Docket: T1340/7008

CANADIAN HUMAN RIGHTS TRIBUNAL

BETWEEN:

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 and Northern Affairs Canada)

Respondent

-and-

CHIEFS OF ONTARIO and
AMNESTY INTERNATIONAL CANADA

Interested Parties

AFFIDAVIT OF DR. MICHAEL KIRLEW

I, Dr. Michael Kirlew, of the Municipality of Sioux Lookout, in the Province of Ontario, **MAKE OATH AND SAY:**

1. I am a Community and Family Physician for Wapekeka First Nation ("Wapekeka"), a Staff Physician at the Sioux Lookout Meno Ya Win Health Center, as well as an Investigating

Coroner for Ontario's Northwest Region, and as such I have knowledge of the matters to which I herein depose.

I. PURPOSE OF SUPPLEMENTARY AFFIDAVIT

2. This affidavit is intended to bring to the attention of the Tribunal recent tragic events (January 2017) in the Nishnawbe Aski Nation ("NAN") community of Wapekeka, which are sadly reflective of a larger reality concerning the absence of mental health services for Indigenous children in need. Through this affidavit I will speak to my ten years of experience of providing medical care to the residents of Wapekeka and, in particular, I will speak to my experience with the challenges of obtaining much needed mental health services for the residents of Wapekeka, including children in care.

3. What is apparent from the experience in Wapekeka (as set out below) is that even when the Federal Government is presented with concrete credible solutions to support and rescue Indigenous children at risk, the current bureaucracy will not or cannot respond and children are dying as a result.

4. Tragically, in the early days of January 2017, Wapekeka First Nation lost two girls, who died by suicide. On January 8, 2017, Wapekeka lost 12-year old Jolynn Winter. Two days later, on January 10, 2017, Wapekeka lost 12-year old Chantel Fox. Wapekeka is currently in a state of crisis and on high-alert for other youth contemplating suicide.

5. I believe that these deaths were preventable.

II. INTRODUCTION

(A) Medical Training and Background

6. I have lived and practised medicine in northern Ontario for nearly ten years. I obtained my Doctorate of Medicine in 2005 and completed my Family Medicine Residency in 2007 at the University of Ottawa. Currently, I am an Assistant Professor at the Northern Ontario School of Medicine and I am the Director of Education for the Sioux Lookout First Nations Health Authority. Since 2012, I have served as the President of Medical Staff and as a Board Member of the Sioux Lookout Meno Ya Win Health Center. In addition to publishing academic articles on First Nations health issues, I also produce study review podcasts for family medicine residents across Ontario. In 2015, I received the Community Teacher of the Year Award from the Ontario College of Family Physicians. Attached to my affidavit as **Exhibit A** is a copy of my curriculum vitae which outlines my medical training, experience and current positions.

7. As part of my medical practice, I regularly travel to provide medical care to the residents of Wapekeka, staying approximately 3-5 days on a monthly basis. Our physician teams cover emergency services, the maternity ward, and in patient services for 29 First Nation communities within our catchment area. For continuity of care, physicians are assigned to a specific First Nations. I am assigned to Wapekeka. Over the past 10 years, I have developed a strong relationship with Wapekeka and have direct experience with the availability of health services in the community.

(B) Wapekeka Suicide Crisis in January 2017

8. As stated, in the early days of January 2017, Wapekeka lost 12-year old Jolynn Winter and Chantel Fox to suicide.

9. On January 19, 2017, I participated in a press conference in Ottawa to discuss the Wapekeka suicide crisis, alongside: Nishnawbe Aski Nation Grand Chief Alvin Fiddler; Grand Chief Jonathan Solomon of the Mushkegowuk Council; Assembly of First Nations National Chief Perry Bellegarde; Wapekeka Media Relations Liaison, Joshua Frogg; and, Member of Parliament for Timmins- James Bay, Charlie Angus.

10. A public letter from NAN's Grand Chief Alvin Fiddler, dated January 18, 2017, addressed to Prime Minister Trudeau, summarizes NAN's longstanding concerns regarding youth suicide in several NAN communities. This letter also summarizes the numerous community and regionally driven mental health initiatives, two of which specifically concern Wapekeka, which I discuss later in my affidavit. I am attaching a copy of this January 18, 2017 public letter to my affidavit as **Exhibit B**.

11. I believe that the recent suicide crisis in Wapekeka is yet another example of a preventable tragedy resulting in part from the lack of funding and lack of access to mental health services in Wapekeka.

III. WAPEKEKA FIRST NATION

12. Wapekeka is a remote Oji-Cree community located approximately 450 kilometres northeast of Sioux Lookout, Ontario, with an on-reserve population of approximately 350 people. Wapekeka is accessible only by air and seasonal winter road. Wapekeka is a community located within NAN territory.

13. Because this is not the first suicide crisis in Wapekeka, the community has been pro-active in proposing and organizing healing and suicide prevention resources. I am aware of the Survivors of Suicide ("SOS") initiative, which included a suicide prevention model and a

successful annual conference, hosted by Wapekeka. The SOS conference, which ran successfully for 22 years, brought together various communities and experts in the field of mental health. I presented at this conference for several years. In 2014, the funding for this conference was abruptly ended.

14. In July 2016, Wapekeka submitted a mental health proposal to Health Canada ("the July 2016 Proposal"), requesting funding for a mental health team based *within the community*. This mental health team would implement programming for both suicide prevention and intervention, alongside land based and cultural activities. I was not directly involved with crafting this proposal; however, I was aware of this proposal's existence and I hoped the July 2016 proposal would be funded as I believed it would provide critically needed mental health services where it is needed most - *within the community*. I have attached a copy of the Wapekeka's July 2016 Proposal to my affidavit as **Exhibit C**.

15. In the July 2016 Proposal, Wapekeka specifically identifies that the community has struggled with a long-standing history of youth suicide crises going back to a period of time between 1982-1999 when the community experienced 16 suicide deaths. In the same July 2016 Proposal, Wapekeka registered its concern at the loss of funding for the SOS conference, stating:

> From 1982-1999, Wapekeka First Nation experienced 16 tragic deaths as a result of suicides in the community. Through community leadership and outside agency assistance a suicide prevention model, Survivors of Suicide (SOS), was developed. The SOS gathering was hosted in Wapekeka annually and was open to all other First Nations to attend. This gathering had been successful during its 22 years of operation, however, with funding cuts the program has not been offered for the last two years. The leadership in the community is very concerned about this program not continuing in the future as they have already identified many negative experiences since its sudden end. There has been a substantial increase in oxycontin and non-prescription drug abuse in the community. As well there have been many

> suicide attempts by youth in the past year **and it is believed that there is a suicide pact with a group of young females.**[1] [emphasis added]

16. I am aware that this proposal did not receive funding from Health Canada. According to a CBC news article of January 19, 2017, Health Canada acknowledged it had received Wapekeka's July 2016 Proposal but that the proposal came at an "awkward time" in the federal funding cycle. When is it the right time to fund mental health proposals and protect other Indigenous children and families from suffering the same tragedy currently affecting Wapekeka? I am attaching a copy of this January 19, 2017 news article to my affidavit as **Exhibit D**.

