, labour market dynamics and family life. However, there are only 30–40 children in each Wave of data collection, and most children are living with parents. The data pool was thus too small to derive rates of familial and non-familial kinship care (Melbourne Institute of Applied Economic and Social Research, University of Melbourne, personal communication February 2016).
Longitudinal Study of Australia's Children (LSAC)	*Growing Up in Australia: The Longitudinal Study of Australian Children (LSAC)* is a major study following the development of 10,000 children and families from all parts of Australia and investigating the contribution of children's social, economic and cultural environments to their adjustment and wellbeing. A major aim is to identify policy opportunities for improving support for children and their families. The dataset was not of sufficient size to identify numbers of unrelated children in the care of kinship carers. Further, the carer identification is self-identification and may not be exclusive (AIFS, personal communication November 2014).

a. Usual place of residence is defined as the address at which a person lives or intends to live for six months plus.
b. This 1% does not include step-parents, foster carers or adoptive carers of children.

Children's relationship with carer – statutory kinship care in Australia

The 2017 Child Protection Report (Australian Institute of Health and Welfare, 2017) presented preliminary data about the relationship between carer and child on 30 June 2016 in four Australian jurisdictions: Queensland, South Australia, Tasmania and the Australian Capital Territory. Supplementary Table S36 (here presented as Table 2 with this writer's highlights) reports that three-quarters (75.8%) of the 5,074 children in these four jurisdictions were living with relatives: nearly half (48.1%) were with their grandparents, and over one-quarter (27.7%) with

other relatives. Nearly one-quarter (24.1%) were either in non-familial care (17.5%) or 'Other' care (6.6%). Table S36 Note (d) below refers to another 916 children excluded because the relationship between kinship carer and child was unknown. (These 916 children, 15% of the overall number, were included in Supplementary Table S35 not quoted here.) It cannot be assumed that the excluded cases were spread proportionately across the relationship categories. This report of carer relationships is therefore regarded as a best first estimate.

Table 2: Excerpt from 2017 Child Protection Report Supplementary Data

Preliminary analyses, children in relative/kinship placements at 30 June 2016, by relationship of relative/kinship carer (AIHW 2017, Table S36)

Relationship of relative/kinship carer	Number	%
Grandparent	2,442	48.1
Aunt/uncle	1,121	22.1
Sibling	80	1.6
Other Relative	205	4.0
Non-familial relationship	887	17.5
Other Indigenous kinship relationship	6	0.1
Other	333	6.6
Total	**5,074**	**100.0**

Notes:

a. This table includes data for Qld, SA, Tas, and the ACT.

b. The relationship between an authorised relative/kinship carer and a relative/kinship child placed in their care can be full, half, step or through adoption.

c. For households containing more than one authorised relative/kinship carer, only the relationship of the carer identified as the 'primary' carer is recorded.

d. Placements where the relationship of relative/kinship carer is unknown have been excluded from this table.

Children's relationship with carer – statutory kinship care in Victoria

The CRIS data extract provided included information about the relationship between children and kinship carers for the six years 2010 to 2015 and associated *Placement Commencement* and *Placement End* dates.

Technicalities

CRIS contains fields for the *Role* of an individual in a child's life and the *Relationship* between an individual and a child, whether as family or another non-family relationship. Completion of the *Role* field is mandatory, but completion of the *Relationship* field is not. The *Role* menu option *Caregiver – Kinship* covers kinship carers with both familial and non-familial relationships with children in their care. There are some historical records where the *Role* of kinship carer was recorded as the *Relationship Caregiver – primary* rather than as *Role Caregiver – kinship*.

An individual recorded in the *Relationship* field may also be recorded as having the *Role* of Caregiver. Where no *Relationship* has been recorded for the child's caregiver, no inference can be drawn about the type of relationship the caregiver may have with the child.

Findings and conclusions

Data obtained is presented in Table 3. Over the years 2010 to 2015, less than half the children (34% to 42%) were identified as having a familial relationship with their caregivers. Around

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University of Victoria | Economics

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FIRST PEOPLE LOST: DETERMINING THE STATE OF STATUS FIRST NATIONS MORTALITY IN CANADA USING ADMINISTRATIVE DATA

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February 2018

Abstract

We present the most comprehensive set of estimates to date for Status First Nations mortality in Canada. We use administrative data from Indigenous and Northern Affairs Canada to establish a set of stylized facts regarding Status First Nations mortality rates from 1974 to 2013. Between 2010 to 2013, the mortality rates of Status First Nations men and boys are highest in nearly all age groups considered with the exception of Status girls between the ages of 10 to 14. On reserve, Status boys between the ages of 15 to 19 have mortality rates nearly four times that in the general population, while Status girls between the ages of 15 to 19 have mortality rates five times that in the general population. We demonstrate substantial regional variation in mortality rates which are correlated with economic factors. We document that there has been no improvement in mortality among Status women and girls living on-reserve in the last 30 years and relative mortality rates for all Status people on-reserve has not changed in 40 years. Mortality rates may be worsening among some age groups.

Keywords: Mortality, First Nations, Native American, Status First Nation, gender bias
JEL Classifications: J15, J16, I15, I14

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First People Lost: Determining the State of Status First Nations Mortality in Canada using Administrative Data

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February 14, 2018

Abstract

We present the most comprehensive set of estimates to date for Status First Nations mortality in Canada. We use administrative data from Indigenous and Northern Affairs Canada to establish a set of stylized facts regarding Status First Nations mortality rates from 1974 to 2013. Between 2010 to 2013, the mortality rates of Status First Nations men and boys are highest in nearly all age groups considered with the exception of Status girls between the ages of 10 to 14. On reserve, Status boys between the ages of 15 to 19 have mortality rates nearly four times that in the general population, while Status girls between the ages of 15 to 19 have mortality rates five times that in the general population. We demonstrate substantial regional variation in mortality rates which are correlated with economic factors. We document that there has been no improvement in mortality among Status women and girls living on-reserve in the last 30 years and relative mortality rates for all Status people on-reserve has not changed in 40 years. Mortality rates may be worsening among some age groups.

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Acknowledgments. We would like to thank two anonymous referees for invaluable feedback. We would also like to thank Siwan Anderson, Patrick Button, Pascal Courty, David Green, Robert L. A. Hancock, Stephen Hume, Anke Kessler, Eric McGregor, Kevin Milligan, David Scoones, Manisha Shah, Erin O'Sullivan, Steven Stillman, Jacqueline Quinless and all those who commented on this work along the way. We would also like to thank Statistics Canada's Research Data Centers Staff and Indigenous and Northern Affairs for the access they granted to the data. Any errors or omissions are ours alone.

1 Introduction

Avoiding an early death is one of the greatest advantages of being born in a wealthy country (Deaton, 2013). However, this advantage is not shared equally. In Canada there is evidence of substantial health disparities between First Nations peoples and the general population, but existing statistics are at best sparse (Truth and Reconciliation Commission of Canada (TRC), 2015, p 161). In this work we provide the most comprehensive analysis of the patterns and trends in mortality rates for the largest First Nation's population in Canada – Status First Nations – to date.[1] We do this by using administrative data from Indigenous and Northern Affairs Canada (INAC) from 1974 to 2013 which, to our knowledge, is the most complete and consistent source of First Nations vital statistics data available. Our goal in this work is to provide a benchmark set of stylized facts on Status First Nation's mortality in Canada that can be used for future academic and policy research.

This work was conducted in response to the recent calls in Canada for reconciliation between Indigenous and non-Indigenous peoples by the Truth and Reconciliation Commission of Canada: the commission called for all Canadians to contribute to the process of reconciliation and called for the establishment of comprehensive measures of well-being for Indigenous peoples (TRC, 2015, p 161). The commission also called for cooperation between the federal government and Indigenous groups to establish measurable goals to identify and close the gaps in health outcomes between Indigenous and non-Indigenous communities and to publish annual progress reports and assess long-term trends (TRC, 2015, p 322). It is our hope that this work helps to establish a foundation for the dialogue and that it takes a step towards establishing comprehensive measures of well-being for Indigenous peoples.

Using administrative data on births and deaths for Status First Nations people that

[1] "Status First Nations" are individuals who are governed explicitly under the *Indian Act* as "Indians". "Indian Status" is determined through genetic relation to the first peoples classified by the federal government as "Indians."

includes information on the gender, age, band of membership, and whether an individual resides on or off reserve, allows us to create measures of mortality rates at the national level and by location on and off reserves. We also link patterns in mortality over time, and at the regional level, with data available from the 1991-2006 Canadian Census and 2011 National Household Survey.[2] With this data we make three main contributions: 1) we provide the first national and regional level estimates of mortality among Status youth; 2) we provide the first modern estimates of how Status mortality rates differ by reserve residence and province and the correlation with province-level economic factors; and 3) we provide the first description of how Status mortality rates have changed since the 1970s and how this is correlated with economic changes and to changes in Status First Nations definitions. Despite the relative simplicity of our analysis, we find striking and unsettling results.

We begin by confirming the findings of earlier, less comprehensive studies using our data: age-standardized mortality is higher for Status males than Status females, and Status First Nations age-standardized mortality are always higher than for the general population. Using the most recent data available, 2010 to 2013, we find that age-standardized mortality rates are close to twice that of the general population. However these aggregate statistics mask significant differences by age: Status women and girls have mortality rates that are three to four times that of the general female mortality rates between the ages of 10 and 44. These relative mortality rates are statistically higher than the relative mortality rates for Status males, which are themselves two to two and half times that of the general population. While previous researchers have found higher rates of relative mortality for Status women, to our knowledge no one has identified the disproportionately high mortality rates borne by Status women and girls at such young ages at the national level (Health Canada, 2008, 2014; Mao et al., 1992; Park et al., 2015; Tjepkema et al., 2009). We also demonstrate that the proportional difference in mor-

[2]Unfortunately, the data does not provide information on cause of death or detailed individual socio-economic characteristics and we do not report on these causes in the current analysis.

tality between Status peoples and the general Canadian population is larger than the proportional difference in mortality between Native Americans and non-Hispanic Whites and the difference between African Americans and non-Hispanic Whites in the United States. We also demonstrate that the gender bias in relative mortality rates for Status First Nations women and girls is not present among either Native Americans or African Americans relative to non-Hispanic American Whites.[3]

Next, we examine the patterns in mortality by place of residence. We show mortality rates are higher on-reserve relative to off-reserve: between the ages of 15 and 19 in 2010 and 2013, the mortality rate of Status First Nations girls was *five times* the rate for girls in the general population. The mortality rates of boys on-reserve was also notably higher, nearly four times that of boys in the general population. We also show that absolute and relative mortality vary significantly by province and age. While First Nations mortality rates are highest in Alberta, Manitoba and Saskatchewan, we find that Alberta and Ontario exhibit the highest relative mortality rates. We provide evidence that this regional variation is associated with economic differences between Status peoples and the general population.

Finally, we examine trends in mortality rates from 1974 to 2013 (the years for which we have data). We find that here has been no improvement in relative, age standardized mortality rates between Status peoples on-reserve and the general population in the past 40 years. In absolute terms, mortality rates for Status women and girls below age 40 have not changed in the past 30 years and may have even increased for some age groups. We present suggestive evidence that this lack of convergence in female mortality rates relative to male mortality rates is not easily explained by differential convergence in economic characteristics. If anything, Status women have converged economically to the general population more quickly than Status men. While off-reserve mortality rates have exhibited some improvement, this change occurs primarily in the Status First Nation

[3]This is not simply due to relatively higher female, non-Hispanic white mortality rates in the United States.

male population.

We believe our findings have implications for the recently called Canadian National Inquiry into Missing and Murdered Indigenous Women and Girls which has gained international attention (Amnesty International, 2015; Levin, 2016; The Economist, 2014; The Government of Canada, 2015). The inquiry was called to investigate the extremely high rates of disappearance and homicide experienced by Indigenous women and girls. Our findings suggest that the marginalization of Indigenous women and girls is more widespread and systemic than previously documented; our mortality rate estimates are generally larger than previous analysis for Status First Nations females. We are also able to document relatively high mortality rates for Status men relative to the general male population as well; the on-reserve Status male probability of death was 31 percent on average by age 64, while it was only 14 percent for the general population. The on-reserve Status female probability of death was 21 percent before the age of 65 while it was 13 percent for the general population.

This work also makes a more general contribution to the literature on "missing women."[4] Since the seminal work of Sen (1992) nearly 30 years ago, high male-to-female gender ratios in the developing world have been associated with excess female mortality (Bulte et al., 2011; Das-Gupta, 2005, 2006; Duflo, 2012; Jha et al., 2006; Klasen and Wink., 2002; Rosenblum, 2013; Sen, 1992).[5] However in our context, we see notably low male-to-female gender ratios in survey data, but high rates of relative female mortality.[6] This is a similar result as found by Anderson and Ray (2010) who identify excess mortality among women in developing countries with relatively balanced gender ratios; our results are novel in that we identify relatively high female mortality in a wealthy,

[4]The term "missing women" has been used differential in the demography, economics, and sociology literature than recently in Canada in the National Inquiry for Missing and Murdered Indigenous Women and Girls. The term missing in this literature has tended to refer to excess female mortality from all sources, not just murder or women who have gone missing from their communities.

[5]This effect has also been observed among Asian immigrant families in Canada and the United States (Abrevaya, 2009; Almond and Edlund, 2008; Almond et al., 2009).

[6]See Akee and Feir (2016) for an early working paper that includes previous mortality estimates and argues that high rates of institutionalization and homelessness of Status men skew result in the low male to female gender ratio.

developed country with low male-to-female gender ratios.

In the next section, we provide some important background information on Status First Nations in Canada and discuss prior estimates of Indigenous mortality in Canada. In Section 3 we discuss the data that we use to estimate First Nation mortality rates and note both the benefits and drawbacks of the data. We also briefly discuss the economic characteristics data that we use in an associative manner with the estimated mortality rates. In Section 4 we discuss the methods used to estimate the Status First Nation and general mortality rates. In Section 5 we present our main results. We discuss variation in mortality by age, gender, location, and discuss the factors that are closely associated with observed mortality rates. Finally, we contrast our results with previous estimates of Status First Nations mortality. In the last section, Section 6, we summarize the set of facts we establish, the questions they raise, and conclude.

2 The Canadian Context and Existing Estimates of Registered Indian Mortality

As of 2016, the Status First Nations Population in Canada was approximately 744,855 which represents roughly 76 percent of the total First Nations population in the country.[7] Overall, this figure represents about two percent of the Canadian population (Statistics Canada, 2017).

It is well established that First Nations are among the most economically marginalized populations in Canada – in 2006, 37 percent of First Nations women off-reserve were living below the low income cut-off, compared to 16 percent of non-Aboriginal women (O'Donnell and Wallace, 2011). For other figures on the degree of First Nations income disparity see, for example, AANDC (2015); George and Kuhn (1994); Pendakur and Pendakur (1998, 2011). Indigenous peoples elsewhere also face economic and social

[7]Some First Nations people may not meet the full legal requirement for Status under Canada's *Indian Act* which is largely based on ancestry yet still either ethnically, culturally, or politically identify as First Nations (Feir and Hancock, 2016).

marginalization.[8] Status First Nations, especially those living on-reserve are systematically poorer than non-Aboriginal people, or the Metis or Inuit in terms of health and income (Pendakur and Pendakur, 2011; Tjepkema et al., 2009).[9] However, much of the work in Aboriginal health and mortality rates in Canada suffers from major data limitations (Feir and Hancock, 2016).

We first begin by defining important terms for the First Nations population in Canada. The *Indian Act* is the legal framework that defines who has "Status" and outlines the set of laws that govern "Status Indians" (referred to here as Status First Nations). Status confers certain rights and benefits. For example, Status confers the right to live on-reserve, vote in band elections, receive money from one's band, and own or inherit property on-reserve (Furi and Wherrett, 2003). However, Status has also historically limited other rights and access to benefits available to non-Status peoples. Until 1960 Status peoples were unable to vote in Canadian elections, did not have access to usual opportunities to acquire credit, and were not eligible for the same educational or health care opportunities (The Government of Canada, 2011). The federal government also has jurisdiction over many services provided to Status peoples that would typically be provided by the provinces.[10] Status can also be lost through out-marriage with non-Status peoples. In 1985 all women (and their children) who lost their First Nations Status through out-marriage had their Status rights reinstated (Hurley and Simeone, 2014). In 2011, there was also reinstatement of the grandchildren of women who lost Status. Both these points will be important for interpreting the results presented later.

Indigenous and Northern Affairs Canada (INAC) implements the *Indian Act* and is the Canadian Federal agency overseeing Indian peoples in Canada. The *Indian Act* estab-

[8] See United Nations (2009) for a global discussion of Indigenous economic disparity.

[9] The Métis and Inuit are the two other legally defined "Aboriginal" peoples in Canada under *The Constitution Act 1982*. While there are legal infrastructures surrounding these groups as well, to our knowledge, there is nothing as systematic and pervasive as that governing Status First Nations (Feir and Hancock, 2016).

[10] For example, up until the late 1960s, the provincial health care systems were not the main source of medical care and the federal government had responsibility for medical care for Status First Nations provided often through Indian Hospitals (Waldram et al., 2006).

lishes Status peoples as wards of the state for whom the Canadian Federal government has the responsibility of managing, defining, and documenting. In 1951, a centralized Indian Register was established to more consistently document who has "Status". Before this, the lists of Status First Nations individuals were created and maintained by government agents at the band-level.[11] The Indian Register is the official record identifying all Status First Nations in Canada and everyone who is classified as a Status person is listed in the Indian Register (Indigenous and Northern Affairs Canada (2010)). The Indian Register is kept up to date by band-level Indian Registry Administrators (IRAs); they are tasked with collecting and reporting vital statistics event data for their community.[12] Death events must also be reported to the Indian Register in order to execute a will of a Status person or make other arrangements for the administration of that person's estate and to determine appropriate funding levels for the band.

To date, five reports document modern Status First Nation mortality rates in Canada: Health Canada (2008, 2014); Mao et al. (1992); Park et al. (2015); Tjepkema et al. (2009). One important advantage of this previous research is that they are able to identify the cause of death in the cases that they describe. Tjepkema et al. (2009) and Park et al. (2015) use the 1991 Canadian Census and Cancer follow-up survey and are able to link mortality and cause of death to individual level demographics available from the long-form Census in 2001 and 2006.[13] Health Canada (2008) and Health Canada (2014) use vital statistics data from the provinces or sub-provincial areas that have identifiers for people with Status to examine mortality rates by age and gender averaged over 2001-2003 and later averaged over 2003-2007. The Health Canada studies include cause of death but do not include individual level demographics. Mao et al. (1992) uses data from

[11] Bands are the political unit defined in the *Indian Act* that the federal government uses to discern different groups of First Nations peoples.

[12] This was determined through conversations of the head of the Indian Register through email correspondence. No public record of this could be found.

[13] Tjepkema et al. (2009) and Park et al. (2015) differ in the precise population and time frame they study: Tjepkema et al. (2009) focuses on Status First Nations peoples, Métis, and non-Status peoples and uses data linked between the 1991 and 2001 Census to determine mortality rates. Park et al. (2015) focuses on all First Nations people and non-Status peoples and uses data linked between the 1991 and 2006 Census to determine mortality rates.

the Indian Register as we do, but their data only includes the two time periods 1979-83 and 1984-88. They match the Indian register with data from the Canadian Generalized Iterative Record Linkage System to obtain cause of death for 1981.[14] To our knowledge, it is not currently possible to link these records.

A significant drawback to these studies is that they are unable to describe the entire population of Status First Nations peoples. First, both Tjepkema et al. (2009) and Park et al. (2015) necessarily exclude First Nations peoples living on reserves that were not enumerated in the 1991 Census (approximately 98 reserves were not enumerated). Those two studies include individuals linked across Census data and tax-filer data in order to obtain their cause of death. The record matching was not complete, however, and differed significantly by gender and First Nations status. The match rates were 47 percent for Status men, 59 percent for Status women, 79 percent for non-Aboriginal men, and 75 percent for non-Aboriginal women. Their sample also excludes anyone without an address or those living in shelters, collective dwellings, or institutions such as prisons. In addition, both Tjepkema et al. (2009) and Park et al. (2015) consider only the population aged 25 to 75 and thus are unable to estimate mortality rates for the youngest age cohorts - which we later show have some of the highest mortality rates overall relative to the general population.

The Health Canada (2008, 2014) analysis includes people of all ages, however, their data does not cover all Canadian provinces or sub-provincial areas. Their analysis includes two provinces (British Columbia and Alberta) and the on-reserve population for Manitoba and Saskatchewan. The substantial difference in population coverage between these studies makes interpreting the differences in their results difficult for national statistics comparisons. For example, the findings of Health Canada (2008) are most comparable in time frame to Tjepkema et al. (2009), but the estimates of life expectancy in Health Canada (2008) are much shorter than those in Tjepkema et al. (2009). It is difficult to conclude whether the difference is due to the different regions included or due to the

[14]The match rate for males was 90 percent for males and 88 percent of females.

differential population match rates. Similar issues arise when comparing the results of Health Canada (2014) to Park et al. (2015).

While Mao et al. (1992) used data that covered the entire Status population, there was a significant change in 1985 in the Status First Nations qualification requirements. Specifically, all women (and their children) who lost Status through out-marriage had their Status rights reinstated (Hurley and Simeone, 2014). Therefore, the estimates of Mao et al. (1992) are not generalizable to the current population governed by the *Indian Act* given that there are likely compositional differences between Status women who out-married and Status women who did not out-marry. We return to the importance of this in Section 5.4. In Table 1 we summarize how our work differs from prior work and contrasts the time periods and populations covered in each study.

Despite the literature's shortcomings, these are important foundational statistics that provide critical information about Indigenous mortality in Canada. The literature currently suggests that Status people over the age of 25 have mortality rates one and a half to two and a half times higher than the average population for both men and women. The mortality rates of Status men are the highest; Status women's are the second highest and comparable to non-Status men; and non-Status women have the lowest mortality rates. The existing evidence suggests that the differences between Status and non-Status peoples' mortality is higher at younger ages (although this evidence is only available for specific sub-regions of Canada). While estimates of the ratio of Status to non-Status mortality rates are often higher for women than for men, there is only sporadic evidence of statistically significant gender differences (Health Canada, 2008, 2014; Mao et al., 1992; Park et al., 2015).

The studies summarized here attribute from 50 to 70 percent of the differences in mortality rates between Status and non-Status peoples to the differential incidence in endocrine and digestive system diseases and to the differential incidence in death from external causes (such as accidental death, suicide, or homicide). Tjepkema et al. (2009) and Park et al. (2015) find that while differences in income, education, occupation, and

urban residence can explain two thirds of the differences in the probability of death between the ages of 25-75 between Status and non-Status men, these factors can explain less than one third of the difference for women.

Table 1: Summary of Previous Literature Regarding Status First Nations Mortality Contrasted with Current Paper

Source	**Years**	**Population Coverage**	**Data Source**	**Advantages**
Health Canada (2008, 2014)	Averaged ; 2001/2002; 2003/2007	On reserve in SK, and MN, & all off-reserve AB & BC	CVSDD^{+}	Information on cause of death
Park et al. (2015)	Death between 1991 & 2006	15% Sample of Long-form Census pop. tax filers over 25	CCMFS*	Data on cause of death & individual level demographic data
Tjepkema et al. (2009)	Death between 1991 & 2001	15% Sample of Long-form Census pop. tax filers over 25	CCMFS*	Data on cause of death & individual level demographic data
Mao et al. (1992) 1984-1988	1979-83	All Status First Nations matched via CGIRLS**	Indian Register	Data on cause of death
This Paper	1974-2013	All Status First Nations, band members	Indian Register	Total Status pop by gender, band, and location

$^{+}$ = Canadian Vital Statistics and Deaths Databases ; *CCMFS = Canadian Census Mortality Follow Up Study; **CGIRLS = Canadian Generalized Iterative Record Linkage System

3 Data Description

3.1 Data from the Indian Register

The primary data set for our analysis comes from the Indian Register at INAC. The register contains two separate types of information: the first data set is a population count for all Status First Nations for each year from 1974 to 2013 in 5-year age groups for everyone 64 and below, gender, place of residence (whether they live on or off-reserve), as well as First Nation band of membership over this time period. The second data set contains an accounting of every death event by date of birth, year of death, gender, place of residence at the time of death (whether they live on or off-reserve) and First Nation band membership. We combine these two data sets and estimate Status mortality by gender and age group. Unfortunately, the death event data collected by INAC does not contain the cause of death.

3.2 Indian Register Data Limitations and a Validation Exercise

In this section we discuss the potential limitations of using the Indian Register data and use supplemental data collected by Health Canada to gauge the accuracy of reporting to the Indian Register. We conclude from this exercise that the Indian Register data is able to provide accurate estimates of mortality on-average between the ages of 5 and 64.

While the Indian Register data contains the official count of Status peoples, there may be concerns about its accuracy as there are often delays in the reporting of births or deaths. The register relies on band-level Indian Registry Administrators (IRAs) to report deaths. Births are under reported on average by about three years. Additionally, infants that die before being registered are not required to have a death certificate submitted to the Indian Register. Therefore, it is possible that there is an under-reporting of infants and infant deaths.

A second potential limitation is that if deaths go unreported for adults or older chil-

dren, then the Indian Register will have a larger than actual population count since those who have already died will still be included in the data set. For example, if someone dies in 1970 at age 69 and their death is not recorded, that individual will still be included in the Register in 2000 and will be reported as 99 years old. This under-reporting of deaths would result in an under-estimation of mortality rates at older ages.

A third potential limitation of our data is that while the Indian Register has provided population counts in five-year age groups for most ages, the population count of those over age 64 is reported as one large age category. As a result, comparisons of mortality rates between Status peoples and the general population will be confounded by differential age distributions within the "65 and over" age category.

Another concern is that some Status people are not members of a First Nation band recognized by INAC and therefore vital statistics are not recorded by an IRA in a band office. The vital statistics for these individuals are administered by a regional administrative body for multiple bands. This may result in a greater degree of under-reporting of deaths for this population. In addition, some bands have their governmental affairs and data administered by a regional body, and thus again, these deaths may be less likely to be recorded. Thus we will consider only Status peoples who are members of a First Nation.[15]

In order to assess the degree of under-reporting of deaths to the Indian Register, we compare the mortality rates estimates from our data, to the most credible, independently collected data we are aware of: the data collected by Health Canada Vital Statistics from Alberta, British Columbia, and on-reserve in Manitoba and Saskatchewan. We restrict our Indian Register data to the same regions and time periods as that in Health Canada (2008, 2014). Then we estimate mortality rates from our data by age and gender and

[15]Including all Status peoples has little impact on our conclusions. Upon the suggestion of INAC Indian Register officials, we also estimated our results including and excluding First Nations in the Yukon, North West Territories, and Nunavut and there is no effect on our main conclusions. However, when assessing regional or First Nations level variation in mortality rates, we exclude the Territories because of concerns with under-reporting. We inquired about a list of vital statistics data for these Territories, but, according to our discussions with Indian Register, no list for these territories and provinces has been kept over time.

calculate a simple ratio of Health Canada's estimates to our estimates.

