Nikan Kakike Awasisak

Children Always First

Implementing Jordan's Principle in the Kee Tas Kee Now Member Nations

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University of Colorado Boulder

CENTER FOR RESEARCH ON CHILDREN AND FAMILIES

CENTER DE RECHERCHE SUR L'ENFANCE ET LA FAMILLE

Nikan Kakike Awasisak (Children Always First):
Implementing Jordan's Principle in the Kee Tas Kee Now Member Nations

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Contents





Acronyms and Abbreviations

AFN ---------- Assembly of First Nations

AoTC ---------- Assembly of Treaty Chiefs

CFI ---------- Child First Initiative

CFS ---------- Child and Family Services

CHRT ---------- Canadian Human Rights Tribunal

ESC model ---------- Enhanced Service Coordination model of care

FASD ---------- Fetal Alcohol Spectrum Disorders

FNHC ---------- First Nations Health Consortium

FNIHB ---------- First Nations and Inuit Health Branch

HCoM ---------- Health Co-Management

KTC ---------- Kee Tas Kee Now Tribal Council

KTC CFS ---------- Kee Tas Kee Now Child and Family Services

KTC Health ---------- Kee Tas Kee Now Health Administration

KTCEA ---------- Kee Tas Kee Now Education Authority

OT ---------- Occupational Therapist

PT ---------- Physiotherapist

SARF ---------- Service Access Resolution Fund

SLP ---------- Speech and Language Pathologist

TA ---------- Therapy Assistant

Acknowledgements

This report is dedicated to the individuals, families and organizations working to meet the needs of children within the KTC member Nations. More broadly, it is written in honour of all those working to realize systemic changes to a discriminatory framework of public services, in order to meet the needs of First Nations children.

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Executive Summary





Kee Tas Kee Now Tribal Council Health Administration (KTC Health) supports the development and delivery of health services to the five member Nations of Kee Tas Kee Now Tribal Council: Lubicon Lake Band, Woodland Cree First Nation, Whitefish Lake First Nation #459, Peerless Trout First Nation and Loon River First Nation. All five Nations are located in Treaty 8 territory, in northern Alberta. KTC Health supports capacity building that is focused on health services in the five Nations. It also seeks to leverage economies of scale in order to seize emerging opportunities that directly benefit KTC member Nations.

Since 2018, KTC Health has focused significant effort on the development of a Children's Resources team, which provides allied health, mental health and wellness, early education and disability-related services to children and families in KTC member Nations. Work on establishing a Children's Resources team began when KTC Health realized the potential to access funding through the Jordan's Principle Child First Initiative (CFI). The CFI was the federal government's short-term response to Jordan's Principle—a child-first principle that aims to ensure First Nations children receive equitable health, education and social services. Under terms established by the Canadian Human Rights Tribunal (CHRT), services funded by Jordan's Principle must also meet children's needs and protect their best interests without compounding historic disadvantage (see Textbox 1). The creation of the Jordan's Principle CFI, which initially consisted of a $382.5 million budgetary allocation lasting from 2016–19, was announced by the federal government in July of 2016.[1, 2, 3, 4, 5]

The allocated funding included support for services to meet the needs of individual First Nations children, as well as funding for "group requests," which provide necessary services to groups of children. However, the process and parameters for making Jordan's Principle requests were inconsistent and unclear. By 2018, with the original CFI funding nearing an end, KTC Health submitted a group request for initial funding for the Children's Resources team. The request was approved, and KTC Health was granted one year of funding. Canada's 2019 budget included three years of extended funding for the Jordan's Principle CFI, and, as a result, KTC Health has been able to renew and expand funding for the Children's Resources team.[6]

Textbox 1 What is Jordan's Principle?

Jordan's Principle is a legal principle designed to ensure that First Nations children have access to equitable public health, education and social services. It is named in honour of Jordan River Anderson, a First Nations child from Norway House Cree Nation, in Manitoba. Jordan was born with a rare neuromuscular disease. His complex medical needs could not be treated on-reserve, and he was transferred to a hospital that was far from his Nation. In 2001, a hospital-based team decided that Jordan's needs would be best met in a specialized foster home. However, federal and provincial governments argued over financial responsibility for Jordan's in-home services. Federal and provincial officials disagreed over the funding of foster care and also over-payment for smaller items such as a showerhead. During these conflicts, Jordan remained in hospital, even though it was not medically necessary. Jordan died in 2005, at the age of five, never having lived in a family home.[7]

Named in honour of Jordan River Anderson, Jordan's Principle was initially articulated as a child-first initiative intended to ensure that First Nations children have timely access to the same services as other children in Canada. Although this vision of Jordan's Principle was unanimously endorsed by the House of Commons in 2007, the federal government adopted a very narrow interpretation of Jordan's Principle. As a result, no Jordan's Principle cases were officially identified between 2007 and 2016.[8] The federal approach to Jordan's Principle radically shifted in 2016 in response to a series of rulings in a decade-long legal Canadian Human Rights Tribunal (CHRT) battle over discrimination in child welfare services. The CHRT ruled that the inequitable funding and administration of on-reserve child welfare services constituted discrimination against First Nations children.[9]

As one of the remedies in this case, the CHRT ordered the federal government "to immediately implement [Jordan Principle's] full meaning and scope."[10] In a series of subsequent rulings, the CHRT clarified that Jordan's Principle applies to *all* First Nations children, living on or off-reserve, and instituted strict timelines for response in Jordan's Principle cases. The CHRT also ruled that the funding of services through Jordan's Principle must reflect consideration of "the distinct needs and circumstances of First Nations children and families [. . .] including their cultural, historical and geographical needs and circumstances—in order to ensure equality."[11] Accordingly, Jordan's Principle may fund services that exceed those provided under normative provincial standards in order to meet the needs and best interests of a First Nations child.

For more information on Jordan's Principle see:
https://www.canada.ca/en/indigenous-services-canada/services/jordans-principle.html

This report presents the results of a formative evaluation of KTC Health's Children's Resources team. The report describes the development and implementation of the Children's Resources team within historical, organizational and interorganizational contexts that have been shaped by both the strength and resilience of KTC member Nations and the ongoing impacts of settler colonialism. The report also identifies successes and challenges faced by the Children's Resources team during the first years of its operation.

Research collaboration

KTC Health partnered with Dr. Vandna Sinha, a researcher at the University of Colorado, Boulder, to document the development and implementation of the Children's Resources team. The evaluation was grounded in a participatory, mixed-methods approach. Data collection spanned from March of 2019 until January of 2021. The data analyzed for the report included:

- KTC Health and Jordan's Principle documents including, but not limited to, Children's Resources team funding proposals, communications between KTC Health and the First Nations and Inuit Health Branch (FNIHB) Alberta region, and Jordan's Principle policy information;
- 38 interviews conducted with Children's Resources team and additional service providers in the KTC member Nations; and
- Participant observation during Children's Resources team meetings and events.

At the core of the participatory approach to this evaluation were regular, bi-weekly meetings between the research team and the Children's Resources Child First Manager, who oversees the administration and development of the Children's Resources team. These meetings served as a forum for sharing updates on developments around Jordan's Principle, the Children's Resources team and KTC member Nations. The meetings also provided a space for information verification and discussion of emerging themes and challenges. The evaluation was also informed by an Advisory Committee, which was composed of key staff from KTC Health, the Children's Resources team, representatives from KTC Child and Family Services (CFS) and a Director of Education from one of the KTC member Nations. Regular meetings with the Advisory Committee served as a forum for sharing and discussing data collection and emerging narratives, and for soliciting valuable input on the best way to approach and adjust the study in the midst of the COVID-19 pandemic.

Summary of findings

Chapter 1 — Miyo-wîcêhtowin (Living in Harmony): KTC member Nations and services in a colonial context

KTC Health is one of three organizations that support the delivery of health, education and child welfare services in the five, semi-remote Nations that are members of the Kee Tas Kee Now Tribal Council. These Nations have long worked to ensure their rights to self-determination and to ensure the well-being of their people. Successes in recent years include the resolution of long-standing land claims, advocating for and implementing policies that embody a respectful relationship to the land, partnerships that support education within KTC member Nations and the development of needed infrastructure. Recent successes also include the implementation of programs and practices that support and celebrate traditional language and culture.[12, 13, 14, 15, 16, 17, 18, 19] Such achievements demonstrate the strength and commitment of the Nations to meeting the holistic needs of their members.

However, efforts to meet the needs of children and families within the KTC member Nations have also been shaped by settler colonial policies that disrupted holistic, traditional systems of care and imposed the fragmented and discriminatory framework of services that exists in First Nations today. The failure to honour Treaty agreements and the long-term underfunding of services within First Nations have made it challenging to meet the needs of children and families. These challenges are amplified by heightened needs that reflect the intergenerational impacts of policies of cultural genocide.

In recent years, funding for services in First Nations has increased across service domains.[20, 21, 22] These funding shifts, which resulted from the settlement of legal cases and other long-term advocacy efforts by First Nations, have increased access to services for children and families within the KTC member Nations.[23, 24, 25, 26] However, the new services being developed must address the long-term impacts of disparities and gaps in services to First Nations. They also face the challenge of addressing these impacts in a complex organizational context that is shaped by interactions between the multiple, independent organizations that provide services within the KTC member Nations.

Chapter 2 — Soniyaw Natamakewin (Securing Money): Jordan's Principle funding for the Children's Resources team

Jordan's Principle is a child first principle designed to address the disparities and gaps in service that exist within the fragmented colonial system of services in First Nations. Jordan's Principle originated in 2005, but the federal government failed to meaningfully implement Jordan's Principle until 2016.[27] In 2016, the Canadian Human Rights Tribunal (CHRT) began issuing a series of decisions that mandated the full implementation of Jordan's Principle, and also dramatically expanded its interpretation.[28] In response to CHRT orders, the federal government established a three-year child first initiative that included funding for services to meet the needs of individual children as well as "group requests" made by Nations or organizations seeking to address the needs of multiple First Nations children. The CFI initiative was renewed for an additional three years in 2019.[29, 30, 31, 32, 33]

In 2018, KTC Health submitted a request for funding to provide allied health and mental health/wellness services, as well as supports for the families of children with disabilities. As KTC Health learned about the need for additional services, the organization requested increases in Jordan's Principle funding. Through the submission of Jordan's Principle group requests, KTC Health was able to establish funding for a unique system of services, which were designed to address identified needs and extend services that had not been previously available within KTC member Nations. The five KTC Nations appear to stand among only 11 Nations in Alberta that, by fall of 2020, had used Jordan's Principle group funding to provide mental health/wellness services. They also appear to comprise five of the 11 Nations in Alberta that, by fall of 2020, succeeded in establishing a system of Jordan's Principle funded allied health services comparable to those provided off-reserve, by the province.[34]

KTC Health was able to implement this system of services despite the fact that Jordan's Principle policies continually shifted and evolved. KTC Health administrators had to revise their proposals to meet new requirements around the submission of evidence to justify funding requests and renewals. They were also required to adapt existing plans and services in order to comply with the changing parameters of what could be supported by Jordan's Principle funding. Moreover, funding was allocated and renewed on an annual basis, with no assurance of funds continuing beyond the fiscal year. Last minute announcements of funding renewal created uncertainty and risk, while frequent changes in eligibility criteria necessitated the labour intensive revision of previously approved applications. This left KTC Health and the Children's Resources team racing to secure funding and uncertain about the potential for continued funds, even as the organization worked to build up a system of needed services.

The tenuous nature of Jordan's Principle funding became clear in the first five months of 2020–21 when overall funding for Jordan's Principle requests in Alberta decreased dramatically. In keeping with this pattern, the funding for the Children's Resources team was reduced, and funding for previously approved mental health, wellness and cultural supports was denied. Accordingly, KTC Health was faced with the challenge of sustaining needed services without renewed funding, while continuing to advocate for reinstatement and expansion of resources in order to meet the needs of children and families within the KTC member Nations.

Chapter 3 — Ayaman Osihchikewin (A Difficult Creation): Developing the Children's Resources team

KTC Health's initial Jordan's Principle funding was approved for only one year, and no indication of terms under which further funding would be available was provided. With time-limited resources in hand, KTC Health sought to offer services directly to children and families in the KTC member Nations as quickly as possible. The initial efforts of the Children's Resources team largely focused on providing supports in response to a suicide crisis. This focus subsequently expanded to include the provision of long-term mental health and wellness supports, allied health services and supports to the families of children with disabilities. KTC Health acted creatively and decisively to recruit and retain qualified staff and contractors for the Children's Resources team. The strategies used included recruiting from within team members' professional networks, offering competitive salaries and benefits, and staffing through flexible contract positions. By early 2021, the Children's Resources team had grown to six staff members and 15 contracted service providers who, collectively, provided individual-level services and supports to 86 children in the KTC member Nations and supported group activities for over 300 children.

The Children's Resources team is organized into two smaller teams—a clinical team and a community team—that have complementary roles and responsibilities. The clinical team is involved in the direct provision of allied and mental health services. It is composed primarily of part-time contractors who commute to the KTC member Nations from Edmonton and smaller towns in northern Alberta. A flexible approach to hiring clinical team members has been necessary in order to recruit qualified clinicians, but the flexibility in hiring has also resulted in a complex team structure, with responsibility for managing and supervising the majority of Children's Resources team members distributed across seven contractors.

The community team plays a leading role in building relationships with the families and communities served by KTC Health. Community team members, who are primarily full-time staff, also provide vital logistical and administrative support for the clinical team. KTC Health has maintained a consistent goal of staffing this team with KTC Nation members. However, clear understanding of community team members' roles and responsibilities emerged over time, and recruiting Nation members for the evolving roles proved difficult. KTC Health is currently engaged in a process of restructuring the community team and is actively recruiting staff for new positions developed in response to the emergent needs of families within the KTC member Nations.

KTC Health's focus on rapidly extending services within the KTC member Nations meant that the development of organizational infrastructure and interorganizational protocols and polices was approached on an as-needed basis. Three years into development of the Children's Resources team, interviewees identified a clear need for greater attention to organizational and interorganizational development. At the organizational level, Children's Resources staff and contractors indicated a need for formal onboarding procedures, more detailed organizational policies and clearer communication structures. Staff and contractors also identified a need for greater interorganizational communication and collaboration in order to clarify the roles and relationships of different service providers, and to more clearly define the role of the Children's Resources team.