17. In summary: we have a community with a *long-standing history* of youth suicide; we have a community that has attempted to proactively address this issue, in particular through the SOS program and most recently, through its July 2016 Proposal to Health Canada; and, we have a community whose specific requests for help and concrete proposals for action have been ignored. Now, in January of 2017, Wapekeka is dealing with the tragedy of having lost two more *children* and crisis teams have descended on the community yet again.

IV. IMPACT OF LACK OF MENTAL HEALTH SERVICES IN WAPEKEKA

18. Over my ten years of practising medicine in both Sioux Lookout and Wapekeka, I have observed that there is a significant difference between the level of mental health services available through the provincial health care system in rural/urban centers and the patchwork of mental health services available to Indigenous people living on reserve. Although I am

[1] See Page 5 of **Exhibit C** of my affidavit: Wapekeka's July 2016 Proposal

under no illusions that the provincial health care system is without its problems, the differences between the two systems, in terms of *access* to mental health care, is significant.

19. This lack of access to mental health care in Wapekeka arises from the following factors: firstly, there is a lack of mental health services available *within the community*; secondly, mental health services that are periodically flown into the community are too infrequent, more often reactive and not responsive to any emergent community need; and, thirdly, community driven proposals are ignored, defunded, or left unfunded, as already discussed above.

20. In a typical urban centre, a child could obtain mental health services through various avenues including via the education system, the health care system, or the child welfare system. In Wapekeka, all three systems mentioned above, suffer from significant gaps in services and inadequate funding, leading to a general lack of access to mental health services.

21. In Wapekeka, there are informal mental health supports (such as family members) and counsellors are flown up to Wapekeka periodically however the *frequency* of these counselling services is wholly inadequate, due to lack of funding for these services. The inadequate frequency of mental health services, however, is not the only problem. Throughout my practice, I have made several requests for *emergency* mental health services which were denied on the basis that a previously scheduled mental health service would be arriving in Wapekeka in a few days to a few weeks from the time of my request. The fact that my request was on an *emergency basis* seemed to have no bearing on the consideration of my requests.

22. There is also a lack of developmental resources in Wapekeka and this lack of developmental resources can lead to and/or compound mental health problems experienced by children and youth. For example, if a young child has a developmental need (such as occupational therapy, speech language therapy, etc.) these services are typically not available in Wapekeka. On exceptionally rare occasions, small organizations may fly up to Wapekeka to provide developmental services; however, these organizations are typically not funded well enough to make regular visits. This means that a child who requires developmental services has to travel outside of the community for both an assessment for the service and to access the actual service itself.

23. Funding for such travel is subject to the approval of Health Canada via the Non-Insured Health Benefits ("NIHB") program. In my medical practice, funding for travel for services that I have *medically assessed as being necessary* are routinely denied by NIHB. In some cases, I have been told that the service is not funded per the transportation policies of NIHB. In some cases, I have been told that without a medical diagnosis or without disclosing further personal medical information (raising significant privacy concerns) that the request would be denied. The individuals assessing travel requests are not medical professionals who are subject to the oversight of a regulating body such as the College of Physicians and Nurses. Rather they are federal bureaucrats who are in effect making decisions with real impacts to a person's medical health.

24. In the remote north, where in-community services are limited to non-existent and where travel to services outside of the community is the only available option, if you **control transportation, you control health care**. In my experience, NIHB routinely denies

transportation funding requests and, in effect, controls the access of people living in Wapekeka to much needed health care services outside of the community.

25. As a result, a child living on-reserve with developmental needs, requiring access to developmental resources (such as occupational therapy, speech language therapy, etc.), is at significant risk for having this need unmet. What happens to a child who cannot keep up at school due to a neglected developmental need? They fall behind. They struggle. They may be teased or bullied and become depressed and other mental health ailments can result. After years of suffering, some of these children commit suicide.

26. I have copies of two internal Health Canada documents, which were obtained via an access to information request. The first document is a memorandum to the Federal Minister of Health, dated February 15, 2016, which advises the Minister of Health about the Tribunal's January 2016 decision. I have attached a copy of this February 15, 2016 Memorandum to my affidavit as **Exhibit E**. This document notes that the Tribunal's January 2016 decision, while directed at INAC, implicates the entire federal government, and in particular Health Canada. The document notes that the Tribunal has found that there is a general lack of coordination and integration of health and social services for First Nation children and families, that there is jurisdictional ambiguity of services, in particular for mental health, and gaps related to services which are not covered under the NIHB program. This memo to the Health Minister states:

> "The CHRT noted that INAC's FNCFS program cannot work in isolation as too many factors affect the overall need for child and family services. While not specifically referencing HC [Health Canada]**, INAC's efforts to reform their program will require improved linkages with health programs and services funded by HC. There may also be requests to provide additional health**

> **services for children in care, such as mental health services, allied health supports, etc.**"[2] [Emphasis Added]

27. The second internal Health Canada document is an undated document titled 'Vulnerability to FNIHB Programming Resulting from January 2016 Canadian Human Rights Tribunal Decision'. This document includes a chart, containing Health Canada's internal assessment of the risk exposure of each type of FNIHB Programming as a result of the Tribunal's January 2016 decision. I have attached this document containing Health Canada's internal risk assessment of FNIHB programming to my affidavit as **Exhibit F**. Notably, under the category of 'health promotion and disease prevention', Health Canada has labeled this a high risk category and itemises the fact that diagnostic services (such as occupational therapists, speech and language pathologists, pediatricians, psychiatrists/psychologist) "are not available and accessible to First Nations to the same degree as children living off-reserve" and that "[o]nce diagnosed, little support to the child/family is available within communities"[3]. Under the sub-category of Mental Wellness, the document states the following:

> There is a shortage of mental wellness services for children in Canada generally with access more limited in remote and isolated communities. With respect to FN children, access is further limited due to higher needs; limited or no federal mental health services for FN children and youth other than services provided through the National Aboriginal Youth Suicide Prevention Strategy; lack of culturally appropriate treatment and counselling approaches that where they exist have limited overall capacity to effectively address intergenerational trauma linked to residential school experiences, and cycles of poverty, violence and addiction.[4]

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[2] Page 2, **Exhibit E** to my affidavit, Memorandum to the Minister of Health, February 15, 2016
[3] Page 1, **Exhibit F** of my affidavit, 'Vulnerabilities to FNIHB Programming resulting from January 2016 Canadian Human Rights Tribunal Decision, undated.
[4] *Ibid* & Page 2 of **Exhibit F** of my affidavit.