Figure A1 depicts the results of restricting the Register sample to the same sub-regions of Canada and years available in Health Canada (2008, 2014) and generating the ratio of Health Canada's mortality rates to our own. The mortality rates are computed in each year via the estimation method described later in Section 4 and averaged over either 2001-2002 or 2003-2007. The time variation is used to construct the standard errors for the estimated ratio. Ratios above one indicates the extent to which the Indian Register data under-reports deaths in those age groups assuming the Health Canada data is accurate. We see in Figure A1 that in most age groups, our mortality estimates are statistically indistinguishable from Health Canada's. However, as expected, the Indian Register data likely under-reports both infant mortality and mortality over the age of 65.[16] It appears that on average, the Health Canada estimates of the mortality rate between zero and four years of age is twice as high as ours. There also seems to be some under-reporting of deaths over the age of 65 in both periods, with Health Canada's estimates 1.30 to 1.45 times as large as our estimates. For these reasons, in most of what follows, we focus on estimating mortality rates between the ages of 5 and 64.[17] Overall, however, we find that our results from the Indian Register align with the independently collected data from Health Canada and thus we have confidence in our results for the age range 5 to 64 years.

3.3 Additional Data

To construct comparable estimates of mortality for the general population, we use population and death count data compiled by gender, province, and five-year age group from Health Canada Vital Statistics. These data are available for the general population by age, gender, and province from 1974 to 2013. In order to gain a sense of whether time and regional patterns in mortality are correlated with basic economic characteristics, we

[16]The result regarding infant mortality is unsurprising given that if infants die before they are registered, neither their birth nor death will be registered.

[17]There is also some evidence is marginal under-reporting of deaths over the age of 40 in 2001-2002 and over 60 in 2003-2007, particularly for males. However, this small degree of potential under-reporting would not change the conclusion of this work in a substantive fashion.

use data from the 1991, 1996, 2001, and 2006 Long Form Census and the 2011 National Household Survey. To our knowledge, the Long Form Census and National Household survey contain the most complete population coverage of Status and non-Status peoples in Canada. For a more complete description of the advantages and disadvantages of Census and National Household survey as it relates to Indigenous peoples, see Feir and Hancock (2016). For a summary of the data sources and how they are used, see Table 2.

Table 2: Summary of Data Sources and Use

Data Source	**Use**
Indian Register	Population and death counts used to construct mortality rates for Status peoples
Health Canada Vital Statistics Compiled by Statistics Canada	Population and death counts used to construct mortality rates for general Canadian population
1991-2006 Census & 2011 NHS	Used to construct basic socio-economic information by Status, gender, province and age group over time to assess the correlation with trends and regional patterns

Notes: INAC is Indigenous and Northern Affairs Canada; NHS is the National Household Survey.

4 Methodology

Our analysis focuses on estimating mortality for Status First Nations. We use the INAC data with the methods described below to produce First Nations and Canadian average mortality rates overall, in five-year age-groups, across provinces, First Nations reserves and over time.

4.1 Estimating Mortality By Age Group, Age-Standardized Mortality Rates, and the Probability of Death

We estimate mortality rates for Status peoples and the general population separately by age and gender by calculating

$$\eta_{agt} = \frac{\#deaths_{agt(endofperiod)}}{population_{agt(startofperiod)}} \times 100,000 \tag{1}$$

where a denotes five-year age group, g denotes gender, and t denotes year. Reporting deaths per 100,000 is consistent with prior literature. Data for the numerator and the denominator in Equation 1 come from the Indian Register for the Status population and from Health Canada Vital Statistics for the general population. The Indian Register provides information on the date of birth, the age of death, and the year of death, thus even if a death is reported a few years after it occurs, we are still able to identify the year and age group to which that death belongs. Late reporting of death appears to be a very minor concern for the age groups we focus on.

In addition to these simple five-year age range mortality rates, we also compute age standardized mortality rates (ASMR) between the ages of 5 and 64. These age standardized mortality rates are useful when comparing populations over time or across populations with very different underlying age distributions. Since mortality rates are highly age-dependent and the Status population is much younger than the general Canadian population, comparing the overall mortality rates of the general Canada population with the Status population may provide an overly optimistic view of equality of mortality rates. This skew towards younger ages in the Status population alone could result in lower mortality rates for Status populations. Therefore, we calculate a direct age standardization (Ahmad et al., 2001) using the age distribution approximated in five-year age bands with the base population of Status First Nations people of all genders in 2010. Let the proportion of the population age a for all Status First Nations in 2010 be denoted as p_{a2010}. Thus the age standardized mortality rate (ASMR) is given by:

$$\eta_{gt} = \sum_{a=5to9}^{60to64} p_{a2010} \times \eta_{agt}. \tag{2}$$

We compute the ASMR for both genders, for all years, for Status peoples and the general population. It is worth noting that different base age distributions will emphasize differences in different parts of the life cycle across the populations. We also present our results by each five-year age group as well, rather than only the ASMR.

Our final estimates of interest are the estimated probabilities of dying before a particular age is reached. The probability of dying before one reaches age $a+1$ is computed as follows with a set of synthetic cohorts:

$$\rho_{a+1gt} = 1 - \frac{population_{agt(endofperiod)}}{initialpopulation_{gt(startofperiod)}} \tag{3}$$

These tables estimate the period life expectancy which provide mortality rates over a specific time period for each age group of individuals.[18] These period life tables (in our case we invert them to show the probability of death) show the overall mortality conditions operating over this particular time period (when the deaths occur). This implies that if all conditions were to remain constant over time and over age cohorts, then a cohort born in this time period could expect mortality rates as provided in these tables. However, to interpret these estimates in this way, we need to assume that there are no differential genetic endowment effects across birth cohorts or time period effects (for example, being born during a famine, war, or boom periods). We also need to assume that there is no selection with regard to unobserved characteristics of the individuals in each age cohort. We acknowledge that these are strong assumptions, but they are standard ones for the computation of these tables in the literature (Guillot, 2011).

Data used to calculate the probabilities estimated in Equation 3 come from the Indian

[18]The other alternative method for computing life expectancy tables is to estimate a cohort life expectancy for a single birth cohort over their entire lifetime. We are unable to do this as the data quality is complete for more recently born cohorts – specifically cohorts born after 1940. Cohort life expectancy tables require all or almost all of the cohort to have died in order to conduct such analysis and would require cohorts born from the early 1900s.

Register for the Status population and from Health Canada Vital Statistics for the general population. These probabilities are presented for each age group up to age 64 by gender for the Status and general population. Note that to compute the number of deaths from age zero to four for the Status population, we also inflate the number of deaths in the register in this age group by the factor computed in 2003-2007 presented in Figure A1 to adjust for under-reporting in the register. In doing this, we assume that the extent of under-reporting of deaths between the ages of zero and four on-reserve in Manitoba, Saskatchewan, Alberta and British Columbia are the same as elsewhere in Canada.

4.2 Associative Analysis

We perform two sets of associative exercises. These exercises are not intended to be causal, but rather useful for identifying potential correlates of mortality rates for the Status First Nations population. The first exercise creates measures of the ASMR by province, Status, age,and gender between 2000 to 2011 and measures of economic characteristics by province, Status, age, and gender from the 2001, 2006 and 2011 Censuses. We then use this data to examine the association between these economic characteristics and mortality rates across Canadian provinces.

The second exercise adds in two additional Canadian Censuses for 1991 and 1996. We regress mortality rates on economic and social characteristics from the Census data as well. In this analysis, we focus on changes in mortality rates over time by gender and First Nations Status.[19] We focus on the time period 1991-2011 in particular as this was a period of stability in how First Nations Status was defined; there were changes in definitions and Status requirements earlier in 1985 and subsequently in 2010-2011. The covariates of interest in this analysis are educational attainment and income levels, therefore we only analyze the population over the age of 25 in this exercise.

A third potential analysis would be to conduct a Oaxaca-Blinder decomposition to

[19]We create mortality rates by averaging over three years spanning each Census year for a more stable mortality estimate. For instance, we average over the years 1990, 1991 and 1992 to create an estimate of the mortality rate for the 1991 Census year

explain the differences in mortality rates between the Status and non-Status populations. There are two reasons that we do not conduct such analysis. First, the finest level available for Canadian mortality rates is at the health region level and they are aggregated up to the age of 75. This aggregation makes it difficult to compare to the Status mortality data we have available. Second, and perhaps more importantly, in order to perform a meaningful decomposition analysis, the characteristics of the groups one compares must overlap one another (Fortin et al., 2011). However, in our data there are no Health Regions with economic characteristics that significantly span the economic characteristics of First Nations communities. In other words, Status First Nations communities can be perfectly predicted based on their economic characteristics alone. Thus the results of any decomposition analysis would be difficult to interpret. As discussed in Section 2, the studies conducted at the individual level among a more selected population suggest that differences in income, education, occupational skill, and urban residence can account for two thirds of the difference in the probability of death between Status men and non-Status men between the ages of 25-75 and about a third of the difference for women (Park et al., 2015; Tjepkema et al., 2009).

5 Results

5.1 A Snapshot of Mortality by Gender, Age and Status in 2010-2013

In this section we provide an overview of Status First Nations mortality rates averaged over 2010 to 2013 and compare them with the mortality rates in the general population by gender and age.[20] Our analysis focuses on the most recent years where there is a consistent definition of First Nations Status. For the analysis over time we directly

[20]We focus on these years since they are the most recent years for which we have data. We report the average of three years in order to reduce noise in the yearly mortality rate. The results are unchanged if 2010 is excluded.

address the issue of changes in the definition of First Nations Status in section 5.3.

In Table 3 we provide the overall age standardized mortality rates calculated as specified in Equation 2 as well as the five-year age group mortality rates by gender for Status First Nations and the Canadian average. The age standardized mortality rates (ASMR) are provided in the first row. Between ages 5 and 65, the ASMR is 226 deaths per 100,000 for the Status First Nations male population, and 161 deaths per 100,000 for the general Canadian male population averaged over 2010 to 2013. For the Status female population, the ASMR is 165 deaths per 100,000 and for the general female population it is 101 deaths per 100,000. Note that these ASMR estimates are not strictly comparable to other studies because we have age standardized to the Status First Nation age distribution in 2010; thus we provide the mortality rates in five-year age groups for males and females in the remaining rows. We find that Status men consistently have the highest mortality rates at almost all age groups. It is worth noting, however, that the mortality rate of Status girls between the ages of 10 to 14 is actually higher (36 per 100,000 as compared to 24 per 100,000) than that of Status boys. This is the only age for which the mortality rate of Status females is above that of Status males. Next, notice that Status females have mortality rates that are higher than both non-Status males and non-Status females.[21]

To more clearly illustrate the relative patterns in Table 3, we present in Figure 1 the ratio of the Status First Nations mortality rate to the General population mortality rate. The dashed horizontal line at one represents parity with the average Canadian in terms of mortality rates at the various age groupings. The figure indicates that the relative mortality rates (or, equivalently, mortality rate ratios) are above one in all cases and above two in most age and gender groups. This indicates that Status First Nations have nearly

[21]In Table A1 we show the mortality rates for Status First Nations and the General population by age and gender computed by year and averaged over 2000 to 2009 and demonstrate that the patterns observed in 2010-2013 are not anomalies. The estimates in this table show that the patterns described above are characteristic over the decade of the 2000s: Status male mortality rates are higher than the general population and Status female mortality rates are lower than Status men in most age groups but significantly higher than for women and comparable to the general male population in many age groups. In addition, the mortality rate ratios are more significantly biased against Status women between 10 to 39.

Table 3: Summary of Mortality Rates per 100,000, 2010-2013

	Males		Females	
Age Group	Canadian Average	All Status First Nations	Canadian Average	All Status First Nations
ASMR (5 to 64)	160.71 (1.94)	225.89 (9.26)	100.81 (0.92)	165.41 (1.62)
05 to 09	9.12 (0.8)	13.51 (5.67)	7.88 (0.73)	12.83 (2.92)
10 to 14	11.97 (1.23)	23.85 (12.08)	10.77 (1.24)	35.62 (10.73)
15 to 19	46.9 (4.31)	123.22 (8.66)	24.72 (1.17)	92.85 (18.35)
20 to 24	73.18 (3.93)	172.05 (38.84)	30.42 (0.44)	113.25 (3.89)
25 to 29	75.64 (2.19)	204.53 (15.5)	32.95 (0.98)	112.84 (19.72)
30 to 34	81.15 (2.43)	217.34 (17.09)	43.46 (1.16)	165.46 (3.82)
35 to 39	101.44 (2.89)	241.24 (18.74)	59.04 (1.6)	191.98 (24.67)
40 to 44	149.58 (5.4)	358.6 (28.48)	93.61 (2.32)	257.43 (33.35)
45 to 49	232.3 (4.94)	459.84 (20.93)	155 (2.81)	324.95 (18.45)
50 to 54	372.6 (9.52)	593.2 (53.19)	247.96 (8.35)	408.75 (41.4)
55 to 59	595.89 (10.49)	926.5 (26.97)	383.4 (4.18)	493.62 (52.78)
60 to 64	926.3 (10.41)	1,288.04 (49.34)	576.24 (9.44)	883.98 (76.01)

Notes: Data comes from the Indian Register and Health Canada Vital Statistics Births and Death Database. The age standardized mortality rates (ASMR) are standardized to the age distribution of Status people in 2010.

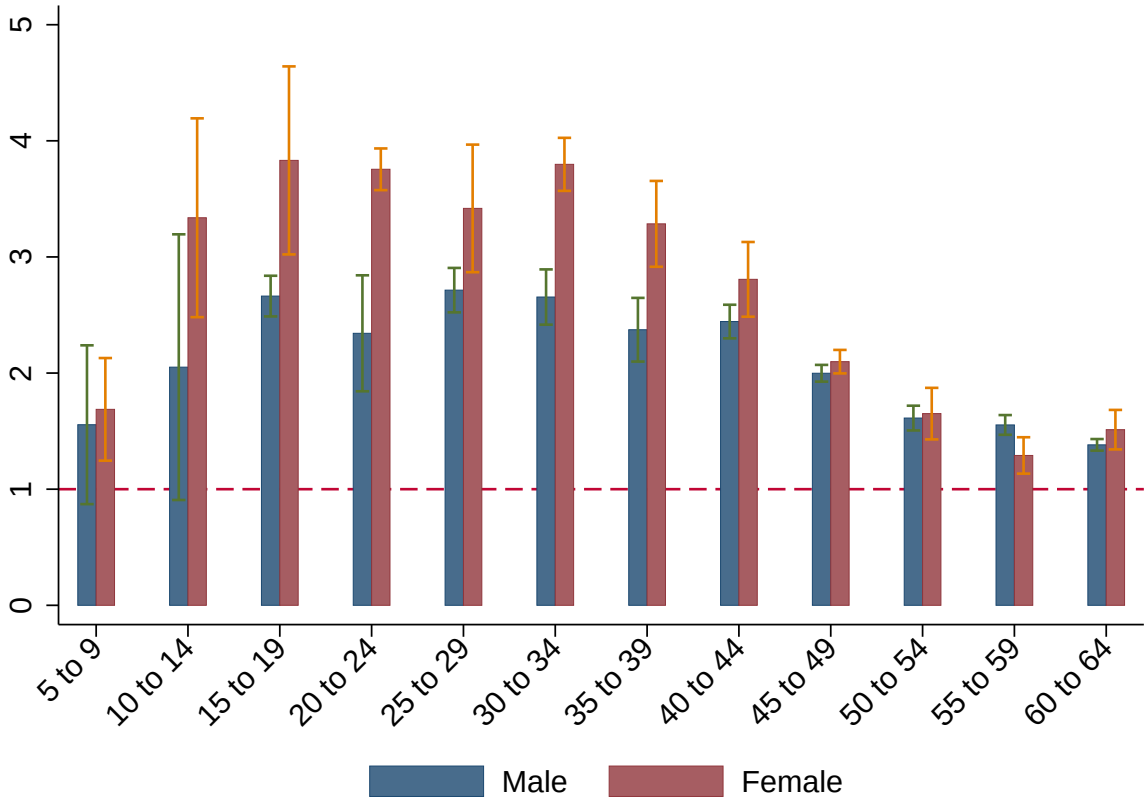
double the mortality rate as compared to their relevant reference group for the population as a whole. The mortality rate ratio is particularly high for females (approaching a ratio of four) starting at age 15 and going through 39 years of age. Status males have higher levels of mortality in this age range as compared to the average Canadian male and have a ratio approaching three. We note that the difference in the male and female mortality ratios shown here are statistically different from one another from ages 10 to 44.[22]

To our knowledge, we are the first to document these gender-biased mortality rate ratios at such young ages across Canada. These high rates of female mortality are not identifiable in survey data through imbalances in male-female gender ratios. Our results echo the finding of female-bias relative mortality rates in developing countries (Anderson and Ray, 2010) where there are relatively balanced gender ratios.[23]

[22]If we were to inflate our estimates of male and female mortality by fraction suggested in the first panel of Figure A1, this conclusion would not change.

[23]In the case of Status First Nations, the high rates of institutionalization and homelessness among Status First Nation men (Akee and Feir, 2016) actually skew the gender ratio in the Status First Nation population towards women.

Figure 1: Mortality Rate Ratio (Status First Nation Mortality per 100,000 divided by Average Canadian Mortality Rate per 100,000) averaged over 2010 to 2013 By Gender and Age



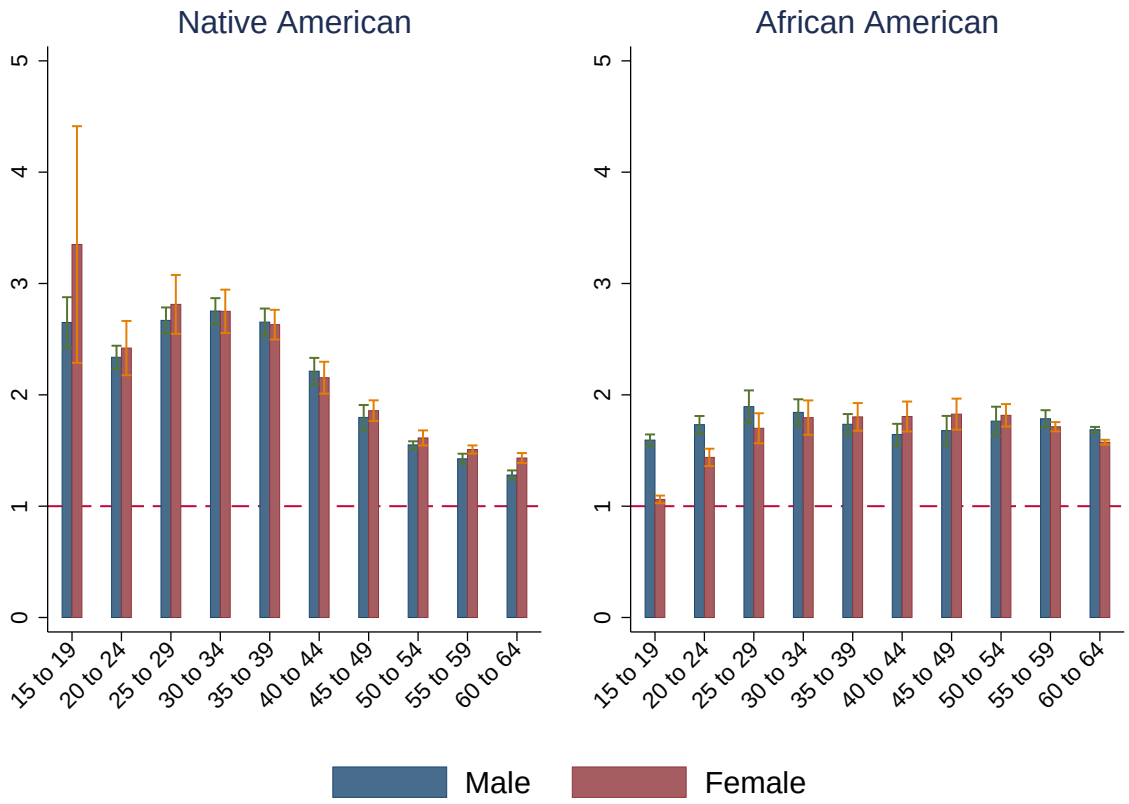
Notes: This figure shows the mortality rate ratio between Status First Nations and all Canadians with their 95 percent confidence intervals averaged over 2010 to 2013. The data is from the Indian Register on population size and death rates by age and gender and from Vital Statistics data from Health Canada.

We contrast our results for Status First Nations populations relative mortality rates with those of Native Americans and African Americans in the U.S. relative to the majority population in that country. In Figure 2, we estimate the relative mortality rates by gender for Native Americans and African Americans using data from the National Center for Health Statistics.[24] The first panel depicts the mortality rate ratios for Native Americans relative to the majority population in the US across the range of ages 15-64; the mortality rate ratios are particularly high in the young adult years and are approximately of equal

[24]http://www.cdc.gov/nchs/hus/american.htm#deaths

magnitude for both males and females.[25]

Figure 2: Mortality Rate Ratio of Native and African Americans to White Americans, 2010-2013



Notes: The y-axis denotes ratio of either Native American or African mortality rates divided by the non-Hispanic white mortality rate. The data on mortality rates by race were computed using counts on number of deaths and population from CDC Wonder data files on Underlying Cause of Death, 1999-2015 Centers for Disease Control and Prevention. https://wonder.cdc.gov/ucd-icd10.html.

The mortality rate ratio for Native Americans exceeds three for females in the age group 15-19 and hovers around three until about age 40 for both male and females. These are quite high mortality rate ratios, but they are smaller than those found for the

[25] Schulhofer-Wohl and Todd (2015) find high female mortality rates for a few select counties in the U.S. with relatively high American Indian populations. While their estimates include non-American Indians, the implication is that a large proportion are most likely American Indian females. They report that "for the four decades since the late 1960s, the age-adjusted mortality rate for women (of all races) in American Indian-dominated Menominee County, Wisconsin, has ranged between the highest and fourth-highest among all counties in the 48 states." However, the mortality rate ratios we presented for Canada are substantially higher than for North American Indians and African Americans in the United Status on average.

Status First Nations population in Canada, especially for Status First Nations women and girls.[26] The next panel provides similar data for African Americans. At younger ages, there appears to be higher mortality rate ratios for males than for females especially at ages 15-19 and the mortality rate ratio hovers around two. The comparison of the Status First Nations mortality rates to these two US-based groups suggests the extreme nature of the former's conditions in Canada. We find that the ratio of the Native Americans' and African Americans' mortality rates compared to white Americans is lower than the ratio of First Nations mortality to the general population in Canada; it should be noted that Native Americans and African Americans are among the most at-risk and impoverished groups in the US. Additionally, the mortality ratios are approximately similar by gender for these two groups in the US and we do not observe the extreme mortality rate ratios for First Nations females. However, the mortality rates we estimate (as opposed to mortality rate ratios) for Status First Nations men are roughly comparable to those in the African American population before the age of 35 while Status First Nations women have higher mortality rates than those in the African American population.

Given that we have information on the year of birth and death, we compute the probability of death for the Status First Nations populations. In Table 4 we provide the Canadian Average and the First Nations average probability of dying before a certain age (in five year intervals) for each gender. For this analysis we use the most recent data available on mortality for 2010-2013. For instance, in the first row of the table, the probability of dying for a Canadian male by age five is 0.6 percent and it is also 0.6 percent for Status First Nations males. For females, the probability of death is 0.5 percent for a Canadian female but it is slightly higher for a Status First Nations female at 0.7 percent. Differences in the probability of dying before a specific age begin to appear by age 20 with Status First Nations individuals having consistently higher probabilities of death as

[26]To determine if this simply due to the general female population in Canada having significantly better outcomes than their American or Status counterparts, we re-compute Figure 2 using the Canadian mortality rate as the denominator. Figure A2 shows that the differences across countries in the gender bias in the mortality rate ratios are not due to relatively low young female Canadian mortality rates.

compared to the general Canadian population. By age 50, a Status First Nation male has about a 10 percent chance of dying while his Canadian counterpart has about a 5 percent chance of death; for females it is 7.3 percent and 2.8 percent respectively. Finally, in the bottom row of the table, we find that by age 65 Status First Nations men have a 24 percent chance of dying as compared to a 14 percent chance of dying for their Canadian counterparts. For Status First Nations women there is a 16.2 percent chance of dying by age 65 while it is 9 percent for Canadian women. These are quite large differences in the probability of death and this data has implications on the continuity of households and communities.

Table 4: Probability of Dying Before Age X, 2010-2013

	Male		Female	
Age	General	All Status	General	All Status
5	0.006	0.006	0.005	0.007
10	0.007	0.007	0.006	0.008
15	0.007	0.008	0.006	0.01
20	0.009	0.015	0.007	0.014
25	0.013	0.023	0.009	0.02
30	0.017	0.033	0.011	0.026
35	0.021	0.044	0.013	0.034
40	0.026	0.056	0.016	0.044
45	0.034	0.075	0.02	0.057
50	0.045	0.098	0.028	0.073
55	0.064	0.128	0.04	0.093
60	0.094	0.174	0.06	0.118
65	0.14	0.238	0.088	0.162

Notes: The probability of death before a given age group is given in each of the cells. The probabilities are calculated over five year age groups. It is computed from the average mortality rate between 2010 to 2013 for each age group. The standard errors are given below in parenthesis. The data is taken from the Indian Registrar.

5.2 A Snapshot of Mortality by Location - On- or Off-Reserve and by Province in 2010-2013

In this section, we examine differences in Status First Nations and average Canadian mortality rates by geographic location. We examine two different geographic areas: Canadian provinces and location on and off First Nations reserves. Our analysis provides deeper insight into the differences in mortality rates across these different geographic regions in Canada. Later, we will conduct analysis to show whether these differences are due to an association with specific regional or geographic endowments or other characteristics. While this analysis is not causal, it does illuminate several potential paths for future research on this topic. This is also the first, to our knowledge, display of differences in mortality rates between the on- and off-reserve population of Status First Nations.

In Table 5 we provide the mortality rates for Status First Nations males and females residing on and off of reserves and the average Canadian mortality rates. This analysis is similar to Table 3 with the added dimension of geographic differences. The first item to note is that the ASMR for males and females are higher for the on-reserve population as compared to both the off-reserve and Canadian averages. The off-reserve Status First Nations population also has a higher ASMR than the Canadian average. Overall the mortality rates for the on-reserve population tend to be almost always twice that of the Canadian average for males across most of the five-year age groups; the rate for females on-reserve is often triple to quadruple the Canadian average at many ages.