Chapter 4 — Nîsohkamatowin (Supporting Others): An emerging Children's Resources model

Children's Resources team members articulated a clear, shared approach to service provision. At the core of this approach was an emphasis on building trust and on following the lead of children, families and community members. Children's Resources team members identified trusting relationships as a necessary foundation for addressing family needs. Team members also expressed a shared commitment to combining universal and individual approaches to working with children and families. Universal approaches are utilized whenever possible; staff and contractors viewed universal approaches as a less stigmatizing way to develop trusting relationships and to model tools and techniques for service providers and caregivers in a supportive group setting. Individual strategies, which require consent forms, allow for the time and space to address specialized needs, provide more intensive support and undertake assessments. Finally, Children's Resources staff and contractors emphasized the importance of collaboration within and across the clinical and community teams, and also with other service providers, as being essential to ensuring that children and families receive quality care.

Within this emerging practice approach, there were areas in which team members were themselves earning and searching for solutions, strategies and best practices. One such area of tension emerged around the geographic dispersal of the Children's Resources team members, and the lack of dedicated space for the Children's Resources team within the KTC member Nations. KTC Health's flexible approach to hiring facilitated the quick development of the Children's Resources team, but it also resulted in a clinical team composed primarily of people who had long, sometimes difficult, commutes to the KTC member Nations. Staff and contractor commute times limited the time they had for relationship building and collaboration, which were key aspects of the Children Resources team's practice approach. These time limitations were exacerbated by space restrictions within the KTC member Nations. Working within existing health and early education settings facilitated relationship building, but it also complicated the work of the Children's Resources team. Team members lacked consistent or appropriate spaces to meet with individual clients, store confidential files or collaborate with colleagues.

A second area of tension was tied to the cross-cultural nature of KTC Health's work. Children's Resources team members were all engaged in

processes of learning about the KTC member Nations and adapting their practice to the social and cultural contexts within each Nation. However, they engaged with this process in different ways. Some Children's Resources team members discussed the initial process of learning about the KTC member Nations' cultures and contexts, while others focused on modifying services to reflect the cultures within KTC member Nations. Still other team members highlighted the importance of striving for cultural safety; they emphasized the need to systematically ensure that KTC member Nations, children and families were driving decisions about services. These team members looked for ways to transfer power from service providers to the people and communities accessing services. Differences across this continuum of approaches to culture were sometimes a source of tension for Children's Resources team members, but staff and contractors were united in consistently expressing desires for additional supports to facilitate learning about and centring culture in their practice.

Recommendations

Based on this formative evaluation of KTC Health's Children's Resources team, we make four key recommendations. The first recommendation focuses on national level advocacy. The second and third recommendations highlight a need for interorganizational development and building capacity across KTC member Nations. The final recommendation focuses on internal organizational development. KTC Health's Children's Resources team has already taken some important steps to advance each of the recommendations. These steps are discussed, along with a more detailed presentation of each recommendation, in the concluding chapter of this report.

1 We recommend that KTC member Nations and organizations advocate for the transformation of Jordan's Principle from a short-term 'initiative' to a flexible, long-term funding stream that can support a systemic approach to service delivery.

Jordan's Principle has introduced expansive new funding for services to First Nations children and supported the development of First Nations led services that are tailored to the context and needs of specific communities. However, funding for Jordan's Principle is still short-term, and federal policies and expectations around Jordan's Principle have been inconsistent. In Alberta, funding for Jordan's Principle was more limited in 2020–21 than in prior years, and it appears that the approach to Jordan's Principle funding in Alberta is more restrictive than in other regions. We recommend that KTC leadership join with other First Nations and First Nations organizations to advocate for a revised federal approach to Jordan's Principle. A new approach to Jordan's Principle should maintain the current emphasis on locally-generated proposals and adopt more consistent federal guidelines and policies. Long-term federal funding commitments that include funds for infrastructure and capital costs and support self-determination in First Nations health, education and social services can provide necessary stability to support a systemic approach to service delivery.

2 We recommend that KTC member Nations and organizations prioritize, engage in and fully support an effort to transform the current siloed approach to service provision.

KTC leadership should mandate KTC Health, KTC Education, KTC CFS and Nation-level service providers to work together to develop:

- Clear systems for ongoing communication and information sharing;
- Shared understanding of roles and responsibilities;
- More open, trusting relationships across organizations;
- Clearly articulated, shared values;
- Common standards and expectations for service provision; and
- A coordinated strategy for educating other organizations about work within the KTC member Nations.

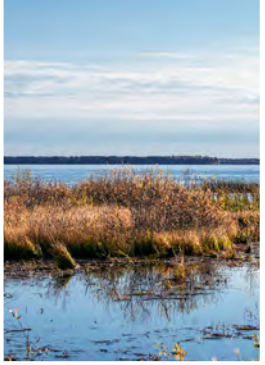
3 We recommend that the leadership of the KTC member Nations prioritize and collaboratively develop initiatives that support Nation members in building on their strengths, skills, language, culture and knowledge to better address the needs of children and families.

Leadership in the KTC member Nations should collaboratively develop and support the implementation of a comprehensive and coordinated approach to capacity development that nurtures future service providers and leaders, across service domains and at different levels of education and training. These capacity development efforts must extend beyond the current employees of the organizations providing services in KTC member Nations and focus on the whole population.

4 We recommend that KTC Health and Children's Resources team administration prioritize organizational development with a focus on centering cultural safety throughout its policies and processes.

KTC Health and the Children's Resources team should intensify their focus on organizational development including, but not limited to, the development of clearer and more comprehensive organizational policies, communication mechanisms and onboarding procedures. Through this organizational development process, KTC Health and the Children's Resources team can strive to develop a stronger, shared culture. A focus on creating processes and mechanisms through which children, families and KTC member Nations drive decision-making at every level of Children's Resources service development and provision should be central to this organizational culture. Clear and effective action to realize recommendations two and three are essential in order to facilitate this transfer of power.



Miyo-wîcêhtowin
(Living in Harmony)
KTC member Nations and services in a colonial context

Chapter 1





Kee Tas Kee Now Health Services supports health service delivery in a group of five small Cree Nations in Treaty 8 territory. The members of Kee Tas Kee Now Tribal Council include: Lubicon Lake Band, Woodland Cree First Nation, Whitefish Lake First Nation #459, Peerless Trout First Nation and Loon River Cree First Nation. KTC member Nations have long built on communal strengths to advocate for self-determination and rights of their members. Each Nation has taken diverse approaches to meet their members' needs, while also working in partnerships with the other members of the KTC Tribal Council.

The work of KTC member Nations occurs within a context shaped by Canada's settler colonization and failure to honour Treaty obligations. These historical patterns disrupted First Nations' traditional care networks, economic systems and cultural practices while also creating new needs among children and families. Canada's failure to honour Treaty obligations enacted a fragmented, under-resourced policy framework that has compounded the harms done to First Nations populations by settler colonial policies.[35, 36, 37, 38, 39] Accordingly, current efforts to meet the needs of First Nations children cannot be understood apart from a colonial history that laid the foundation for the siloed structure of contemporary provision of health, education and social services in First Nations.

In this chapter, we examine the context of contemporary service provision and provide a brief overview of the impacts of settler colonization and colonial policies on efforts to provide necessary services to children and families in the KTC member Nations. While a thorough examination of the historical context of the KTC member Nations is beyond the scope of this project, we highlight examples that demonstrate both the persistent efforts that KTC member Nations have made to meet the needs of their people and the challenges to meeting these needs in a colonial policy framework. We close this chapter with a discussion of the context of services in KTC member Nations prior to KTC Health's development of the Children's Resources team.

KTC member Nations

The five member Nations of Kee Tas Kee Now Tribal Council are located in northern Alberta, more than a four-hour drive north of Edmonton. The territories of Lubicon Lake Band, Woodland Cree First Nation, Whitefish Lake First Nation #459, Peerless Trout First Nation and Loon River First Nation are dispersed across land that is dotted by lakes and surrounded by ecological diversity that includes swamps, prairies and woodlands.[40] Westman (2008) described the beauty of the region around KTC member Nations:

> *In spite of encroachments by industry in many areas, the region retains its natural beauty. Tree growth in the boreal plains alternates between shimmering stands of aspen and dark foreboding white spruce. In sandier areas (the beaches and beds of prehistoric lakes), jack pines grow; in moister regions, birch and stunted black spruce are found. In season, shrubs, sedges, tiny flowers, roots and berries prevail everywhere amongst the ever present trees. A major feature of the landscape is its poor drainage creating many lakes, slow meandering rivers and huge muskegs (from maskek, a Cree word meaning "swamp"). In some areas, the boreal forest is interrupted by parklands. Here the landscape resembles that around Edmonton: stands of aspen alternating with open grassy areas. The open areas are called maskote ('prairies').*[41]

The KTC member nations are located near the junctions of Highways 750 and 986 with Highway 88. Whitefish Lake First Nation #459, also known as Atikameg, is the southernmost KTC member Nation. It is located along Highway 750, 92km northeast of High Prairie, on the northwestern shore of Utikuma Lake. Northeast from there, Peerless Trout First Nation is located at the end of an unimproved dirt road that branches off from Highway 88. Almost 80km southwest from Peerless Trout First Nation is Loon River Cree First Nation, which sits near the junction of Highways 88 and 986. Further west, Lubicon Lake Band is centered in the community of Little Buffalo, just off of Highway 986. Nearby Woodland Cree First Nation is almost 270km from Slave Lake and 500km from Edmonton; the Nation is made up of four reserves that include Cadotte Lake, Simon Lake, Golden Lake and Marten Lake. Both Woodland Cree First Nation and Lubicon Lake Band are approximately 100km from Peace River.

Map 1 Map of KTC member Nations

KTC member Nations have long fought for their rights and supported their people in ways that reflect their distinct cultures. Within this diversity, key historical patterns are shared across the five member Nations. At the most fundamental level, some KTC member Nations have engaged in long and difficult land claims processes in order to secure government acknowledgment of their basic rights and title to land because they were excluded from a poorly planned and implemented Treaty 8 process. In the 1980s and 1990s a number of actions were taken by Nations to rectify long-standing land claims that resulted from federal oversight during the initial signing of Treaty 8. Lubicon Lake Band, which was excluded from the initial Treaty 8 negotiations and signing, initiated a land claims process in 1933.[42] The federal government promised a reserve when it began the land claim settlement process in 1939, but territory was not returned.[43, 44, 45] Conflict surrounding the dismissal of Treaty negotiations resulted in a call to boycott the Calgary Olympics and a five-day road blockade in 1988. Lubicon Lake Band became emblematic of First Nations work towards self-determination.[46] Woodland Cree First Nation was also unaccounted for in the initial Treaty 8 negotiations. The community was recognized as a First Nation in 1989, and, after extensive advocacy by Nation leadership, officially claimed settlements and became a signatory to Treaty 8 in 1991.[47] Loon River Cree First Nation, which was excluded due to the Nation's location away from main river access, signed an addendum to Treaty 8 in 1999.[48]

Some land claims extended into the 2000s and were only recently resolved. Lubicon Lake Band's land claim settlement was recognized by federal and provincial governments in 2014, after extended negotiations and advocacy from Nation leadership.[49, 50] Peerless Trout First Nation was also not accurately accounted during the initial Treaty period. As a result, the Nation's independence was denied. It was not until 2010, after years of advocacy, that Peerless Trout First Nation was officially established.[51] Alongside these prolonged fights for recognition and self-determination, each Nation has also worked to ensure the health and wellness of its members. As is discussed in the final section of this chapter, each Nation operates their own system of health, social and early childhood services such as Head Starts and daycares. In addition to these independent services, the Nations have collaborated to benefit from economies of scale in the provision of health, education and child and family services across KTC member Nations. Examples of independent initiatives undertaken by the Nations, identified through searches of Nations websites and media reports, are highlighted below.*

Examples of education initiatives independently developed in order to address the needs of Nation members can be found in Loon River Cree First Nation and in Peerless Trout First Nation. In 2017, Loon River Cree First Nation entered a partnership with Northern Lakes College. The partnership committed to enhancing the Community Access Point on-reserve, which allows students to access education locally and reduces the frequency with which students leave the community to receive an education. There was significant attendance from Nation members.[52] Peerless Trout First Nation started a trust fund to support community projects in 2012. Projects to date have included the development of minor hockey, a medical emergency fund, the Brushing Program for youth employment, adult literacy, the Cemetery Renovation program and many others.[53]

* Plans to more systematically document current initiatives and incorporate community member perspectives and voices in this report were, unfortunately, disrupted by COVID-19 related travel restrictions.

Nations have also implemented innovative programs and partnerships to protect and preserve traditions and traditional knowledge. For example, in 2019, Whitefish First Nation #459 partnered with researchers from InnoTech Alberta and the Alberta Biodiversity Monitoring Institute on a three-year wildlife monitoring project. The research documented the habitats, ranges and seasonal behaviours of large mammals in the region, and will be used to inform future infrastructure and land management developments.[54] A similar program in Woodland Cree First Nation integrates traditional knowledge in the community's relationship with the land. In 2019, the Nation became a signatory to the Buffalo Treaty, which aims to guide collaborative re-introduction of buffalo populations across North America.[55] In 2020, wood bison were reintroduced to Woodland territory with the aim to gradually create a sustainable food source while providing connection to language revitalization and "purpose" within the community.[56, 57] The Lubicon Lake Band's Mihkowapikwaniy Cultural Preserve for youth and Elders began as a memorial and has since evolved into an annual camp that supports engagement with cultural traditions and community. The Mihkowapikwaniy storytelling leadership camp has also been offered for five years on the same site.[58]

As evident in Textbox 2, which outlines the KTC member Nations' response to COVID-19, community strengths are also at the core of emergency response. Prior examples include wildfire responses by Whitefish First Nation #495 and Loon River First Nation. During these emergency efforts, mutual support within extended family networks and responsive leadership functioned as protective factors while infrastructure initially developed to prevent house fires allowed for active response.[59, 60]

The strengths of each Nation have sustained Nation members despite the imposition of settler colonization and colonial policies that are still in place today. The following section provides an overview of the pre-Treaty period in the Alberta region, the processes of Treaty 8 negotiation, and the implementation of colonial policies that continue to impact First Nations across Canada. The impacts of these historic processes on contemporary service provision are discussed in the concluding section of this chapter.