28. In the same document (**Exhibit F**) under the category of NIHB, where Health Canada has deemed this service to be at a 'medium risk', the document states:

> For the provision of MT [Medical Transportation] support, the NIHB mandates is that MT benefits (limited to transportation, accommodations and meals) are to access medically necessary services, which, relative to P/T services, means that such services are insured under the P/T health plan. **Travel to attend services that are not P/T insured health services (e.g. therapies such as physiotherapy, speech and language, social services), and paid attendant care are exclusions.**" [Emphasis Added]

29. These two internal Health Canada documents (**Exhibits E and F** to my affidavit) corroborate my observations from my medical practice in Wapekeka and Sioux Lookout. There are significant gaps, particularly in the provision of mental health services and the approval of transportation to obtain developmental services (such as occupational therapy, speech language therapy, etc.). These documents demonstrate that the Government of Canada has been aware of these issues since at least around the time of the Tribunal's January 2016 decision.

30. The mental health problems underlying the suicide crisis affecting so many Indigenous communities do not occur in a vacuum. These crises are the result of many compounding factors, including the legacy of the residential school system, intergenerational trauma, abuse, etc.; however, in my daily medical practice, I can draw a direct correlation between the lack of access to *early* medical interventions leading to compounded mental health problems and youth suicide.

31. I am often unable to obtain the developmental or mental health services my patients need *when they need them*. When these needs are left unaddressed, the problems compound until one of two things occur: (1) a child requires *emergency* care and has to be medevaced out of

the community; or (2) I receive a call on my cellphone to let me know that another child has made the tragic decision to end their life.

32. This recent suicide crisis in Wapekeka is not the first suicide crisis that has occurred and I fear that it will not be the last suicide crises if the status quo remains. Wapekeka has routinely identified what they need to address the high rate of youth suicide. These tragedies are preventable and more *children* do not need to die.

33. I make this affidavit for the purposes of NAN's submissions on immediate relief for the hearing currently scheduled for March 22, 23 and 24, 2017 in the *First Nations Child and Family Caring Society v. Canada*[5] proceedings before the Tribunal and for no other or improper purpose.

AFFIRMED BEFORE ME this)
27th day of January, 2017)
in the Municipality of Sioux Lookout)
in the Province of Ontario.)
)
)
A Commissionner etc.)

Dr. Michael Kirlew

Diana Lynne Moxam, a Commissioner, etc., Province of Ontario, for Kevin W, Romyn Professional Corporation, Barrister and Solicitor. Expires February 6, 2017

[5] *First Nations Child and Family Caring Society v. Canada*, 2016 CHRT 2. File No.: T1340/7008. Decision rendered January 26, 2016.

This is Exhibit ..A..... referred to in the affidavit of ..DR...MICHAEL KIRLEW sworn before me, this ....27..... day of ...JANUARY.....2017.....

.....L.M.Moxam.....
COMMISSIONER FOR TAKING AFFIDAVITS

Diana Lynne Moxam, a Commissioner, etc., Province of Ontario, for Kevin W, Romyn Professional Corporation, Barrister and Solicitor. Expires February 6, 2017

Dr. MICHAEL KIRLEW B.Sc MD CCFP
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E-mail: michaelkirlew@icloud.com
CPSO 82492

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EDUCATION:

2005 - June 2007	University of Ottawa – Family Medicine Residency
2001- 2005	Doctorate of Medicine

ACADEMIC APOINTMENTS

August 2009 – Present	Assistant Professor – Northern Ontario School of Medicine
August 2011 – Present	Director of Education Sioux Lookout First Nations Health Authority
October 2007-Present	Assistant Professor, Department of family medicine, University of Ottawa
October 2008	Block Chair for the Integration unit of the undergraduate medical curriculum, University of Ottawa
July 2008 – July 2010	Director of Education – Family Medicine Inpatient Teaching Service Civic Campus
August 2009 – Present	Lecturer – University of The West Indies

ACADEMIC ACHIEVEMENTS

2005 Received Young Achiever award from the Jamaican Ottawa Community Association
2008 Received Family Medicine Teacher of the Year Award at Ottawa Civic Hospital-Melrose Unit
2009 Family Medicine Teacher of the Year at the Ottawa Civic Hospital – Melrose Unit
2009 Professional Association of Interns and Residents of Ontario (PAIRO) Clinical Teacher of the Year – University of Ottawa
2010 Family Medicine Teacher of the Year Ottawa Civic Hospital – Melrose Unit
2013 Professional Association of Interns and Residents of Ontario (PAIRO) Clinical Teacher of the Year – Northern Ontario Medical School
2015 Community Teacher of the Year - the Ontario College of Family Physicians.

EXTRACURRICULAR ACTIVITIES/VOLUNTEER ACTIVITIES

2012 to Present	President of Medical Staff Sioux Lookout Meno Ya Win health

	Center
2012- Present	Investigating Coroner – Northwest Region
2013- Present	Board Member Firefly Northwest
2012 – Present	Board Member Sioux Lookout Meno Ya Win Health Center

WORK EXPERIENCE

July 2007 –Present	**Community Physician – Wapekeka First Nation** Family Physician – Wapekeka First Nation **Sioux Lookout Meno – Ya Win Health Center** Staff Physician Teaching staff for Medical Students and Medical Residents **Ottawa Civic Hospital** -Staff Physician (Family Medicine) -Teaching staff to Family Medicine residents
July 2005 – June 2007	**University of Ottawa** University of Ottawa Family Medicine department – Residency Program

Publications

Community-wide measures of wellness in a remote First Nations community experiencing opioid dependence: evaluating outpatient buprenorphine-naloxone substitution therapy in the context of a First Nations healing program. Kanate D, Folk D, Cirone S, Gordon J, Kirlew M, Veale T, Bocking N, Rea S, Kelly L. Can Fam Physician. 2015 Feb;61(2):160-5.

Fever in our First Nations. Gordon J, Kirlew M, Saginur R, Bocking N, Kelly L, Kennedy C, Farrell T, Schreiber Y. CMAJ. 2015 Sep 22;187(13):996.

Kirlew M, Rea S, Schroeter A, Makahnouk D, Hamilton M, Brunton N, Muileboom J, Schreiber Y, Saginur R, Kelly L. Invasive CA-MRSA in northwestern Ontario: a 2-year prospective study. Can J Rural Med. 2014 Summer;19(3):99-102.

McCuskee S, Kirlew M, Kelly L, Fewer S, Kovesi T. Bronchiolitis and pneumonia requiring hospitalization in young first nations children in Northern Ontario, Canada. Pediatr Infect Dis J. 2014 Oct;33(10):1023-6.