We depict these mortality rates in Figure 3 as a ratio of the on and off reserve Status First Nations' mortality rates divided by the relevant Canadian average. Once again, the horizontal line at one indicates parity with the Canadian average mortality for the age group and location. In the first panel we present the results for males. The on-reserve mortality rate ratios are consistently above two for ages 10 to 49 for Status First Nations males. In young adulthood the ratio is above three. The ratios for off-reserve Status First Nations males is consistently above one except for at ages 60 to 64 where it is slightly

Table 5: Summary of Mortality Rates per 100,000, 2010-2013

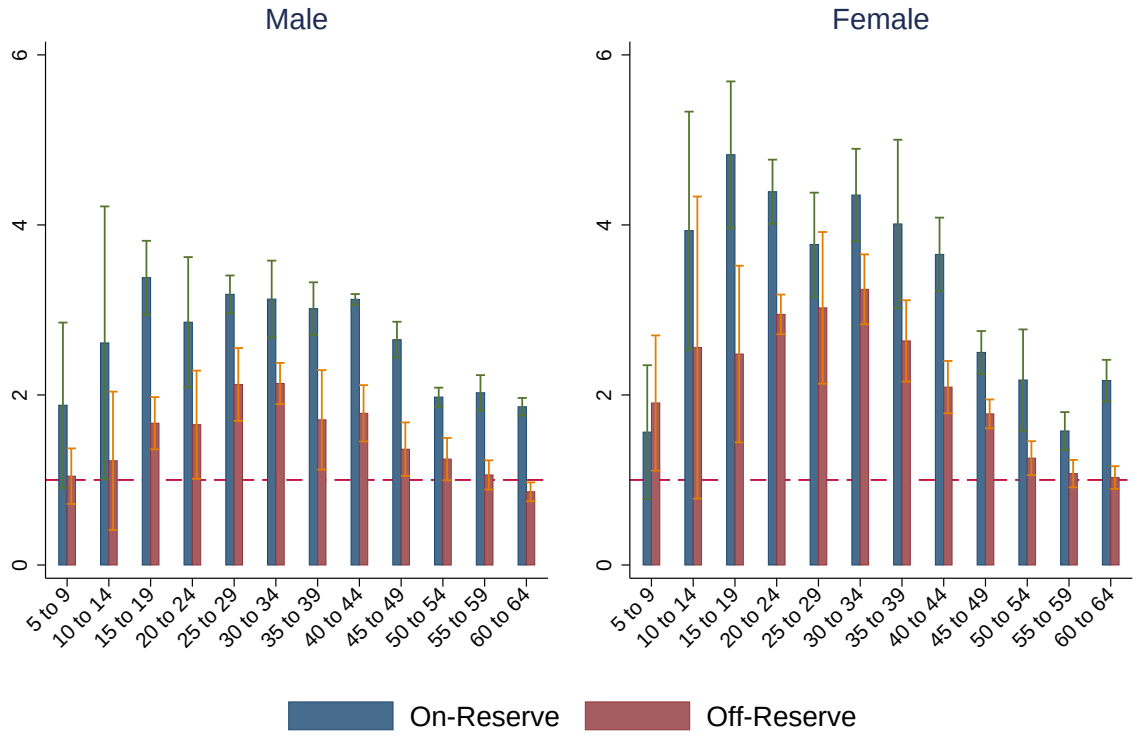
	Males			Females		
	Canadian Average	On-Reserve	Off-Reserve	Canadian Average	On-Reserve	Off Reserve
ASMR	160.71	261.06	181.36	100.81	179.79	149.56
(5 to 64)	(1.94)	(9.34)	(17.2)	(0.92)	(12)	(10.77)
Age Group						
05 to 09	9.12	16.23	9.25	7.88	11.65	14.80
	(0.8)	(8.07)	(2.99)	(0.73)	(5.21)	(7.01)
10 to 14	11.97	29.32	16.00	10.77	42.09	27.20
	(1.23)	(16.46)	(11.38)	(1.24)	(17.99)	(15.66)
15 to 19	46.9	152.02	82.75	24.72	114.95	62.49
	(4.31)	(11.76)	(17.61)	(1.17)	(17.83)	(24.29)
20 to 24	73.18	204.38	127.88	30.42	129.92	91.97
	(3.93)	(61.19)	(43.21)	(0.44)	(11.23)	(5.98)
25 to 29	75.64	233.64	167.65	32.95	121.24	103.39
	(2.19)	(18.26)	(29.05)	(0.98)	(19.24)	(34.67)
30 to 34	81.15	244.91	186.93	43.46	182.23	148.54
	(2.43)	(36.87)	(11.77)	(1.16)	(22.3)	(17.56)
35 to 39	101.44	296.71	183.17	59.04	228.07	159.53
	(2.89)	(33.98)	(46.44)	(1.6)	(56.85)	(29.68)
40 to 44	149.58	448.19	270.6	93.61	328.15	196.95
	(5.4)	(17.76)	(56.65)	(2.32)	(38.29)	(35.48)
45 to 49	232.3	590.52	329.79	155	372.12	286.82
	(4.94)	(57.94)	(67.54)	(2.81)	(43.53)	(23.89)
50 to 54	372.6	708.02	474.83	247.96	514.52	328.41
	(9.52)	(54.75)	(97.96)	(8.35)	(132.62)	(34.18)
55 to 59	595.89	1162.71	675.77	383.4	581.86	425.98
	(10.49)	(111.74)	(108.54)	(4.18)	(86.86)	(50.28)
60 to 64	926.3	1657.44	876.77	576.24	1200.03	648.05
	(10.41)	(105.32)	(135.39)	(9.44)	(128.8)	(63.75)

Notes: Data comes from the Indian Register and Health Canada Vital Statistics Births and Death Database. The age standardized mortality rates (ASMR) are standardized to the age distribution of Status people in 2010.

below one. In general the mortality rate ratio for the off-reserve Status First Nations is more muted than the on-reserve populations.

For females, the on-reserve population has mortality rate ratios that are around four4 for ages 10 through 44. The ratio declines after that but increases again at ages 60 to 64. The off-reserve Status First Nations women all have high mortality ratios relative to their Canadian counterparts. Overall, there is evidence that Status First Nations females have higher relative mortality rates (both on and off reserve) than their male counterparts.

Figure 3: Mortality Rate Ratio (Status First Nation Mortality Rate divided by Canadian Average Mortality Rate) averaged over 2010 to 2013 By Place of Residence, Gender, and Age



Notes: This figure shows the difference between women and men in the ratio of mortality rates between Status First Nations and all Canadians with their 95 percent confidence intervals averaged over 2010 to 2013 using Data from the Indian Register on population size and death rates by age and gender and from Vital Statistics data from Health Canada. The label "on-reserve" indicates the figure that provides the relative mortality rates calculated for the population reported to be living on legally defined reserve land and the label "off-reserve" indicates the figure that provides the relative mortality rates calculated for the population reported to be living off legally defined reserves.

Table 6 provides the probability of death for the on and off reserve populations by select ages. This analysis is comparable to Table 4 except we calculate the on and off reserve probability of death in this table. The first column provides the probability of death for all Canadian males and the next two columns provide the probability of death for Status First Nations males residing on- and off-reserve respectively. The next three columns provide data for females. The data indicate that the on-reserve population has the highest probability of death for both Status First Nations males and females. The difference in probability of death diverges for males around age 20 for the on-reserve and off-reserve population as compared to the Canadian average. The divergence appears to start slightly earlier for females around age 15, but the most dramatic differences emerge by age 20. By age 50, the on-reserve population has a probability of death that is at least two times as high as for the Canadian average for both genders.

Table 6: Probability of Dying Before Age X On- and Off-Reserve, 2010-2013

	Male			Female		
Age	Canadian Average	Status On-reserve	Status Off-Reserve	Canadian Average	Status On-reserve	Status Off-Reserve
5	0.006	0.006	0.007	0.005	0.008	0.005
10	0.007	0.007	0.007	0.006	0.009	0.006
15	0.007	0.009	0.008	0.006	0.011	0.007
20	0.009	0.017	0.012	0.007	0.017	0.01
25	0.013	0.027	0.018	0.009	0.024	0.015
30	0.017	0.039	0.026	0.011	0.03	0.02
35	0.021	0.052	0.034	0.013	0.039	0.027
40	0.026	0.067	0.043	0.016	0.051	0.035
45	0.034	0.091	0.056	0.020	0.068	0.045
50	0.045	0.121	0.072	0.028	0.088	0.059
55	0.064	0.158	0.095	0.040	0.115	0.076
60	0.094	0.218	0.127	0.060	0.145	0.098
65	0.140	0.305	0.167	0.088	0.207	0.131

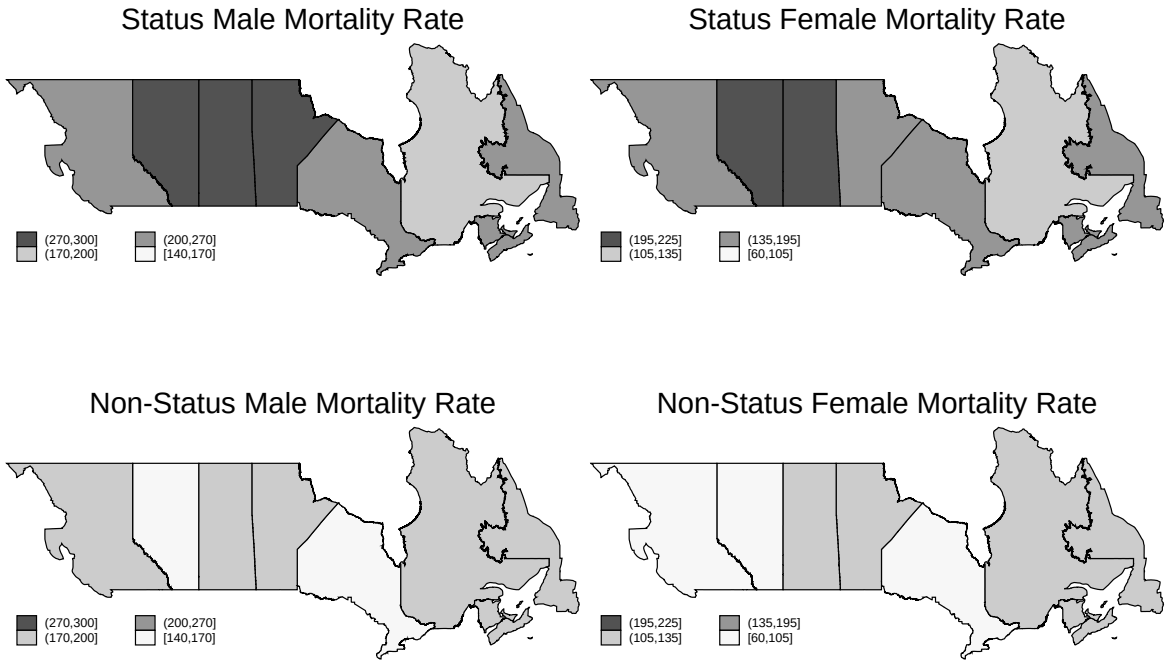
Notes: The probability of death before a given age group is given in each of the cells. The probabilities are calculated over five-year age groups. It is computed from the average mortality rate between 2010 to 2013 for each age group. The standard errors are given below in parenthesis. The data is taken from the Indian Registrar.

Previous work suggests several reasons why mortality rates are higher on-reserve than off-reserve: economic conditions for those living on-reserve in Canada are systematically poorer than for those living off-reserve (AANDC, 2015; Feir, 2013; Pendakur and Pen-

dakur, 2011), unsafe drinking water is a reality for many communities (Simeone, 2010), and access to emergency medical care is limited (Lavoie et al., 2010).

Next, we present age-standardized mortality rates by province. Figure 4 provides the observed ASMR for Status First Nations individuals across the Canadian provinces in the first row and for the average Canadian population in the bottom row. This data provides an augmented view of geographic differences in mortality rates for the Status First Nations population. For instance, the mortality rates for the average Canadian is relatively low across all provinces, but it is particularly low for both males and females in places such as Alberta. Conversely, Alberta, along with Manitoba and Saskatchewan, have the highest mortality rates for both Status First Nations males and females; as a result, the relative mortality rates are exacerbated when one compares First Nations to average Canadian mortality in different provinces (the results can be see in Figure A3). We also show that provinces vary in the extent to which Status people have higher mortality rates than the general population by age group. The details of this can be found in Figure A4.

Figure 4: Age Standardized Mortality Rates by Province, 2010-2013



Age-standardized mortality rate: Status First Nations Rate and General population.

Table 7 provides some associative analysis for the differences in mortality rates across provinces with their respective province-level characteristics. This associative analysis relates the differences in mortality rates between Status and non-Status peoples by province to the differences between Status and non-Status peoples in the Atlantic provinces (omitted group). The first three columns provide results for male mortality rates for all provincial residents across the time period 2000 to 2011 and the next three columns for females. We include province and age-group fixed-effects in all analyses.

In the first column we find that Status First Nation males in Alberta, Manitoba and Saskatchewan have higher relative (Status compared to non-Status) mortality rates as compared to their counterparts in the Atlantic provinces. Relative mortality rates are statistically significantly lower for Status First Nations males in Quebec relative to their counterparts in the Atlantic provinces. Including additional covariates such as average

household income percentiles, proportion female and proportion single in column 2 reduces the size of the estimated coefficient for Alberta, however, the estimated coefficient increases in magnitude for both Saskatchewan and Quebec and are still statistically significant. In the third column we include measures of the share of provincial employment in manufacturing or primary industries; this reduces the magnitude and statistical significance of the estimated coefficients for the Status x Alberta and Status x Saskatchewan variables but increases the magnitude of the estimated coefficient on the Status x Quebec variable.

In the next three columns we provide a similar analysis for females. There appears to be higher relative mortality rates for Status First Nations females in Alberta; however, this estimated coefficient decreases in magnitude and statistical significance once additional controls are added in columns 5 and 6. Relative mortality rates are consistently lower in Quebec for Status First Nations females in all three specifications. These results show that the high relative mortality rates for Status First Nations females in Alberta and Saskatchewan are closely tied to economic and social conditions in those two provinces; the same does not hold for Status First Nations males in those same provinces.

Table 7: Regional Variation Explained by Observable Characteristics?

	Male			Female		
	(1)	(2)	(3)	(4)	(5)	(6)
AB X Status	137.4***	120.6***	95.49*	123.6*	38.52	21.02
	(38.66)	(42.534)	(51.206)	(69.14)	(96.117)	(105.034)
BC X Status	42.18	30.33	32.97	-70.9	-137.0*	-116.1
	(38.184)	(37.852)	(39.108)	(61.84)	(75.677)	(72.742)
MN X Status	93.82**	85.35**	45.52	41.24	-21.72	-66.92
	(40.733)	(38.74)	(49.476)	(62.766)	(89.085)	(112.714)
ON X Status	9.37	-22.32	-47.78	-48.71	-97.01	-112.9
	(37.733)	(39.317)	(42.851)	(54.271)	(63.941)	(74.449)
QB X Status	-67.58*	-106.5**	-137.7**	-185.7***	-218.7***	-229.0***
	(36.277)	(50.598)	(55.682)	(54.464)	(79.499)	(81.119)
SK X Status	142.6***	174.9***	132.1**	25.6	9.38	-30.51
	(50.212)	(46.277)	(56.697)	(59.132)	(78.025)	(109.77)
Dropout		312.4***	361.4***		356.1*	397.7**
		(118.678)	(124.04)		(183.917)	(187.361)
Employed		496.1***	498.4***		368.5**	336.9*
		(140.216)	(134.628)		(184.702)	(184.536)
10-p Family Income		-0.345	0.364		0.65	-1.155
		(5.31)	(5.267)		(4.481)	(4.748)
50-p Family Income		-1.596	-1.682		-1.563	-1.398
		(1.374)	(1.516)		(2.214)	(2.047)
90-p Family Income		-1.336	-1.375		0.229	0.214
		(1.198)	(1.174)		(1.216)	(1.214)
Prop. Lone Parents		-278.6	-244.3		-300	-224.5
		(200.303)	(189.639)		(382.977)	(383.458)
Prop. Female		346.6*	370.3*		-192.6	-249.1
		(206.614)	(198.674)		(316.276)	(302.272)
Prop. Single		-61.27	-48.69		426.5***	396.4***
		(119.614)	(114.214)		(137.028)	(138.938)
Share employed			-519.9			-379.8**
in Manufacturing			(316.69)			(170.127)
Share employed			-501.4			-171.5
in Primary Industries			(366.257)			(273.853)
Status	143.8***	174.7***	160.5***	296.3***	316.1***	280.6***
	(27.816)	(46.03)	(45.72)	(47.693)	(53.738)	(63.098)
Year	-8.737***	-6.981***	-9.141***	-13.34***	-11.70***	-14.15***
	(1.525)	(1.87)	(2.373)	(1.812)	(2.912)	(2.943)
Province FE	X	X	X	X	X	X
Age Group FE	X	X	X	X	X	X
Observations	378	378	378	378	378	378
Adjusted R^2	0.877	0.89	0.892	0.899	0.905	0.906

Notes: The outcome variables is the mortality rate obtained from the Indian Register averaged over the three years surrounding each Census year by Status, gender, age-group, province and year. Census years included are 2001, 2006, and 2010. Data on economic characteristics comes from the Census and the National Household Survey. The omitted provinces are the Atlantic provinces. The omitted age category is 15 to 19. Family income is in 2002 dollars. Robust standard errors in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

5.3 First Nations Mortality across time 2010-2013

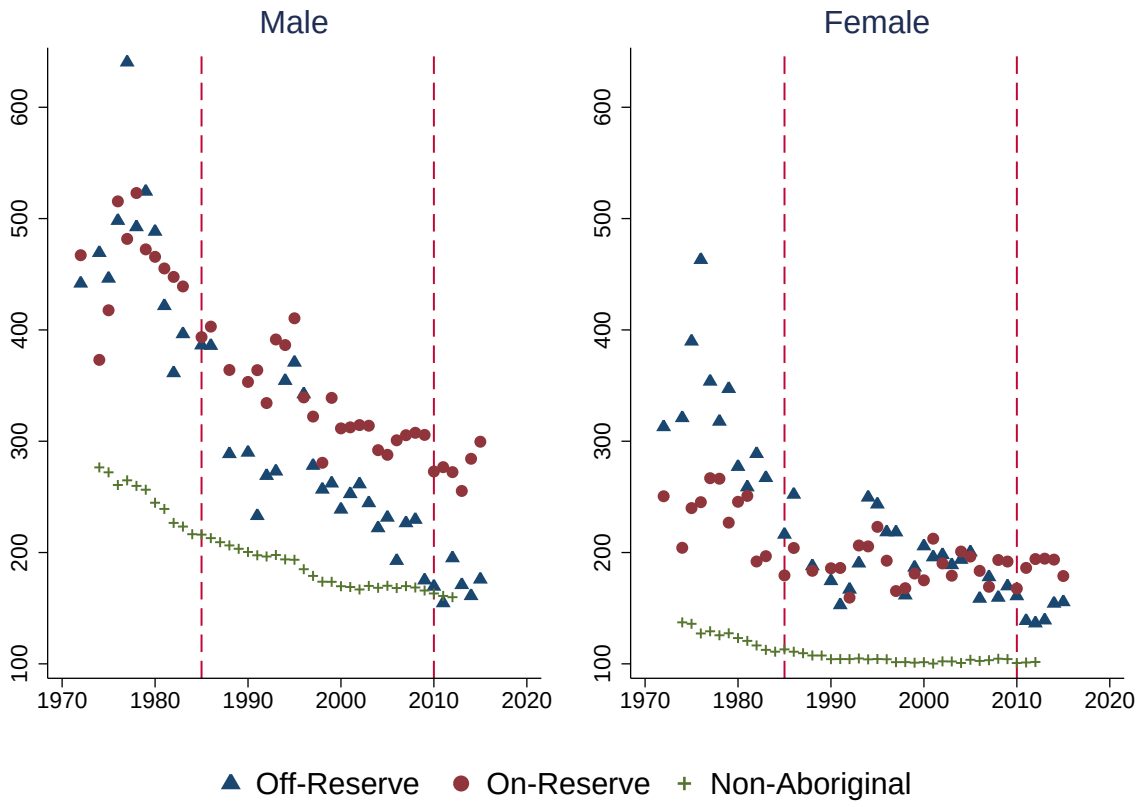
In this section we describe changes in the observed mortality rates for Status First Nations populations in Canada across several decades. In Figure 5 we show the age-standardized mortality rates for Status males and females and for the general population between 1974 to 2013. The vertical lines indicate the year of Bill C-31 and Bill C-3, which both resulted in significant changes in the definitions of the Status First Nation population. There are distinct increases in population counts off-reserve after these changes are made to the definition of Status First Nations and are shown in Figure A5.[27]

We first note that mortality has declined significantly for Canadian males from the 1970s onward. A similar decline in mortality rates is observed for both the on and off-reserve Status First Nations male populations. Two points are worth noting in regard to the decline for Status First Nations males. First, there is higher variability in mortality rates primarily due to the fact that these estimates are based off of much smaller populations than for the average Canadian male. Second, while it appears that the average mortality rate has converged for the off-reserve Status First Nation male population, it is consistently higher for the on-reserve population.

There is a relative reduction in average mortality rates for Canadian females over time but it is smaller than for men. For the Status First Nation females, before 1985, there appears to be significant declines in the ASMR but there is quite a lot of variability. After 1985 there appears to be a level-shift in mortality for Status First Nations females. There has been virtually no change in ASMR for women subsequently. One reason for this shift downward in mortality rates could be compositional changes of the First Nations populations as a result of changes to the definition of First Nations Status in 1985.

[27] We address the importance of this further in Section 5.4.

Figure 5: The Status First Nation Mortality Rates and the General Population per 100,000



Notes: All populations are standardized to have the age distribution common to all Status First Nations at the national level in 1991.The vertical lines indicate the year of Bill C-31 and Bill C-3.

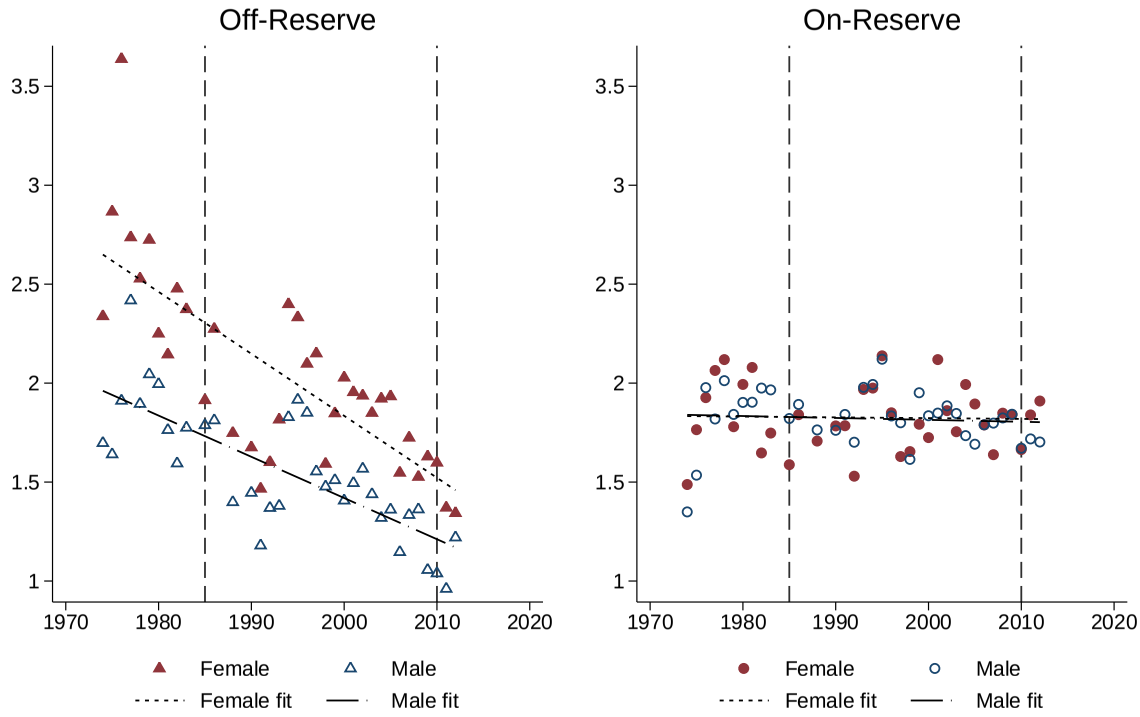
In Figure 6 we present the ratio of the ASMR in the Status to non-Status ASMR to highlight the extent to which trends in mortality have mirrored those in the general population. We have fitted a line to the data by gender and location on or off the reserve. The first panel presents results for the off-reserve population and the second panel for the on-reserve population. In the first panel, we observe that the off-reserve population of both males and females has experienced a significant reduction in the ASMR ratio (which is indicated by the two downward sloping fitted-lines in the graph). There are still level differences in the ASMR ratio between males and females (with females having higher mortality rate ratios), but both appear to have decreased at approximately the same rate

from the 1970s onward relative to the general population (allowing for a linear trend).

In the second panel, we fit two lines to the data points for Status female and male mortality rates for the on-reserve population. These two lines are both horizontal lines. This result indicates that over time the ratio of the on-reserve Status to non-Status ASMR has not changed in over 40 years. However, given that there were significant changes in the definition of Status during the mid-1980s, we next consider what has happened over time from 1991 to 2011; this time period is subsequent to the largest change to First Nations Status which occurred in 1985 for women. Our intention in this analysis is to investigate whether there have been systematic changes in Status First Nations female mortality over time holding the definition of "Status" constant. Over this period, Status male mortality rates decreased more quickly than those of Status females. We also include variation by age group. In Figures A6 and A7 we show trends in the mortality rate by age group. While generally all figures show a similar pattern, improvements in mortality tend to be greatest among older age groups and start earlier for men. On the other hand, in some age groups, on-reserve female mortality appears to be rising.

Table 8 continues this same analysis in a regression setting. We investigate whether there are associative differences in mortality rates by gender and Status over time. Once again, we use data for the time period 1991-2011 where there is a single, consistent definition of "Status". The outcome variables in these three regressions are the average mortality rates by year, gender, and Status. All three models include province and age-group fixed effects. The first column provides estimated results for the variables Status, Year and Female and their interactions. Column 2 and 3 add in additional control variables for income levels, employment, and high school dropout rates and proportion of the province that is single or female, respectively. There are several points that can be made from the estimates in this table. First, Status peoples have higher mortality rates in all three specifications under a time period with consistently defined Status. Second, mortality rates have been falling for Status and non-Status men over time even controlling for economic factors. Third, non-Status women have lower mortality rates

Figure 6: The Ratio of Status Mortality Rates to General Mortality



Notes: Ratio of 5 to 64, age-standardized mortality rate: Status First Nations Rate/General population.

than non-Status men, but their mortality rates are not falling over time at the same rate as non-Status mens'.

However, we think the estimated coefficient on the interaction term, Status X Female X Year, is of the most interest. This coefficient suggests that since the 1990s, Status females have experienced a relative increase in their mortality rates over time relative to non-Status peoples and Status men. We have noted the relatively higher mortality for Status females and Table 8 indicates that this difference is increasing over time. This increase is not explained by readily available, observable factors. In fact, Status women's relative economic well-being has been improving faster than for men over this time period (Feir, 2013) and we would have predicted a reduction in their mortality rates as a result.[28] Nor is the increase explained by changes in the composition of the population due to changes in the definition of First Nations Status after 1985 since this analysis explicitly holds that factor constant by focusing on the time period 1991-2011.

5.4 Reconciliation and Comparison with Previous Estimates

In this section we compare our estimates of Status First Nations mortality rates to that of previous research. Our findings are broadly consistent with the patterns observed in previous work (for example, the age and gender distribution of mortality over the age of 25). However, we do differ with the Mao et al. (1992) findings that mortality rates on-reserve are significantly lower than those off-reserve in data. Our results show that on-reserve mortality rates are much higher than off-reserve mortality rates.

In order to reconcile this stark difference with the findings of Mao et al. (1992), we restrict analysis to the pre-1985 period prior to the change in the definition of First Nations Status and a time frame that is consistent with that in Mao et al. (1992). The data from this time period can be seen in Figure 5. Examining the data points to the left of 1985 (the first vertical line in the figure) it is immediately clear that the mortality

[28] We show trends in the employment, the 10th percentile of income, and the proportion of dropouts for both Status and non-Status men and women in Figure A8 to illustrate this point.