Pre-Treaty period

Prior to colonization, First Nations peoples living in the territories now known as Lubicon Lake Band, Woodland Cree First Nation, Whitefish Lake First Nation #459, Peerless Trout First Nation and Loon River First Nation had diverse child-rearing practices grounded in the knowledge, language, culture, economy and worldview of each Nation. Families organized themselves to provide mutual aid through shared resource harvests in times of stability and scarcity; and mutual aid was also integrated into child rearing practices.[61] Caring for and educating children was not exclusive to the nuclear family, and was instead viewed as a shared and highly valued community responsibility in which all adults participated.[62, 63, 64]

Within First Nations, medicinal plants were traditionally administered to individuals for medical issues, such as rat root for sore throats.[65] Traditional medicine, which emphasized the interconnectedness of individuals to their communities and the surrounding environment, was also offered to the broader community to address wellbeing. Ceremony that supported communal medicine included the sharing of resources, sweat lodges, tea dances and non-disruptive hunting and gathering practices which were imbued with respect for the Creator's gifts.[66]

Textbox 2 KTC member Nation's response to COVID 19

In December of 2019, a novel respiratory disease emerged in Wuhan, China, spreading rapidly and creating complications in people with co-occurring health issues; the disease came to be known as "COVID-19".[67, 68] As death tolls rose, the World Health Organization (WHO) declared COVID-19 to be a pandemic on March 11th, 2020.[69] In mid-March, the Alberta provincial government announced the closure of schools and daycares, declaring a state of emergency.[70] Non-essential services—including wellness centres, retail services, hair salons and non-essential health services such as dental and rehabilitation services—were closed.[71]

First Nations communities are vulnerable to the fast spread of communicable diseases as a result of colonial and recent policies that have resulted in a high prevalence of underlying medical conditions, underfunding of health centres, a lack of access to essential services, limited access to safe drinking water and poor housing.[72, 73, 74, 75] In recent pandemics, these challenges were compounded by inappropriate governmental responses. For example, during the Influenza A (H1N1) outbreak of 2009, the rate of hospitalization for First Nations people reached 72 per 100,000 First Nations people; in comparison, the overall national rate of hospitalization was 25.7 per 100,000 people.[76] The federal government initially hesitated to send basic supplies to First Nations. In one case, when they did send flu kits, face masks and hand sanitizer, they also sent body bags. This was culturally offensive since "to prepare for death is to invite death."[77] Within this context, the COVID-19 pandemic posed a grave threat to First Nations communities. Still, the federal government's initial funding for COVID-19 related supports for Indigenous people of $315 million represented less than 1% of the total $82 billion in allocated funds in Canada.[78, 79]

Leaders in the KTC member Nations acted decisively to ensure the health and safety of Nation members, undertaking a pandemic response that highlighted the self-determination and resourcefulness of their Nations. Starting on March 17th, roadblocks and curfews were implemented in order to protect Nation members from exposure to the virus.[80] Food insecurity associated with this lockdown was addressed by enlisting local hunters and fishermen to supply food, collaborating with KTCEA and KTC Health around food delivery and drawing on local resources that provided food boxes.[81] Some member Nations tackled misinformation about COVID-19 by re-sharing and re-posting mental health supports and public health announcements on social media. Nations also utilized social media to virtually connect with members during lockdown, sponsoring engagement contests such as ice sculpting, baking contests and "Hair Updo" events.[82, 83, 84, 85, 86]

Textbox 2 KTC member Nation's response to COVID 19 ...continued

The Children's Resources team shifted services to remote formats, providing access through virtual platforms at health centres or other community venues; text messaging, informative videos and weekly newsletters also became standard communication tools with families.[87] In addition, KTC Health and KTCEA explored ways to bolster connectivity and internet access for families to facilitate both virtual learning and remote health service delivery. [88] Despite these efforts, there were significant limitations to service delivery.[89] It was not possible to provide virtual assessments, and this presented a barrier to provide comprehensive services for some families. In addition, some families indicated the need to establish routines in their personal lives before accessing services again.[90] A Children's Resource team member reflected on the mixed response from families:

> *I think, like, say just under half of families are really happy to receive clinical services digitally and another half of our community members [are like] you know what, I think I am good.*[91]

On May 14th, 2020, the provincial government announced a "three-phase" relaunch approach.[92] On the same day, KTC member Nations asked to work with the provincial government to coordinate an approach to reopening within the Nations. The provincial government did not respond.[93, 94] The omission of KTC member Nations, and First Nations in general, from provincial relaunch planning meant that provincial plans failed to address the challenges that First Nations faced in organizing testing, contact tracing and mobile outbreak response teams from under-equipped health centres.[95] As the province proceeded with the relaunch, a service provider in a KTC member Nation noted the isolation that surrounded continued efforts to maintain curfews and limit external access to the Nations:

> *The world is opening up out there, but we are not. We are still having curfews, we have asked the municipalities to close the highways. We are looking at another three months. We feel totally alone and on our own.*[96]

On June 22nd, KTC member Nations, with the exception of Whitefish First Nation #459, announced they would once again welcome external service providers into Nations.[97] This allowed the Children's Resources team to hold some in-person summer camps. However, relaxation of restrictions was short lived. First Nations peoples were hit hard by the second wave of COVID-19, comprising half the number of hospitalizations in Alberta, British Columbia, Manitoba and Saskatchewan.[98, 99] In November of 2020, the National Advisory Committee on Immunization (NACI) recommended key populations, including First Nations, for early vaccination.[100] KTC member Nations, their members and the service providers who work in the Nations have worked tirelessly to maintain safety and wellbeing during the COVID-19 pandemic.

The well-being of the family was supported by the community, which was reliant on the surrounding environment for trade, shelter, medicine and other basic needs.[101] Historically, First Nations peoples in northern regions of Alberta lived in large, organized communities. They practiced resource management and non-disruptive hunting of animals, such as wood bison and moose, which preserved ecological balances of animal populations, provided sustainable nutrition and enabled the creation of stable, long-standing winter and summer communities.[102, 103] First Nations peoples living in drought prone plains regions recognized that access to water was integral to the survival of communities, and they developed water management strategies that included a deliberate refrain from hunting beaver to preserve waterways. These resource management strategies allowed communities to thrive and also served as a protective factor against disease by reducing the prevalence of starvation and inadequate housing.[104]

The stability of Nations in the northern region was intricately connected with their surrounding environments, and was sustained through traditional practices grounded in years of intergenerational knowledge that was specific to survival in those territories. From the mid-1700s into the late 1800s, settler colonization fundamentally changed life for First Nations peoples. Trading companies and fur traders decimated buffalo and beaver populations. The loss of the dams constructed by beavers reduced the creation of wetlands that supplied plants and animals for harvest.[105, 106] As a result, the severity and impacts of naturally occurring droughts increased in southern communities. Traditional, non-disruptive hunting practices were also destabilized across the northern and southern regions.

With droughts, consecutive years of crop failure and significant buffalo population loss came ecological devastation and subsequent deprivation of economic and resource stability. As a result, famine became common for many First Nations.[107, 108] Famine, displacement and the inadequate housing resulting from displacement increased community vulnerability to tuberculosis, which decimated populations and caused a significant loss of life amongst Elders and Chiefs. Years of unsustainable resource extraction, famine, disease, regional conflict and community loss left many Nations in newly vulnerable positions.[109]

The northern Nations across contemporary Treaty 8 territory maintained their autonomy and traditional ways of life with limited disturbance by settler colonizers for longer than the southern Nations, which suffered from the pressures brought on by colonization, including resource depletion, starvation

and displacement from traditional territory in the 1800s. Canada took the position that Treaty would not be negotiated until the Alberta region became an economic or settlement resource for the state, and the northern region was not initially viewed as economically viable for colonizing. This changed when gold was discovered in the Yukon region in the summer of 1896, and Canada desired to enter negotiations in order to remove First Nations title to potentially resource-rich northern territory.[110, 111, 112]

Treaty 8

After years of rapid destabilization due to starvation, disease and disruption from settler colonization, many Nations in the Alberta region entered into Treaty negotiations with Canada.[113] Treaties 6, 7 and 8 were negotiated in the Alberta region in the last decades of the 1800s.[114] These three Treaty agreements laid the foundation for the current structure of First Nations in the Alberta region; 46 First Nations are spread across three Treaty areas that extend into British Columbia, Saskatchewan and the Northwest Territories.[115]

Though Nations in the Alberta region entered Treaty negotiations in the late 1870s, Treaty 8—which encompasses territory that spans across northern regions that are now known as Alberta, British Columbia, Saskatchewan and a southern portion of the Northwest Territories—was not negotiated until 20 years later.[116, 117] Following the Yukon gold rush, a flood of prospectors entered the region. First Nations saw their lands exploited and their traditional hunting practices significantly disrupted.[118] One report indicates that a group of First Nations traveled and camped at Fort St. John, refusing to allow prospectors to continue traveling north until Treaty 8 negotiations were completed.[119, 120]

The first signing of Treaty 8 occurred in June of 1899 after extended negotiations. Additional adhesions to the Treaty were negotiated at trade posts across the region until 1900.[121] Canada began Treaty 8 negotiations with minimal understanding of First Nations interests, needs, or cultural norms. Negotiations were also approached with an intent to eliminate First Nations land titles while increasing control over the northern population in order to facilitate resource extraction.[122, 123] Canadian missionaries helped broker relationships between First Nations and Canada's negotiators, while the North-West Mounted Police documented the geographic and community makeup of the region to establish a minimal knowledge of northern First Nations communities in advance of negotiations.[124, 125] Advice from Treaty commissioners, who suggested allocating land tracts based on families' traditional hunting territories, was dismissed by federal officials. Instead, Ottawa-based officials drew Treaty boundaries based on the government's estimated location of mineral resources and created a replica of the southern reserve system negotiated in Treaties 6 and 7.[126] Throughout negotiations, First Nations leaders sought to secure their traditional ways of life; they emphasized the need for freedom of movement to preserve hunting, trapping and fishing traditions for northern regions in which crop-based agriculture was not viable.[127]

The original text of Treaty 8 included agreements on: the allocation of land to community members, annual payments, the provision of farm equipment, livestock, ammunition, fishing line and the payment of salaries for teachers. Agreement was also reached on the preservation of traditional land use and Crown use of First Nations lands.[128] Intergenerational knowledge passed down from Elders clarifies that the language of ceded land was never agreed to in Treaty negotiations, which were signed with

an understanding that the land would be shared amongst First Nations and settler colonizers and that no First Nations title to territory was eliminated.[129, 130]

Treaty negotiations embodied and reified the dishonesty and oppressive power dynamics of settler colonialism. The Treaty agreements that Canada codified and accepted excluded the provisions that First Nations identified as necessary for the health, welfare and economic stability of their peoples.

Oral history passed down by Elders as well as written documentation from witnesses and Canadian officials indicates that significant, additional agreements made in-person on un-ceded lands were not included in the formal Treaty 8 text produced by Canada.[131, 132, 133] The oral agreements included: freedom of movement; exemption of forest lands from farm purchases; full retention of hunting, fishing, trapping and gathering rights; the retention of water, mineral and sub-surface rights; exception from taxes; the provision of police services; exemption from participation in war; exemption from hanging; the provision of legal representation; fixing annuity to levels agreed to in Treaty 6 negotiations; the retention of barter rights; a supply of canvas for tents; and agricultural supports for rearing animals including the provision of tools, bullets and equipment. Oral negotiations also included multiple agreements around the provision of health and social services; food support in times of famine; the provision of education that was not affiliated with religion; access to medicines, hospitals and a doctor; and support for care of the elderly.[134, 135, 136] Interviews conducted with Treaty 8 Elders in the 1980s indicate Treaty would have been refused had these provisions not been guaranteed in face-to-face negotiations.[137]

A discriminatory framework for services to First Nations children

As the Numbered Treaties were signed in the late 1800s, Canada passed legislation establishing a framework for the provision of services to First Nations. The *Indian Act* of 1876 and the *Constitution Act* of 1867 together established the foundation for a discriminatory system of services for First Nations in Canada; this system continues in the contemporary period. The *Indian Act* of 1876 created a legal framework to support Canada's systematic attempts to assimilate First Nations peoples within the growing settler population. It formalized a mechanism for the federal government to regulate First Nations

identity based on blood quantum and patriarchal settler norms. The *Indian Act* established criteria for eligibility, acquisition and transmission of "Indian" status. Status continues to be the mechanism used by the federal government to delineate the First Nations population directly under its jurisdiction in accordance with the *Constitution Act*.[138, 139]

Article 91(24) of the *Constitution Act* assigns responsibility for "Indians, and lands reserved for the Indians" to the federal government.[140] Though the federal government frames funding for services within First Nations as "humanitarian," courts have interpreted Article 91(24), along with Treaty components such as the Medicine Chest Clause, as meaning that the federal government has responsibility for the provision of health, education and social services on-reserve.[141, 142] In contrast, Article 92 of the *Constitution Act* assigns responsibility for the provision of most health and social services to the provinces. Accordingly, each province has its own legislation that informs the programming and administration of health, education and social services.[143, 144] As a result of Articles 91(24) and 92 of the *Constitution Act*, the funding and provision of services differ within and outside of First Nations. Services outside of First Nations are funded and provided by the provincial government, either directly or through contracts with independent service organizations. Services for First Nations people in First Nations are primarily federally funded. This has resulted in significant disparities between on-reserve federally funded services and off-reserve provincially funded services.[145, 146]

The basic framework of health and social services for First Nations, which was established in the late 1800s, continues to be in effect today, with some important revisions. Key among these was the addition of Section 88 to the federal *Indian Act*. Section 88 extended provincial laws of general application—including those governing health, education and social services—to First Nations peoples living in First Nations communities.[147, 148, 149] Accordingly, for the first time, on-reserve services were governed according to provincial laws and standards. As a result, services for First Nations people in First Nations communities are primarily federally funded and often provided by First Nations. However, services may also be provided by the federal government and the province of Alberta also funds some health and social programming on-reserves. In contrast, services outside of First Nations communities are funded and legislated by the provincial government and either provided directly by the province or through contracts with independent service organizations.[150, 151]

First Nations are bound by provincial standards but constrained by inequitable federal funding. Avenues to pursue the self-determined implementation of services or advocate for reforms exist, but they are limited. For example, First Nations in Alberta may influence services through the Assembly of Treaty Chiefs (AoTC), which is the region's political leadership body. They may also shape policy through Health Co-Management (HCoM), which supports information sharing and joint decision making between First Nations and the federal government on First Nations health programs and services in Alberta.[152]

This complex framework for funding of public services results in First Nations children experiencing denials, delays and disruptions of needed services.[153] Recent examples of disputes over responsibility for the funding and provision of services include services for status-eligible children, responsibility for services to First Nations people temporarily living within/outside of First Nations and the responsibility for transition from provincial institutions to First Nations community

settings.[154, 155, 156] At a more fundamental level, First Nations children are negatively impacted by gaps in the health, social and educational supports and services available in First Nations. At the national level, numerous reports and legal decisions have noted governmental failures to adequately fund services, reform federal and provincial policies in order to eliminate racial discrimination, honour Treaty obligations and fulfill Crown responsibilities to First Nations populations.[157, 158, 159, 160, 161, 162, 163] The following section describes the impacts of settler colonial aims of cultural genocide in the provision of historic health, education and child welfare services to First Nations peoples.