Muileboom J, Hamilton M, Parent K, Makahnouk D, Kirlew M, Saginur R, Lam F, Kelly L.Community-associated methicillin-resistant Staphylococcus aureus in northwest Ontario: A five-year report of incidence and antibiotic resistance.Can J Infect Dis Med Microbiol. 2013 Summer;24(2):e42-4.

Ponka D Kirlew M Top 10 differential diagnoses in family medicine: Edema
Can Fam Physician, January 2008; 54: 81.

Ponka D Kirlew M Top 10 differential diagnoses in family medicine: Chest pain
Can Fam Physician, December 2007; 53: 2146.

Ponka D Kirlew M Top 10 differential diagnoses in family medicine: Vertigo and dizziness
Can Fam Physician, November 2007; 53: 1959.

Ponka D Kirlew M Top 10 differential diagnoses in family medicine: Headache
Can Fam Physician, October 2007; 53: 1733.

Ponka D Kirlew M Top 10 differential diagnoses in family medicine: Generalized abdominal pain. Can Fam Physician, September 2007; 53: 1509.

Ponka D Kirlew M Top 10 differential diagnoses in family medicine: Dyspnea
Can Fam Physician, August 2007; 53: 1333.

Ponka D Kirlew M Top 10 differential diagnoses in family medicine: Fever
Can Fam Physician, July 2007; 53: 1202.

Ponka D Kirlew M Top 10 differential diagnoses in family medicine: Low back pain
Can Fam Physician, June 2007; 53: 1058.

Ponka D Kirlew M Top 10 differential diagnoses in family medicine: Fatigue
Can Fam Physician, May 2007; 53: 892.

Ponka D Kirlew M Top 10 differential diagnoses in family medicine: Cough
Can Fam Physician, April 2007; 53: 690 - 691.

Office of the Grand Chief
Nishnawbe Aski Nation
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100 Back Street, Unit 200 Thunder Bay, ON P7J 1L2
Tel: (807) 623-8228 Fax: (807) 623-7730

This is Exhibit B referred to in the affidavit of MICHAEL KIRLEW sworn before me, this 27 day of JANUARY 2017

A COMMISSIONER FOR TAKING AFFIDAVITS

Diana Lynne Moxam, a Commissioner, etc., Province of Ontario, for Kevin W. Romyn Professional Corporation, Barristers and Solicitors. Expires February 6, 2017

January 18, 2017

SENT VIA EMAIL

The Right Honourable Justin Trudeau, P.C., M.P., Prime Minister of Canada, Ottawa
House of Commons
Ottawa, ON
K1A 0A6
justin.trudeau@parl.gc.ca

Dear Prime Minister,

Re: Preventable Deaths of Our Youth

On behalf of Nishnawbe Aski Nation, I write to you following the funerals of two twelve-year-old girls who committed suicide earlier this month in Wapekeka First Nation. As community members gather again to grieve together, it is impossible to convey the sense of loss felt by their families, their community and across NAN territory.

In your tenure as Prime Minister (since October 2015) numerous community driven solutions have been proposed that have been shelved or simply met with silence and inaction.

I now write to draw your attention to these solutions and supports that Nishnawbe Aski Nation ("NAN") has proposed to the federal government during your tenure in office. I write not to embarrass you, not simply to make a political point, but to plead for the sake of our youth and, as a matter of life and death, that you immediately act on these solutions.

As is clearly demonstrated by the facts below, there is a great chasm between the political goodwill of your new government and the vestiges of the bureaucratic culture of Indigenous and Northern Affairs Canada (INAC) and the Ministry of Health (MOH). There appears to have been little to no culture change since the Harper regime, as the same bureaucrats remain in the same roles carrying on in the same way.

As you have acknowledged in the House of Commons, these tragedies are a result of our colonial history, and we need to fix a relationship that has broken over the past decade, and indeed over centuries between Canada and Indigenous peoples. We are Treaty partners. But, this partnership changed over time, increasingly defined by choice on one side, and legislative constraints on the other.

First Nations are not sitting on their hands and expecting the federal government to solve the tragedies of their communities. But, we have been legislated into a position where our power is to make proposals and seek program dollars from your bureaucracy. When we are then ignored, our hands are tied and our children continue to needlessly die.

Opportunities Lost/Lives Lost

It has almost been one year since NAN declared a Public Health Emergency (February 24, 2016). During that time, we continued our work to address this crisis, and to keep our children with us. While we worked with what we had, we submitted various NAN proposals and community proposals to your government that have been ignored. Of course, there were many reports and initiatives created prior to your term as Prime Minister, but I set out below various NAN and community proposals, inquest, inquiry, and court orders, ignored by your government during your tenure in office.

Ignoring proposals and terminating successful community led programing is the starkest example of the problems within the INAC and Ministry of Health bureaucracies.

In the last year alone, specific concrete solutions from Wapekeka have been ignored.

Wapekeka Suicide Prevention Strategy Ignored

To remind you, in July 2016, the leadership of Wapekeka First Nation filed a mental health proposal expressly directed at suicide prevention and the increasing risk of loss of their youth.

The proposal states in part that Wapekeka First Nation would like to create a mental health team that would provide the necessary services to reduce the high rate of suicide attempts, to create a healthy well being community environment, and reduce the alcohol and non prescription rate among the youth.

In their detailed submission, Wapekeka sought $376,706 to hire four workers to implement land based activities and deliver prevention and intervention programs. Unfortunately, there has been no uptake. There was acknowledgement by INAC that the proposal was submitted but then it was shelved, and six months later it remains outstanding.

Tragically, this is not the first time for Wapekeka First Nation that their detailed and formal cries for help have been ignored. Survivors of Suicide (SOS), a suicide prevention model and a successful annual gathering which has been held for 22 years, lost its funding in 2014 without explanation and has now not been held for the last two years.

Wapekeka brought this reality to your attention in a tragically prescient manner:

> "The leadership in the community is very concerned about this program not continuing in the future as they have already identified many negative experiences since its sudden end.

> There has been a substantial increase in oxycotin and non-prescription drug abuse in the community. As well there have been many suicide attempts by youth in the past year and it is believed that there is a suicide pact with a group of young females" (see pg. 1, Wapekeka First Nation, Youth Mental Health Program, submitted July 2016).