Table 8: Correlation between Mortality rate and Observable Characteristics 1991-2011

	(1)	(2)	(3)
Status	269.5***	207.6***	209.1***
	(16.381)	(20.086)	(20.610)
Year	-1.951***	-3.745***	-3.855***
	(0.404)	(0.579)	(0.564)
Female	-81.27***	-95.26***	-82.93***
	(7.254)	(8.355)	(10.909)
Status X Year	-6.215***	-4.623***	-5.271***
	(1.139)	(1.102)	(1.114)
Status X Female	-125.3***	-120.8***	-132.8***
	(20.087)	(19.614)	(20.726)
Status X Female X Year	4.392***	4.148***	3.843***
	(1.422)	(1.397)	(1.367)
Female X Year	1.595***	1.984***	1.861***
	(0.577)	(0.570)	(0.548)
Dropout		-14.18	14.22
		(43.507)	(43.934)
Employed		-46.60	-38.11
		(44.971)	(45.750)
10-p Family Income		-3.170**	-3.306***
		(1.273)	(1.250)
50-p Family Income		-1.635***	-0.949
		(0.575)	(0.618)
90-p Family Income		0.366	0.224
		(0.400)	(0.402)
Prop. Lone Parents			77.81
			(71.290)
Prop. Female			-1.364
			(105.389)
Prop. Single			153.1***
			(41.223)
Province FE	X	X	X
Age Group FE	X	X	X
Observations	700	700	700
Adjusted R^2	0.775	0.786	0.792

Notes: The outcome variables is the mortality rate obtained from the Indian Register averaged over the three years surrounding each Census year Status, gender, age-group, and year. Census years included are 1991, 1996, 2001, 2006, and 2010. Data on economic characteristics comes from the Census and the National Household Survey. The omitted provinces are the Atlantic provinces. The omitted age category is 15 to 19. Family income is in 2002 dollars. Robust standard errors in parentheses. $^{*}p < 0.10$, ** $p < 0.05$, *** $p < 0.01$

rates for off-reserve Status females are higher than their on-reserve Status counterparts. For males, it is a bit more mixed, but there are several high mortality years for off-reserve Status males prior to 1985. Subsequently, there is an inversion in the mortality rates with off-reserve Status males experiencing a lower mortality rate over time and approximately similar result for off-reserve Status females relative to their on-reserve counterparts. We see this as being primarily driven by compositional changes in the Status First Nations populations both on and off reserves subsequent to the change in the definition of Status in 1985.[29]

A second potential explanation for the observed differences in mortality rates over time by residence on reserves is the availability and access to quality health care services. Until the late 1960s, Status peoples' health care was the responsibility of the Federal government and Status First Nations people were cared for in racially segregated federal "Indian hospitals" (Waldram et al., 2006). During the 1960s, 70s and 80s, there was significant reform in the delivery of health care to Status peoples and a shift of responsibility towards the provinces. We see a constant trend downward in the ASMR during this period which would be consistent with these reforms improving Status peoples' health. These declines are also much stronger for those living off-reserve which is the population that may gain the most from these reforms (specifically, they would have the greatest degree of access to pre-existing provincial systems of health care). We believe the ultimate reasons for this decline are of significant interest and would be an interesting and fruitful area for research.

It is informative to compare our findings to those of Tjepkema et al. (2009) and Park et al. (2015) and to discuss the Health Canada findings more broadly. As noted earlier,

[29]Recall that before 1985, if a Status woman married a non-Status man, then she (and her children after the age of 21) would lose their Status, thus implying she (and they) would no longer be included in the Indian Register. The woman and her children would also lose the right to live on-reserve. Thus, the only off-reserve First Nations women who are included in the data are women who are either single or married to Status men. This applies to their children as well - whether they are male or female. Thus the "off-reserve" population is a very select group. We can see that after 1985, the mortality rates off-reserve plummet rapidly for women and men. This suggests that differential composition of the on/off-reserve populations is at least in part responsible for the change in mortality rates over time.

a significant drawback of the Health Canada studies is that they only have data on Status peoples' mortality in British Columbia and Alberta, and on-reserve in Manitoba and Saskatchewan. As we have shown in Section 5.2, Status mortality rates in Alberta, Manitoba, and Saskatchewan are the highest in the country, and the on-reserve population is also subject to higher mortality rates. Thus the national level estimates are lower than those published by Health Canada for the sub-regions they report on, even accounting for the potential under-reporting to the Indian Register at older ages.

We also provide evidence that the mortality estimates in Tjepkema et al. (2009) and Park et al. (2015) likely over-estimate mortality rates for the general Status population. In Table 9 we show our estimates of Status and non-Status mortality rates relative to Tjepkema et al. (2009) using the same age standardization to the Status population in 1991 and excluding from our sample members of bands who did not participate in the 1991 Census to make our sample as comparable to Tjepkema et al. (2009) as possible. We cannot match their sample completely because they excluded individuals that were not matched between Census records and tax records. This creates an unknown sample selection and we are unable to replicate this sample in our data for comparison, unfortunately. We exclude the estimates of Park et al. (2015) since they pool both the Status and non-Status First Nations population and thus are obviously not strictly comparable.

The first thing to note in Table 9 is that between the ages of 25-34 (for both women and men) our mortality rate estimates are either slightly higher or empirically indistinguishable from Tjepkema et al. (2009). Our estimates are lower on average for older age groups and this difference becomes more pronounced at older ages. If we scaled our estimates up by the amount suggested in Figure A1, it still would not fully account for the difference between our estimates and Tjepkema's estimates. Recall that the sample in Tjepkema et al. (2009) was potentially heavily selected. The table below suggests one of two things: 1) the sample in (Park et al., 2015; Tjepkema et al., 2009) may be such that individuals with a higher probability of death are more likely to be observed in their data due to their sample selection, or 2) the under-reporting in the Indian Register is greater

than the comparison with the Health Canada data suggests. Should the latter be the case, our estimates should be thought of as conservative estimates of Status mortality.

Finally, all of these findings taken together provide an explanation for why the estimates of mortality in Health Canada (2008, 2014) are greater than those in Park et al. (2015); Tjepkema et al. (2009): the difference is likely due to both the regional selection inherent in Health Canada (2008, 2014) and the population selection in Park et al. (2015); Tjepkema et al. (2009).

Table 9: Age Standardized Mortality Rate Reconciliation with (Tjepkema et al., 2009))

	Tjepkema et al. 2009		Our Best Comparable Estimates	
Men	Status	General Pop	Status	General Pop
25-34	310.2	105.1	340.8	110.9
	(18.02)	(1.73)	(51.77)	(14.82)
35-44	508.9	207.3	440.1	175.7
	(28.22)	(2.39)	(82.15)	(18.3)
45-54	1077	573	760.4	377.9
	(54.26)	(4.87)	(112.32)	(26.86)
55-64	2411.1	1621.3	1652.3	1053.1
	(113.45)	(9.34)	(223.66)	(105.77)
Women				
25-34	168.3	52	175.4	44.1
	(11.32)	(1.17)	(27.78)	(3.11)
35-44	335.3	131.2	270	94.6
	(20.15)	(1.88)	(47.92)	(3.59)
45-54	766	336.1	482.1	233.3
	(41.17)	(3.86)	(45.49)	(12.05)
55-64	1837.5	844	1050.9	607.6
	(90.51)	(7.26)	(126.48)	(42.21)

Notes: Age-standardized mortality Rates per 100,000 from 1991 to 2001 age standardized to the 1991 Status age distribution as per Tjepkema et al. (2009). Our "best comparable estimates" refer to restricting the analysis to the same time period, standardizing by the closest age distribution we have available (we cannot fully replicate the sample selection in Tjepkema et al. (2009)) and doing the same age groups.

6 Conclusion

In this work we provided novel estimates of Status youth mortality, evidence on variation in mortality by region and residence, and longitudinal estimates of First Nations mortality. We established several stylized facts about Status First Nations mortality in Canada:

1. On-reserve mortality rates are higher on average than off-reserve mortality rates for Status First Nations peoples.

2. The highest mortality rates are observed for Status youth under the age of 25 – the mortality rates of on-reserve Status girls between 15 and 19 are nearly five times as high as the general population.

3. Status women and girls between the ages of 10 to 44 have higher mortality rate ratios (compared to the general Canadian population) than Status men.

4. With the exception of the 10 to 14 year old age group, Status men have the highest overall probability of death: while there is 14 percent chance of dying before the age of 65 for the average Canadian man, there is a 24 percent chance of dying before the age of 65 for a Status man living on-reserve.

5. There is significant regional variation in mortality rates that are correlated with economic factors and the highest mortality rates are found in the prairie provinces.

6. Mortality rates have not improved for women and girls on reservation in the last 30 years, and relative mortality rates have not improved on-reserve for all Status people in the past 40 years. However, absolute and relative mortality rates have fallen for off-reserve Status men and women over time.

Based on these findings, we believe productive research in the future would examine the early, most dramatic declines in off-reserve Status mortality rates and discern the effects

of dramatic shifts in policy from dramatic shifts in selection. Developing a further understanding of differences between on- and off-reserve mortality rates and the shockingly high relative mortality rates of women and girls would also be a major contribution, as would be a more complete understanding of the regional distribution of mortality. Future work should continue with the recommendations of the Truth and Reconciliation Commission by tracking trends in mortality and other health statistics and work to improve the relative state of First Nations' health in Canada.

Compliance with Ethical Standards:

Funding: No grants or other external funding were used for this project.

Conflict of Interest: The authors declare that they have no conflict of interest.

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Compliance with Ethical Standards:

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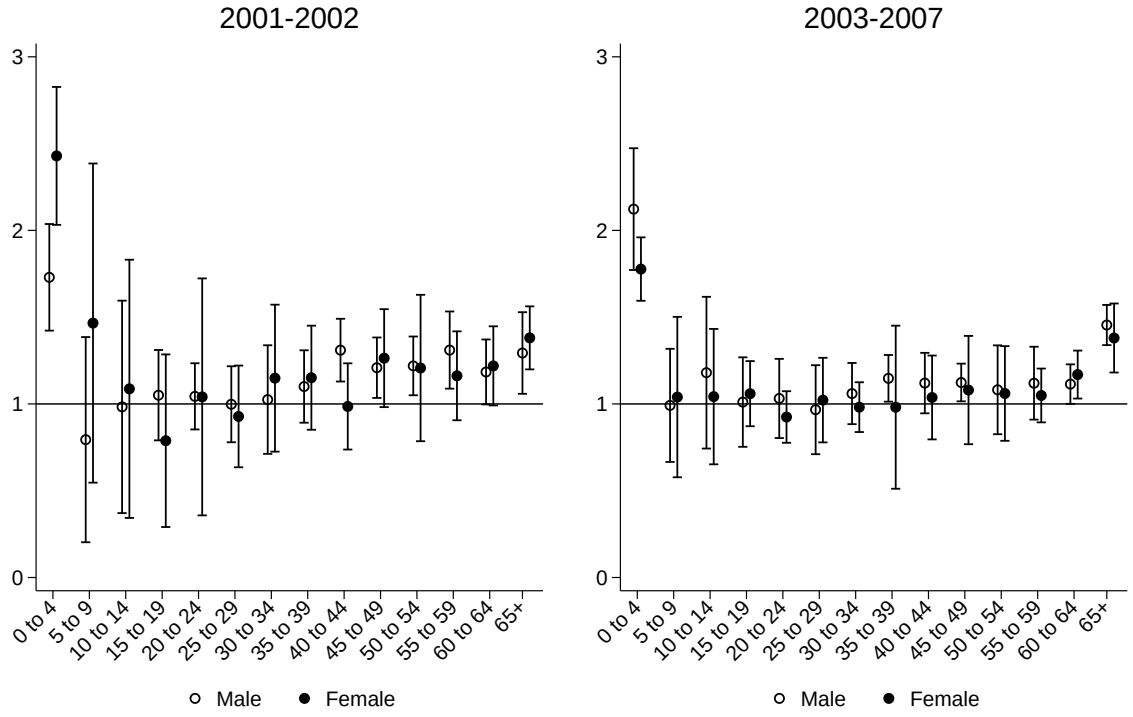
Appendix For 'Status First Nations and General Mortality in Canada: From 1974 to 2013."

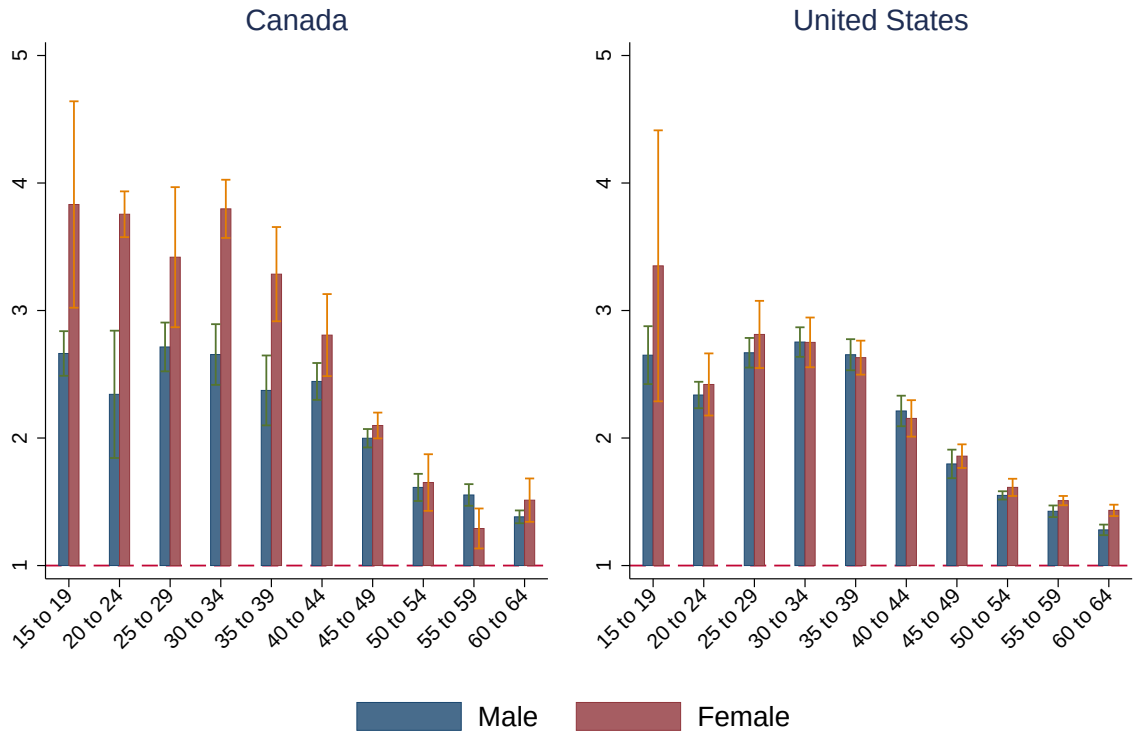
A Appendix Figures

Figure A1: Comparing Indian Register Mortality Rates per 100,000 Relative to Vital Statistics Rate of Death for Status First Nations in Alberta, British Columbia, and on-reserve in Manitoba and Saskatchewan



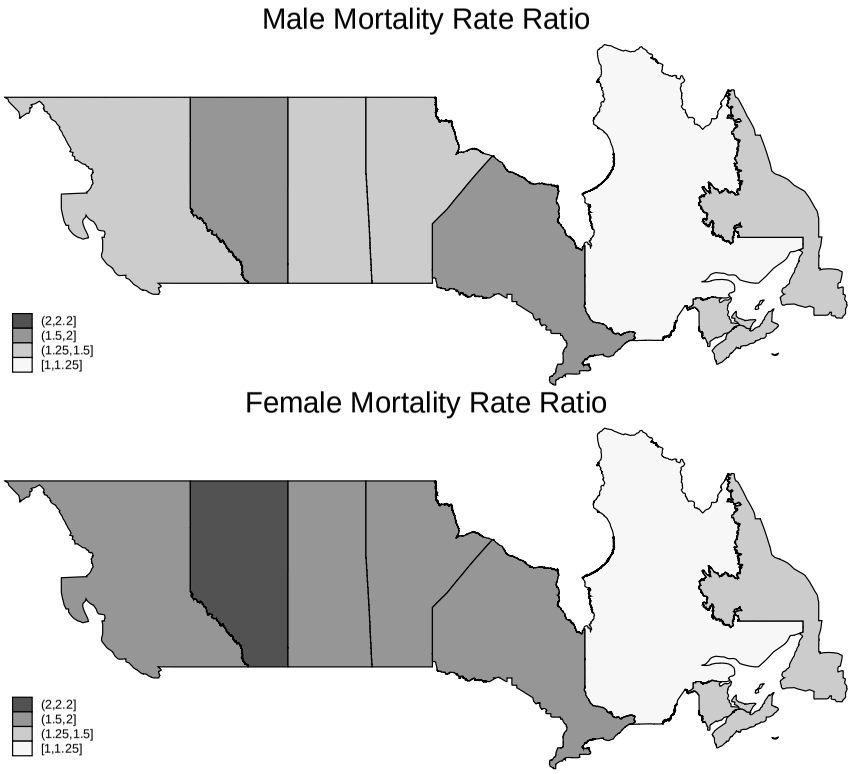
Notes: These are the ratios of the mortality rates from the vital statistics data in for First Nations in Alberta, British Columbia and on-reserve in Manitoba and Saskatchewan compared with those computed from Indigenous and Northern Affairs Indian Register for the same geographies and times periods. The mortality rate from Vital statistics is the numerator and the mortality rate from the Indian Register is the denominator.

Figure A2: Mortality Rate Ratio of Native and African Americans to General Canadian Population, 2010-2013



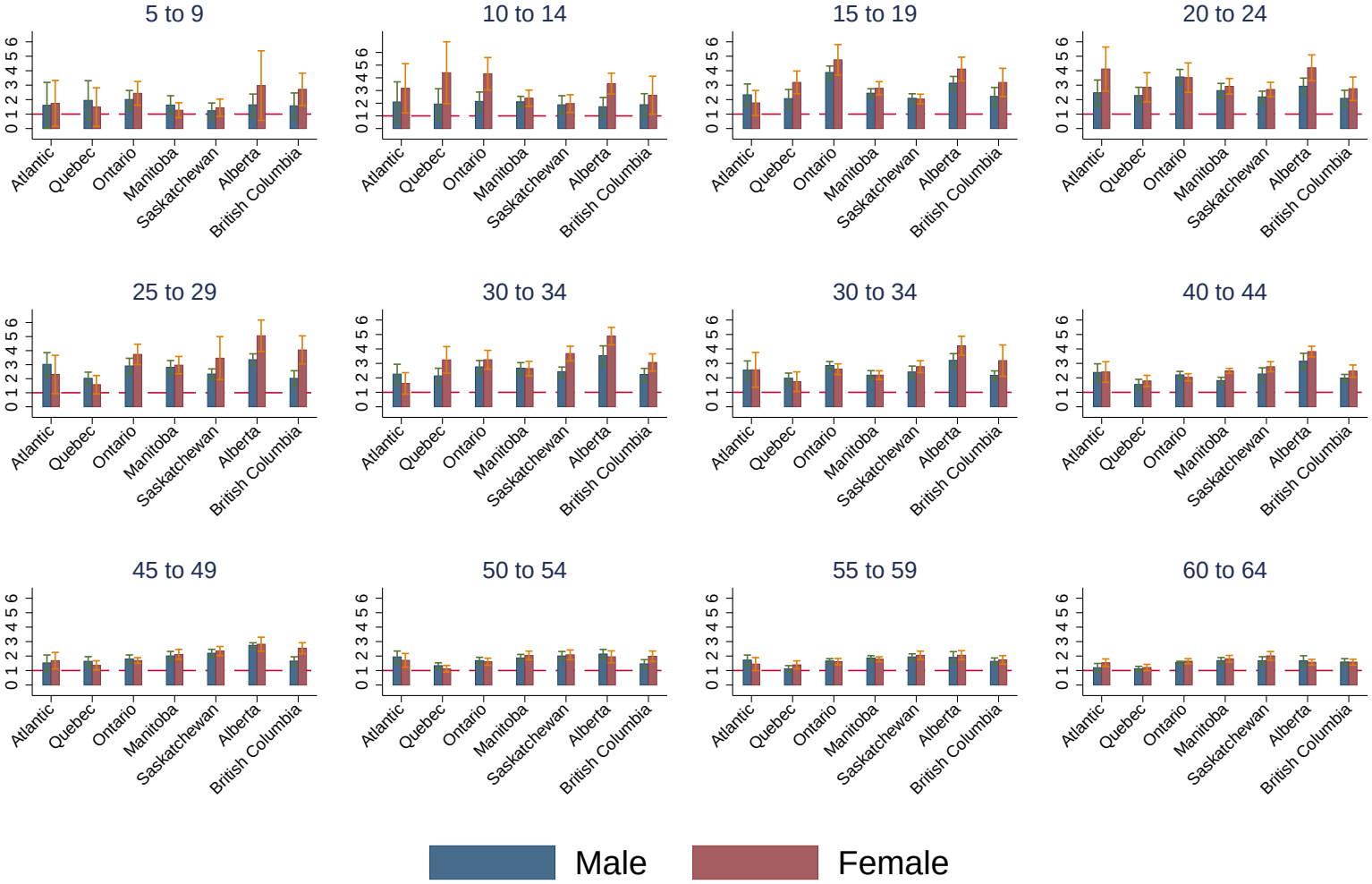
Notes: The y-axis denotes ratio of either Native American or African mortality rates divided by the general Canadian mortality rate. The data on by race mortality rates were computed using counts on number of deaths and population from CDC Wonder datafiles on Underlying Cause of Death, 1999-2015 Centers for Disease Control and Prevention. https://wonder.cdc.gov/ucd-icd10.html. The Canadian mortality rates are generated using data from Health Canada Vital Statistics Birth and Death database compiled by Statistics Canada.

Figure A3: Age Standardized Mortality Rates by Province, 2010-2013



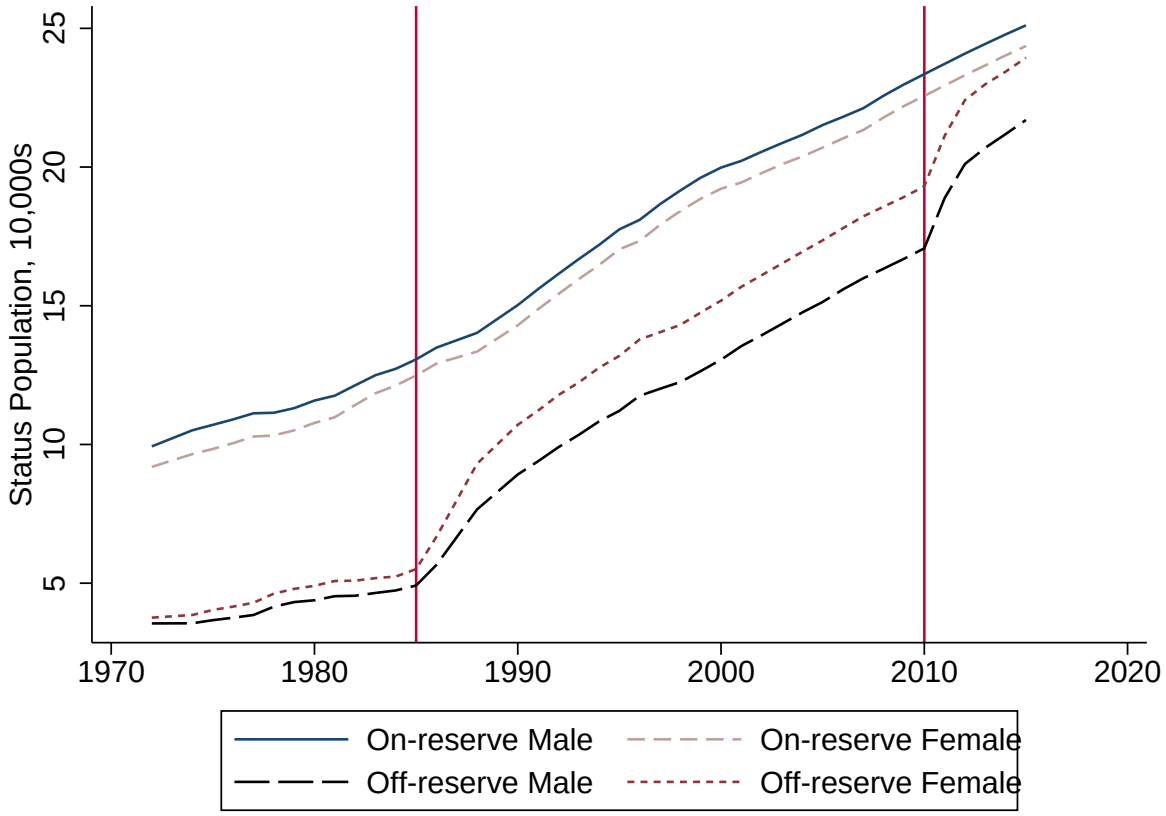
Age-standardized mortality rate: Status First Nations Rate/General population.

Figure A4: Mortality Rate Ratio by Province and Age Group



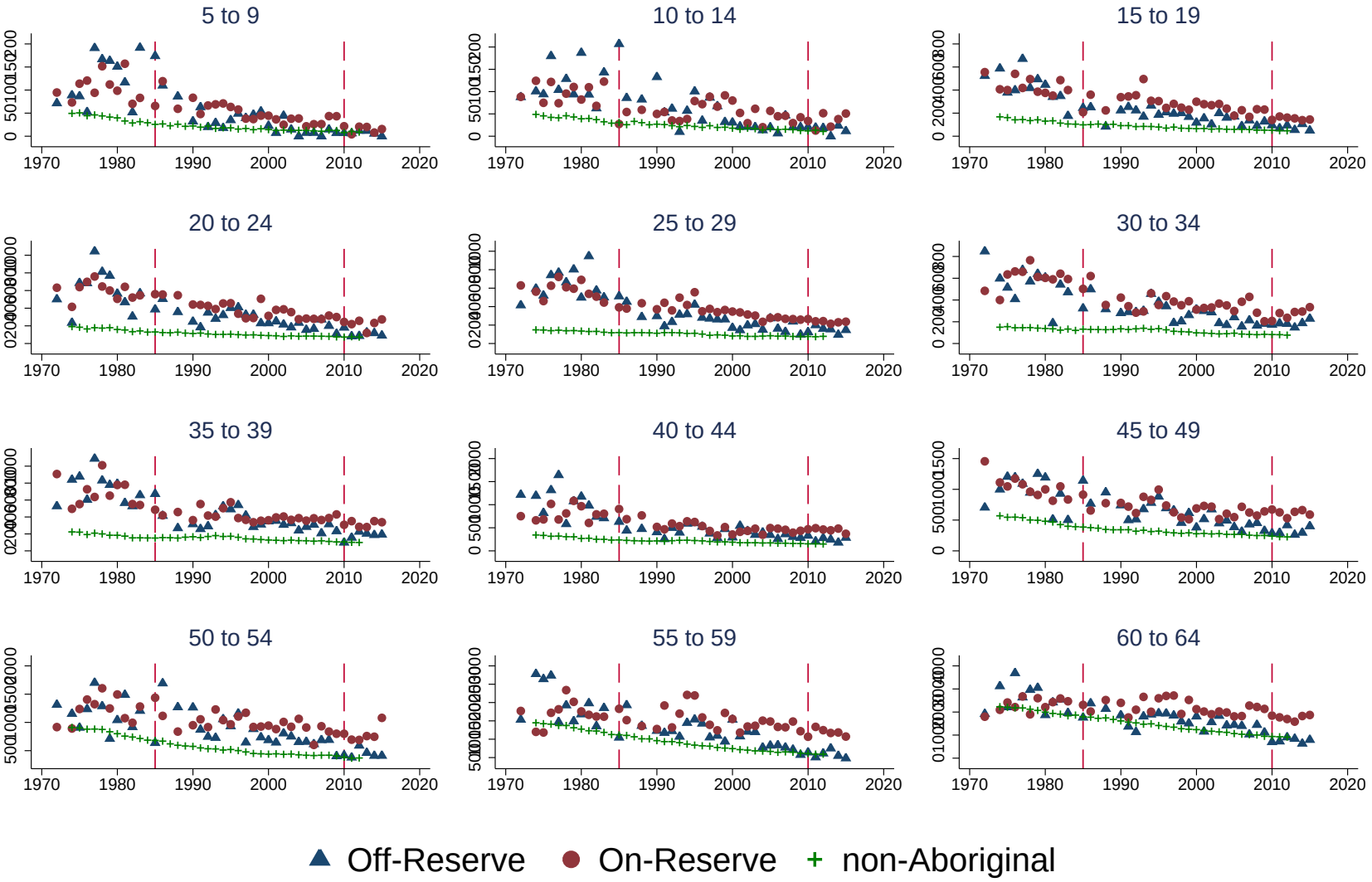
Ratio of 5 to 64, age-standardized mortality rate: Status First Nations Rate/General population.