Foundations of the current system of services in First Nations

When Nations entered Treaty in the late 1800s, traditional ways of life had already been impacted by displacement and exploitive resource extraction resulting from settler colonization. These impacts were amplified by the colonial government's approach to providing the services agreed to in Treaty. By the early 1900s, the federal government delivered services through the residential school system, Indian Hospitals and poorly resourced on-reserve medical services supervised by Indian agents.[164, 165] Over time, the provision of medical, education and social services evolved into a more complex model that exists today. The current structure of services for First Nations children began to emerge in the middle of the 20th century, with responsibility gradually being transferred from the Department of Indian Affairs to the Department of National Health and Welfare in 1945. Programs extending services to First Nations were consolidated into a Medical Services Department in 1962.[166, 167] During the same time period, the residential school system began closing, and its responsibilities were divided between the child welfare and education systems.[168] Thus, it was during the mid-20th century that the current, siloed structure of services emerged. In this structure, health, education and social services are managed as independent programs. A recent re-organization of government ministries has placed health, education and social services for First Nations under a single ministry, Indigenous Services Canada (ISC). However, a half century of siloed services continues to impact the internal functioning of ISC, and internal organizational silos are still evident in the federal government's approach to services.[169, 170, 171, 172, 173, 174] Though a thorough accounting of the evolution of these service systems extends beyond the scope of this report, we highlight key aspects of a service system that was instrumental to cultural genocide which continues to characterize contemporary services for First Nations children.

Services for First Nations children have persistently relied on out-of-home-care, which separates children from their families and communities. A reliance on residential and out-of-home-care was embodied by the 25 residential schools which operated in Alberta, and which systematically separated children from their caregivers and communities.[175] Indian Hospitals similarly relied on coercive residential care that fragmented families and removed vulnerable people from their medicinal traditions.[176, 177] A pattern of family separation continued under the child welfare system. By 1979, Indigenous children represented 51% of all children across the province in temporary out-of-home care and 44% of children in permanent out-of-home care.[178] By 2016, First Nations children, who represented 5.7% of the child population in Alberta, comprised 59.1% of children in foster care; First Nations children were 32 times more likely to be placed in foster care than non-Indigenous children.[179, 180]

Services for First Nations children have inflicted lasting harm. The testimony of residential school and Indian Hospital survivors indicates that significant harm occurred in both systems.[181, 182, 183, 184, 185, 186, 187, 188] The long-term and intergenerational impacts of these traumas have been extensively documented. The intergenerational impacts of trauma stemming from cultural genocide include increased risk of: suicidal ideation, suicide attempts and mental health distress; child and family service involvement; and growing up with food insecurity in crowded, low income households.[189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200] Research indicates that children with a parent who attended residential school have an increased risk of involvement with child and family services due to the overall increased presence of adversity factors that include household members being imprisoned, attempting suicide, or having mental health needs.[201]

Services for First Nations children have been persistently underfunded. Chronic underfunding was common in residential schools, and continues to impact contemporary First Nations schools which are funded by the federal government.[202, 203, 204, 205] Underfunding has resulted in limited service delivery options, recruitment and staff retention challenges, infrastructure that requires significant renovation and is unable to respond to population growth and limited capacity to provide basic education services such as lending libraries or computer and science labs.[206, 207, 208] Contemporary First Nations healthcare has also been characterized by chronic underfunding of on-reserve services, jurisdictional disputes, short-term funding initiatives, experiences of stigma when accessing off-reserve services and the absence of culturally appropriate interventions.[209, 210, 211, 212] CFS agencies have also been severely underfunded. For example, in 2016, the CHRT found that all federal child welfare funding models were discriminatory.[213]

Disparities between health, educational and social outcomes for First Nations and non-Indigenous people are also persistent. For example, there is a continued disparity in graduation rates; 88% non-First Nations people between the ages of 18 and 24 have their high school diploma compared to 44% of First Nations peoples in the same age range.[214] First Nations people living in Alberta also experience disparate healthcare outcomes, including lower life expectancy, increased infant mortality and increased rates of diabetes and suicide.[215, 216] National surveys have consistently shown that chronic disease such as diabetes, hypertension, substance misuse and mental health concerns are three to five times more prevalent for Indigenous peoples than for non-Indigenous people in Canada.[217, 218, 219]

Social determinates of health such as low employment rates, disparate education rates and discrimination when seeking or accessing services are compounded by the limited access to health care, which have exacerbated disparities between Indigenous and non-Indigenous populations in Canada.[220, 221, 222, 223, 224, 225, 226] For example, in 2016 over 55% of Indigenous children in Alberta lived in poverty, with Status First Nations children experiencing a higher rate of poverty than other Indigenous populations.[227] First Nations people living on-reserve in Alberta also experience a multitude of challenges related to housing: 35% of people living on-reserve live in a home which the federal government categorized as "crowded," 45% in housing that was "unsuitable" and over half living in homes that needed significant repairs.[228, 229, 230] These disparities reflect the fact that First Nations people in Alberta continue to experience barriers to accessing appropriate health, education and social services due to inadequate funding, a lack of services in remote communities, inadequate insurance coverage, lack of culturally competent care, racism and poverty.[231, 232, 233, 234]

Children's Services in the Kee Tas Kee Now member Nations—A complex context

It is this complex history and policy framework that shapes the context of services for children and families in KTC member Nations today. The Kee Tas Kee Now member Nations include approximately 5,000 people.[235, 236] Children and youth make up 37% of this population; 25% are between the ages of 6 and 19 and 12% of the population is under 6 years of age.[237] In comparison, national data indicates children and youth only represent 19% of the overall Canadian population.[238] The average family size is 5.5 for households headed by couples and 4.3 for single parents. Some families have relatively high incomes, as is reflected in the fact that couples with children have a median income of $67,584 and single parents have a median income of $35,200.[239] However, a significant proportion of families living in KTC member Nations have very little income. The 2016 census indicates that 35% of families in the KTC member Nations were in the lowest decile of the Canadian income distribution; across Canada families in this category earned an average of $3,677.[240, 241] KTC member Nations are historically Cree Nations, and 97% of the 2016 census respondents reported Cree ancestry.[242] Census and community research indicates that English is spoken in 95% of households; 48.5% of households indicated that Cree is also spoken and 71.4% indicated that they understand Cree.[243]

Thus, services that meet the needs of children and families in the KTC member Nations must be equipped to meet the needs of a large youth population, of families with very limited incomes and of families for whom speaking and hearing Cree is an integral part of daily life. As described in the prior sections of this chapter, delivering services in the KTC member Nations also means: addressing the long-term harms resulting from the failure to honour Treaty negotiations and working within a fragmented system that has persistently underfunded services in First Nations. Provision of services to the residents of the small KTC member Nations is also complicated by the remoteness of KTC member Nations. All Nations are accessible by road throughout the year and, thus, do not experience the same challenges as fly-in Nations or those that lack year-round road access. However, the drive to Edmonton or other, much smaller, service centers is lengthy and can be challenging. This is especially true for those traveling to or from Peerless Trout First Nation, which is at the end of an unimproved road. Children and families sometimes have to travel long distances to access even the most basic and essential services; similarly, service providers traveling to the KTC member Nations face long commutes.

Kee Tas Kee Now Tribal Council

Within this complex context, the KTC member Nations have worked together to meet the needs of children and families. Kee Tas Kee Now Tribal Council (KTC) was created in 1995 "to facilitate joint action by the member Nations on matters of mutual concern," while providing guidance and support to member Nations.[244] The creation of KTC was part of the movement of smaller Nations creating collective decision-making bodies. This movement began after the Lesser Slave Lake Indian Regional Council "take-over," which returned administrative control over programs and services to Kapawe'no First Nation, Sucker Creek First Nation, Driftpile First Nation, Sawridge Band and Swan River First Nation in 1979.[245] Following the Lesser Slave Lake example, other Nations began forming Tribal Councils based on common interests and communal ties in order to support the reclamation of program and service delivery from the federal government.[246] The original members of KTC were White Fish Lake First Nation #459, Woodland Cree First Nation and Loon River First Nation. Peerless Trout Lake First Nation joined in 2010 to increase collaborative management and service delivery capacity while still retaining independence.[247] Lubicon Lake Band joined KTC in 2013 in the midst of negotiating its land claim settlement.[248, 249]

KTC has a vision of providing "innovative service and support with professional advice and recommendations" to all member Nations.[250] The Tribal Council also identifies its mission as one of engaging "through respectful partnerships, empowering our Nations by being a forward thinking exemplary team" that seizes "opportunities by facilitating innovative and productive strategies to reach both individual and collectively defined objectives."[251] KTC supports collective decision making while respecting the independence of each member Nation. As one administrator explained:

> *It's a matter of support as [member Nations] build capacity to administer their own programs and services. [The council] gives [member Nations] political strength, negotiating strength, with larger numbers. And as far as the human resources, we exist to serve the communities and support them in what they want to do and every community is different so we support them in figuring out*

how to do a and b... We are [the Nations'] eyes and ears to the outside world, bringing info and opportunities home and figuring out how we can take advantage of what's available.[252]

Over time, KTC expanded and diversified the services and supports it provides to KTC member Nations, developing a complex administrative infrastructure that is delineated by federal policies and funding agreements. The KTC member Nations play a primary role in service delivery; each Nation operates a health center and a Head Start and/or daycare. Additional services for children are provided through KTC Health, the KTC Education Authority (KTCEA) and KTC Child and Family Services (KTC CFS).[253] These organizations are structured differently. KTCEA and KTC CFS are independent organizations that provide education services directly to KTC member Nations and child welfare services to four of five Nations. KTC Health is a department of the Tribal Council; it offers services and supports that complement those provided by Nation-run health centres.[254] A brief description of each of these organizations, and the recent expansions in their funding and services, is provided in Textbox 3.

Although they have different structures and mandates, KTC Health, KTCEA, KTC CFS and Nation-operated services serve the same children and families. The roles and responsibilities of these service organizations to a specific child or family may shift based on factors such as a child's age, family structure, context and even season. All three organizations have responsibility for providing services to children in KTC member Nations. KTCEA has responsibility for services to children enrolled in school in their individual Nations, and services are typically delivered at the school and provided throughout the school year. KTC Health provides services for children that are younger than school age, children out of school for the summer and school-aged children who are not enrolled in school. KTC Health also provides services to enrolled, school-aged children to address needs that are beyond the scope of a school setting, such as bedtime routines, respite services, at home mobility devices and other services or supports. KTC CFS also serves children and families, providing services that support families' safety and well-being; KTC CFS also has responsibility for supporting children who are in out of home care.[255, 256, 257]

Children's services in KTC member Nations

Despite the best efforts of KTC member Nations and organizations, the need for early childhood services in the KTC member Nations is acute, and the range of services available to children and families has been chronically limited.