Health Transformation Submission

An indigenous partnership of NAN, the Federation of Sovereign Indian Nations, and Manitoba Keewaytinowi Okimakamak submitted a detailed health proposal on October 7, 2016 through me as Grand Chief of NAN. I submitted the 33-page plan for Health Transformation to the Minister of INAC and MOH. This strategic plan sets out a detailed road-map and budget for Indigenous-led Health Transformation. As explained in the proposal:

> We have created a strategy to identify, redesign and measure health system processes to address Indigenous health disparities.
>
> The community will lead the new process, the community will align through the new process and will define the problems, solutions and how to implement the strategies. (pg. 4 "Time for an Indigenous Health Revolution: and Indigenous-led, Data-driven, Collaborative Strategy for Health Transformation")

The Health Transformation proposal describes precisely what is contemplated:

> "We are creating three levels of alignment, mapping existing processes, identifying new processes, measurements to track outcomes to change, redesigning process collaboratively among Indigenous and non-Indigenous stakeholders, and creating community capacity for implementation strategies.
>
> The Alignment Process includes the following components:

- establish mandate to determine oversight
- 9 Steps to measure progress
- charting to summarize issues/concerns/solutions and inter-relationships
- validation so stakeholders understand their part of the 'big picture'
- prioritization to quantify "Alignment Gap"
- collaborative teams for advisory support, coordination and implementation
- result measurement to close feedback loops on whether we achieved an outcome" (see pg. six of "Time for an Indigenous Health Revolution: and Indigenous-led, Data-driven, Collaborative Strategy for Health Transformation")

Leading up to the Wapekeka deaths, this proposal suffered the same fate as the other initiatives, silence.

Inquests, Inquiries, Court Orders: Ignored

Further to the solutions that have been proposed by our communities to you and your bureaucracy, there is a failure of INAC to comply with court orders, inquests, and inquiry recommendations. There were significant investments in these processes in the hopes of finding solutions. They all represent opportunities for change, time, and community members that are now lost to us.

The Orders of the Canadian Humans Rights Tribunal from the Caring Society Case

There has been an abject failure of INAC to comply with the Orders of the Canadian Human Rights Tribunal (CHRT). Despite clear findings that the failure to include funding for mental health services discriminates against Indigenous children in need, Canada has yet to create such funding. In particular, the CHRT's January 26, 2016 decision found that INAC was discriminating against First Nations children by not funding the full range of provincial services that are provided for under the *Child and Family Services Act*, R.S.O. 1990, c. C.11 which includes mental health services.

> "INAC is ordered to provide its rationale, data and other relevant information to assist this Panel in understanding INAC's Budget 2016 investments and how they are responsive to the needs of the First Nations children and how it addresses the findings in the Decision, in the short term, especially in terms of mental health services and Band Representatives." (see para. 73, 2016 CHRT 16)

In September 2016, a further decision by the CHRT sought further information from INAC regarding recent funding announcements and how they would address the needs of First Nations children, in particular with regard to mental health services.

In its October 2016 compliance report, INAC failed to identify any immediate actions it is taking with regard to mental health services.

Mushkegowuk Council Releases Findings from "The People's Inquiry into our Suicide Pandemic"

In January 2016, the Mushkegowuk Council called on all levels of government, First Nations, community members, and agencies to implement recommendations identified in the above report. This report followed two years of public hearings and the documentation of personal stories and identifying possible solutions to address the suicide pandemic crippling the region. A response to these recommendations is still pending.

State of Emergency Declaration

Following on the heels of the Mushkegowuk Council's Peoples Inquiry, we declared a state of emergency on February 24, 2016 with immediate actions to be completed within 90 days. Several were directed specifically at needs associated with mental health services.

First Nation Youth Inquest Recommendation

The Coroner's Inquest into the death of Seven First Nation Youth released 145 recommendations on June 28, 2017. The recommendations present a recipe for healthy First Nations Youth. In particular, I would highlight the following, where there have been no action taken.

- **Recommendation 37** was directed at Canada and Ontario, recommending that both levels of government assist NAN First Nation communities in the development of a comprehensive Mental Health program for children, youth and adults. This program should consider the need for integrated mental health services including models which incorporate traditional practices as defined by the individual First Nation.

- **Recommendation 38** was directed at Ontario, recommending that the Provincial government work with the Federal government and First Nations to improve consistency, enhance coordination, and increase resources to support mental health and wellness, including programs on-reserve.

Charter of Relationship Principles

In September 2016 work had already commenced on establishing a Charter of Relationship Principles between Canada, Ontario and NAN. Five months have passed and progress remains pending.

A Culture that is the Problem and Not Part of the Solution

You are in possession of visions for change. We have generated these visions by empowering communities to initiate change at the community level. Each solution presented remains pending or shelved and each is an opportunity where your government has failed.

NAN has experienced first hand the ongoing resistance to change exhibited by ministry personnel at both INAC and the Ministry of Health. Accepting that you and your ministers have truly issued directions for change, these directions are not being followed at the bureaucratic level.

The experience of NAN and the other parties in the Human Rights Caring Society Tribunal proceedings in which there has been a blatant disregard for Tribunal findings and orders is the starkest example of this resistant culture.

Political leadership must be accountable for the performance of its ministries and so I write to you and your political colleagues and urge you to implement real and impactful change in your respective bureaucracies.

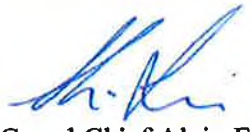
In the short term, we ask that you immediately provide Wapekeka First Nation funding for their mental health team proposal in 2017 dollars. We also ask that you reinstate funding for the

Wapekeka Survivors of Suicide initiative. These two actions would show the good faith of your government to move forward with us to substantively address and take action on the other efforts outlined above.

I look also look forward to immediate action on those broader systemic remedies that have been presented.

Quite simply, Canada has run out of excuses for these tragedies. As the 150th anniversary ceremonies approach for Canada, it is difficult to envisage honouring this milestone while our children continue to needlessly perish.

Sincerely,
NISHNAWBE ASKI NATION



Grand Chief Alvin Fiddler

cc. NAN Chiefs
NAN Executive
National Chief Perry Bellegarde
Regional Chief Isadore Day
Cindy Blackstock
Hon. Carolyn Bennett, Minister of Indigenous and Northern Affairs Canada
Hon. Jane Philpott, Minister of Health
Adam Vaughan, MP, Parliamentary Secretary to the PM

Wapekeka First Nation
P.O. Box 2
WAPEKEKA, ONTARIO
P0V 1B0
Phone 537-2315 or 537-2382
Fax 537-2336

This is Exhibit ...S..... referred to in the affidavit of ...D.B...M.I.C.H.A.E.L...K.I.R.L.E.W sworn before me, this ...27..... day of ...J.A.N.U.A.R.Y.....2017..

.....
A COMMISSIONER FOR TAKING AFFIDAVITS
Diana Lynne Moxam, a Commissioner, etc., Province of Ontario, for Kevin W, Romyn Professional Corporation, Barrister and Solicitor. Expires February 6, 2017

July 18, 2016

Tracey Clarke
Health Canada
tracey.clark@canada.ca

Dear Tracey,

Re: Youth Mental Health Submission

Please see our application, enclosed, for your review and acceptance. We are in direct need of addressing some mental health needs and supports. We have had some dire experiences with youth suicides in the past and we are hoping to establish support systems in place to help out our young people in their mental health struggles.