Figure A5: The Status First Nation Population, 100,000s



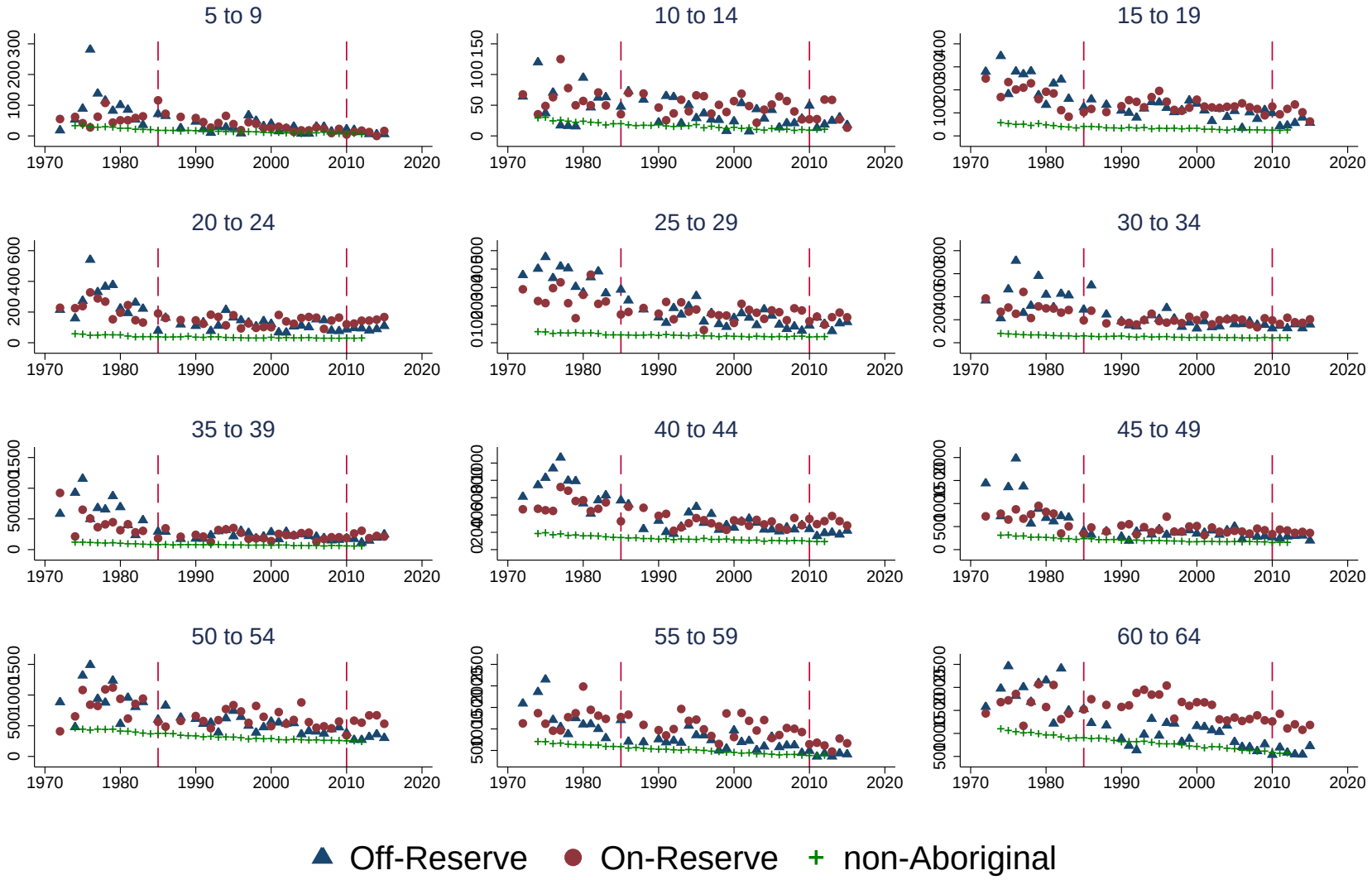
Notes: This figure shows the increase in the Status First Nation population from 1970 to 2016. The vertical lines indicate the year of Bill C-31 and Bill C-3.

Figure A6: The Status Male Mortality Rates and the General Population per 100,000 by Age Group



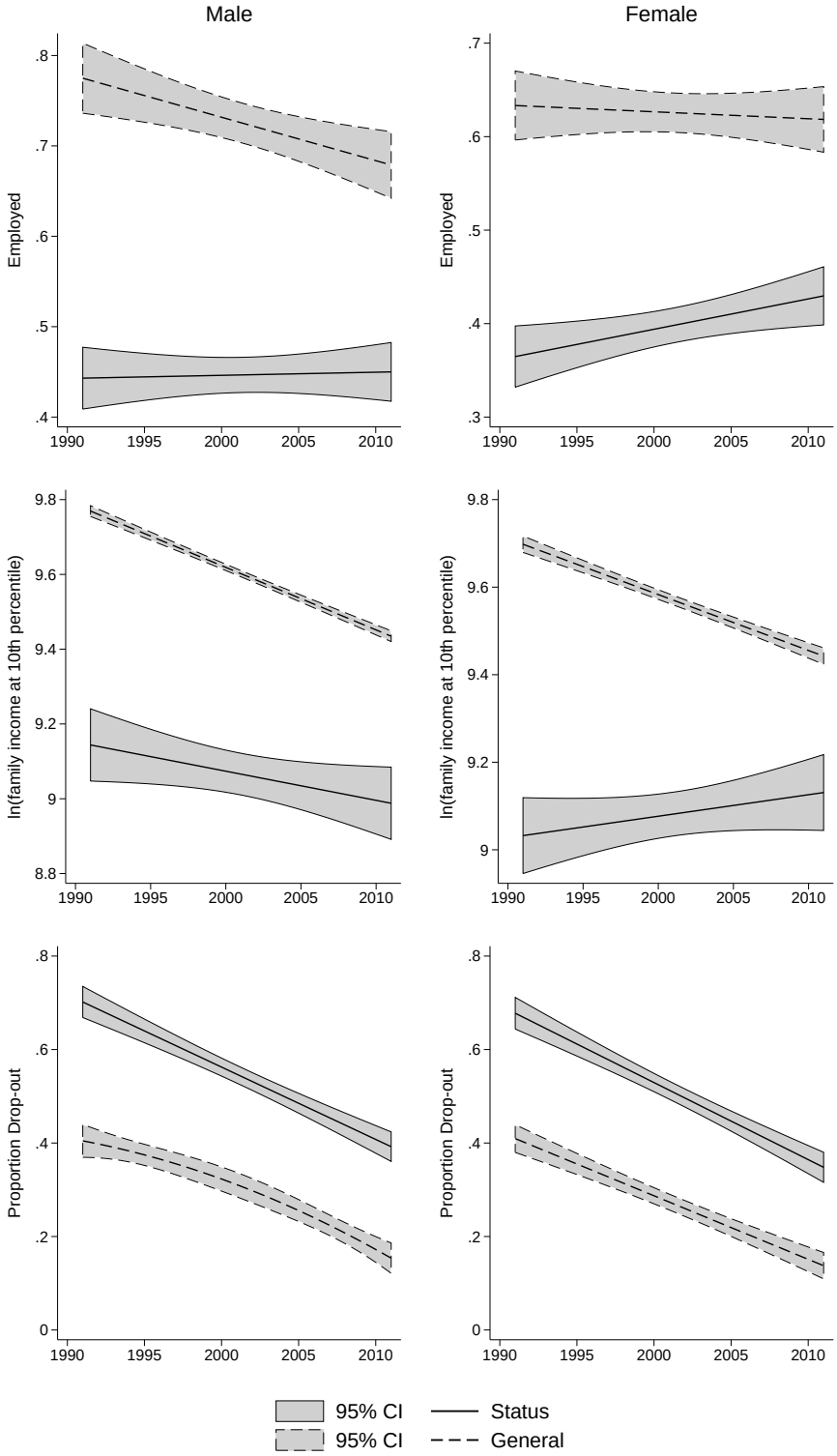
Notes: The mortality rate per 100,000 is on the y-axis. All data comes from the Indian Register. The vertical lines indicate the year of Bill C-31 and Bill C-3.

Figure A7: The Status Female Mortality Rates and the General Population per 100,000 by Age Group



Notes: The mortality rate per 100,000 is on the y-axis. All data comes from the Indian Register. The vertical lines indicate the year of Bill C-31 and Bill C-3.

Figure A8: Trends in Economic Observable Characteristics by Status and Gender



Data from the 1991, 1996, 2001, and 2006 Census and 2011 NHS.

B Appendix Tables

Table A1: Summary of Mortality Rates per 100,000, 2000-2009

	Males				Females			
	Canadian Average	All Status First Nations	Off-Reserve	On-Reserve	Canadian Average	All Status First Nations	Off-Reserve	On-Reserve
ASMR	129.89	229.08	199.55	249.72	76.56	154.15	156.16	152.59
(05 to 64)	(2.22)	(18.68)	(29.3)	(14.5)	(1.05)	(10.83)	(13.56)	(12.11)
Age Group								
05 to 09	12.04	24.21	12.26	31.18	9.35	19.81	21.35	18.82
	(1.52)	(6.36)	(11.86)	(8.6)	(1.56)	(6.96)	(10.08)	(8.06)
10 to 14	15.13	33.75	22.78	40.3	10.89	39.12	32.21	43.29
	(1.83)	(10.07)	(12)	(12.76)	(1.41)	(9.73)	(14.09)	(15.55)
15 to 19	58.73	186.73	138.43	216.63	27.41	109.63	94.98	119.01
	(5.06)	(35.47)	(37.55)	(45.86)	(1.89)	(8.67)	(24.9)	(12.98)
20 to 24	82.16	264.89	212.77	299.78	31.37	127.57	108.96	140.9
	(4.62)	(41.3)	(56.06)	(46.76)	(1.6)	(16.64)	(34.34)	(26.73)
25 to 29	79.78	235.26	186.59	271.98	33.69	140.29	119.6	157.59
	(3.05)	(30.53)	(50.16)	(29.01)	(1.63)	(24.35)	(35.98)	(28.51)
30 to 34	88.78	270.35	228.42	306.16	44.45	180.31	176.02	184.38
	(5.15)	(46.45)	(56.42)	(69.28)	(1.99)	(24.56)	(30.66)	(29.85)
35 to 39	116.98	325.96	284.42	363.29	66.92	210.45	211.97	208.87
	(7.3)	(45.1)	(71.76)	(31.7)	(4.93)	(35.85)	(42.74)	(45.25)
40 to 44	167.85	403.76	382.68	423.65	104.15	284.57	276.59	293.42
	(8.37)	(37.37)	(85.69)	(42.83)	(4.85)	(33.36)	(49.4)	(42.65)
45 to 49	264.06	540.13	460.92	609.5	171.69	363.37	352.01	376.38
	(14.82)	(74.24)	(119.59)	(71.15)	(7.07)	(51.45)	(77.97)	(49.66)
50 to 54	421.8	768.91	674.99	843.97	268.26	499.81	466.22	540.03
	(17.14)	(108)	(129.63)	(122.53)	(7.84)	(83.23)	(68.74)	(144.12)
55 to 59	662.51	1123.07	921.67	1279.66	412.69	776.27	624.33	961.25
	(34.38)	(132.06)	(218.51)	(138.25)	(19.63)	(136.6)	(121.94)	(206.19)
60 to 64	1064.92	1707.91	1425.78	1919.47	654.06	1095.68	904.22	1324.76
	(90.64)	(175.33)	(326.69)	(161.32)	(43.32)	(171.82)	(223.69)	(136.95)

Notes: Data comes from the Indian Register and Health Canada Vital Statistics Births and Death Database. The age standardized mortality rates (ASMR) are standardized to the age distribution of Status people in 2010.

This is **Exhibit "L"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)
Sarah Clarke LSO # 57377M

National Inquiry into
Missing and Murdered
Indigenous Women and Girls

RECLAIMING POWER AND PLACE

THE FINAL REPORT
OF THE NATIONAL INQUIRY
INTO MISSING AND
MURDERED INDIGENOUS
WOMEN AND GIRLS

Volume 1a

Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1a

Cette publication est également disponible en français :

Réclamer notre pouvoir et notre place : le rapport final de l'enquête sur les femmes et les filles autochtones disparues et assassinées, volume 1a

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COVER IMAGE:

Special thanks to the artists whose work appears on the cover of this report:

Dee-Jay Monika Rumbolt (Snowbird), for *Motherly Love*

The Saa-Ust Centre, for the star blanket community art piece

Christi Belcourt, for *This Painting is a Mirror*

Darlene Osborne

Tansi, Kitatamiskatinawow, I am a member of the National Family Advisory Circle and have attended five hearings across the country in Winnipeg, Regina, Saskatoon, Calgary, and Quebec City. My husband, John, often attended with me as my support.

For John and I, there was truth in the words and tears of the families who shared their stories and experiences about their loved ones. While this National Inquiry represents a start, there is so much more to do. The limitation of the process, and its structure, could not shine enough light on so many dimensions of truth we had hoped the Inquiry's noble mandate would illuminate. In the end, we as family members, because of the Inquiry, are able to stand strong together and united in the singular message that there cannot be any more violence against women and we must find a way as a nation to end these shameful and preventable deaths and murders.

There are many solutions that were offered by families and by survivors. While the National Inquiry's mandate was limited to Indigenous women and girls, we heard from many other families who lost Indigenous men and non-Indigenous women; families who felt their grief and loss but who did not have a voice or a way to contribute to the National Inquiry. Their stories need to be heard, too.

We also feel there is a need to further investigate policing in this country; we are concerned that the truth around how police departments treated the investigations of our loved ones at the time will be lacking. We need this information to truly tackle the problems; to make changes so that our women and children do not go missing or, if they do, these crimes no longer go unpunished.

We realize that as we seek the truth, we must also focus on healing. Healing needs to happen to address violence that still occurs today. Our community of Norway House Cree Nation has many members who have lost loved ones to senseless violence. We need true healing centres where there is long-term aftercare, particularly for the children of the murdered and missing women. Many of these children are now young teens and adults. They are lost and angry for what has been stolen from them. A healing centre would recognize the lasting legacy these crimes have had on our community; a healing centre would also allow our community to offer a place to heal that addresses each family member's needs.

We are honoured that we could be part of the National Family Advisory Circle. We hope our words and reflections are taken in the spirit with which we intend: a sincere desire for change, rooted in an honest reflection on the achievements and failings of this process, and on the difficult task of finding truths and answers that end the loss of our sisters', mothers', and daughters' lives. The losses of our loved ones have profoundly affected those of us who were there when our loved ones went missing – and who are still here now, looking for answers. We demand more from this nation called Canada.

Understanding Youth Suicide

In testimonies before the National Inquiry, many witnesses cited the important barriers to rights that come with challenges in the area of mental health, particularly for youth. The epidemic of suicide, particularly among youth, represents a manifestation of many of the factors that have been outlined in this report, including intergenerational and multigenerational trauma, the apprehension rates within the context of child welfare, and the social and economic marginalization of Indigenous Peoples more broadly.

Contextualizing the Suicide Crisis in Remote Communities

In Saskatchewan's Advocate for Children and Youth Corey O'Soup's home province, the rates of youth suicide are epidemic. As he explained, "Indigenous youth suicide is an epidemic within our province. And I know it's not just Saskatchewan and I know it's not just Indigenous kids. It's all across our country in all areas of life but specifically we've targeted our Indigenous kids and mental health."[I] In Saskatchewan, Indigenous girls are 26 times more likely to die by suicide than non-Indigenous girls.[II]

As award-winning journalist and author on the issue of youth suicide Tanya Talaga shared, in an interview with Anna-Maria Tremonti on CBC's *The Current*, part of the reason for the high incidence of youth suicide is the normalization of it: "What is so hard for someone, who doesn't live in that community and is not surrounded by suicide, to understand is, it becomes part of your normal everyday life." She cites her uncle, her mother's friend, and her friend as examples of people close to her that took their own lives. In the same interview, Talaga expressed how the foundational factor to all of these deaths is something that can be addressed in attending to the issue of inequality.

> Growing healthy children, it's not really rocket science. You have to have safe housing, you have to have a family that loves you, someone who tucks you in at night, to say to you, "You belong." You need nutritious food, you need access to an education, you need access to health care. And when you're growing up in a community that's missing all of these things, all these things that every other ... non-Indigenous Canadian enjoys in urban and rural settings – suicide is there, suicide becomes normal.[III]

In a study analyzing trends across 23 different studies of Indigenous youth suicide, researchers Henry G. Harder, Josh Rash, Travis Holyk, Eduardo Jovel, and Kari Harder found evidence to suggest that some of the factors raised by Talaga manifest themselves in mental health challenges and specifically, in depression. Their synthesis of existing literature found that the strongest risk factors to Indigenous youth suicide emerge as depression, and having a friend or someone close die by suicide.[IV] This explains, in part, why youth suicides within Indigenous communities tend to appear in clusters, rather than as isolated incidents, particularly when the community is tight-knit or small. The next strongest factors included conduct disorder, defined as "violent behaviour, aggression, violent ideation, anger, delinquency, antisocial behaviour," and substance or alcohol abuse. The third most likely risk factor was the existence of another psychiatric disorder other than depression and suffering from childhood abuse or trauma.[V]

Importantly, the same analysis also showed that the strongest protective influence against Indigenous youth suicide was "high support, whether social or familial…. Personality variables of high self-esteem

and having an internal locus of control further reduced the risk of suicide."[VI] As the researchers explain, "Individuals are likely to search for identity during developmental crises where psychological growth can be triggered through the experience of stressful life events…. If such meaning cannot be located and the struggle for identity cannot be resolved, then a serious period of hopelessness or depression occurs."[VII] The failure to find continuity or a sense of belonging can lead youth to adopt addictive lifestyles or to adopt unhealthy self-images leading to suicidal thoughts or attempts.

Compounding these problems is a perceived sense of isolation in some communities, and a lack of access to services that could help in a crisis situation. As O'Soup testified, the challenges in addressing mental health are particularly severe in northern and remote communities: "We have 15 child psychiatrists – and I'm just using this as an example – in Saskatchewan. One of them travels one day every two weeks to our northern communities. So I'm guessing that the actual wait list for them is longer than two years."[VIII] In her testimony, Tanya Talaga highlighted a similar issue, citing the example of the community of Wapekeka, a community of approximately 400 people in northwestern Ontario, where youth experiencing mental health crises and needing to see someone "have to be flown away, flown away from their families, flown away from everything that they know, put in a hotel or put into the Sioux Lookout Hospital…. I mean, all by themselves, you know, without any support. And, these are children in crisis."[IX] In part, and as we heard in many testimonies, improving outcomes includes properly resourcing health services, including mental health services, for children and youth, to decrease these kinds of barriers to well-being.

Part of the problem, as O'Soup testified, is the way that mental health issues are treated in Canada today. He pointed out:

> When you break your leg or you have a flu … when something like that happens to you, what do you do? You go to the doctor. You go to the emergency room if it's really bad. And the doctor sees you. They'll give you some medicine. They'll write you a prescription. If your leg's broken, they'll set your leg. They'll put a cast on it. And you'll go away and you'll feel like you've received some sort of help and, like, you're on the way to getting better. But when you look at our mental health system, the challenges there exist. They're real for our children and our youth.… You take the same child that's suffering with mental health issues, whatever it is, you know, ADHD, anxiety, OCD, ODD, youth – there's so many of these different diagnoses. If you take that same child into that same emergency room or that same health clinic, that child sits there for 10, 12, 14, 16 hours. And you know what happens? Someone on a phone says, send them home. So those kids go home. I'm telling you, we're dealing with life-and-death situations when that happens.[X]

Suicide among Inuit Youth

In the decades before the way of life based on the land and in geographic mobility was changed to a more sedentary life in centralized settlements as a result of colonization, Inuit suicide was a phenomenon reserved for a very few and older Inuit. Back then, Inuit who were suffering from illness, famine, or old age could decide which moment they wished to die. The choice by individuals to die by suicide was in keeping with the respect Inuit have for the autonomy of their fellow Inuit to make decisions about their own matters and lives.[XI] However as societal changes occurred through colonization and settlement, the death of Inuit youth by suicide began to occur. While Indigenous groups across Canada have also experienced increased suicide rates among their youth, Inuit have seen very high suicide rates. Inuit youth suicides began in the 1970s followed by a dramatic increase in the 1980s, and Inuit youth suicide rates continued to rise since. In Inuktitut someone who chooses to end one's life is *qivittuq* and more commonly now, *imminiartuq*, taking one's own life.

According to the "*Learning From Lives That Have Been Lived," Nunavut Suicide Follow-Back Study: Identifying the Risk factors for Inuit Suicide in Nunavut*, Nunavut, as in the three other Inuit regions of Canada, currently has a suicide rate 10 times higher that the Canadian suicide rate. Nunatsiavut and Nunavik suicide rates are similar to the Nunavut region.

Here are some facts: studies over the last five decades have consistently shown that more young Inuit men die by suicide than young Inuit women. The study above examined 120 cases of suicide completers in the period from 2005-2010, and compared them to another 120 who did not die by suicide. Of the 120 suicide completers, 99 (82.5%) were male and 21 female (17.5%). The average age was 23.6 years old. As for the level of education of individuals who died by suicide, they were 3.6 times more likely to have had less than seven years' education. Dropping out of school could be an indication of living in more difficult situations that could lead to suicidal behaviour.[XII] Another fact was their contact with the legal system, showing a greater tendency to experience legal problems. Crowded houses, which impact many families in Inuit Nunangat, did not appear to be a factor linked to suicide. Adoption, whether it be adoption between kin, or adoption outside of kin showed there was no major difference between those of the suicide group and the comparison groups.

The study also demonstrates the close link mental health problems have with the suicidal behaviours, such as anxiety, depression and drug and alcohol abuse or dependence problems.[XIII] The most important issue raised in the follow-back study was childhood maltreatment, which encompasses physical abuse, sexual abuse, emotional abuse and neglect during childhood.[XIV] There are strong indicators that survivors of childhood abuse attempt or die by suicide in greater numbers than those not maltreated in their childhood. As well, childhood maltreatment could lead to serious issues impacting on mental and physical health and suicidal behaviour. The study found that almost half of those who died by suicide had been abused, physically and/or sexually, during their childhood compared to one third of the comparison group.[XV] Another major factor was the state of mental health – 61% of those who died by suicide and 24% of those in the comparison group suffered from a major depressive disorder six months prior, and these rates were higher than the national average of 8%.[XVI] Alcohol dependency or abuse was an indicator for higher risk for suicide, as the data showed that 37.5% of those who died by suicide had abused alcohol or had a dependence on it in the last six months of their lives.[XVII]

As mental health researcher Eduardo Chachamovich concludes in his study on Nunavut:

> The rapid increase in suicidal behaviour in recent decades, especially young people, is probably the result of a change in the intensity of social determinants – among them the intergenerational transmission of historical trauma and its results (increased rates of emotional, physical, and sexual abuse, violence, substance abuse, etc.).… Since difficult life experiences are associated with the onset of mental disorders (particularly if substance abuse is included in the definition of "mental disorder"), it is reasonable to deduce that there are elevated rates of mental disorders in Nunavut society.[XVIII]

The Inuit regions are well aware of the crisis among youth and are developing strategies for the prevention of suicide, such as the *National Inuit Suicide Prevention Strategy* created by the national Inuit organization Inuit Tapiriit Kanatami (ITK), which supports families and youth to be strong and resilient as the Inuit ancestors once were. Its Strategy addresses social inequity, community safety and cultural continuity to help create well-being in the Inuit communities. It expresses its vision of suicide prevention as a shared national, regional and community-wide effort, that collaborative and well supported policies and programs can and will make a difference. The Strategy defines priority areas such as creating social equity and cultural continuity, nurturing healthy Inuit children from birth, access to comprehensive mental wellness services for Inuit, healing unresolved trauma and grief and mobilizing Inuit knowledge for resilience and suicide prevention. These are themes that were consistently identified by Inuit witnesses testifying before the National Inquiry, as well. The ITK *Suicide Prevention Strategy* prioritizes the importance of Inuit perspectives and knowledge to bring about action in the Inuit communities. It is an example of self-determination, working with Inuit communities and regions, to acknowledge the crisis of suicide among Inuit youth and to help heal Inuit communities.

Child Welfare and Aging Out of Care

For Indigenous girls and 2SLGBTQQIA youth, the dangers associated with moving from one place to another or with being displaced from a safe community are significantly heightened. However, given the extensive violence and abuse experienced by many youth in care, leaving a foster home or other living accommodation may be the only option that seems to exist in order to escape violence.

In recounting the violence and abuse her sister, Laney E., experienced while in foster care, Danielle E. reflected on her sister's efforts to create safety for herself in a world where it was otherwise unavailable: "I don't believe my sister in her entire life ever felt safe, that the only safety that she had was what she could create when she was able to get out of care."[114] Like the stories we heard of many other Indigenous and 2SLGBTQQIA girls, youth, and young adults whose disappearance or death occurred while displaced from or living in the foster care system, Danielle's story about her sister was echoed in various ways by other witnesses, whose truths demonstrated how many of those factors that impede safety in the lives of adults – such as poverty, homelessness, addiction, seeking or travelling to find services or meet basic needs, and fleeing violent situations – are most prevalent or heightened for young Indigenous girls, youths, and young adults in foster care or those who have "aged out of care." Erin Pavan, the manager of STRIVE Youth in Care Transition Program, poignantly described the lack of security that exists for Indigenous girls, youth, and 2SLGBTQQIA people in these contexts: "So, aging out of care is really like a euphemism for the abrupt termination of all … services. Like, this 'aging out,' I don't even like this term, I think it's too gentle for what the experience is; it's like being pushed off a cliff, right?"[115]

For many of the family and friends who shared their truths, the failure to address the realities of abuse and violence experienced by children and youth within child welfare forces many youth, in their attempts to escape violence, to enter into more dangerous situations, which usually begin with running away. Even for those youth who do remain in care, aging out of care and the lack of support are akin to – as Erin puts it – pushing them off a cliff. In both cases, poverty, housing, barriers to education, and unique vulnerabilities to drugs, trafficking, and other forms of interpersonal violence collectively remove safety. As we heard from many families, recognizing what happens at the edge of this cliff and how basic economic and social security is undermined here is key to understanding the violence that leads to the disappearance and death of Indigenous women and girls.

In speaking about the experiences of aging out of care, members of the Youth Panel in Vancouver talked about the daily realities of poverty and the constant threat of homelessness. Fialka Jack talked about her struggle to find housing.

> A month after aging out of care, my social worker moved me to the Downtown core of Vancouver into an SRO [single room occupancy]. And until that day, I didn't know what the word SRO stands for. And it was horrifying to see, so fresh into my adulthood, to see that this is where people were living. Like, I couldn't imagine how people could live

> happily in those types of places, and it was horrifying and it, to be honest – I did some things that I promised I would never do, and I regret it. But like, from there, I've grown and to be honest, I don't think social workers should be putting their children into SROs. I think, like, looking for housing and teaching us how to look for housing, should be an important piece. Because you shouldn't have to worry about homelessness every second of your life after aging out of care. And that is something that at almost 25, I still fear, every day.
>
> And I live in a house, I live in South Van, I live with a lot of people, people that love me. But I have been homeless twice since aging out of care. I was homeless for a year; I lived in downtown Vancouver, I lived in Stanley Park. Like, I slept in Stanley Park. That's how bad it was, aging out of care.[116]

In addition, as Erin Pavan explained, Indigenous youth must also contend with discrimination.