Textbox 3 KTC's role in service provision

Kee Tas Kee Now Tribal Health

KTC Health Administration supports health programs and services to all five KTC member Nations. Programs are provided by their local health centres, through direct clinical supervision of front-line staff that is provided by the Nations, and through a clinical consultative model by KTC Health contractors.[258] The greatest portion of services are designed and delivered by KTC member Nations; KTC supplements and supports this service delivery as needed, based on requests from member Nations.[259, 260] KTC Health Administration continues to seek more services for their member Nations and to provide services that include: an Opioid Crisis Response Project, a Cultural Restoration and support program, regional efforts such as training coordination, coordination of Teddy Bear fairs and coordination of an oral health initiative. KTC Health also helps coordinate key primary care services in member Nations as requested. These include physician services, psychological services, dental services, home care and public health nursing.[261, 262]

As will be discussed in detail in Chapter 2, KTC Health has accessed Jordan's Principle funding to directly extend allied health services, mental health and wellness services, and supports for families of children with disabilities across the five member Nations.[263] In addition, KTC Health has supported member Nations in accessing Jordan's Principle funding for: therapy assistants and learning aides in Head Starts and daycares; FASD family support workers; operational funds for transportation of children with high needs; and youth suicide prevention through increased community mental health support and community connections workers.[264]

Kee Tas Kee Now Tribal Council Education Authority (KTCEA)

KTC Education Authority (KTCEA) was founded in 2017, with a governing board comprised of representatives from each of the five member Nations. It was the second First Nations education authority in Alberta. KTCEA currently provides administration for six schools, serving roughly 1,200 students within the five KTC member Nations.[265, 266] KTCEA developed policies and took on administration of three schools in 2017–18 and the remaining three schools in 2018–19.[267, 268, 269] By the 2018–19 school year, all schools in KTC member Nations shifted to a shared, land-based learning program for students, with the goal of strengthening Nêhiyawêwin (Cree) while attenuating attendance and graduation rates.[270]

In 2019, a historic funding agreement between Indigenous Services Canada and the five KTC member Nations ensured greater equity between KTCEA and provincial schools by increasing KTCEA per-student funds from $17,000 to $20,000, thereby bringing it in line with provincial

Textbox 3 KTC's role in service provision

...continued

funding of $19,000–$20,000 per year per student.[271, 272] In the same year, with the support of KTC Health, KTCEA also submitted a request for Jordan's Principle funding. This funding was renewed in 2020–21. These funds allowed KTCEA to expand the speech and language, occupational, physical and behavioral therapy services provided to school age children and to incorporate additional mental health supports into school settings.[273, 274]

Kee Tas Kee Now Tribal Council Child And Family Services (KTC CFS)

KTC Child & Family Services (CFS) was incorporated and delegated to provide child welfare services in 1997, following a tripartite agreement with the governments of Canada and Alberta.[275] The initial agreement included Loon River Cree Nation, Woodland Cree First Nation and Whitefish Lake First Nation #459. Peerless Trout First Nation and Lubicon Lake Band joined KTC CFS in 2013.[276] KTC CFS offers a full range of child welfare services, including family group conferences, band designate consultations, case conferences, permanency planning, the family enhancement program, foster care and kinship care.[277] KTC CFS is currently mandated to provide services to four of the five KTC member Nations. Indigenous Services Canada funds KTC CFS to enhance the lives of children, youth and families through community based and culturally appropriate programming, in keeping with the Alberta Child, Youth and Family Enhancement Act.[278, 279]

KTC CFS has experienced significant changes in recent years. In 2019, as a result of a Canadian Human Rights Tribunal decision ordering Canada to fund the actual cost of prevention services for child and family service agencies operating on-reserve, KTC CFS received substantial, targeted, prevention funding for the first time.[280] These funds supported the development of prevention programming to serve families living within the five KTC member Nations and families who are temporarily located in the urban centres of Slave Lake, Peace River, Grande Prairie and Edmonton.[281] In January of 2020, the federal legislation *An Act Respecting First Nations, Inuit and Metis Children, Youth and Families* came into force. The Act affirms the inherent right of Indigenous people to self-determination and self-government and specifies the terms under which First Nations, Metis and Inuit groups and communities that have created their own child welfare legislation may assume jurisdiction over child and family services.[282, 283] AFN and the federal government signed a protocol that outlines a structure to implement the Act in the summer of 2020.[284] Shortly afterwards, in October of 2020, Whitefish Lake First Nation #459 separated from KTC CFS, with the intent of ensuring that children remain in the community, and the goal of bringing children home so they remain connected to their relatives and their culture.[285]

Textbox 3 KTC's role in service provision

...continued

Additional Kee Tas Kee Now Tribal Council Programs And Services

KTC Social Development encompasses the whole of social, economic and cultural aspects to support individuals and community growth.[286] KTC Social Development programs include income assistance, social assistance, employment, training, income support, a learners program, special needs supports, a child out of parental home program, pre-employment supports and assisted living.[287] Additional programs and services operated by Kee Tas Kee Now Tribal Council include the Indigenous Skills and Employment Training Program (KTC ISET), which has a mandate to increase member participation in the local labour market.[288, 289]

The limitations on services available within the communities posed particular challenges given their semi-isolated status. As detailed in Map 2, which is based on a 2013 presentation prepared by KTC Health, community members had to travel between 90km and 500km, one way to access Alberta Health Services facilities and specialized children's services.[290] The closest early childhood development professionals and hospital services were 90km for Woodland Cree First Nation, while families and children from Peerless Trout First Nation had to travel 235km for the nearest services. Specialized children's services were the furthest away for all five Nations with families and children traveling between 380–500km to the nearest available services. For Loon River, the closest acute care facilities were a one-way trip of 180km to Slave Lake, 180km to High Prairie, or 155km to Peace River. Specialized health services were available only with a 453km trip to Edmonton. Accessing specialized dental or vision services and medical services such as Magnetic Resonance Imaging (MRIs) and Computerized Tomography (CT) scans also required significant travel.[291] These distances increased costs and imposed burdens on families accessing services outside of their communities. The semi-isolated status of KTC member Nations also increased the costs of implementing local services.[292]

A 2013 presentation by KTC outlined the health services available in each community at that time (see Table 1 for a summary). At that time, none of the communities were able to provide emergency, specialized, or acute care services. They also entirely lacked, or had very limited access to, essential primary care, such as services provided by physicians, psychiatrists, dentists, audiologists and other health care professionals. Challenges identified by KTC member Nations in 2013 included problems linked to coordination of medical transportation, the lack of accessible emergency services, the frequency of travel to Edmonton to access services, inadequate discharge planning and the lack of local obstetrical services.[293] Looking back on the services available to children, a service provider who has long been involved in KTC member Nations noted, "I would have to say there was hardly any services at all" prior to the implementation of Jordan's Principle funding.[294] Like others, that interviewee noted the existence of basic maternal child health services, child welfare services and some services for school-age children that were provided through the education system, but could not identify any other services targeting children and youth.[295]

Map 2

Location of early childhood development professionals, hospital services, and specialized children's services for KTC member Nations

	Whitefish Lake First Nation #459	Woodland Cree First Nation	Loon River Cree First Nation	Lubicon Lake Band	Peerless Trout First Nation
Early Childhood Development Professionals	Peace River	Peace River	Slave Lake	Peace River	Slave Lake
Hospital	Peace River	Peace River	Slave Lake	Peace River	Slave Lake
Specialized Child Services	Edmonton	Edmonton	Edmonton	Edmonton	Edmonton

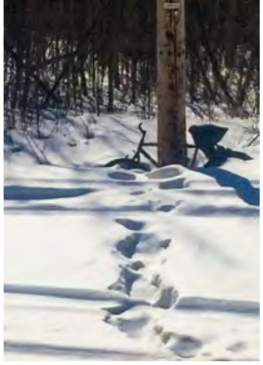
In 2019, a team from the University of Alberta Public Health department completed an environmental scan that detailed the services available in KTC member Nations.[296] Despite the extension of some needed services that were not available in 2013, the research confirmed persistent limitations in basic services in KTC member Nations. Researchers identified a long list of services that were absent across Nations, including: vision, hearing, dietitian, youth addictions, youth recreation and parenting education/support services. Families and children still had to travel long distances to access primary care, rehabilitation services, mental health care and other services.[297] As noted in 2013, challenges in accessing and coordinating services were complicated by limited cellphone coverage in the communities, which decreased the ability for service providers and families to connect remotely.[298]

Access to basic services required by all children was severely limited in KTC member Nations, and the situation for children with special needs was even more difficult. There is currently no research documenting the experiences of families of children with special needs who live in KTC member Nations. However, prior research in a Manitoba First Nation with similarly limited service access clearly documented the stark choices faced by families of children requiring specialized services or ongoing supports.[299] These choices included leaving their community and relocating to a larger area with more readily available services. This relocation meant leaving their support networks, sometimes without the chance of returning because of limited housing. To access services, families might also need to incorporate long commutes into their weekly routines, sometimes to the detriment of a child's

health and/or the economic status of the family. Some families also faced an impossible choice between placing their child in the care of CFS in order to access services or going without services. Going without services in order to retain custody of a child meant risking the emergence of more acute needs later on. The lack of accessible services resulted in "stressed, overwhelmed, exhausted, isolated, and frustrated caregivers" who were sometimes "forced to give up any employment they might have to take care of their children, without training or support beyond that which their families could provide."[300]

Recognizing the ways that families are negatively impacted by inequitable services, KTC Health has long worked to address the needs of children and families in the KTC member Nations. It has done so within a context that has been shaped by the persistence and determination of Nations and by the impacts of historic, and ongoing, federal policies. Federal policies have failed to fulfill the obligations outlined in Treaty and have led to the separation of families, the infliction of long-lasting harms and the persistence of disparities in outcomes for First Nations children. In Chapter 2 of this report, we detail KTC Health's efforts to address long-term underfunding and gaps in services by accessing funding through Jordan's Principle.



Soniyaw Natamakewin
(Securing Money)
Jordan's Principle funding for the Children's Resources team

Chapter 2





Jordan's Principle is a legal requirement intended to address inequities in the fragmented framework of policies for the funding and delivery of services to First Nations children. Despite strong support for Jordan's Principle from families, First Nations and advocates, the federal government resisted implementing the principle for over ten years after its creation in 2005.[301, 302] In 2016, the Canadian Human Rights Tribunal (CHRT) issued the first in a series of rulings and compliance orders mandating the full implementation of Jordan's Principle. The 2016 ruling also extended the interpretation of Jordan's Principle to require that services meet the best interests of First Nations children without compounding historical disadvantage.[303, 304, 305] In response, the federal government created the Jordan's Principle Child-First Initiative (CFI), which allocated $382.5 million in funding for 2016–2019. The CFI included a Service Access Resolution Fund (SARF) to support both services to individual children and services for groups of children. The CFI also included funding for service coordination efforts intended to help families access SARF funding and existing services.[306, 307, 308, 309, 310]

The procedures for and parameters of Jordan's Principle group funding requests were unclear. However, over time, KTC Health came to see the Jordan's Principle CFI as a time sensitive opportunity to develop a comprehensive range of resources for children in the five KTC member Nations. A first group request was submitted in 2018, with less than one year left of the initial three years of Jordan's Principle funding.[311] As KTC Health learned more about the needs of KTC children and families, administrators sought to renew and expand Jordan's Principle funding in order to support additional services. However, they faced the challenge of rapidly changing federal Jordan's Principle policies and processes, which necessitated revising and adapting their requests to meet new requirements. The ongoing policy changes affected not only new requests, but also the renewal of funding. For KTC Health administrators, constant changes in the federal implementation of Jordan's Principle brought the burden of adapting to changing standards, uncertainty about whether funding would be renewed, and the risk that they might lose the funding needed to pay staff and contractors they worked hard to recruit and retain.

Jordan's Principle—Genesis and initial implementation

Jordan River Anderson, a First Nations child from Norway House Cree Nation in Manitoba, was born with a rare neuromuscular disease. His complex medical needs required treatment, in-hospital in Winnipeg, far from his community and family home. When Jordan was two, his medical team determined his needs would best be met in a specialized foster home. Unfortunately, the federal and provincial governments could not agree on financial responsibility for Jordan's out-of-hospital care. Government officials argued over the funding of foster care and necessary supports, such as a specialized showerhead. Jordan remained in hospital, even though it was not medically necessary for him to be there. He died at the age of 5, never having had the opportunity to live in a family home.[312, 313, 314, 315, 316]

Jordan's Principle was named in Jordan River Anderson's honour and developed in recognition of the fact that Jordan's case was not an isolated incident. Jordan's Principle was initially articulated as a child-first principle that was intended to ensure that First Nations children had timely access to the same services as other children in Canada.[317, 318] It stated that when a First Nations child required services the government or department to which the request was originally made should pay for or provide the needed services without delay.[319] Since its inception in 2005, Jordan's Principle was championed by Jordan's family and community, First Nations in Manitoba and the First Nations Child and Family Caring Society. Jordan's Principle was minimally implemented for over a decade, despite the unanimous endorsement of a 2007 House of Commons resolution in support of Jordan's Principle and strong advocacy from First Nations, Canadian and international bodies.[320, 321, 322, 323, 324]

Between 2007 and 2016, the federal government's approach to implementing Jordan's Principle was so restrictive that no Jordan's Principle cases were officially identified. The government interpreted Jordan's Principle as applying only to: children who had been professionally assessed as having multiple disabilities, required services from multiple providers, and were ordinarily resident on-reserve.[325] Additionally, the services requested had to be comparable to existing provincial services in a "similar geographic" location.[326] A case that met these strict criteria had to pass through a lengthy, eight-step case conferencing process in order to be recognized by the government as a Jordan's Principle case.[327] The impact of the restrictive definition of Jordan's Principle was clear in federal government assertions—in 2010, 2012 and 2015—that it knew of no Jordan's Principle cases in Canada. Similarly, the effect of the federal government's narrow interpretation of Jordan's Principle was evinced in the fact that, between 2008 and 2012, no child accessed federal funding allocated to resolve jurisdictional disputes in Jordan's Principle cases.[328, 329, 330, 331] Few details of the implementation of Jordan's Principle in Alberta during this period are available. The Alberta government expressed support for Jordan's Principle, but there is no public record of Jordan's Principle practices or policies being developed.[332, 333, 334]

Jordan's Principle as interpreted by the CHRT

Since 2016, the federal approach to and understanding of Jordan's Principle has been transformed by a series of sweeping decisions from the CHRT. These decisions came in response to a human rights complaint filed by the First Nations Child and Family Caring Society (Caring Society) and the Assembly of First Nations (AFN) in 2007. The complaint alleged that the underfunding and poor administration of child welfare services in First Nations constituted systemic discrimination against First Nations children "because of their race and national ethnic origin."[335] One component of the complaint identified the failure to implement Jordan's Principle as perpetuating discrimination in child welfare.[336] The federal government stalled the case through years of technical appeals and the withholding of documents. Though the original complaint was filed in 2007, the CHRT's first ruling in the case was not issued until 2016.[337, 338, 339, 340]

In 2016, the CHRT ruled that Canada discriminated against First Nations children through its funding and administration of child welfare services. Between April of 2016 and December of 2020, the CHRT issued ten additional orders responding to Canada's continued failure to comply with the Tribunal mandates (see Figure 1). These orders required Canada to develop revised child welfare funding and administration policies. They obligated Canada to provide funding based on the "real needs of First Nations agencies." The CHRT required that the revised funding formula include, but not be limited to, infrastructure repair, prevention services, assessment, service gaps and costs associated with remoteness.[341, 342, 343]