I thank you kindly for your understanding.

Sincerely,

Chief Brennan Sainnawap

Cc Wapekeka First Nation Council

Wapekeka First Nation

Youth Mental Health Program

Submitted to: Health Canada

2016

WAPEKEKA FIRST NATION

YOUTH MENTAL HEALTH PROGRAM

SUBMITTED TO: HEALTH CANADA

JULY 2016

Objective

To create a mental health team in the community of Wapekeka that will implement programming and counselling sessions to prevent suicides among the youth and to promote mental, emotional and behavioural well-being in the community .This team would also assist in the prevention of underage drinking, non-medical use of prescription pain reliever drugs by youth and to work on reducing the occurrence of mental, emotional and behavioural disorders among youth.

Rationale

From 1982-1999, Wapekeka First Nation experienced 16 tragic deaths as a result of suicides in the community. Through community leadership and outside agency assistance a suicide prevention model, Survivors of Suicide (SOS), was developed. The SOS gathering was hosted in Wapekeka annually and was open to all other First Nations to attend. This gathering had been successful during its 22 years of operation, however, with funding cuts the program has not been offered for the last two years. The leadership in the community is very concerned about this program not continuing in the future as they have already identified many negative experiences since its sudden end. There has been a substantial increase in oxycotin and non-prescription drug abuse in the community. As well there have been many suicide attempts by youth in the past year and it is believed that there is a suicide pact with a group of young females.

The population of Wapekeka First Nation is approximately 500 members living on reserve with half of the population being youth. There are limited activities for the youth and there is no youth mental health worker that is available on a consistent basis.

Increasing evidence indicates that:

- promotion of positive aspects of mental health is an important approach to reducing disorders and related problems.
- Early alcohol use is an important risk factor for many chronic diseases, involvement in violent behaviors, suicide attempts among youth, and other emotional/behavioral problems, including bulimia, borderline personality disorder, obsessive-compulsive disorder and anxiety disorders.
- Mental, emotional and behavioral disorders are developmental and their severity is likely to worsen without treatment
- Every suicide is preventable. Suicide and suicide attempts are associated with depression. Youth with suicidal risk behaviors and substance abuse disorders are more likely to have experienced trauma, an event more overwhelming than a person ordinarily would be expected to encounter, such as sexual abuse, or witnessing a murder

Wapekeka First Nation would like to create a mental health team that would provide the necessary services to reduce the high rate of suicide attempts, to create a healthy well being community environment. reduce the alcohol and non prescription rate among the youth.

The workers would be supervised by the health director and their duties would include the implementation of land based activities as well as delivering prevention and intervention programs that embraced a holistic approach. Counselling and case management of files would be completed with a wrap around approach to include family and extended family members in the development of individual treatment plans.

Work Plan

Activity	Description
Design job description And advertise job postings	Create a job description to be advertised in online and in other suitable mediums such as Wawatay News and on community radio stations. Job description will provide an extensive outline of expectations, as well as skills and training that are required or preferred.
Fill job postings	Review applicants and hold interviews
Train workers	After workers are hired, a two day strategic training session will be held to introduce the workers and establish their workplans
Create awareness	When workers have been selected and have begun in their roles it will be necessary to alert and inform local residents of the services offered. Workers will be required to host a community forum plus utilize local media services such as radio to introduce themselves to the community and talk about the services offered. In addition, many communities have local radio stations that can be utilized.

Annual Budget

Item	Description	Cost
Salaries	4 workers @ $52,500	$210,000
Benefits	4 workers @ $13,125	$52,500
Rent	4 workers @ 250.00 per month x 12 mths	$12,000
Training	4 workers @ $2500 per year	$10,000
Materials	Office and program supplies	$15,000
Travel	Gas to conduct home visits	$19,200
Computers	Start up computers/desks/phones/filing cabinet	$18,000
Networking	4 workers @120.00 per mth x 12mths	$5760
Subtotal		$342,460
Administration	@ 10% of subtotal	$34,246
Total		$376,706

CBC
CBCnews
Thunder Bay

Wapekeka First Nation asked for suicide-prevention funds months before deaths of 2 girls

Health Canada says request came at 'awkward time' in the budget cycle, when funds were already allocated

By Jody Porter, John Paul Tasker, CBC News Posted: Jan 19, 2017 5:00 AM ET Last Updated: Jan 19, 2017 3:50 PM ET

Jolynn Winter, 12, left, and Chantel Fox, 12, centre, from the community of Wapapeka First Nation in Ontario, died by suicide this month. Chantel is survived by her twin sister, Chanel, pictured far right. (Supplied by the Winter and Fox families)

First Nations leaders in northern Ontario say the federal government ignored their pleas to help a group of suicidal children last summer and is only now stepping forward with funding, days after two pre-teens died by suicide.

The girls, both 12, died within days of each other earlier this month in Wapekeka First Nation, a small community of about 400 residents located approximately 450 kilometres north of Sioux Lookout, Ont.

Jolynn Winter died on Jan. 8, while Chantel Fox died two days later. Four other children were flown out of the community for medical treatment "lest they be next in this suicide pact that was identified by the community several months ago," said a statement released from Wapekeka.

Another 26 children were "triggered by these deaths and are at high risk for suicide," the statement said.

"We had identified that several children were secretly planning suicide several months ago and we immediately applied for health funding to work with the children in preventing any suicides from happening," Wapekeka spokesperson Joshua Frogg said.

Joshua Frogg on the suicide of his niece

'Awkward' time for funding

Health Canada said it received a funding proposal from Wapekeka First Nation in September, though the proposal was dated for July 18.

That's an "awkward time" in the federal funding cycle when all the available money has already been allocated, said Keith Conn, the regional executive for Ontario with the First Nation and Inuit Health Branch of Health Canada.

The community had requested $376,706 to hire and train four mental health workers to help establish counseling sessions for young people on the remote fly-in reserve.

"We just didn't have the funding to support the program," he told CBC News. "We don't have necessarily a flexible fund that we hold back for different projects."

The proposal specifically mentioned the threat of suicide and aimed to connect a group of high risk youth and their families with cultural activities on the land.

"The question our community is asking today: When is it the right time for this government to act and support our communities, especially for our youth and our children?" Nishnawbe Aski Nation Grand Chief Alvin Fiddler told reporters Thursday.

Kids from Wapekeka First Nation are shown in a music video they made and posted on YouTube earlier this month. (YouTube)

NDP MP Charlie Angus balked at the department's suggestion that the timing was awkward.

"An awkward time for who? Too damn bad. It has to be said if these were white kids in a provincial school system or a provincial health system … people would be fired. But when it comes to the federal government, [Indigenous Affairs] and Health Canada, it's just another day at the office," Angus said.