> And the youth are facing also discrimination, too, right? If you're on income assistance you've got to bring this paper … showing that you're on welfare, and people just slam the door in your face. And same with, no one wants to rent to young people either, right? And also people of colour experience discrimination when they're renting. So, they've got a lot stacked against them trying to rent here, and having that money coming in for their rent from Agreements with Young Adults while they're attending STRIVE helps us to actually be able to say, "Okay, now you've got your housing. What do you actually want to do?" You know, like, "What are you passionate about, or what do you want to do with your life? Or, what other help do you need, like maybe you need mental health supports or whatever it is. Do you want to go back to school?" And that's been really helpful.[117]

"SO, AGING-OUT OF CARE IS REALLY LIKE A EUPHEMISM FOR THE ABRUPT TERMINATION OF ALL … SERVICES. LIKE, THIS 'AGING-OUT,' I DON'T EVEN LIKE THIS TERM, I THINK IT'S TOO GENTLE FOR WHAT THE EXPERIENCE IS; IT'S LIKE BEING PUSHED OFF A CLIFF, RIGHT?"

Erin Pavan

Understandably, the challenges of daily survival mean that, for many youth in foster care or those who have aged out of foster care, completing high school, pursuing post-secondary education, or finding employment become impossible. Erin Pavan put things into perspective.

> They're not graduating high school; I think that by age 19, like 32% of youth aging out of care will have a high school diploma, compared to 84% for the general population. And, so they're not finishing school.

They're also less likely to have a job. They're going to make less money. A lot of them are relying on income assistance right off the bat, 40% will go right onto income assistance.

The income assistance rate just finally got raised in BC, but for Vancouver it is not even near enough money to live off of. You can't even pay rent with it, never mind buy food. So they're going into extreme poverty right off the bat, with no high school diploma, not enough supportive people in their lives. Obviously, by definition, anyone who's been through care is going to have trauma. So they've got trauma; they're more likely to have issues with their mental health, with substance use, more likely to be involved with the criminal justice system, become young parents. They're more likely to die young. Of the 1,000 youth who age out of care in BC every year, three to four will be dead before they turn 25.

So I think you can really see the connection, right, between the missing and murdered young women and the care system.[118]

National Inquiry into
Missing and Murdered
Indigenous Women and Girls

RECLAIMING POWER AND PLACE

THE FINAL REPORT
OF THE NATIONAL INQUIRY
INTO MISSING AND
MURDERED INDIGENOUS
WOMEN AND GIRLS

Volume 1b

Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1b

National Inquiry into
Missing and Murdered
Indigenous Women and Girls

Cette publication est également disponible en français :

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COVER IMAGE:

Special thanks to the artists whose work appears on the cover of this report:

Dee-Jay Monika Rumbolt (Snowbird), for *Motherly Love*

The Saa-Ust Centre, for the star blanket community art piece

Christi Belcourt, for *This Painting is a Mirror*

in healthy ways, such as through hugs. One participant in the 2SLGBTQQIA Perspectives session noted that 2SLGBTQQIA children and youth face an increased risk of experiencing harm in care;

- inadequate support services for children and youth in care, including gaps in capacity and funding to support children with Fetal Alcohol Syndrome, or children who have experienced trauma or abuse;

  "In Nunavik we had 40 kids in foster care waiting for the Sûreté du Quebec to interview them on their sexual abuse case, but the one officer was on sick leave so those children were just left in limbo." (Inuit Perspectives)

- lack of stability for children cycling in and out of foster care or through multiple foster homes. For instance, one participant described how they had moved through 14 foster homes over the course of their childhood;

- profound sense of loss for parents, increasing their likelihood of engaging in substance abuse, violence, or experiencing mental health concerns, and limiting their ability to improve their parenting skills; and

  "My best friend died because of the system. Her kids got taken away, then her house, then she ended up dying from alcohol poisoning. She had nothing. Nothing to live for. Nothing supporting her." (Métis Perspectives)

  "They are still quick to take children away. So, they are taking away the parenting learning." (Inuit Perspectives)

- lack of support for youth aging out of care, as well as a lack of guidance for those still in care, increasing their risk for homelessness, poverty, substance use, exploitation, and engaging in criminal behaviour.

  "[Youth aging out of foster care] have nowhere to go, they feel like 'throw-aways.'" (Inuit Perspectives)

  "The child can turn from victim to perpetrator without the proper guidance." (Métis Perspectives)

In Depth: Understanding the Crisis of Child Welfare

While the alarmingly high rates of child apprehension are related to many of the different themes discussed in the Dialogues, including culture, health, security, and justice, participants discussed this system in relation to its impact on families and on connection as the starting point for discussing how it violates other basic human rights.

As a result, there was a strong call across all sessions for a preventative approach to child and family welfare services, with an aim to preserve family unity and avoid recourse to foster care interventions insofar as possible. Participants stressed the importance of providing support for the whole family, not just the children, because individual well-being is inherently connected to that of the family.

> "Our child protection system is focused on crisis management. It needs to be reversed [to] focus on keeping families whole and healthy, [addressing] housing, parenting, counselling, food, financial problems." (Inuit Perspectives)

> "We don't just work with the kid … if we are going to help the child, we are going to help the family." (Quebec Perspectives)

Specific recommendations include:

☑ **increased financial assistance for families**, as participants noted the disparity between funding allocated toward foster care in significant amounts and the lack of funds directly supporting families to address their basic needs and long-term stability.

☑ **increased funding for family welfare services in general**, increasing child tax credits and social assistance amounts to support low-income families, and ensuring that all children have equitable access to services through Jordan's Principle[7];

> "Maybe they need a spare bed, maybe they need some more food security, and maybe they need to go back to school. We shouldn't be separating families." (Inuit Perspectives)

> "They are paying non-Inuit to raise our children. Yet we don't get support to raise our own children…. If we only changed one thing, to put the money in the family, it would change things dramatically." (Inuit Perspectives)

☑ **family healing and treatment centres** that provide multigenerational, wraparound care, including substance use treatment, mental health supports, and guidance from Elders. Participants noted that this model would help address root causes of substance use or family violence, allow parents and children to remain together throughout the healing process, and provide specialized support for children experiencing trauma, violence, or neglect in their family home;

> "Keep the families together during times of healing and a transition. Provide them with the support they need to work out their issues and rebuild their life." (Métis Perspectives)

> "Whole family restoration and healing as opposed to removing one person and not addressing possible root issues and opportunities for re-traumatization when returning to the home." (Inuit Perspectives)

> "When we talk about removing men from violent situations, from home, we are actually continuing that cycle [of removing people] from home to go to residential school. We need to give people a place that feels like home, and to help children, [a place] that is age-appropriate for children, to help people to reconnect, to switch the dialogue from 'your parents are bad' to 'your parents are hurt.' Children are probably the most able to break that cycle. We need to understand why people are abusing, how we can [address this] in a way that reflects our values, and not the values of a court system." (Inuit Perspectives)

☑ **outreach services**, bringing preventative services and support directly into the home; and

> "When someone loses someone, our way is to go visit them. You do not ask them to go somewhere. People don't have the care they need to recover their children and recover their life.… Sometimes it just takes one warning for someone to change their behaviours. But you need to go there and talk to the person." (Inuit Perspectives)

☑ **culturally informed support and education for parents and caregivers**, including early education about healthy relationships, family planning, and parenting skills that are rooted in specific, local Indigenous values. Additionally, participants called for increased emotional support for new mothers, and support for parents or caregivers of youth involved in the justice system or engaging in high-risk behaviour.

> "It's grandparents that are now being parents for their grandchildren for whatever reasons. We hold sessions to support grandparents so they are not alone." (Métis Perspectives)

> "We need Inuit-specific parenting teachings. Keep the kids together and the families together. The mother and the child are learning. Single mothers want to be with their child, but it's a struggle without support." (Inuit Perspectives)

> "Now, when someone gets pregnant, it's a panicky, difficult experience. But we should prepare them for traditional parenting [not just home economics] in advance in schools." (Inuit Perspectives)

> "Parents are not always equipped with parental skills to work with their teenagers. Create environments for parents, make a budget, make menus, equip parents to take care of children. Cooperative group workshops to equip parents." (Quebec Perspectives)

In the 2SLGBTQQIA Perspectives session, participants recommended offering parents and caregivers 2SLGBTQQIA competency training to increase their understanding, acceptance, and ability to support their children – especially for parents whose trans children are receiving gender-affirming care, and in communities outside of urban centres.

> "If there is a transphobic family and that forces the child to run away, the kids can be taken under child welfare. The family should be able to receive support on how to parent their child better, and [how not to be] transphobic." (2SLGBTQQIA Perspectives)

> "There is a need too for families to adopt more inclusive and affirming languages. The families have to adapt to the reality of their children." (2SLGBTQQIA Perspectives)

Participants also identified various recommendations to improve the safety and well-being of children and youth in care, including:

- ☑ **Indigenous child welfare agencies**,[8] or culturally specific child welfare legislation that would be tailored to the cultural context of particular communities. One participant recommended that Elders be involved in shaping the legislation, offering guidance so that Indigenous child welfare agencies are shaped "from a spiritual and cultural place, not [a] colonial place" (2SLGBTQQIA Perspectives). Similarly, a participant in the Métis Perspectives session recommended the involvement of Métis child welfare agencies prior to apprehensions;

- ☑ **local foster care placements and kinship care**, including increased recognition and financial support for existing informal arrangements where children and youth are being cared for by extended family;

- ☑ **access to culture**, especially for children placed in non-Indigenous homes, such as by providing foster families with dedicated funding for cultural enhancement, and engaging children and youth in care in community-based cultural programs specific to their heritage;

- ☑ **stability** within group home staff, social workers, and foster care placements;

- ☑ **support for youth aging out of care**, including legal guidance, living skills, mentorship, and connections to Elders. One participant cited policies that allow children above the age of majority to continue receiving child support if they are enrolled in a full-time educational program. They suggested that as the "de facto parent" for children in foster care, the government should be responsible for comparable support; and

- ☑ **national or provincial advocacy bodies** to oversee and champion the needs and rights of children and youth, and to provide legal representation to children and youth who are not receiving adequate care in foster systems.

> "There is an existing [new] advocacy group for children who are not being supported, but it's only for children and only in the capital. So, [it] needs to be in other communities and not just for youth. Travelling from one community to the next is not working. Especially not for crises." (Inuit Perspectives)

This is **Exhibit "M"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)
Sarah Clarke LSO # 57377M

Children's Adjustment to Parental Death

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This article reviews the evidence regarding the effects of parental death on children's acute and long-term psychological adjustment, as well as the clinical literature describing interventions for bereaved families. The risk of adjustment difficulties for bereaved children has shown no consistent relation to complications of grieving, but is instead largely accounted for by an increased probability of inadequate care following the loss of a parent. The literature describing interventions for bereaved families offers little formal evaluation, and reflects our incomplete understanding of children's grief responses, and thus of appropriate treatment goals. Further research should focus on more molecular analysis of grief processes, including grief-related interactions between children and parents, and should take into account developmental variation in children's needs and experiences. The use of multiple informants of child and parent behavior is strongly recommended, and the unique contributions of longitudinal research in understanding children's adjustment to loss are highlighted.

Key words: **parental death, childhood grieving, bereavement intervention.** ***[Clin Psychol Sci Prac 5:424–438, 1998]***

The untimely death of a parent represents a profound crisis in both acute and long-term adaptation for surviving family members. Parental loss almost invariably deprives children of an enormously significant emotional exchange, and may leave the remaining parent ill-prepared to continue in his or her own role, let alone take on the functions of the deceased. Approximately 1 in 20 children experience the loss of a parent before their eighteenth birthday (U.S. Bureau of the Census, cited in Schroeder & Gordon, 1991). This review explores children's adjustment to parental death through an examination of current knowledge concerning the nature of childhood grieving, predictors of children's adaptation to loss, the prevalence and severity of adjustment difficulties following parental death, and the evidence regarding interventions to assist bereaved families.

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PATTERNS OF GRIEVING AND ADJUSTMENT

What Is "Normal" Childhood Grieving?

Attempts to examine the impact of parental loss should be guided by an understanding of normal or typical childhood grieving patterns. Thus, it would be helpful to be able to define and assess children's grief responses, to articulate the ways in which children's grief is similar to or different from that experienced by adults, and to consider the implications of any differences that emerge. Despite efforts from several theoretical perspectives to describe a "normal" grieving process, appreciating the scope of grief's impact and differentiating "complicated" or "pathological" mourning from a normal developmental process continue to present challenges for the field. This is particularly true of childhood grieving: Because children are presumed to have different emotional capacities than adults, and do not express their grief in the same ways that adults do, there has been considerable uncertainty about how children experience grief.

Traditionally, psychoanalysts have maintained that preadolescent children are incapable of overcoming primitive defenses (denial and repression), to successfully tolerate the pain of the separation process (see Osterweis, Solo-

mon, & Green, 1984). Attachment theorists, too, have suggested that children are at risk for hasty and superficial processing of the loss, amplifying the potential for persistent distress. Nevertheless, one would find general consensus that the achievement of object permanence, around age 3 or 4, renders the child capable of some semblance of grief, and Bowlby (1980) emphasized the similarity between grief responses of adults and children even as young as 6–9 months, following the formation of an attachment bond. Empirical observations have, in fact, revealed some broad parallels between grief presentations in children and adults: The general pattern of mixed anxious and depressed symptoms, demonstrably above the norm but falling short of clinical levels, has been documented among toddlers (Kranzler, Shaffer, Wasserman, & Davies, 1990), prepubertal children (Silverman & Worden, 1992; Weller, Weller, Fristad, & Bowes, 1991), and adolescents (Gray, 1987).

Even very young children experience recognizable grief symptoms, but their overt behavior differs in some ways from that of grieving adults. They may appear glib or unemotional in the face of a loss, perplexing adults by "inappropriately" persisting at play, or blithely announcing the death to casual acquaintances. An inability to grasp the significance of the loss all at once and ignorance of social expectations regarding mourning behavior likely contribute to this apparent lack of emotional responsiveness. Children may approach grief in doses they can tolerate, interspersed with periods of avoidance (Osterweis, Solomon, & Green, 1984). In addition, a lack of fluency in identifying and describing feeling states may prompt more somatic expressions of distress in children. Children also often display intense concern for their own continued welfare: Will they become sick and die too? Will the remaining parent be able to care for them? What will happen to their home? Who will take the place of the lost parent, and when? Children may repeatedly seek reassurance or information related to these issues, sometimes to the discomfort of surrounding adults. Finally, decrements in children's own functioning or that of their environment may manifest themselves in adjustment difficulties that may not be generally recognized as part of normal grief (e.g., conduct problems; see Rutter, 1966).

Long-Term Consequences of Parental Death

The choice to begin with the examination of distal rather than proximal effects of parental loss in some ways reflects the development of research in this area, where much of the early interest derived from attempts to understand adult depression. Other problematic consequences of early parental loss have received scattered attention and support, for example, Tweed, Schoenbach, George, and Blazer (1989), who report elevated rates of agoraphobia and panic among a community sample of adults who had experienced maternal death as young children (see also Finkelstein, 1988, for an array of other hypothesized outcomes). Nevertheless, the bulk of theoretical and clinical interest has focused on a putative heightened susceptibility to depression well into adulthood. These hypotheses were shaped by a psychodynamic conceptualization of depression that places object loss at its core, by the similar presentation of grief and depression when seen in clinical settings, and by the reportedly high rate of parental loss in the histories of depressed clients. Examination of the evidence for the link between early parental loss and adult adjustment difficulties has, however, over the past two decades, simultaneously introduced some doubt as to the potency of parental death by itself as a risk factor, and stimulated interest in strategies for enhancing children's already quite remarkable resilience in the face of life stressors.

Reviews published simultaneously in the United States (Crook & Eliot, 1980) and Great Britain (Tennant, Bebbington, & Hurry, 1980) concluded that the link between early parental death and depression in adulthood had been overstated. Most studies of this relationship, they asserted, had been characterized by serious methodological flaws including misspecification of adult "caseness," inadequate comparison samples, and inappropriate statistical analyses. The earliest and most plentiful evidence bearing on this issue was derived from studies comparing the frequency of childhood parental loss among depressed patients and control groups. The criterion variable in this type of study is not psychological morbidity per se, but the entire constellation of circumstances that prompt someone to seek professional services for emotional distress (Tennant et al., 1980). What is interpreted as an increased risk of depression among those with a history of parental loss has been confounded by a potential increased probability of service utilization, a distinction that can only be teased apart by studies of unreferred, community populations.

Perhaps a greater threat to this body of evidence has been the frequent use of general hospital patients as comparison samples, with no effort to control for group differences in factors such as age, gender, or social class. These factors can be related to parental loss or depression

in ways that confound the interpretation of group differences. For example, the psychiatric wards from which depressed samples were often obtained were likely to have an older population than the general hospital wards that furnished comparison samples (Crook & Eliot, 1980). Their age alone rendered the psychiatric patients much more likely to have lost a parent during childhood than the younger comparison subjects, a cohort effect evident from census records. Much the same can be said for social class, with lower class subjects at greater risk for both parental death and admission to psychiatric hospitals. Any gender differences between identified "loss" and "nonloss" samples could also influence relative frequencies of depression, for women are invariably overrepresented among those presenting with depression. Crook and Eliot alleged that where these factors have been controlled in sampling or data analysis, differences in frequency of parental loss between depressed and nondepressed groups have been much reduced: "We do not conclude from the review that parental death during childhood and adult depression are unrelated, but we suggest that the overwhelming etiologic significance attached to the event by many writers is unwarranted" (p. 258).

More recently, a program of research by Bifulco, Harris, and Brown (1992; see also Bifulco, Brown & Harris, 1987; Harris, Brown & Bifulco 1986, 1990) has contributed substantially to elaborating the link between early losses and maladjustment in adulthood. These investigators conducted extensive interviews with two large epidemiological samples of adult women, selected from the rolls of health centers in London. The results of these interviews indicated that loss of the mother during childhood, whether by death or prolonged separation (more than 1 year), doubled the risk of depression in adult life for women (Bifulco et al., 1992). Loss of father was a much less potent risk factor (Harris et al., 1986). Elevated risk of depression was largely mediated by the lack of adequate parental care following the loss, which may help to explain the different findings with respect to mother versus father loss: Harris et al. (1986) observed that it was much more likely for a mother to take on the breadwinner role of a lost father during the post-World War II period than for a father to combine adequate caretaking with his traditional provider function.

The nature of the preloss relationship between the child and the mother was also found to predict a variety of diagnosable adult psychological difficulties (Bifulco et al., 1992). The construct of childhood helplessness was central in understanding this relationship. Childhood helplessness, assessed via various retrospective indices of childhood competence and confidence, was found to be strongly related to an insufficient or poor-quality preloss relationship with the mother. Either the death of mother prior to the child's age 6, or what the authors termed "aberrant" separation from the mother, that is, under conditions suggestive of preloss trauma to the child, such as the child's removal from an abusive mother, were taken to indicate an insufficient relationship. Lack of care following the death, in the absence of a poor relationship with the mother prior to the death, was unrelated to the helplessness construct. Childhood helplessness was, in turn, related to higher risk of disorder in adult life.

We see in these data the operation of two relatively distinct risk factors—preloss traumatized relationship with the parent and postloss lack of care—which may be associated with parental (particularly maternal) death and which, either singly or additively, increase the risk of adult psychopathology. The emphasis in explaining long-term effects is shifted from the death and accompanying mourning processes to the changes in family circumstances that are associated with loss. Bifulco et al.'s (1992) interpretation draws particular attention to the construct of attachment: "With adequate care prior to and after the loss, the risk of adult caseness is not apparently raised by loss of the mother; therefore, the results suggest that it is the quality of attachment and not the trauma of the loss that holds the key to later psychological well-being" (p. 446).

Breieret al. (1988), analyzing the histories of 90 adults who had experienced parental loss by death or permanent separation between the ages of 2 and 17, reached similar conclusions. Structured diagnostic interviews revealed that 77% of the sample had met research diagnostic criteria for a major psychiatric disorder during adulthood, mostly for affective disorders. This group was then compared with the 23% of the sample that had reportedly not met the criteria for any psychiatric disorder, with respect to grieving patterns, family relations, and home environment following the parental loss, family history of psychiatric disorders, and neuroendocrine measures. Neither the gender of the lost parent nor the manner of loss (death vs. separation) differentiated the two groups. The most powerful predictors of adult psychiatric status were indices of the home environment following the loss. Particularly vulnerable were those subjects who recalled feeling neglected and/or burdened by their remaining parent's

need for emotional support subsequent to the loss, and who were unable to forge supportive peer relationships. Paralleling the work of Bifulco et al. (1992), children's relationships with their caretakers were found to be more predictive of adult adjustment than either their (retrospectively reported) acute grief symptoms or their family history of psychiatric illness.

The research described thus far (Bifulco et al., 1992; Breier et al., 1988) addresses the concept of loss rather broadly, including lengthy separation as well as death. Saler and Skolnick (1992) focused on long-term effects of parenting characteristics and family environment following parental death. Ninety adults who had experienced the death of a parent before age 18 provided information about the circumstances surrounding the death, their recollections of how they mourned the death, perceived parental attitudes and behaviors of the surviving parent, depressive experiences in adulthood, and current depressive symptomatology. It is not clear what proportion of the Saler and Skolnick sample actually met any standard threshold for a depressive syndrome; the authors reported only mean scores of this group on measures of depressive symptomatology and disposition that exceeded instrument norms. It appears that these subjects on average exhibited depressive symptoms and styles to a greater degree than the normative sample but, not surprisingly, not quite in the range thought to represent identified cases of depression. The more interesting findings pertain to predictors of depression within the sample.

Potential predictors of adult depressive symptomatology examined by Saler and Skolnick included (1) the child's age at the time of the loss, for the first 5 years of life and early adolescence are widely believed by loss researchers to be critical periods (see Osterweis, Solomon, & Green, 1984, chap. 5); (2) subsequent caretaker behavior—deficient affection or care, and excessive control or protectiveness on the part of the surviving parent; and (3) restricted "mourning behaviors" (e.g., communication and shared grieving) on the part of the child and family at the time of the death. Neither child's age at the time of death nor control and protectiveness of the child by the surviving parent predicted adult depression in this sample. Being able to talk freely with the surviving parent and other family members about the death appeared to protect against later depressive experiences, as did a high level of care and affection from the surviving parent. In short, parental care following the loss (preloss relationships were not examined in the Saler & Skolnick study) was again confirmed as an important influence on adjustment, and appears to hold whether loss is broadly defined or restricted specifically to death.

The emergence of shared mourning as a predictor of later adjustment in Saler and Skolnick's work may be related to the quality of postloss care by the surviving parent, but also seems to suggest a critical role for communication in helping children adjust to parental death. Such observations might be construed as consistent with what is often termed the "grief work" hypothesis, which holds that there are certain universal aspects of the grief experience that one must negotiate in order to cope with a loss, and that pathological grieving is often caused by failure to "process" the loss through repeated cognitive and emotional confrontation. Saler and Skolnick's findings may indicate benefits for children from engaging in this grief process in concert with others. Other interpretations of the findings are possible, however. For example, shared mourning with a positive coping message could also serve to reassure the child regarding the surviving parent's ability to function, a favorable effect that does not depend on the grief work construct.

This body of work has contributed to a growing recognition that loss construed as a unitary event is not a particularly powerful predictor of subsequent adjustment (see Brown, 1966, for an early appreciation of this point). Loss is more usefully conceptualized as an extended and multifaceted process, whose impact on survivors is strongly influenced by surrounding circumstances and stressors (e.g., the evolution of a "parental child" role in the wake of the loss, availability of social support, relocation to a different community), and by how the various roles performed by the deceased are fulfilled, reshaped, or left vacant in his or her absence (Berlinsky & Biller, 1982; Bifulco et al., 1992; Lamberti & Detmer, 1993; Mireault & Bond, 1992; Rubin, 1986). It is widely believed that these same factors are implicated in children's adjustment to a broad spectrum of parental losses, including not only bereavement, but also abandonment, divorce, extended separation (e.g., military duty), and even limited availability due to chronic physical or mental illness.

Acute And Medium-Term Consequences of Parental Death

The investigations described thus far have all relied on retrospective reports by subjects who, as adults, have agreed to provide information about their loss experiences. Only recently have systematic prospective investigations of children's bereavement reactions, assessed during what might

be regarded as the period of grieving, been undertaken. The investment required to track long-term effects via prospective work has tended to limit these studies to bereavement sequelae that emerge within a few years of the loss event.

The earliest of these efforts was reported by Van Eerdewegh, Bieri, Parrilla, and Clayton (1982; see also Van Eerdewegh, Clayton, & Van Eerdewegh, 1985), who conducted structured interviews with the surviving parents of 105 bereaved children and 80 nonbereaved controls. Both groups were assessed on two occasions, at 1 month and 13 months following the death for the bereaved families, and across a similar span for the control group. Indices of child psychological distress were collapsed across both occasions, noting those that were present within the past year at either assessment point, for comparisons between the bereaved and nonbereaved samples. The bereaved children reportedly exhibited significantly more symptoms of dysphoria (e.g., sadness, crying, irritability), mild depressive syndrome, bedwetting, and decrements in school performance than controls. The groups did not differ significantly in the reported frequency of severe depressive syndrome, or most indicators of somatic distress or externalizing behavior problems. Within the bereaved sample, the proportion of children said by their parent to be exhibiting symptoms of acute grief (sadness, crying) declined across the two interview occasions, from approximately one half at the 1-month interview to one quarter at the 13-month interview.

Van Eerdewegh et al. (1982) found in their results support for the psychodynamic contention that children do not experience the mourning process observed in adults. They suggested that the bereaved children in their sample were generally well adjusted in the short term, exhibiting only a mild and relatively short-lived depressive reaction to the death of the parent. The strength of this conclusion is difficult to ascertain, for at least two reasons that have broad implications for research on child bereavement, and thus bear elaboration. First, the methodology of this study was completely dependent upon the accuracy of parental reports of the child's condition, with no verification from other sources and no direct contact with the child. Not only should this raise concern about the limited scope and potential bias of a single informant, but in this case the informant was likely to be considerably distressed him or herself, a condition that may distort reporting of child behavior problems (see Rickard, Forehand, Wells, Griest, & McMahon, 1981). Furthermore, the adult's distress may not have remained constant across the two interview occasions. Both the level of reported child adjustment problems in the bereaved sample and any changes that may have been observed in that level over time were therefore vulnerable to distortion from the parent informant.

In their second report of this investigation, Van Eerdewegh et al. (1985) acknowledged that the absence of any contact with the child imposed rather severe limitations on the interpretability of their findings. Their observation, for example, that the loss of a father had more deleterious effects than the loss of a mother, and their consequent assertion that mothers are less prepared than fathers to assume the dual responsibilities of caretaker and provider, are, to our knowledge, unique in the parental loss literature. The possibility that fathers are, on average, less attuned than mothers to their child's emotional state—and thus observe and report fewer symptoms of child distress—is both more parsimonious and more consistent with the findings of other investigators (e.g., Bifulco et al., 1992; Worden, 1996).