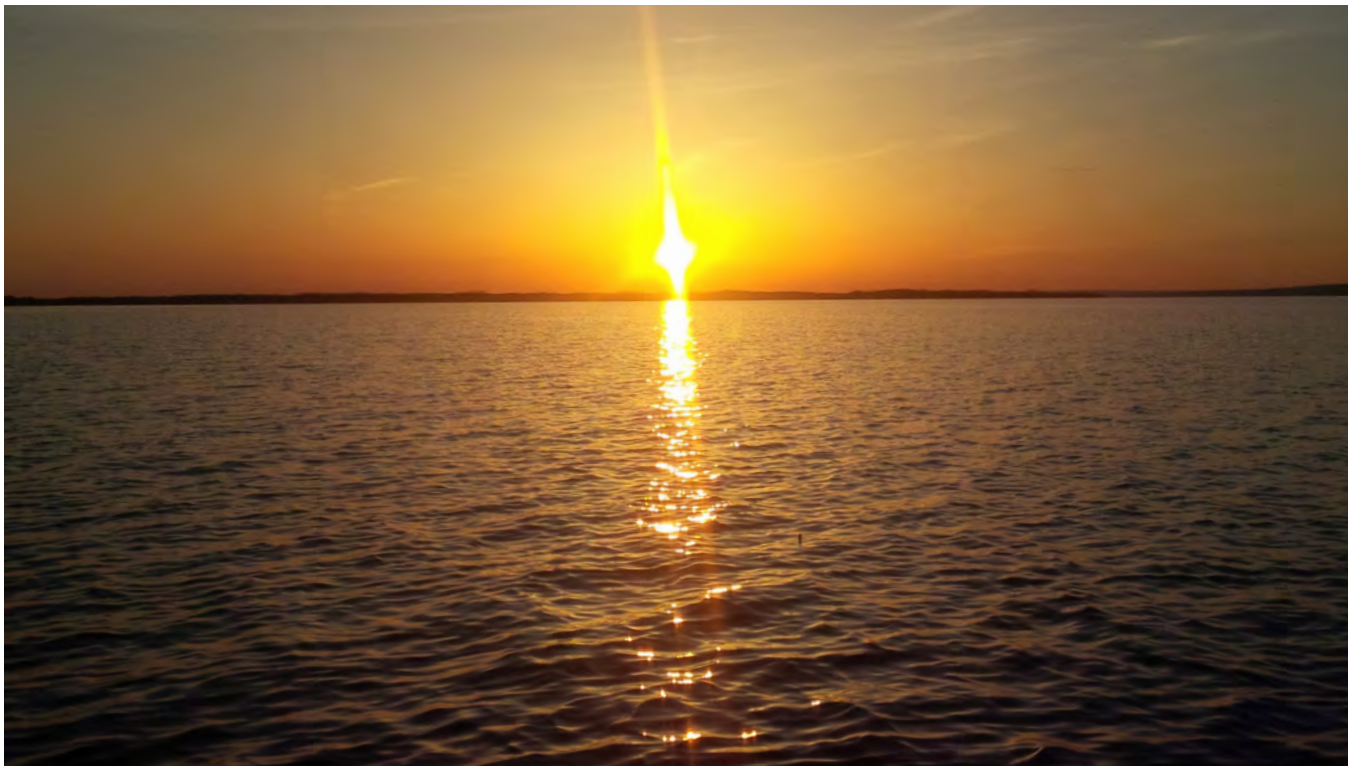


Figure 1

Legend

Red = Canadian Human Rights Tribunal orders
Blue = Federal/regional developments in Jordan's Principle implementation

January 26, 2016
2016 CHRT 2, The Decision

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

April 26, 2016
2016 CHRT 10, Compliance Order #1

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

July 6, 2016
Federal Funding Announcement

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

September 14, 2016
2016 CHRT 16, Compliance Order #2

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

November 1, 2016
House of Commons Motion to comply with CHRT

Federal MP Charlie Angus calls on government to comply with CHRT rulings and motion passes unanimously, across party lines.

May 26, 2017
2017 CHRT 14, Compliance Order #3

Canada ordered to apply broad definition of Jordan's Principle including application to all government services, in the absence of a jurisdictional dispute, and to services beyond the normative standard of care where necessary to ensure substantive equity. Determinations must be made within 12–48hrs.

June 23, 2017
Canada requests judicial review of CHRT order

Canada applies for an order setting aside aspects of Compliance Order #3 including the order to make a determination within 24–48hrs of receipt and without case conferencing.

August 28, 2017
Government cabinet shuffle creates new ministries

Department of Indigenous Services Canada is created to focus on service delivery while Department of Crown/Indigenous Relations and Northern Affairs will lead self-governance and self-determination negotiations.

October 23, 2017
Launch of FNHC service coordination

The First Nations Health Consortium begins to offer enhanced service coordination services. 1-800 number and website go live.

November 2, 2017
2017 CHRT 35, Compliance Order #4

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

January 25, 2018
Canada unveils 6 point plan to reform First Nations child welfare

Commitments include full implementation of CHRT orders, reforming child and family services, and exploring the potential for co-developed child welfare legislation.

Jordan's Principle Timeline: 2016–2020

February 1, 2018
2018 CHRT 4, Compliance Order #5

CHRT orders Canada to fund child welfare agencies for their actual costs, including for prevention services, retroactively to January 2016, and to cease using population thresholds to limit funding. Orders in effect until nation -to-nation agreement on child welfare services reached.

February 9, 2018
Indigenous Services Canada announces new 24hr Jordan's Principle hotline

Hotline advertised on government websites in addition to phone numbers for provincial focal point contacts.

January 7, 2019
2019 CHRT 1, Compliance Order #6

CHRT orders Canada to compensate the First Nations Child and Family Caring Society, the Assembly of First Nations, and the Chiefs of Ontario. Compensation resultant from Canada's failure to disclose 90, 000 documents relevant to the Tribunals July 3, 2013 decision.

February 21, 2019
2019 CHRT 7, Compliance Order #7

CHRT orders Canada to provide Jordan's Principle funding to First Nations children who live off-reserve, do not have Indian Act status, and are recognized by their Nation as members. The CHRT is in the midst of hearings to determine the definition of a First Nations child for Jordan's Principle eligibility.

March 19, 2019
Federal Budget Released

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

June 21, 2019
Bill C-92 receives Royal Assent

Bill C-92, An Act respecting First Nations, Inuit, and Métis children, youth and families receives Royal Assent. The bill outlines the purpose and principles that are integral to the provision of child welfare to First Nations, Inuit, and Métis children and families.

September 6, 2019
2019 CHRT 39, Compliance Order #8

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

October 21, 2019
Federal Election

A minority federal government is elected. During the campaign the federal government issues an appeal of CHRT 39 to review the compensation for First Nations children and their families.

November 29, 2019
Federal court dismisses federal appeal

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

July 17, 2020
2020 CHRT 20

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

November 25, 2020
2020 CHRT 36

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

The CHRT also ordered Canada to immediately adopt the full scope of Jordan's Principle.[344] Subsequent rulings formally defined Jordan's Principle as:

- Applying to *all* First Nations children, regardless of ability, disability, or their place of residence within or outside of First Nation-reserve communities.[345, 346]

- Requiring the federal government to approve emergency cases for First Nations children living off-reserve without status, including children who are ineligible for First Nations status.[347]

- Addressing the needs of First Nations children by ensuring there are no gaps in the government services provided to them.[348, 349] The CHRT orders also specified that "a dispute amongst government departments or between governments is not a necessary requirement for the application of Jordan's Principle."[350]

- Applying to a broad range of health, education and social services; Jordan's Principle can address, but is not limited to "mental health, special education, dental, physical therapy, speech therapy, medical equipment and physiotherapy."[351]

- Requiring the government department of first contact to pay for a government service or assessment that is "available to all other children" and do so "without engaging in administrative case [. . .] conferencing, policy review, service navigation or any other similar administrative procedure before the recommended service is approved and funding is provided."[352]

- Requiring the government department of first contact pay for a government service or assessment that is "not necessarily available to all other children or is beyond the normative standard of care, the government department of first contact will still evaluate the individual needs of the child to determine if the requested service should be provided to ensure substantive equality in the provision of services to the child, to ensure culturally appropriate services to the child and/or to safeguard the best interests of the child." Provincial and federal government officials must do so without engaging in administrative case conferencing, policy review, service navigation or other administrative procedures prior to service approval and provision of funding.[353]

The stipulation that, in some cases, Jordan's Principle requires the provision of services that extend beyond normative standards of care results from the CHRT's linking of Jordan's Principle to substantive equality.[354, 355] Substantive equality is a legal standard that requires the provision of additional services to some groups who experience unique disadvantages so that they may achieve equivalent outcomes.[356] The CHRT's emphasis on substantive equality shifts the goals of Jordan's Principle beyond simply ensuring access to services that are equal to those available to other children; it necessitates the development of mechanisms for responding to the needs, culture and best interests of First Nations children. The federal government has adopted the nine questions in Textbox 4 as guides for assessing substantive equality.[357] The Touchstones of Hope, values originally defined as key to achieving reconciliation in child welfare, have also been integrated into the federal government's understanding of substantive equality. The touchstone values are self-determination, culture and language, a holistic approach to meeting the needs of children, structural interventions and non-discrimination.[358]

Textbox 4 Questions for assessing substantive equality

1. Does the child have heightened needs for the service in question as a result of an historical disadvantage?
2. Would the failure to provide the service perpetuate the disadvantage experienced by the child as a result of his or her race, nationality, or ethnicity?
3. Would the failure to provide the service result in the child needing to leave the home or community for an extended period?
4. Would the failure to provide the service result in the child being placed at a significant disadvantage in terms of ability to participate in educational activities?
5. Is the provision of support necessary to ensure access to culturally appropriate services?
6. Is the provision of support necessary to avoid a significant interruption in the child's care?
7. Is the provision of support necessary in maintaining family stability? As indicated by:
    i. the risk of children being placed in care, and
    ii. caregivers being unable to assume caregiving responsibilities.
8. Does the individual circumstance of the child's health condition, family, or community context (geographic, historical, or cultural) lead to a different or greater need for services as compared to the circumstances of other children (e.g., extraordinary costs associated with daily living due to a remote location)?
9. Would the requested service support the community/family's ability to serve, protect and nurture its children in a manner that strengthens the community/family's resilience, healing and self-determination?[359]

An accurate articulation of historical disadvantage requires both knowledge of historical events and an ability to connect complex processes of discrimination and trauma to a child's individual experience. Although it is the federal government's responsibility to assess eligibility for Jordan's Principle funding, the government has shifted this responsibility onto First Nations families by requiring these questions be addressed in some Jordan's Principle requests. Addressing these questions is time consuming and may be traumatizing for some families. Moreover, the process itself violates the principle of substantive equality, because First Nations people must spend additional time and resources advocating for the government to address heightened needs created by the government's discriminatory treatment.[360, 361]

The CHRT has also outlined key features of a process for assessing Jordan's Principle requests. The government must respond to a Jordan's Principle request within specific time limits: within 48 hours of an initial request for services for an individual child, and within 12 hours for urgent requests after receiving all necessary clinical information.[362] Consultation or case conferencing is permitted only if needed to determine a child's clinical needs. If clinical consultation is required, the federal government must ensure that it responds "as close to the [initial] 48-hour time frame as possible" after all clinical information is provided.[363, 364] Responses to group requests, which address service gaps impacting a large number of children, are required within 48 hours for urgent cases and one week for non-urgent cases.[365]

Following multiple compliance orders and on-going CHRT monitoring, the federal government began formally incorporating both the CHRT's criteria for Jordan's Principle eligibility and the CHRT ordered timelines in its approach to implementing Jordan's Principle. In July of 2016, the federal government announced the creation of the Jordan's Principle Child-First Initiative (CFI), which allocated $382.5 million to support services for First Nations children between 2016 and 2019.[366] The CFI included funding for a Service Access Resolution Fund (SARF), which was to pay for services for individual children approved under Jordan's Principle and for Jordan's Principle group requests that address service gaps affecting large numbers of children.[367, 368] The CFI also included federal funding for an "Enhanced Service Coordination model of care" (ESC model); organizations in each province and territory would receive funding for service coordinators who helped families navigate existing federal and provincial services.[369, 370]

Building on the initial announcement of the three-year CFI, the federal government described their plans for the long-term implementation of Jordan's Principle as a "phased approach."[371] The first, transitional phase involved continued funding of Enhanced Service Coordination, First Nations service delivery and innovation in service delivery. The first phase also involved seeking a mandate and funding from Cabinet for consultation with First Nations. The goal of the second phase has been described as the "implementation of a First Nation vision for Jordan's Principle based on the results of First Nations-led dialogue sessions, including funding needed to fill persistent gaps in service."[372] In line with phase one, the 2019 federal budget included a $1.2 billion allocation to renew the national CFI for three years. However, federal projections taking into account the tripling of Jordan's Principle requests during the 2017–2018 year estimated $840.5 million would be required to adequately fund nationwide Jordan's Principle requests in 2019–20 alone, concluding that if estimated demand continues, an additional $1.3 billion would be required over three years.[373] Publicly available budget information indicates expenditures of $392 million in 2018–19, including administrative and operational costs, and $561 million in 2019–20. Planned spending projections indicate a reduction in funding in 2020–21, with projected spending at $436 million, rising only slightly to $446 million in 2021–22 and $494 million in 2022–23.[374] Organizations in Alberta have received annual renewal of funding or invitation to reapply for funding each year since the CFI was introduced.[375, 376] There is no public information about funding beyond 2022–23, nor any public documentation of the progress towards phase two of the implementation of Jordan's Principle.