Conn said Health Canada kept Wapekeka's proposal on an "active" list and is now able to fund it through "slippage" — money that has gone unspent in the annual budget.There's also been an emergency response and related support from Health Canada since Winter and Fox died.

"It's really sad that young people — in this case two young girls — had to die before Health Canada got around to approving any proposals from that community," Fiddler said.

Wapekeka, in northern Ontario, is home to about 400 residents. (YouTube)

Prime Minister Justin Trudeau pledged an additional $69 million over three years for First Nations mental wellness programs **at the height of the Attawapiskat suicide crisis last summer**. That brings total federal spending to roughly $300 million a year, which is enough to fund 43 mental wellness teams to fan out across the country and minister to those in need.

"Is that enough? Obviously not enough if it's still continuing," AFN National Chief Perry Bellegarde said. "It's a system that's flawed, and it's sucking the hope out of these children."

The leaders present at the news conference in Ottawa on Thursday were unanimous in their calls for a national suicide strategy, and said that while Jane Philpott, Canada's health minister, seems personally concerned with the issue, she is overseeing an incompetent bureaucracy.

"She's got good intentions, but she has people who are dragging everything. Governments announce initiatives but it takes months and months to get started and it's because of the bureaucracy."

Philpott said she is focused on long-term solutions for First Nations communities like Wapekeka.

"This is not the only community that is struggling, and we are continuing to provide resources. We are dealing with a legacy of generations of trauma, of people feeling disconnected from their culture. We also need to address those deep-seeded realities of why people have lost hope."

'Burnt out'

Nishnawbe Aski Nation represents 49 First Nations in northern Ontario, including Wapekeka. Its own statistics show there were more than 500 suicides in those communities between 1986 and 2016, with more than 70 of deaths involving children aged 10 to 14.

For several years, Wapekeka was a shining example of suicide prevention in the region, Fiddler said, developing its own "Survivors of Suicide" program to respond to a crisis in the 1990s and hosting an annual conference.

That started to change as federal funding for the program was cut two years ago, he said Wapekeka has gone through some "tragic experiences and they've learned lessons the hard way," said Fiddler.

"They've been able to formulate strategies based on experience and that's something governments need to support."

Conn said a planning exercise is currently underway at Health Canada examining what "continuum of care" is needed to prevent suicides among Indigenous youth and how can it be sustainable.

Wapekeka's proposal to Health Canada to fund a suicide-prevention program came at the wrong time in the budget cycle, says Keith Conn, of the department's First Nation and Inuit Health branch. (Jody Porter/CBC)

"We've had process after process, study after study, but to no avail," Mushkegowuk Council Grand Chief Jonathan Solomon said Thursday.

"Our front line workers are burnt out; our communities are tired. Yes, the government may announce initiatives but sadly they are just dragging their feet while we continue to bury our loved ones. Certainly, actions would be louder than words."

This is Exhibit ....F..... referred to in the
affidavit of A.B. MICHAEL KIRLEW
sworn before me, this ....27.....
day of ....January.....2017.

.....
A COMMISSIONER FOR TAKING AFFIDAVITS

Diana Lynne Moxam, a Commissioner, etc., Province of Ontario, for Kevin W. Romyn Professional Corporation, Barrister and Solicitor. Expires February 6, 2017

SECRET
FOR INFORMATION

16-101899-679

MEMORANDUM TO THE MINISTER OF HEALTH

Impacts of the Canadian Human Rights Tribunal's Decision on Health Canada (Assembly of First Nations / First Nations Child and Family Caring Society Human Rights Complaint)

SUMMARY

- The January 26, 2016 decision of the Canadian Human Rights Tribunal (CHRT) raises a number of issues with respect to services available to First Nation children living on reserve versus those living off reserve.
- While directed at Indigenous and Northern Affairs Canada's (INAC) First Nations Child and Family Services (FNCFS) program, the decision more broadly impacts all Government of Canada (GoC) programs and services serving that client group, including Health Canada (HC). It also notes a lack of coordination or 'silos' between federal departments, an overly narrow and restrictive definition of Jordan's Principle, and inadequate funding as key to its findings against the GoC.
- The Tribunal has already ordered INAC to cease its discriminatory practices and reform the funding approach for the Child and Family Services Program and is expecting to see an outline and timeline regarding implementation of Jordan's Principle.
- On February 16, 2016 INAC will receive formal correspondence from the complainants to address the requests for immediate relief for FNCFC reform, 1965 Agreement reform, and increased funding.
- HC will support INAC in its response to the Tribunal, which must be completed by February 25, 2016.
- [redacted]
- Departmental officials are working in collaboration with INAC to determine a way forward that would better respond to the health needs of First Nations children and the CHRT's direction, including revising the Jordan's Principle definition, identifying parameters where the definition would be applied and developing a list of vulnerable programming.

s.69(1)(g) re (a)

BACKGROUND:

While not a party to the CHRT's decision, HC is directly implicated as the decision is directed to the GoC broadly. The Tribunal's findings include:

- a general lack of coordination and integration of health and social services on reserve, leading to gaps in service delivery to First Nation children and families;
- jurisdictional ambiguity of services (such as for mental health) for children in care of FNCFS agencies, leading to service gaps; underfunding of programs, contributing to inequitable social/health services;
- a narrow interpretation of Jordan's Principle, resulting in no cases meeting the criteria set by INAC and HC, and therefore service gaps, delays and denials for First Nations children; and,
- issues related to the application of funding authorities between INAC and HC – specifically where a gap exists in HC's authorities or funding levels (i.e. items which are not benefits under the Non-Insured Health Benefits (NIHB) Program, such as physiotherapy or other excluded medical supplies and equipment).

The CHRT noted that INAC's FNCFS program cannot work in isolation as too many factors affect the overall need for child and family services. While not specifically referencing HC, INAC's efforts to reform their program will require improved linkages with health programs and services funded by HC. There may also be requests to provide additional health services for children in care, such as mental health services, allied health supports, etc.

s.23

CURRENT STATUS:

[redacted]

On February 5, 2016 the GoC received the CHRT's directions (Appendix A) outlining a three step process the parties are to follow to provide further information and action plans to the Tribunal in regards to the remedies and compensation.

Step 1 - The complainants/interested parties have until February 18, 2016 to make their submission. INAC will then have until February 25, 2916 (seven days) to respond. Subsequently, the complainants will then have three days to reply.

Step 2: The Tribunal will then deal with requests for mid-long term relief such as redesign of child welfare, training and on-going monitoring.

Step 3: The Tribunal will then determine requests for compensation for the victims of discrimination under section 53(2)(e) for pain and suffering.