A second factor that suggests caution in interpreting these results is the uneven pattern of child symptomatology over time. Specifically, although the percentage of children reported by their parent to be exhibiting sadness or crying did indeed diminish substantially over the 12 months between interviews, the frequency of other symptoms—depressive, somatic, and aggressive—generally remained stable at, or increased to, levels consistently (if not dramatically) higher than those observed in the comparison sample. Van Eerdewegh et al. (1982) themselves cite Rutter's (1966) work indicating that the reactions of children to parental loss are likely to be heterogeneous, not confined to internalizing manifestations. Searching for statistically significant differences across bereaved and comparison samples in individual symptoms may be a less fruitful strategy than comparing some index of total behavior problems. Still, the point is well taken that we would be ill advised to expect most children to respond with a clear depressive syndrome in the months following the death of a parent. The possibility of longer term developmental consequences, stemming from decrements in academic performance or other loss-related circumstances, is appropriately acknowledged (Van Eerdewegh et al., 1982): "Since parental death alone does not seem to trigger important psychiatric problems, at least in the

short term, intervening variables must play a role in determining who will develop problems in later years" (p. 28).

This relatively benign picture of children's short-term grief reactions was supported more recently by the work of Silverman and Worden (1992), who interviewed children and their surviving parents 4 months after a parental death. The purpose of this study was to describe normative grieving responses of a nonclinical sample of children, and the family context surrounding the loss event. The children reported that they were confused and unsure of how to respond in the days following the death, even when it had been expected. Most (91%) cried at some point during the day of the death. Some sought out friends or family members for support, while others chose to be alone. Ninety-five percent attended their parent's funeral; those who did not were likely to be younger and to have lost their mother. By the time of the interview, most acute grieving responses on the part of the children (prolonged crying, withdrawal) had substantially diminished, and they were carrying on reasonably well in school and social relations. The most common somatic difficulties described by the children were headaches (74%) and sleep problems (30%). Seventy-nine percent reported still thinking about the lost parent at least several times per week. The investigators emphasized the profound impact of the loss on these children's way of life, pointing to shifts in roles of surviving family members, and the children's attempts to maintain a connection to the deceased in order to soften the transition to a new reality. They concluded that although the loss was extremely stressful, the stresses did not overwhelm most of these children: Only about 17% displayed significant problem behavior at 4 months after the death.

Follow-up interviews conducted at 1- and 2-year anniversaries of the death cast a slightly less optimistic light on the children's adjustment, revealing continuing struggles on the part of both children and surviving parents to adapt to the loss (Worden, 1996). Surviving fathers often described themselves as initially unresponsive to their children's needs, and even 2 years later were more likely to have problematic relationships with their children than surviving mothers. Families that had lost a mother experienced greater changes in daily routines than those that had lost a father, and the burden of these changes fell most heavily on daughters, who often assumed much greater responsibility for household tasks and care of siblings. By the time of the 2-year interview, the bereaved children had fallen below a nonbereaved control group on parent and self-report measures of social functioning, as many of them described feeling different from, and poorly understood by, their peers. School functioning, by contrast, improved slightly over the course of the study, reaching levels comparable to the nonbereaved comparison group at 2-year follow-up.

Extending the description of normative bereavement responses to very young children, Kranzler et al. (1990) obtained parent and teacher reports of behavior, and child reports of thoughts and emotions, for 3–6-year-olds who had lost a parent within the previous 6 months. In this sample, bereaved children were found to be at significantly greater risk than comparison children from intact families for behavioral disturbance in the clinical range (40% vs. 10%). Bereaved children who reported feelings other than sadness, such as anger and fear, were likely to be more symptomatic, and those least able to discuss grieving emotions were most disturbed. Lower age and male gender predominated in this group: For 3- and 4-year-old boys, bereavement was associated with elevated scores in a wide range of problem areas, whereas bereaved girls were at significantly greater risk for internalizing problems only (i.e., depression and anxiety). Interestingly, the single most powerful predictor of child disturbance in this study, whether that disturbance was indicated by parent or teacher report, was self-reported depressive symptomatology in the surviving parent. This may indicate some critical decrement in supportive parenting among distressed spouses or, alternatively, the depressive effect of coping with a disturbed child in the aftermath of spousal loss. In a now-familiar refrain, Kranzler et al. (1990) concluded by emphasizing the importance of both preexisting and postdeath parent-child relations, noting that "the highest symptom scores were found in children who, before the loss, had a (now) deceased parent who was highly involved and a surviving parent who was relatively less emotionally involved in their lives" (p. 517).

In an investigation that offered a unique opportunity to examine the effects of parental loss independent of drastic changes in life circumstances or caretaking arrangements, Elizur and Kaffman (1983; see also Kaffman & Elizur, 1983) studied the responses of 25 Israeli children who lost a father in the war of October 1973. As residents of kibbutzim, these children were provided with all of their material needs as well as child care, education, and many

social functions, all of which were therefore relatively unaffected by the loss of their fathers. The mothers and teachers of these children were interviewed at 6, 18, and 42 months after the father's death, regarding both specific behaviors and general level of functioning and adjustment on the part of the child. When compared with retrospectively reported prebereavement levels, these children showed clear increases in crying and moodiness, separation anxiety, somatic problems (e.g., enuresis, encopresis, eating and sleeping difficulties), oppositional behavior, and learning problems (Kaffman & Elizur, 1983). Although obvious grief manifestations diminished during the first 2 years, behavioral problems persisted throughout the follow-up period, with about half of the children exhibiting "severe and maladaptive behavior" (p. 435) at each stage of the study.

A matched sample of 21 city-dwelling (nonkibbutz) children who had also lost their fathers to the war was studied as a comparison group (Kaffman & Elizur, 1983). Although indices of adjustment generally favored the kibbutz children, the magnitude of differences between the groups was not large, rarely reaching statistical significance, and the prevalence of multiple and persistent symptoms was nearly identical for the two groups (kibbutz 48%, nonkibbutz 52%). The investigators concluded, to their surprise, that even the degree of instrumental support available through the kibbutz was not sufficient to buffer the trauma of parental loss for these children. Within the kibbutz sample, predictors of more enduring child behavior problems included preloss marital distress, a negative relationship between father and child, and a mother-child relationship characterized by emotional coldness, fostered dependency, or inconsistency. In addition to these family relationship variables, maternal overdependence or "weak ego strength" also placed a child at greater risk for long-term adjustment problems. Finally, the absence of a surrogate father figure (stepfather, male relative or neighbor) and a high level of continued situational stressors were linked to more severe child difficulties at the later follow-up interviews. The investigators emphasized the inadequacy of any single predictor for estimating the severity of a child's bereavement reaction, highlighting instead the cumulative nature of these risks, and changes in the relative weights of different factors over time.

The sample in this study is hardly representative of the larger population that has experienced the loss of a parent, yet many of its findings are familiar, and its unique characteristics offer unusual opportunities for hypothesis testing. It appears, for example, that even a quite remarkable stability of life circumstances, such as was afforded families residing in the kibbutz, is not as protective as recent theory might lead us to expect. Perhaps tempering this interpretation, it is worth noting that even the city-dwelling families who comprised the comparison group had the benefit of a "generous widow's pension provided by the Army" (Kaffman & Elizur, 1983, p. 436), a measure of financial security, at least, that probably exceeds that available to a randomly selected bereaved population in many cultures, and one that might tend to reduce any disparity in stability—and child adjustment—between the two groups. Given the political climate of the region and the shared tragedy of war, it is also conceivable that appreciable community support was available to the city-dwellers, making the two samples less different than they may appear to be. The relatively high base rates of severe child behavior problems in both of these groups (about 50%) may be attributable to any number of differences between this and the other investigations described above, including operationalization of variables, the violent mode of death, or the impact on the community of multiple losses sustained in war.

Finally, we have thus far defined as "prospective" any effort to examine children's bereavement responses as they were unfolding, rather than through the lens of long-term consequences in adulthood. Siegel et al. (1992; Siegel, Karus, & Raveis, 1996) have extended that definition by monitoring children's reactions from several months prior to the death (from cancer) of a terminally ill parent, through a postdeath adjustment period. Sixty-two children, assessed at an estimated 6 months prior to the death, were found to exhibit significantly increased depressive and anxious symptomatology and reduced self-esteem and social involvements, when compared with a demographically matched community sample (Siegel et al., 1992). By 7–12 months postdeath, however, self-reported symptoms of depression and anxiety among the bereaved sample had diminished to levels indistinguishable from those reported by the community sample at follow-up (Siegel et al., 1996). Follow-up data on parent-report measures, self-esteem, and social involvements were not reported, nor were factors associated with variation in psychological adjustment within the bereaved sample—an unfortunate omission given a relatively large sample and its attendant

statistical power. The investigators nevertheless presented a persuasive argument that, for the children of terminally ill parents, the months immediately prior to the death entail greater psychological vulnerability than what is traditionally regarded as the period of grieving. Cautions were appropriately stated regarding the narrow demographic range of the sample (all Caucasian, from middle- and upper-class households with intact marriages), and the possibility of longer term vulnerability in these children.

Summarizing Consequences of Parental Death

The findings presented above underscore the importance of relatively few broad variables in understanding the response of families to the loss of a parent. The quality of parent-child relations and child care both before and after the death (Bifulco et al., 1992; Breier et al., 1988; Elizur & Kaffman, 1983; Gray, 1987; Saler & Skolnick, 1992), the stability of family circumstances, and the availability of social support for children and surviving parents (Elizur & Kaffman, 1983; Gray, 1987; Kranzler et al., 1990; Silverman & Worden, 1992) are the common threads that emerge from this body of work as crucial determinants of acute and long-term adaptation to the loss of a parent. The predictive significance of the precise manner in which a child experiences or expresses grief has yet to be established; most of the evidence currently available does not point to critical elements of childhood grieving beyond the availability of communication when the child desires it (e.g., Breier et al., 1988; Saler & Skolnick, 1992). We may be encouraged to note that although sadness, confusion, and other expressions of distress are common among children reacting to parental loss, serious dysfunctional behavior is far from inevitable (Siegel et al., 1996; Silverman & Worden, 1992). Parental death, then, is best understood as creating a vulnerability, rather than inflicting a crippling injury by itself: Children appear to be at risk for concurrent and later difficulties *primarily to the extent that* they suffer a higher probability of inadequate parental functioning or other environmental support before, as well as after, the loss of a parent.

INTERVENTIONS FOR FAMILIES COPING WITH PARENTAL LOSS

Given that bereaved status does constitute a risk factor for surviving children, the question arises as to whether intervention may facilitate children's adjustment to parental loss, and thus serve to prevent some of the more serious manifestations of psychological distress and decrements in functioning that can result. Surprisingly little empirical work has addressed this issue. Perhaps because of its nosological status as a "problem in living" rather than a clinical syndrome (*DSM-IV* lists "Bereavement" among its "V" codes; American Psychiatric Association, 1994), bereavement has attracted little attention from the scientific clinical establishment. It has been left largely to nonempirical clinicians (particularly social workers) to develop strategies for assisting the bereaved, a task they have approached with considerable ingenuity and vigor, but little formal evaluation (e.g., Christ, Siegel, Mesagno, & Langosch, 1991; Cook & Dworkin, 1992; Siegel, Mesagno, & Christ, 1990; Zambelli, Clark, Barile, & de Jong, 1988).

The literature describing interventions for bereaved families is dominated by group-based strategies. Thus, this section begins with a brief overview of goals and methods frequently associated with bereavement groups. We limit more detailed presentation of individual studies to controlled investigations (i.e., evaluations comparing two or more treatment conditions), of which there are only two examples in English language publications, that focus on child outcomes (Black & Urbanowitz, 1985; Sandler et al., 1992).

Bereavement Support and Psychoeducational Groups

Relatively unstructured support groups are almost certainly the modal intervention at present for bereaved families, offered through grieving centers, hospices, or self-help associations. Groups can provide a powerful source of support, offering participants the sense of being accepted and understood, the opportunity to express emotion, education about loss, and the recognition that they can cope with the massive changes it entails (Folken, 1990; Lagrand, 1991; Lieberman, 1993).

Adult groups that target increased social support may operate simply by assembling members for regular, unstructured discussions. Children's groups usually accomplish these goals through a combination of discussion and more structured activities, such as listening to stories or music, producing artwork, or playing games (Moody & Moody, 1991; Zambelli & DeRosa, 1992). More structured bereavement interventions often include parallel parent and child groups, and aim to serve educational and therapeutic, as well as mutual support, functions (e.g., Zambelli et al., 1988). Children are typically provided with developmentally appropriate explanations of what it

means for a living thing to die, and helped to understand about life cycles throughout their environment. They may be encouraged to explore changes in their family systems and their emotional responses through playing games, listening to stories, or drawing pictures. Creative arts are thought to offer children a symbolic means of expressing painful, frightening, or embarrassing feelings. Parents approach some of the same topics more directly, talking about changes in their families, learning how adults grieve, and what they may expect in the way of grief responses from their children.

Controlled Evaluations of Bereavement Programs

In the first reported controlled outcome study of an intervention for bereaved children, Black and Urbanowitz (1985) offered six home-based family counseling sessions, beginning about 2 months after the death and spaced 2–3 weeks apart, to 46 bereaved families with children under the age of 17. The intervention was not described in detail, but its stated goals were to provide emotional support and problem solving assistance, to encourage communication about the dead parent, and to facilitate "the expression, communication, and resolution of grief" (p. 181). Another 34 bereaved families were randomly assigned to a control group, contacted only at the time of the 1-year follow-up for the treatment condition.

Children in the treatment condition had fewer behavioral, sleep, health, and learning problems (according to their parents) than those in the control condition at 1-year follow-up, and their surviving parents also experienced a lower incidence of depression or health problems. In addition, children in the treatment condition were said by their parents to spend more time talking and crying about their dead parent than control children. Closer examination of the relationship between crying about the dead parent and later adjustment revealed that, particularly for children older than age 5, crying was associated with fewer and less serious behavioral problems. Black and Urbanowitz (1985) interpreted their results as evidence for the capacity and need of children to mourn, and suggested that their intervention exerted its apparently beneficial effect by promoting children's mourning. As the authors themselves acknowledged, however, relying on only the surviving parent as an informant for all follow-up measures introduced substantial opportunity for various forms of method bias. It is conceivable, for example, that the intervention exposed the parent to demand characteristics favoring the reporting of children's crying in association with fewer behavioral problems. This potential threat to the internal validity of the study is difficult to evaluate without a more detailed treatment protocol (to explore the message delivered to families), and other informants of the child's behavioral status.

The most rigorous evaluation of an intervention for bereaved families in the literature is part of an ongoing research program conducted by Irwin Sandler and his colleagues at Arizona State University. The Arizona program began with an epidemiological study (Gersten, Beals, & Kalgren, 1991) to clarify the etiology of bereavement-related problems in children, from which it was determined that children who had lost a parent were at significantly greater risk than the comparison children for symptoms of depression, and perhaps for conduct problems as well (West, Sandler, Pillow, Baca, & Gersten, 1991).

Sandler and his colleagues hypothesized that the effects of parental death on child symptomatology were mediated by disruptions in the family environment, specifically demoralization of the surviving parent, reduced family cohesion and warmth, and a combination of increased negative events and decreased positive events. Structural equation modeling techniques with the epidemiological sample supported this model (West et al., 1991). Following from these findings, a preventive intervention was constructed (Sandler et al., 1992), with the mediating variables that emerged from the causal modeling analysis as proximal targets for change. The Arizona Family Bereavement Program combined a three-session, group-based Family Grief Workshop that utilized exercises to prompt communication about bereavement among parents and children, with an individualized Family Advisor Program that addressed the hypothesized mediating variables. Advisors selected for personal experience with bereavement were trained to teach parents relationship skills, and to provide them with both emotional and task-focused support.

Seventy-two families were randomly assigned to preventive treatment and control (6-month wait list) conditions. Parents in the treatment condition reported significantly greater increases in family warmth and perceived social support, and smaller decreases over time in discussion of grief-related issues, than those in the control condition. Parent reports of child symptoms showed significant reduction with treatment of child conduct prob-

lems, and of depressive symptoms among older (aged 12–17), but not younger children. Child self-reports of psychological symptoms gave no indication of significant treatment effects.

The results from this trial of the Arizona Family Bereavement Program were consistent with the hypothesized theoretical model, although sample size and perhaps other factors limited the ability to confirm several aspects of the model. In particular, family warmth was the only family environment variable for which a mediating role could be confirmed, and then only for older children, and for parent reported indices of mediating and outcome variables. Parental demoralization and the frequency of stable positive and negative events were not sufficiently impacted by the intervention to yield significant treatment effects. Among the younger children, symptomatology measures were not significantly effected by the treatment. What implications do these results hold for the design of interventions targeting bereavement related child behavior problems?

The investigators acknowledged limitations of such a brief intervention for altering the landscape of events in a family's life, in part because many of these events are not entirely within the family's control (e.g., negative financial consequences of the parent's death), and in part because even successfully implemented positive interactions require time to be perceived as *stable* positive events. Sandler et al. (1992) speculated that increased emphasis on effective emotion-focused coping might assist families in dealing with negative events they cannot avert. Shifting to the realm of parent-child interactions, the authors suggested that their reliance on intervention strategies developed to reduce parental conflict with adolescents might have contributed to a failure to decrease symptomatology in younger children. More deliberate attention to the developmental needs of preadolescent children might shape an intervention with greater efficacy for that population. Finally, the intervention targeted parenting roles rather specifically, and thus may have done little to ameliorate other sources of nonspecific distress in parents.

FUTURE DIRECTIONS

The substantial volume of theoretical and clinical writing about bereavement rests upon a disproportionately small empirical foundation. This is particularly true with respect to children: The paucity of data regarding effective interventions for bereaved children reflects in part an incomplete understanding of children's grief responses, and thus of appropriate treatment goals. Our current knowledge provides relatively safe ground for the interventionist with the modest objective of enhancing social support for bereaved families (social support has been identified as a powerful coping resource across numerous domains), but little basis for confidence in more grief-specific intervention targets. Three issues that seem to beg clarification are (1) necessary or helpful forms of grief work among children, (2) parent-child interactions that facilitate versus hinder the child's adjustment to loss, and (3) developmental considerations that we would expect to moderate the needs of the bereaved child.

Grief Work

Several of the interventions cited above (e.g., Black & Urbanowitz, 1985; Cook & Dworkin, 1992; Zambelli et al., 1988; Zambelli & DeRosa, 1992) described among their primary goals the facilitation of children's grief work, via enhanced understanding of death and expression of emotions. As intuitively reasonable as this goal may appear, the question of the necessity or form of grief work among children is very much unresolved, as, indeed, it is for adults (e.g., Stroebe & Stroebe, 1991; Wortman & Silver, 1989). Bereavement counselors tend to be quite sensitive to the possibility that children will not be sufficiently encouraged to express grief feelings, mindful that both professionals and caregivers may have traditionally underestimated the depth of the relatively inarticulate child's reaction to loss. But there may be risks to assuming the need for observable grief work in the absence of compelling evidence. It is conceivable, for example, that we might foster in children too much preoccupation with grief feelings, encouraging grieving behavior to such an extent that we undermine appropriate attempts on the child's part to regain a positive focus on his or her experience. Stroebe (1992) has observed that some types of grief work—notably cognitive rumination—appear to be associated with poor adjustment among bereaved spouses; it seems plausible that Stroebe's identification of maladaptive forms of grief work could apply to children as well.

It is incumbent upon investigators of child bereavement to demonstrate what aspects of "grief work" are, in fact, critical to subsequent adjustment. Qualitative investigations such as the Harvard Child Bereavement Study (Silverman & Worden, 1992; Worden, 1996) have begun to describe the range of grief responses in children and

adults, but have yet to discern a pattern of relations between grief responses and adjustment, with respect to psychological distress, school functioning, peer relations, and so on. The groundwork has been laid, and it is time to proceed to more specific hypothesis testing regarding the adaptation of bereaved families. Stage or task models of grieving processes (e.g., Worden, 1991), for example, invite the development of strategies for assessing progress with each task, and relating that progress to indices of adjustment. Any model positing critical aspects of grieving should be similarly amenable to evaluation.

Parent-Child Interactions

Strengthening the surviving parent's capacity to provide support following the loss is another frequent goal of intervention for bereaved families (Black & Urbanowitz, 1985; Sandler et al., 1992; Siegel et al., 1990; Zambelli et al., 1988). The identification of parenting variables as mediators of child adaptation is supported not only by many of the studies of parental loss reviewed here, but by a broader developmental and clinical literature as well. Nevertheless, despite the undisputed importance of parental support in general, many questions remain about what specific parent behaviors best facilitate the child's adaptation to loss. Some clinical writing, for example, encourages parents to communicate with their children about grief, and even to share some of their own grief feelings with their children, in order to enhance parent-child bonding, normalize the range of emotions the child may be experiencing, and model for the child expression of these emotions (e.g., Moody & Moody, 1991). Again, one wonders whether parental expectations for grief-related communication may, on occasion, demand more overt grieving from children than is helpful (see Silverman & Worden, 1993, p. 312, who reported children feeling overly pressured by their parents to be emotionally expressive). Moreover, this sharing of affect-laden communication would appear to require a delicate balance, lest the child feel burdened with the surviving parent's grief.

Although most writing in this area emphasizes increasing the frequency of grief-related communication between parents and children, we suspect that the adaptive value of such communication will depend more upon its content—the message delivered by the parent—than on the issue of how often it occurred. In particular, is the essence of the parent's message that "I feel awful, too, and I don't know how I'll get through this," or "Yes, this is painful for all of us, including me, but I'll still be able to take care of you and we will be O.K."? The latter is a positive coping message: Even as it acknowledges the parent's own pain, it provides a model for actively and successfully grappling with grief. The former is likely to further undermine a bereaved child's sense of security, and to reflect diminished capacity on the part of the parent.

We would like to see more efforts specifically designed to discriminate helpful from potentially problematic forms and content of communication between bereaved parents and children. Sandler et al. (1992) developed measures to assess the frequency of discussions between parents and children about grief-related issues, but they do not sample behaviors that may indicate the parent is shifting emotional burdens onto the child: focusing on his or her own feelings at the expense of the child's, complaining about added stresses or reduced opportunities since the death. It is possible that expressions of distress on the part of the parent will bear a quadratic, rather than linear, relation to child adjustment, such that, for example, the parent who has never cried in the presence of her child, and the parent who does so almost daily, are both insufficiently attuned to the child's needs.

It will, in addition, be desirable to assess the surviving parent's capacity to maintain structure and consistency in the child's environment following the loss. Schaefer's (1965) Child Report of Parental Behavior Inventory, for example, utilized by the Arizona Family Bereavement Program for the assessment of family warmth, also contains items tapping parental consistency. Other potential indices of parental functioning might include children's absences from school, maintenance of household routines such as bedtimes and mealtimes, and the parent's awareness and facilitation of children's activities.

Developmental Considerations

A perhaps obvious yet underemphasized issue in understanding the needs of bereaved children and the impact of grief-related interactions with surviving parents is the child's developmental status. Findings from the Arizona Family Bereavement Program, in which younger children did not appear to benefit in the way that adolescents did from an intervention that focused on increased parent-child communication (Sandler et al., 1992, table IV), seem to imply a moderating function of child age. It may be that sharing grief work with a parent has very different

effects on older versus younger children, comforting or even empowering an adolescent, who may feel more mature for the parent's confidence, but overwhelming a younger child, who is not prepared to exchange the illusion of the parent's strength for a relationship on a more even footing. Similarly, children depend upon their parents to structure and maintain their daily routines and activities in inverse proportion to their age.

Testing for a moderating effect of child age on circumstances that contribute to the adaptation of bereaved children will compound what is already a challenge for investigators: recruiting sufficient samples for statistical analysis, when the phenomenon of interest occurs at a relatively low base rate. One way to meet that challenge would be for investigators in several communities to launch a collaborative research effort, all testing hypotheses within the same broad theoretical model, so that their data could be pooled for certain analyses. To date, only Sandler and his colleagues have attempted to fit data to a theoretical model (West et al., 1991: Sandler et al., 1992), and they were hampered by restrictions of sample size. Collaboration among investigators could simultaneously reduce obstacles to such work, and contribute theoretical coherence to the field.

Additional Issues for Study

The three issues outlined above are thrust into prominence by the existing literature concerning child bereavement, yet they by no means exhaust compelling questions yet to be explored. How might dispositional coping styles influence adaptation to bereavement? There has been some speculation regarding the adaptive value of more active coping strategies (e.g., Attig, 1991; Stroebe, 1992), but relatively little empirical support to date, and even less investigation of how to promote active coping. Sandler and his colleagues are pursuing this avenue in their Bereaved Families Program (I. Sandler, personal communication, April 12, 1996), and it merits attention from other investigators as well.

Do cultural differences in mourning behavior reflect dramatic differences in the actual experience of grief (e.g., Stroebe, Gergen, Gergen, & Stroebe, 1992), and if so, are there certain irreducible and universal aspects of grief? In a related vein, the role of religious faith and ritual in adaptation to loss is thus far understudied in the empirical literature. Psychologists have traditionally been reluctant to venture into this realm, yet questions about spirituality and meaning in life seem almost invariably woven into bereavement experiences. Religion is one of the more common avenues through which people explore these questions, and we cannot afford to exclude it from our understanding of grief.

Methodological Comments

In this body of research, as in all work related to children, we've seen that very different pictures or details of the child's adaptation may emerge depending upon whom one asks. Confronting this issue directly, Sandler et al. (1992) demonstrated a rather weak correspondence between parent and child reports of family interactions and of child symptomatology in the Arizona Family Bereavement Program. When investigators do not administer parallel measures to parents and children (e.g., Black & Urbanowitz, 1985; Van Eerdewegh et al., 1982), the extent of agreement between these sources, and clues as to potential biases remain unknown. This is not an issue of the "correct" informant, for parents and children simply don't have access to the same information in judging the child's psychological state (e.g., unreported symptoms of anxiety), or the surrounding circumstances. The picture will clearly be incomplete without both parent and child perspectives, and perhaps that of others, such as a child's teacher or friend, as well.

A final issue that deserves mention is the contribution of longitudinal assessment to elucidating grieving processes, and identifying peaks of vulnerability. Siegel et al.'s (1996) discovery that children of terminally ill parents experience greater distress in the months prior to the death than during the postdeath period exemplifies the type of finding that would be very unlikely to emerge from a retrospective or cross-sectional study, yet is extremely valuable from the perspective of secondary prevention. Similarly, Worden's (1996) 1- and 2-year follow-up interviews revealed unfolding challenges and coping strategies of bereaved families that would probably have been underestimated by the initial assessment alone and would be only vaguely apparent from a single interview at one of the subsequent measurement points. Kaffman and Elizur's (1983) interviews with Israeli families across a span of 3 years demonstrated a dissynchrony between grief symptoms and other behavior problems of bereaved children; without repeated assessments, one would have to rely on an informant's recollection of onset and offset of relevant symptoms to explore this type of relationship.

Longitudinal studies are simply the only way to achieve the perspective that makes these observations possible.

The prospects for bereaved children do not appear as bleak as clinical lore might once have led us to believe: With few exceptions among the investigations reviewed here, the majority of children and retrospectively studied adults who lose a parent do not appear to exhibit severe behavior problems or lasting decrements in functioning. In this realm, then, as in so many others (Cicchetti & Garmezy, 1993; Masten, 1989), children exhibit a remarkable degree of resilience in the face of stressors. Much, of course, remains to be understood about children's grieving, about risk factors pertaining to parental loss, and about interventions to assist families in coping with the death of a parent. We have highlighted the need for more molecular analysis of "grief work," including grief-related interactions between children and parents, for the use of multiple informants of child and parent behavior, and for longitudinal research designs to capture these evolving, dynamic processes.