Prior research has documented persistent problems with and questions about the implementation of Jordan's Principle. Among the documented issues are:

- Federal policy that allows for multiple rounds of requests for clarification and new documentation prior to 'starting the clock' on CHRT ordered timelines for responding to Jordan's Principle requests;[377, 378]

- Ongoing failures to meet the designated timelines once the response time clock has been started, particularly when requests are assessed at the national, rather than the regional, level; and [379]

- Inconsistent decisions, over time and across cases, because of shifting federal policies and reliance on discretionary decision making.[380, 381, 382]

Jordan's Principle policies continue to evolve, both as a result of new CHRT rulings and because of other decisions made by the federal government. For example, the CHRT recently ruled on the definition of a "First Nations child." The tribunal ruled that this category includes all status First Nations children living on or off-reserve, as well as:

1. On or Off-reserve children whom a First Nations recognizes as belonging to their community;

2. Children who do not have and are not eligible for *Indian Act* status, but have a parent who has or is eligible for *Indian Act* status; and

3. Children residing off-reserve, who have lost their connection to their First Nations communities due to colonial policies.[383]

The Federal government has sought judicial review of this decision, and the matter is before the Federal Court.[384, 385]

Jordan's Principle and KTC Health

In the context of a historical pattern in which KTC Health and KTC member Nations had inadequate resources to meet the needs of children and families, the CHRT driven implementation of Jordan's Principle provided new hope and opportunities. Within Alberta, the first step towards implementing the CFI occurred in late November of 2016, when the federal government issued a request for proposals for "service coordination" initiatives that would help First Nations families access existing services and Jordan's Principle funding.[386]

With a very short timeline and minimal details of service coordination to guide them, the KTC Director of Health and colleagues from Bigstone Cree Nation, Siksika Nation and Maskwacis Health Services joined together to propose a new organization: the First Nations Health Consortium (FNHC). They proposed that the FNHC could provide enhanced service coordination for First Nations families across the Alberta region. The proposal was accepted in January of 2017. The FNHC began developing the service coordination model shortly afterwards and started providing service coordination in the fall of 2017.[387, 388]

During this same period, under court order, the federal government began expanding Jordan's Principle capacity and promoting public awareness of the availability of Jordan's Principle funding to address children's unmet needs.[389, 390] Prior to 2016, public education around Jordan's Principle was primarily focused in the domain of child welfare. Accordingly, many people working in health services had limited information about Jordan's Principle. For the KTC Director of Health, work with the FNHC provided opportunities to learn about the new funding made available through the Jordan's Principle CFI. The federal government's approach to the implementation of Jordan's Principle, however, complicated this learning process.[391] Although both individual and group requests for Jordan's Principle were being assessed by 2017, formal guidelines—in the form of a standard operating procedures manual—were only circulated in 2019.[392, 393] In the interim, policies surrounding the provision and enforcement of Jordan's Principle shifted continuously in response to new CHRT rulings and federal efforts to understand and respond to the growing number of Jordan's Principle requests.[394]

Further complications were linked to the individualistic, demand-driven approach to the implementation of Jordan's Principle, the lack of information about the requests received and funded and limited transparency about the federal response to those requests. The implementation of Jordan's Principle in Alberta did not involve systematic assessment of the needs of First Nations children and families. Rather, the burden of identifying and documenting unmet needs and service gaps, and of advancing requests for Jordan's Principle funding, fell to First Nations families and organizations. These burdens were amplified when it came to group requests. Organizations seeking group funding had to assess needs and service gaps without any existing service standards to guide their assessments. No call for proposals was circulated, no written guidelines for a group request were provided, and no information about the types of requests being received and approved or denied was publicly available.[395, 396] A KTC Health administrator summarized the request process this way:

> *No guidebook, no examples. It was left to the knowledge of the regions and the humans that serve, and their tenacity to figure it out.*[397]

KTC Health initially took a watch and learn approach, hoping that Jordan's Principle policies and procedures would be clarified. However, the CFI funding had only been allocated for the fiscal years 2016–17 to 2018–19. By the end of 2017, there was no clarity about the long-term implementation of Jordan's Principle or the renewal of CFI funding.[398] By early 2018, uncertainty around the continuation of Jordan's Principle funding created a sense of urgency for KTC Health. Sensing a closing window of opportunity, KTC Health moved forward with the preparation of a Jordan's Principle group request.

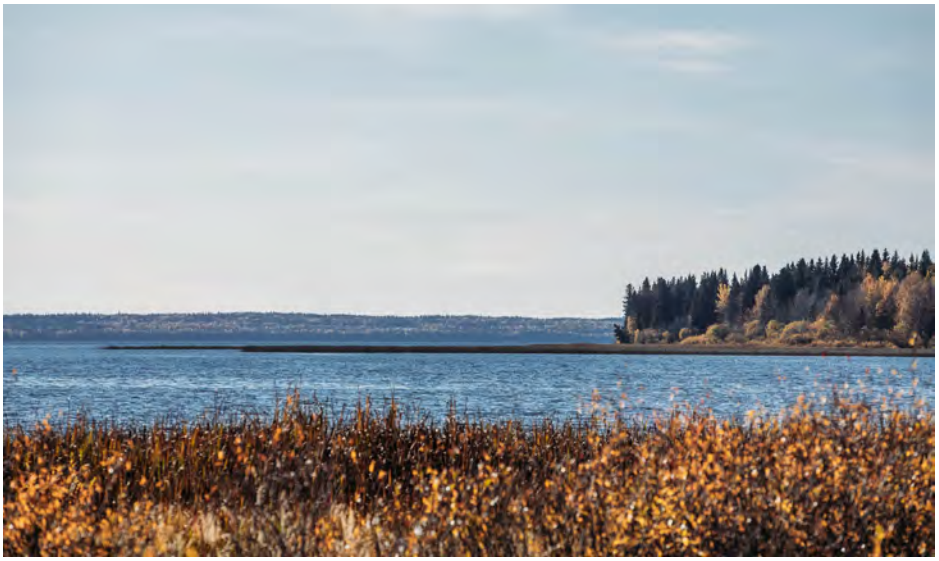
An administrator explained:

> *I just said okay, I feel there is a window open here and I don't know if it is closing so we better do a knee jerk so…we sat down and started rattling off what we need.*[399]

KTC Health administrators reached out to KTCEA and KTC CFS, both of which were experiencing staff shortages and turnover at the time, in the hopes of developing a unified KTC proposal.[400] They arranged for an initial meeting with the First Nations Health Consortium, which by this time had some experience with Jordan's Principle group requests, and KTCEA to discuss a 'joint submission' that requested funding for services to be provided both through KTC Health and KTCEA. KTC Health administrators proposed to take the lead in drafting the full submission.[401, 402]
KTC Health then reached out to Health Directors in the KTC member Nations to inform them of the proposal in development, gain their support and request estimates of the number of children who needed speech and language pathology, occupational therapy, physical therapy and other services.
At the end of April, with KTC Health's part of the joint proposal fully drafted, communication between KTC Health and KTCEA faltered. KTC Health administrators sent multiple queries and requests with no reply.
They eventually arranged a conversation with the Director of Education during which the decision was made that KTC Health should move forward with submissions on behalf of both KTC Health and KTCEA.[403, 404, 405]

Just as KTC submitted the proposals, in May of 2018, KTC member Nations experienced the loss of multiple youth due to suicide.[406] KTC Health administrators immediately amended the joint Jordan's Principle funding request to include crisis response and suicide prevention supports through both the KTCEA and KTC Health.[407, 408, 409]
The request was approved on May 20, 2018.
The approved funding included $3,462,332 for KTC Health to provide services and supports during the 2018–19 fiscal year. Services were to be provided in coordination with early childhood development centers in the KTC member Nations whenever possible. The funded services are listed in Table 1, along with subsequent amendments to funding.

The approval of this Jordan's Principle request laid the foundation for a dramatic shift in the services available to KTC children and families; the awarded funds would support the development of services and programs that had never before been available. Though KTC Health did engage other organizations in the submission process, pressure to secure funds within the 2016–2019 CFI funding allocation period meant that the organization moved quickly, and



without the usual level of engagement with Nations that administrators would have liked. Reflecting back on the process, an administrator said:

> *We didn't have time to talk to anybody. The process around thorough engagement, there wasn't time. We went backwards. We went backwards and have thoroughly engaged the health staff and directors in the community [after submitting the request]. But coming out of the gate it was like, oh man the clock is ticking!...I was very fearful that the federal government would change things April 1st or say things didn't work out.*[410]

This sense of urgency, coupled with the mandate from the Nations to pursue all opportunities that would benefit KTC member Nations, shaped KTC Health's approach to the development of Children's Resources. In combination, the urgency and mandate to pursue opportunities provided an impetus to move as rapidly as possible to establish a system of services that would meet the needs of children and families in the KTC member Nations.

Requesting expanded and continued funding to meet needs

As KTC Health developed an initial range of children's services, administrators' understanding of the gaps in services and the needs of families and children in the KTC member Nations increased. A large-scale needs assessment was not implemented due to community fatigue after months of advocacy for mental health services following the suicide crisis, but ad-hoc discussions with service providers and with Chiefs and Councils helped to provide a better sense of community needs.[411] In early 2019, as they began to consider renewal of their Jordan's Principle funding, KTC Health administrators took stock of the knowledge gained through the first year of operation and identified areas in which additional funding was required in order to meet the needs of children and families. A new Jordan's Principle request was initially submitted in January, but then, on the advice of regional focal points, it was divided in two parts: a request for an amendment to existing funding and a request for funding for new services.[412] (See Table 1)

With the support of KTC member Nations' Chiefs and Councils, KTC Health proposed to amend its original Jordan's Principle funding agreement. Administrators requested additional funds to: recruit and retain qualified clinical staff; provide training for community-based respite workers, therapy aids and learning/teacher's aids; and expand services to address identified needs across KTC member Nations. KTC Health Services submitted a requested amendment for $3,520,440 in February of 2019.[413] One month's funding was approved later that month; full approval came in April after multiple requests from the KTC Director of Health for confirmation of 2019–20 funding.[414] Through the amendment and

Table 1 Health Services in KTC Nations (2013)[454]

Lubicon Lake Band	Pre-manufactured building converted to a Health Centre open full-time during weekdays with services including home care nursing, medical transport, community wellness and supports for substance use.
Loon River Cree First Nation	In June of 2000, a health centre opened in Loon River Cree First Nation. The centre provides "basic public health and community wellness programs and services" on a full-time basis, which includes nursing, home care, supports for substance use, maternal and child health supports, Head Start supports and medical transport among others.
Woodland Cree First Nation	A health centre opened in January of 2002. The centre offers services including home care and public health nursing, supports for substance use, maternal health supports, Head Start services and medical transport among others. Some physician, psychiatric and dental services are also available on a part-time basis.
Whitefish Lake First Nation #459	A full-time health centre opened in February of 2002. The centre provides basic public health and community wellness supports and services, including nursing, supports for substance use, maternal and child health supports, Head Start supports and medical transport services. Some physician, psychiatric and dental service are also available on a part-time basis.
Peerless Trout First Nation	Two health clinics operate 24km apart, one in Peerless Lake and one in Trout Lake on a part-time, weekday basis. This creates a full-time schedule between the two clinics. Services include nursing, home care, mental health and medical transport. Some physician, psychiatric and dental services are also available on a part-time basis. Crisis counseling is provided through FNIHB.

funding renewal process, KTC Health also requested that funding for key positions—including therapy assistants (TAs), learning aids, additional family support coordinators, Elders/knowledge keepers, van drivers and community connectors—be transferred directly to KTC member Nations.[415]

Following the January, 2019, advice of the regional focal point, KTC Health Services also submitted a separate request for new services.[416] Totaling $1,100,000, the request included funds for program space rental, Maternal Child Health support, Head Start workers, administrative costs, and funding to support the development of a children's support model (see Table 2).[417]
The request was denied. The feedback provided indicated the requested services were above the normative standard of care and, accordingly, the request must include documentation justifying the services on the grounds of substantive equality.
In discussion of the decision, regional focal points strongly suggested that an appeal would also be denied. KTC Health made the decision not to pursue an appeal.[418]

Table 2 KTC Health funding: Original Jordan's Principle request and amendments

	036 Original Approved May 2018	036 Amendment Approved February 2019	Amendment Partial Approval July 2, 2019
Service requested	**Services providers and supports**	**Additional services providers and supports**	**Additional services providers and supports**
Speech and Language Pathology (SLP)	• 2 positions plus travel	• Additional salary and recruitment incentive to attract qualified SLPs to remote and rural locations: $350,000	
Occupational Therapy (OT)/ Physical Therapy (PT)	• 1 OT/PT plus travel • 5 OT/PT assistants plus travel and $30,000 cost of supplies; KTC Nations funded directly	• 1.5 additional OT/PT positions • 5 OT/PT assistants, KTC Nations funded directly • $75,000 for OT/PT assistant training to support recruitment of staff from Nations • $140,000 for additional supply costs	
Learning/ Teacher's Aides	• 5 positions, KTC Nations funded directly	• 9 positions, KTC Nations funded directly • $100,000 for training to encourage recruitment of staff from Nations	
Fetal Alcohol Spectrum Disorder Support Coordinators	• 2 positions	• 3 additional coordinators to coordinate supports/services for an expanded range of children & families with disabilities, KTC Nations funded directly	
Respite Care for Children with Disabilities	• $300,000 for 30 families	• 1 coordinator position and $75,000 in respite care training for caregivers	• Additional funding: $300,000
Adaptive Supplies and Product Aides	• Modifications to public spaces to provide support for children with disabilities: $150,000		

Table 2 KTC Health funding: Original Jordan's Principle request and amendments

...continued

Psychologists	• 1.5 positions plus travel		
Cultural Supports and Programming	• Compensation to Elders provided on an honorarium basis. KTC Nations funded directly: $100,000	• Additional funding to respond to needs in larger Nations and equalize per capita support. KTC Nations funded directly: $81,900	• Additional funding requested to shift from honorarium to provide 9 full-time cultural support workers. KTC Nations funded directly • 0.5 medical social worker • 10 summer camp supervisor positions for 2 weeks of service provision, $50,000 for summer camp materials and supplies
Transportation Supports	• 5 accessible, modified vans at cost of $425,000	• 5 van drivers, funding went to KTC member Nations	
Youth Suicide Crisis Response and Prevention	• 3 psychologists, 3 short term social workers, 2 Elders/knowledge keepers for 6 months and 1 social worker for an extended period	• 3 psychologist positions plus travel costs • 5 community connector positions to work with youth. Funding went to KTC member Nations • 1 crisis response coordinator plus travel	
Clinical Managers	• 2 positions plus travel		• Adjustments requested to align with Alberta Health Services standards: $212,580
Administration		• 10% administration including file management, human resources, finance, tracking and reporting. A portion of funding went to KTC member Nations: $320,040	• 10% administration costs: $114,297. A portion of funding went to KTC member Nations
Medical Records Manager			• 1 position, sent to national for review and denied