.../3

In advance of receiving the initial complainant's submission on February 18, 2016, Minister Bennett is preparing correspondence to the CHRT and the complainants indicating that Canada will not seek Judicial Review of the decision, and will engage with stakeholders and partners to determine the most effective path forward. It is hoped that this correspondence will elicit good will on the part of the complainants and other parties to work collaboratively on reforms.

On February 10, INAC received the Tribunal's instructions (Appendix B) to the complainants. The complainants are asked to provide input on a number of issues, including; budgetary changes to FNCFS to ultimately achieve substantive equality in the delivery of culturally appropriate FNCFS to First Nations; how to engage with First Nations' communities at tripartite tables on adequate and culturally appropriate FNCFS; how the requested transition fits into the requests for mid and long term reforms; and an outline and timeline on how to implement the full scope and meaning of Jordan's Principle.

INAC and HC staff are now addressing the themes raised in the Tribunal's letter to the complainants by developing new draft Jordan's Principle definitions, identifying reforms that may be required to programming affected by the decision, and designing a wide-ranging engagement process. It is anticipated that this work will form a part of the submission to the Tribunal on February 25, 2016. The expectations from the complainants about Jordan's Principle include: broadening the definition, setting up a dedicated fund and establishing an appeal process.

HC and INAC will have to amend their *Memorandum of Understanding on the Federal Response to Jordan's Principle*, to reflect revised criteria and updated departmental roles and responsibilities. It is anticipated that the revised MOU should be signed by February 18, 2016.

CONSIDERATIONS:

While not all aspects of the decision apply to HC, it will be imperative to work closely with INAC throughout the process.

It is likely that fully implementing the CHRT's decision, including expanding Jordan's Principle will require significant additional funding, and INAC will also be in the same position.

There are currently two distinct human rights complaints before the Canadian Human Rights Commission challenging HC programs and funding under its Home and

s.23

Community Care and NIHB programs (i.e. Pruden and Taylor Complaints) [redacted]

[redacted]

.../4

There is a risk that the high profile nature of the CHRT's decision and media sensitivity toward Jordan's Principle issues will lead to higher expectations in relation to NIHB coverage and other health services.

NEXT STEPS:

HC is supporting INAC in developing its submissions to the Tribunal, while undertaking a thorough analysis of potential vulnerabilities in programs areas. This includes developing a fulsome response to the Tribunal once the questions from the complainants are received on February 18, 2016.

[redacted]

s.69(1)(g) re (a)

Deputy Minister

MECS# 16-101899-679

Branch Head: Sony Perron, Senior Assistant Deputy Minister, FNIHB, Health Canada
Telephone: 613-957-7701

Attachments:

Appendix A- CHRT's direction letter
Appendix B- Tribunal instruction letter

Document created on: February 15, 2016

Vulnerabilities to FNIHB Programming resulting from January 2016 Canadian Human Rights Tribunal Decision

Programs without annual escalators, that are not universal and that face health human resource challenges are at greatest risk

Program	Risk Level	Annual Escalator	Description
Primary Care	High	Clinical and Client Care: Yes Home and Community Care: No	**Clinical and Client Care** • Limited access to health professionals, due to recruitment and retention issues • Lack of diagnostic equipment, including point of care testing in many communities • Poor state of infrastructure in nursing stations and health centres • Inability for FNIHB/First Nation nurses and other staff to access provincial electronic medical records, usually due to a complex privacy regime, can result in poor communication between service providers. **Home and Community Care** • Care not provided outside of regular business hours or on weekends • HCC does not provide palliative care or rehabilitation therapies • Targeted towards seniors, respite services not always available to children/adults with special needs
Health Promotion and Disease Prevention	High* *Some prevention programs are low risk	Less than half of programming receives growth	**Maternal and Child Health (MCH)** • MCH program is not universal • MCH screening services for expectant mothers/children, key for early identification of issues such as mental health, disabilities, special needs, are insufficient • Diagnostic services such as access to specialized and multi-disciplinary supports (occupational therapists, speech and language pathologists, pediatricians, psychiatrists/psychologists) are not available and accessible to First Nations to the same degree as children living off-reserve. • Once diagnosed, little support to the child/family is available within communities. **Mental Wellness** • There is a shortage of mental wellness services for children in Canada generally with access more limited in remote and isolated communities. With respect to FN children, access is further limited due to higher needs; limited or no federal mental health services for FN children and youth other than services provided through the National Aboriginal Youth Suicide Prevention Strategy; lack of culturally appropriate treatment and counselling approaches that where they exist have limited overall capacity to effectively address intergenerational trauma linked to residential school

This is Exhibit ..F..... referred to in the affidavit of ...D.R. MICHAEL KIRLEW sworn before me, this ...27..... day of ...January.....2017

.....
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Diana Lynne Moxam, a Commissioner, etc., Province of Ontario, for Kevin W, Romyn Professional Corporation, Barrister and Solicitor. Expires February 6, 2017

			experiences, and cycles of poverty, violence and addiction. • Other gaps include psychological testing for Fetal Alcohol Syndrome/Effects and special needs, limited specialised services (social worker, psychologist, psychiatrists and peer support workers). **Addictions Treatment** • Demand for treatment exceeds supply • Health human resource limitations • Re-integration into communities following treatment is a gap and has implications for youth leaving treatment as well as youth transitioning out of child welfare.
Healthy Child Development	Medium	No	**Aboriginal Head Start on Reserve (AHSOR)** • AHSOR is only serving 17% of eligible First Nations children living on reserve. **Children's Oral Health Initiative (COHI)** • Not universal, with insufficient dental therapists to serve every community • Dental therapists are no longer being trained (health human resource limitation) • Dental health is poor amongst FN children compared to the general population
Infrastructure	Medium	Very minimal growth	• The lack of funding for the maintenance and the construction of new infrastructure in First Nation communities across Canada has resulted in serious deficiencies. There are many buildings in poor shape, resulting in limitations to services.
NIHB	Medium	Yes	• Gaps may be seen to exist in the eligibility of clients for some medical supplies and equipment (MS&E) and Medical Transportation (MT) benefits. • Some clients may require certain MS&E items listed as exclusions, which means that such an item is explicitly not available via the NIHB Program to any client (e.g. hospital beds and mattresses, ceiling lifts, other equipment installed in a home, home modifications, or audio FM systems for use at school). • For the provision of MT support, the NIHB mandate is that MT benefits (limited to transportation, accommodations and meals) are to access medically necessary services, which, relative to P/T services, means that such services are insured under the P/T health plan. Travel to attend services that are not P/T insured health services (e.g. therapies such as physiotherapy, speech and language, social services), and paid attendant care are exclusions.

Environmental Health	Medium	Partial growth	• Underfunding has limited the work of Environmental Public Health Officers. They have reduced their on-the-ground work in communities, such as conducting less water quality testing.