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End-of-life experiences of mothers with advanced cancer: Perspectives of widowed fathers

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End-of-life experiences of mothers with advanced cancer: perspectives of widowed fathers

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ABSTRACT

Objective Despite the importance of parenting-related responsibilities for adult patients with terminal illnesses who have dependent children, little is known about the psychological concerns of dying parents and their families at the end of life (EOL). The aim of this study was to elicit widowed fathers' perspectives on how parental status may have influenced the EOL experiences of mothers with advanced cancer.

Subjects 344 men identified themselves through an open-access educational website as widowed fathers who had lost a spouse to cancer and were raising dependent children.

Methods Participants completed a web-based survey about their wife's EOL experience and cancer history, and their own depression (Center for Epidemiologic Studies Depression Scale, CES-D) and bereavement (Texas Revised Inventory of Grief, TRIG) symptoms. Descriptive statistics, Fisher's exact tests, and linear regression modelling were used to evaluate relationships between variables.

Results According to fathers, 38% of mothers had not said goodbye to their children before death and 26% were not at all 'at peace with dying.' Ninety per cent of widowed fathers reported that their spouse was worried about the strain on their children at the EOL. Fathers who reported clearer prognostic communication between wife and physician had lower CES-D and TRIG scores.

Conclusions To improve EOL care for seriously ill patients and their families, we must understand the concerns of parents with dependent children. These data underscore the importance of parenting-related worries in this population and the need for additional clinical and research programmes devoted to addressing these issues.

BACKGROUND

Cancer is the leading cause of death for women aged 25–54 in the USA, the peak parenting years.[1] Although rarely addressed by healthcare professionals, parenting concerns and responsibilities are of high importance to many patients with advanced cancer who have dependent children.[2] Despite the impact of parental cancer and early parental death on families, there is a dearth of research on how parental status can impact the experience of cancer at the end of life (EOL) for patients and their families.

Parents with advanced cancer experience challenges when coping with a life-limiting illness that differ from non-parents. Prior research suggests that parents with advanced cancer who have dependent children may be less likely to acknowledge the terminal nature of their illness and more likely to choose treatment focused on life extension rather than to pursue palliative options.[3] Another study has demonstrated that parents with metastatic cancer experience high rates of anxiety and depressive symptoms and that parenting concerns are correlated with these mood symptoms.[4 5] The few qualitative studies of advanced cancer and parenting suggest that parents struggle with adaptation to incurable illness,[6 7] concerns about the impact of their disease on children[6] and the challenges of being a 'good parent.'[8 9]

Several lines of evidence suggest that dying parents' concerns about their family's coping are well founded. Co-parents who care for their terminally ill spouses are more likely than non-parents to experience symptoms of major depression and generalised anxiety.[3 10 11] Following death, the surviving parent struggles with isolation, parental competence and maintaining family roles.[11 12 13] Similarly, children of terminally ill parents are at elevated risk of

developing depressive disorders during the periods of parental advanced illness and bereavement.[14 15] Existing data suggest that the quality of parenting by the surviving parent is associated with children's psychosocial functioning and that positive parenting leads to improved adjustment of the bereaved child.[16 17] Therefore, research that helps us to understand how families transition from parental illness through bereavement may be particularly useful.

Many parents with advanced cancer struggle to balance their roles as a parent and terminally ill patient,[7] yet very little is known about their EOL concerns and dying experiences. Bereaved spouses' perspectives on patients' EOL experiences are rarely solicited and can provide important insights into the psychological concerns and dying experiences of parents with advanced cancer when direct assessment from the ill patient is neither possible nor practical.[18] Additionally, perceptions of EOL care by bereaved caregivers may contribute to their development of complicated grief and other adverse mental health outcomes.[19]

The goals for this exploratory study were to: (1) better understand widowed fathers' perspectives on how being a parent affected the EOL experiences of their wives with advanced cancer, and (2) identify possible relationships between these EOL experiences and bereaved fathers' depression and bereavement symptoms. By focusing on the mother's concerns and treatment decision-making at the EOL, as reported by the husband, we hope to improve our understanding of how to optimise the EOL care for parents with advanced cancer and their families. We hypothesised that widowed fathers would report high degrees of maternal parental concerns at the EOL. We also hypothesised that widowed fathers' negative perceptions of their wife's EOL experience and absence of hospice care would be associated with higher paternal depression and bereavement scores.

METHODS

Study design and sample

We conducted an online survey of fathers following the death of their children's mother through an open-access educational website for widowed fathers due to cancer (http://www.singlefathersduetocancer.org). This survey was available to all individuals who visited the website and self-identified as a father of one or more biological or adopted children currently under the age of 18 whose mother died from cancer. Most widowed fathers due to cancer are not regularly in contact with cancer care providers and institutions after the death of their loved one, therefore a broad outreach strategy was employed to inform potential participants about the online educational resource. The website and survey were advertised through word-of-mouth among cancer support professionals and through print, television and radio media.[20–22] The educational website contains written and video vignette information about coping with bereavement (for fathers and their children), common experiences related to single fatherhood, and resources for parents and professional providers. Suggested resources included books written by widowed fathers about their experiences, more general information about widowhood, and information about single fathers support groups. Website content was specifically developed for widowed fathers because cancer is the leading cause of widowed father-led families in the USA[23] and due to concerns that widowed fathers may experience worse psychological outcomes than widowed mothers and potentially benefit from targeted interventions such as an online resource and support groups.[24]

Data were collected between October 2012 and December 2014. Owing to the small number of men who were not married to the mother of their children at the time of her death, the analysis was restricted to married men. The analysis was also restricted to men whose wife died within 5 years of completing the survey in order to focus on recently bereaved widows. Informed consent was obtained prior to start of the survey, which was approved by the University of North Carolina (UNC) at Chapel Hill Institutional Review Board.

Survey

Description of participants and details about the development of the survey have been previously reported.[11] Fathers were asked questions regarding their current symptoms of depression (Center for Epidemiologic Studies Depression Scale; CES-D)[25] and bereavement (Texas Revised Inventory of Grief; TRIG);[26] sociodemographic characteristics; psychological adaptation (Psychological Adaptation Scale);[27] and parenting self-efficacy (Kansas Parenting Satisfaction Scale[28] and an investigator-designed, 12-item assessment of widowed parenting self-efficacy). The survey included multiple questions about their wife's cancer history and EOL experience, such as location of death, presence or absence of hospice and prognostic awareness. Additionally, the fathers were asked 13 questions specifically about her psychological and parenting concerns at the EOL. These EOL queries were presented as statements with a four-point ordinal response scale (0='not true at all' to 3='very true'). Phenomena such as 'saying goodbye' and 'feeling strain' at the EOL are often more nuanced experiences than can be captured by a forced true/false choice, and for that reason we used a four-point scale. Investigator-designed questions were developed for this study and were based on the authors' clinical experience and subsequently pilot tested with recently widowed men who had lost a spouse to cancer and were fathers of young children.

All data were collected online using Qualtrics software (Qualtrics, LLC, Provo, Utah, USA).

Data analysis

Descriptive statistics were employed to characterise the sample of widowed fathers and their wives, including frequency distributions, means, ranges and SDs as appropriate. Fisher's exact tests were used to evaluate associations between mother's parenting concerns at EOL and other EOL characteristics (eg, hospice and peace with dying). Separate linear regression models were fit to evaluate the associations between mother's EOL characteristics and father's CES-D and TRIG scores. Only respondents who completed all questions on the CES-D were included in final analyses. Time since wife's death (<6, 6–12, 12–24, >24 months) was included as a covariate in all regression analyses to control for possible differences in father's CES-D and TRIG scores based on time. Given the exploratory nature of this study, no other covariates were included in regression analyses.

Data for this study came from a larger study evaluating bereavement outcomes of widowed fathers based on time since death. Since then, additional respondents have completed the survey but did not significantly differ from the original sample on sociodemographic or maternal illness characteristics or CES-D or TRIG scores.[13] Of 420 survey responders, 76 were excluded from further analyses for the following reasons: 17 reported having no children under 18 at the time of death, 52 completed the survey more than 5 years after the time of death, and 7 since they were not married at the time of death. Unmarried men were excluded from the final sample due to their low numbers and because of prior research suggesting worse bereavement outcomes in spouses than other adult family caregivers.[29]

All analyses were performed using SAS V.9.3 (SAS Institute, Inc, Cary, North Carolina, USA). All p values were derived from two-sided statistical tests.

RESULTS

Respondent and patient characteristics

A total of 344 self-identified married fathers of dependent children at the time of their wives' deaths completed the survey within 5 years of their wives' death. Mean time between death of spouse and survey completion was 1.3 (SD, 1.3) years. Three quarters of the sample (n=261, 77%) completed the survey within 2 years of their wife's death. Mean age of respondents was 46.4 (SD, 7.3) years. Eighty-nine per cent (n=276) were Caucasian and nearly three quarters of the sample (n=238, 74%) had a college degree or higher. Additional sociodemographic details are described elsewhere.[11] Respondents' mean CES-D score (n=291) was 23.9 (SD, 12.5), with 71% (n=206) exceeding the screening threshold criteria (score≥16) for major depressive disorder in community samples.[30] The mean score on the TRIG-A (assessing bereavement symptoms at the time of death of the loved one) was 24.2 (SD 5.8). The mean score for the TRIG-B (assessing current bereavement symptoms) was 46.1 (SD 9.4).

Mothers' characteristics are summarised in table 1. Mother's mean age at time of death was 43.7 (SD, 7.1) years. The most common type of cancer was breast cancer (n=125, 36%). Hospice services were involved for two-thirds of the women (n=231, 67%).

Characteristics of mother's dying experience

According to the fathers, most mothers experienced substantial worry about their family at the end of their lives (figure 1). Over three quarters of the fathers (n=269, 78%) stated that it was 'very' or 'mostly' true that their wives were worried about the strain on him at the EOL. Nearly 90% (n=307) of the respondents stated it was 'very' or 'mostly' true that their wives were worried about the strain on their children. Slightly less than half of the sample reported it was 'very' or 'mostly' true that their wife was 'at peace

Table 1 Mother characteristics

Characteristic	Total sample (N=344) n	Per cent
Age, years, mean (SD)	43.7 (7.1)	
Number of children aged<18 years, mean (SD)	1.9 (0.9)	
Age of youngest child at time of mother's death, years, mean (SD)	8.0 (4.8)	
Time between diagnosis and death, years, mean (SD)	3.1 (3.4)	
Cancer site		
Breast	125	36.4
Gastrointestinal	41	12.0
Gynecological	33	9.6
Lung	21	6.1
Brain	19	5.5
Other	104	30.4
Metastatic disease at diagnosis		
Yes	145	42.5
No	155	45.5
Unknown	41	12.0
Hospice services received		
Yes	231	67.2
No	106	30.8
Unsure	7	2.0
Location of death		
Home	142	41.3
Hospital	137	39.8
Hospice facility	61	17.7
Other	4	1.2
Death at location of choice		
Yes	160	46.5
No	63	18.3
Unknown	10	2.9
Had not expressed a preference	111	32.3

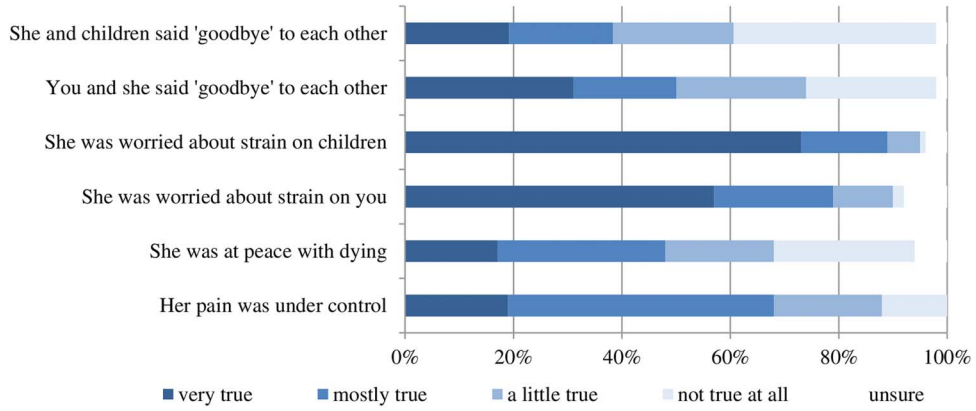

Figure 1 Mothers' EOL characteristics as reported by widowed fathers. EOL, end-of-life; CES-D, Center for Epidemiologic Studies Depression Scale.

with dying' during the final weeks of life (n=165, 48%). Mothers who received hospice services were significantly more likely to be described by their spouses as being at peace with dying (77% vs 62% p=0.006). Widowed fathers who believed their wife's physician was clear with her about her prognosis were also more likely to describe their wives as being at peace with dying (78% vs 57%, p<0.0001) compared to those who were unclear or never discussed her prognosis. In contrast to their wife's psychological distress, fathers mostly described her as physically comfortable at the EOL, with two-thirds of fathers (n=232, 68%) reporting that it was 'very' or 'mostly' true that her pain was under control in the final weeks of life.

Influence of maternal role on decision-making

When asked about the influence of the parental role on their wife's advanced cancer treatment decision-making, nearly a quarter of the sample (n=83, 24%) reported that their wives' decision-making was 'almost totally' impacted by being a mother. An additional 16% (n=56) said it moderately impacted her decisions, and 20% (n=67) reported parental status was a small impact. Of the 206 respondents who said their wives' treatment decisions were influenced by being a mother (either a small amount, moderate amount, or almost totally), 64% (n=132) of them reported that her treatment choices were more aggressive due to being a mother. Only 16 men (8%) believed that their wives opted for less aggressive treatment because of having dependent children. Despite the importance of the parental role in their wife's treatment decision-making, only half of the sample (n=104, 51%) believed that her physician 'completely' understood this. There were no significant associations between a father's report of how maternal status influenced his wife's treatment decision-making and his own depression and bereavement scores.

Preparation for death

Only half of the widowed fathers reported that they and their wives had said goodbye to each other in the final weeks of life (n=171, 50%, figure 1). A smaller percentage (n=132, 39%) believed that their wife and children had said goodbye to each other and over a third (n=127, 37%) of men reported that saying goodbye to the children was 'not true at all' for their wife.

Fathers whose wife received hospice services were more likely to report that they had said goodbye to each other before her death (83% vs 61%, p<0.001). They were also far more likely to report that their wife and children had said goodbye (73% vs 40%, p<0.001). Father's reports of clearer prognostic communication between physicians and wife (how clear do you feel doctors were with her about her prognosis: completely/mostly clear vs not at all/never told) were also associated with having said goodbye to spouse (79% vs 65%, p=0.014) and children (66% vs 50%, p=0.01).

Associations between mother's dying characteristics and father's depression and bereavement

There were no significant relationships between a mother's participation in hospice services or having died at her preferred location with the father's CES-D and TRIG scores. Table 2 demonstrates the univariable analyses between mother's EOL characteristics and father's CES-D and TRIG scores, after controlling for time from mother's death to survey completion. All of the mother's EOL characteristics, except for having said goodbye to her children, were significantly associated with either the father's CES-D or TRIG scores in univariable analyses (see table 2). Multivariable regressions for CES-D, TRIG-A and TRIG-B were also performed but no individual maternal EOL characteristic was predominantly predictive of father's depression and bereavement scores.

In univariable analyses, men who believed it was more true that their wife was 'at peace with dying' reported lower depression and bereavement scores (see figure 2). With each increasing level of agreement regarding peacefulness, fathers' CES-D scores decreased by an average of 1.68 points (p=0.02).

Table 2 Linear regression model results for mother's EOL characteristics and father's CES-D, TRIG-A, and TRIG-B scores*

	CES-D			TRIG-A			TRIG-B		
	Estimate	SE	p Value	Estimate	SE	p Value	Estimate	SE	p Value
Peace with dying	−1.68	0.70	0.02	−0.72	0.37	0.05	−1.72	0.61	<0.001
Worried about strain on you (father)	1.66	0.92	0.07	1.55	0.48	0.002	2.23	0.80	0.006
Worried about strain on children	2.95	1.23	0.02	1.62	0.64	0.01	2.83	1.02	0.006
Said goodbye to each other	−1.20	0.62	0.05	0.22	0.33	*ns*	−0.26	0.53	ns
Children said goodbye	−1.02	0.64	*ns*	0.32	0.35	*ns*	−0.24	0.56	ns

*Each model included the mother's EOL characteristic as the predictor of interest and time from death until survey as an additional covariate, since father's scores are expected to change over time.
CES-D, Center for Epidemiologic Studies Depression Scale; EOL, End-of-life; ns, non-significant; ns, not significant; TRIG-A, Texas Revised Inventory of Grief-A; TRIG-B, Texas Revised Inventory of Grief-B.

Similarly, with each level of agreement about peacefulness, TRIG-B scores also decreased (p<0.001).

Men who reported that their wife's physician was 'completely' or 'mostly' clear with her about prognosis had, on average, a six-point lower score on the CES-D (22.7, SD, 12.3) as compared to those who reported that her physician was 'not very' or 'not at all' clear (28.6, SD, 12.1) (p=0.003) (see figure 3). A relationship was not found for fathers' bereavement scores and reported physician prognostic clarity.

Father's report that it was true that he and his wife said goodbye before her death was associated with a small decrease in his CES-D scores (p=0.05) and his report of maternal worry about their children was associated with both his depression and bereavement scores. For each level of father's report of maternal worry, father's CES-D scores increased 3.0 points (p=0.017), TRIG-A scores increased by 1.6 points (p=0.012), and TRIG-B scores by 2.8 points (p=0.006) (figure 2).

CONCLUSIONS

Parents dying with cancer are an under-examined population despite high levels of distress among these individuals and the far-reaching consequences of early parental loss for bereaved families. These patients have unique concerns at the EOL and their parental status may influence their dying experience in important ways.[3] Additionally, widowed partners must grieve their own loss while simultaneously addressing the bereavement and parenting needs of their children.[10 13 23]

Information from widowed fathers suggests that at the EOL, mothers with cancer experienced substantial worries about their family and low levels of peacefulness. These results indicate that additional clinical programmes and studies are needed to address the unresolved psychological distress of dying parents at the EOL. In addition, according to the surviving fathers, many of the women described in our sample had not said goodbye to their spouses and the majority did not say goodbye to their children. The inability to say goodbye is noteworthy because of the importance that families, patients and healthcare providers

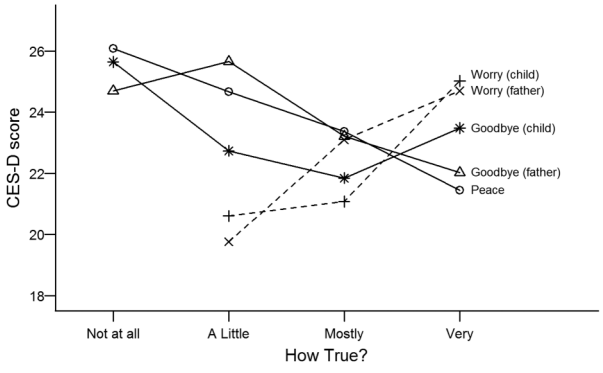

Figure 2 Relationships between mother's EOL characteristics and father's CES-D scores*. EOL, end-of-life; CES-D, Center for Epidemiologic Studies Depression Scale. *The following data points for 'not at all' are not shown due to low n: worry (father) n=8; worry (child) n=1.

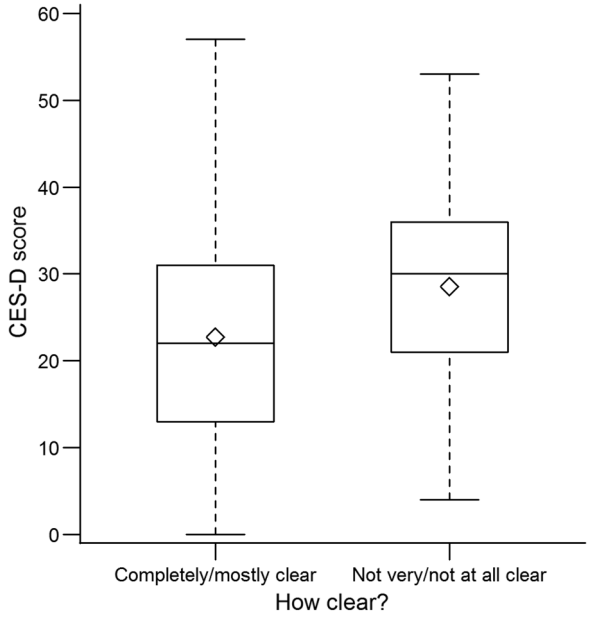

Figure 3 Physician's clarity about death and father's CES-D scores. CES-D, Center for Epidemiologic Studies Depression Scale.

place on life completion as a component of a good death. Research by Steinhauser *et al*[31] has demonstrated that the opportunity to say goodbye to important people is consistently valued among patients and their family members at the EOL.

Although these findings cannot demonstrate causality, they do suggest that worry at the EOL, unresolved tasks associated with life completion, and unclear prognostic communication between ill mothers and their physicians are positively correlated with depression scores of widowed fathers with dependent children. Identifying EOL variables that influence father's depression symptoms are particularly important given the relationship of the surviving parent's well-being and parenting style with their parentally bereaved children's psychological adjustment.[32] Our results are consistent with prior research, which has demonstrated an association between complicated grief among bereaved caregivers and their perception that their loved one did not achieve a sense of completion about his or her life.[19] Similarly, research from the Coping with Cancer study found that the perception of patient suffering is associated with poorer bereaved caregivers' mental health.[33]

A larger percentage of mothers described in this sample received hospice services at the EOL, as compared to the national average of 44.6%.[34] In this study, fathers whose wife received hospice services were more likely to report that their wife was at peace with dying and that she said goodbye to her spouse and children. While this study does not demonstrate causality, these results suggest a positive relationship between receipt of hospice services and improved EOL experiences for mothers with advanced cancer. We did not find an expected relationship between maternal participation in hospice care and lower measures of fathers' depression and bereavement. However, we did not collect data on the duration of hospice use. Very brief hospice utilisation may not be associated with measurable improvements in depression and bereavement scores of surviving spouses with dependent children. A study by Bradley *et al*[35] found higher rates of major depression in surviving caregivers when the ill patient was enrolled in hospice for less than 3 days as compared to caregivers of patients with longer hospice enrollment. Other studies have demonstrated greater caregiver benefit with longer lengths of stay in hospice.[36 37]

Parental status may also influence advanced cancer treatment decision-making. Nearly a quarter of widowed fathers reported that their wife's decisions about treatment were 'almost totally' impacted by being a mother. The influence of parental status on advanced cancer treatment decision-making has been understudied despite the potential impact this may have on cancer and EOL outcomes.[3] This study was not designed to specifically evaluate this issue, but for at least a subset of these parents, parental status was motivation to seek an aggressive course of cancer treatment. Widowed fathers' assessment of mother's advanced cancer treatment preferences were not associated with their own grief or depression outcomes, but future prospective studies of this phenomenon may provide a more nuanced understanding of potential relationships between patient's treatment decision-making for advanced cancer and bereavement outcomes of surviving family members.

Owing to the open-access nature of this web-based survey, we could not confirm whether men who completed the survey met eligibility criteria. A related limitation concerns the representativeness of this sample. Respondents were a group of men with relatively high levels of education and income, were predominantly Caucasian, and married to their children's mother at the time of her death. Further, it is possible that widowed fathers who found the website and took the survey were more likely to be distressed about their wife's EOL experiences than typical widowed spouses or that exposure to informational content about depression and bereavement on the website influenced the fathers' recognition or reporting of depression symptoms. The website itself serves as an intervention for these at-risk fathers and we do not know how interactions with the website may have influenced their reporting of their wife's EOL experiences or their own psychological symptoms. The average CES-D score of our respondents is consistent with 'probable' depression,[38] and it is possible that depressive symptoms may influence their reporting of their wife's dying experience through recall bias. Depression itself is associated with biases in attention and memory and these cognitive processes may lead to increased propensity to recall negative life events.[39] In turn, these cognitive biases may contribute to negative perceptions of their communication with their wife or encounters with her oncologist. It should also be noted that the information learned about mothers' dying experiences was provided by their spouse, which therefore reflects the perception of concerns and experiences of these mothers, rather than direct ascertainment from the dying parents themselves.

Despite these limitations, these findings suggest a need for further exploration of the influence of the parental role on the dying experience of terminally ill patients with cancer. The complex experiences of parents with advanced cancer support the need for qualitative studies providing in-depth analyses of these processes.[7] Further studies that utilise prospective assessment of patients, caregivers and their providers may also help build a framework for how and when parental status impacts treatment decision-making, ability to prepare for death, and EOL concerns. Studies that incorporate other models of data collection, such as face-to-face interviews, are also needed as these may reveal differential responses as well as a more diverse participant population. In addition, as

this study only reported on the experiences of mothers with advanced cancer, future research that incorporates ill fathers and mothers, as well as those with other life-limiting illnesses, would provide greater understanding of these phenomena.

In summary, families affected by the premature death of a parent due to cancer face serious challenges during the period of advanced illness and after death. Widowed fathers' assessments indicate that the EOL experiences of dying mothers with cancer are in need of substantial improvement. Further research is needed on how to optimise the care of these patients and their families.

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BMJ Supportive & Palliative Care

End-of-life experiences of mothers with advanced cancer: perspectives of widowed fathers

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Notes

This is **Exhibit "N"**
to the affidavit of
Cindy Blackstock
sworn before me this 30th
day of June, 2023

Commissioner for Taking Affidavits
(or as may be)
Sarah Clarke LSO # 57377M

BANK OF CANADA
BANQUE DU CANADA

FOR IMMEDIATE RELEASE
September 4, 2019

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Bank of Canada maintains overnight rate target at 1 ¾ percent

OTTAWA – The Bank of Canada today maintained its target for the overnight rate at 1 ¾ percent. The Bank Rate is correspondingly 2 percent and the deposit rate is 1 ½ percent.

As the US-China trade conflict has escalated, world trade has contracted and business investment has weakened. This is weighing more heavily on global economic momentum than the Bank had projected in its July *Monetary Policy Report* (MPR). Meanwhile, growth in the United States has moderated but remains solid, supported by consumer and government spending. Commodity prices have drifted down as concerns about global growth prospects have increased. These concerns, combined with policy responses by some central banks, have pushed bond yields to historic lows and inverted yield curves in a number of economies, including Canada.

In Canada, growth in the second quarter was strong and exceeded the Bank's July expectation, although some of this strength is expected to be temporary. The rebound was driven by stronger energy production and robust export growth, both recovering from very weak performance in the first quarter. Housing activity has regained strength more quickly than expected as resales and housing starts catch up to underlying demand, supported by lower mortgage rates. This could add to already-high household debt levels, although mortgage underwriting rules should help to contain the buildup of vulnerabilities. Wages have picked up further, boosting labour income, yet consumption spending was unexpectedly soft in the quarter. Business investment contracted sharply after a strong first quarter, amid heightened trade uncertainty. Given this composition of growth, the Bank expects economic activity to slow in the second half of the year.

Inflation is at the 2 percent target. CPI inflation in July was stronger than expected, largely because of temporary factors. These include higher prices for air travel, mobile phones, and some food items, which are offsetting the effects of lower gasoline prices. Measures of core inflation all remain around 2 percent.

In sum, Canada's economy is operating close to potential and inflation is on target. However, escalating trade conflicts and related uncertainty are taking a toll on the global and Canadian economies. In this context, the current degree of monetary policy stimulus remains appropriate. As the Bank works to update its projection in light of incoming data, Governing Council will pay particular attention to global developments and their impact on the outlook for Canadian growth and inflation.

Information note:

The next scheduled date for announcing the overnight rate target is October 30, 2019. The next full update of the Bank's outlook for the economy and inflation, including risks to the projection, will be published in the MPR at the same time.