* Number of positions or amount (for equipment, supplies, training and honoraria)

In June of 2019, KTC Health Services submitted a second amendment to its initial funding request. The amendment requested $1,258,367 in funding to: achieve parity with AHS standards for clinical supervisor salaries, provide respite services to an additional 30 families and offer a summer culture camp. The request also included funding for an operational manager, administrative fees and a medical records manager.[419] (See Table 1)
The amendment was approved for the amount of $1, 045,787. The request for a medical records manager was sent to the national Jordan's Principle office, in Ottawa, for review and was eventually denied.[420, 421]

In July of 2019, KTC Health submitted an additional new request for $1,309,627 to address gaps in services including dietitian services, a mobile audiology clinic, training for families of children with disabilities and administrative costs.[422]
The audiology, training and administrative costs were approved for the amount of $401,307.[423]
Dietitian services, valued at $908,320, were sent to the national Jordan's Principle office for further review. An email informing KTC Health that the dietitian request had been denied was received in early August; an official denial letter was received in early October.[424, 425]

KTC Health's request for a dietitian included an explanation of the ways in which settler colonialism disrupted traditional food patterns, resulting in greater food insecurity, poorer nutrition and higher risk of diseases such as type-2 diabetes for First Nations children. It also noted that the nearest dietitian services through Alberta Health Services were 2–3 hours away, and that NIHB does not cover transportation costs to access these services. Moreover, the services available were not culturally tailored and the AHS dietitian assigned to the KTC region was not able to provide any one-on-one counselling. The submission included letters of support, from community clinicians and leadership, identifying the importance of dietitian services for youth living in KTC member Nations.[426]

Focal points indicated that they felt the request failed to provide documentation that identified how dietitian services would address the needs of KTC children. In addition, they indicated that dietitian services were not typically available to all children.[427] Accordingly, the request was deemed above the normative standard of care and the denial indicated the proposal must provide documentation that addressed substantive equality. KTC appealed the decision around dietitian services, responding to the reasons for denial and providing a substantive equality justification.[428] On December 18th, 2019, this appeal was denied. This new denial noted that

the supporting documentation KTC Health provided to addresses substantive equality had been reviewed and indicated that the appeal was denied because the request failed to connect the specific needs of *individual children* to the requested services.[429, 430]

During a January, 2020, meeting with regional focal points, KTC Health discussed the dietitian funding request and sought clarity on required documentation. Focal point staff suggested future requests include de-identified information on the needs of *individual children* along with a description of how the requested service would resolve those needs.[431] This was the first time that the KTC Health team was notified that group requests should connect the requested services to the needs of specific, individual children. Focal point staff further indicated that, since the KTC Health proposal framed dietitian services as part of a holistic approach to children's health, documentation supporting the potential impact of dietitian services across multiple domains was recommended.[432] These suggestions seemed to contradict a February, 2019, communique from the Jordan's Principle office in Alberta, which indicated that complete proposals needed only document "the number of children to be served by the proposal (including age/grade range)" and "information detailing circumstances and disadvantages."[433] Finally, focal point staff suggested that, in order to improve the chances of approval, KTC Health should shift away from requests that provided preventative services, stating that Jordan's Principle does not fund "programs" or "prevention."[434]

KTC Health Services attempted to secure dietitian services beginning in July of 2019. Its initial request clearly identified a gap in services, provided an estimate of the number of children to be served and included supporting documentation from relevant service professionals. Additional documentation that supported a need for the service under a substantive equality standard was also submitted. The request went through a process of being submitted, denied, appealed and denied again. Each of the two denials were justified by assertions that additional documentation was needed despite KTC Health administrator's attempts to verify the required documentation with focal point workers in advance of each submission. It was not until May of 2020 that the dietitian was approved, after almost a year of appeals.

Fighting for existing funds

On February 11th, 2020, with less than two months before the end of the fiscal year, KTC Health administrators were informed by regional focal points that, for the first time, they must 'reapply' in order to receive continued funding for approved group requests.[435] In a follow-up meeting on March 11th, KTC Health administrators were informally told that they should expect substantial reductions in funding and informed that Jordan's Principle group requests cannot be used to support prevention services. Administrators were also notified that the upcoming funding renewal application would likely entail altering previously approved group request submissions to include information that directly connected the provision of services to individual children. This left KTC Health administrators with 17 days to prepare an application for the new fiscal year.[436]

KTC Health administrators reviewed previously approved group requests, line-by-line, with focal points and the regional Jordan's Principle Director in an attempt to identify strategies for retaining funding for vital services. Services identified as being at risk for funding cuts included: TAs, suicide prevention, preventative mental health services and cultural supports such as Elders who worked with Nations to support youth. Focal point staff helped

brainstorm strategies to bring these services in line with the assessment criteria for resubmissions, but provided little in terms of workable solutions. Focal points suggested that the cost of TAs and other non-clinical supports could be rolled into broad categories of clinical supports, rather than being presented as line items. In addition, in order to provide evidence of the impact of Elders' work on individual children, focal points suggested Elders might begin keeping files on each child with whom they interact. KTC Health administrators rejected this suggestion as being culturally inappropriate.[437] Focal points also suggested KTC Health explore sustaining key Jordan's Principle services by accessing the prevention funding that KTC CFS received as a result CHRT orders, but the staff could provide no details on how such a resolution might be pursued. KTC Health administrators later noted that KTC CFS had already developed prevention programming with the received funds.[438]

On March 23rd, with 18 staff and contractor salaries on the line, a burgeoning COVID-19 crisis and no indication of the level of Jordan's Principle funding that would be available on April 1st, the KTC Director of Health wrote to regional Jordan's Principle Director requesting confirmation of funding for the 2020–21 fiscal year.[439] The response, received 3 days later, approved the extension of KTC Health's existing funding for April and May of 2020. It also indicated that the regional office would "revisit the need for further extension in May 2020." The email noted that the 2-month funding was being extended because of the "unique circumstances," alluding to the global pandemic and reiterated that "Jordan's Principle is a child specific initiative."[440]

On April 30th, KTC Health submitted its reapplication for Jordan's Principle group funding (see Table 3). The reapplication incorporated the regional focal point's suggestions around the framing of non-clinical positions and thorough documentation to justify the need for mental health and cultural supports.[441] KTC Health subsequently received a request for extensive clarifications and submission of details that far exceeded the expectations previously communicated by focal points.[442] Regional officials explained that this was not a result of a change in national assessment standards, but rather an attempt to bring regional standards in line with national expectations and practices.[443]

Partial approval of the request, in the amount of $4,656,772, was received on May 30th, just as KTC Health's funding extension was to expire. Funding was approved through December 2020, with funding for January–March 2021 conditional upon expenditure of the June–December 2020 funding. Allied health (OT/PT/SLP), learning/teacher aides, specialized supports for children with disabilities, psychology services and transportation supports were approved. The request for $3,492,734 to support clinical case management, audiology, cultural supports, youth suicide response and prevention and administrative costs were sent to the national office for further review.[444] Six weeks later, KTC Health was informed that the national office had completed its review and funding to support clinical case management, audiology, cultural supports, youth suicide response and prevention and administrative costs was denied.[445] This meant that KTC Health would be forced to terminate key positions and already established services.

Table 3 KTC Health funding: additional Jordan's Principle requests

Group request 139 Denied, March 2019	Group request 167 Partial approval, July 2019
Program space rental: to house support workers funded through Jordan's Principle: $350,000 was requested for 1-year office rental for 7 office spaces	**Dietician services:** 1 dietician salary with travel costs and clinical supervision* **Healthy Eating Program:** $350,000 materials and supplies. Cost based on estimate of $175 per child in 5 communities and employment costs of 14 youth leaders across 5 communities to run program 4 days per week during school year
Family Support Workers: 3 full-time workers to support high risk families of young children in Lubicon and Peerless Lake and Trout Lake through home visitation plus travel: $135,000 for 3 vehicles for home visitation	**Audiology:** mobile clinic audiology testing for all children who exhibit signs of hearing loss and/or speech and language delays
Qualified Head Start Workers: funding to recruit and retain qualified Head Start staff; 10 salary supplements to equalize wages with urban areas for head start coordinators and teachers	**Training support for families with children with disabilities:** 0.5 FTE medical social worker salary, travel,* $60,000 materials and supplies for 5 member Nations at a cost of $12,000 per Nation
Children's Support Model Development: funding to develop a cross-sectoral children's support model adapted to unique needs of each community. $100,000 space rental plus materials for community dialogue sessions	**Administration:** includes file management, human resources, finance management, tracking and reporting: $119,057 cost accounts for 10% of total submission
Administration: file management, human resources, finance management, tracking and reporting: $100,000 cost accounts for 10% of total submission	

Blue cells: funding approved Red cells: funding denied

* Indicates clinical supervision was built into this cost to cover the additional need for clinical supervision hours each time a clinical contractor joins the KTC Children's Resources team

Table 4 KTC Health funding: Jordan's Principle requests

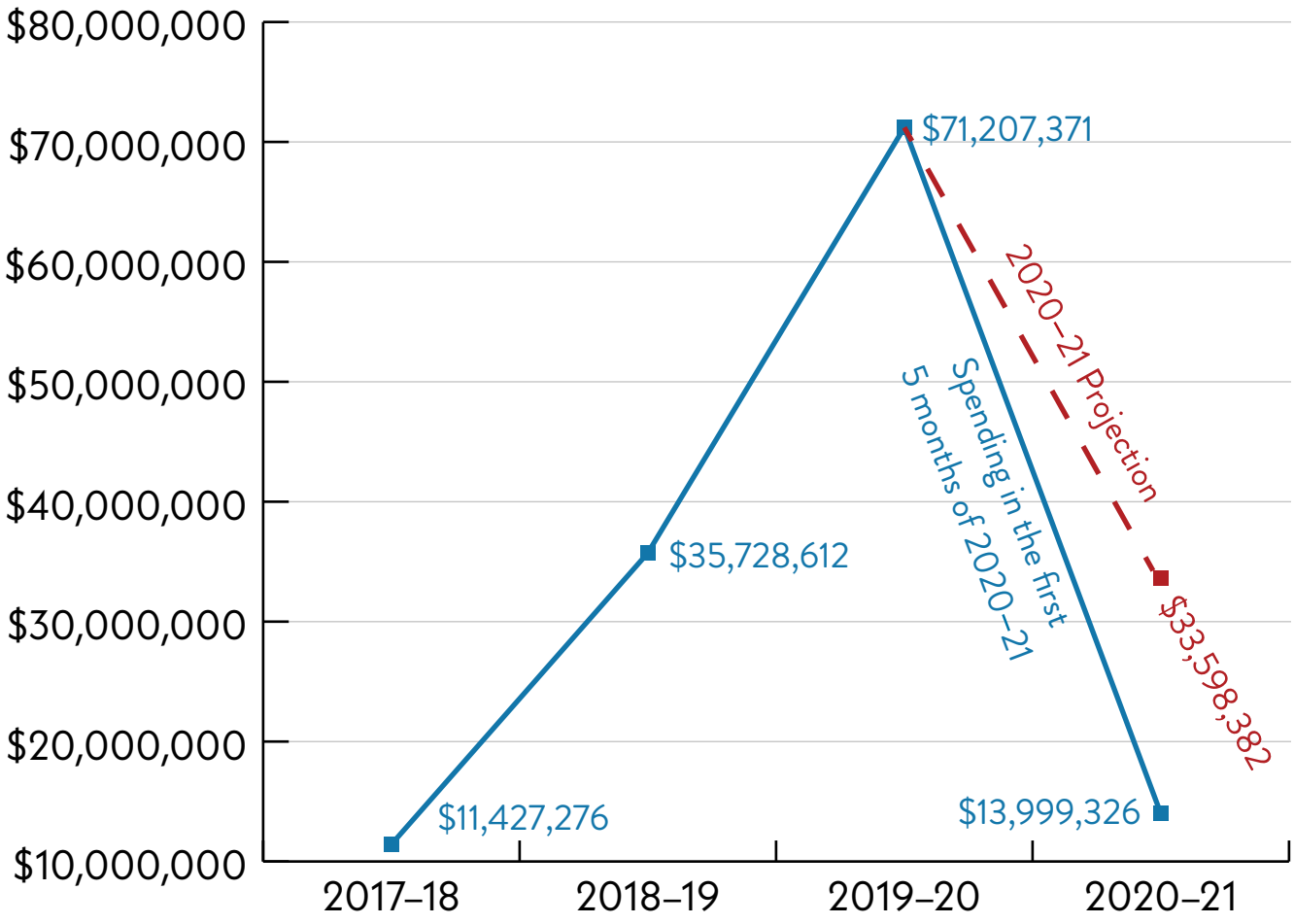
Service	Requested amount	Anticipated children served
Speech and Language Pathology	$1,071,670	39 continuing children, 10 new children
Occupational Therapy	$701,670	43 continuing children, 10 new children
Physiotherapy	$371,670	16 continuing children, 3 new children
Clinical Case Management	$629,438	114 continuing children, 23 new children
Audiology	$80,000	25 continuing children, 5 new children
Learning/Teacher Aides	$660,000	34 continuing children, 7 new children
Specialized Supports for Children with Disabilities	$425,000	92 continuing children, 18 new
Respite Care Services	$1,102,475	19 continuing children, 3 new
Psychology Services	$235,000	37 continuing children, 7 new
Cultural Supports	$626,432	278 children continuing, 44 new
Transportation supports	$189,500	35 continuing children, 7 new
Youth Suicide Crisis Response Prevention	$1,416,000	At risk children estimated at 328, with 40 children profoundly at risk
Administration	10% of total submission	

Blue cells: funding approved

Red cells: funding denied

The reduction in KTC Health's Jordan's Principle funding fits with broader patterns of group funding denials in Alberta. As shown in Figure 2 below, Jordan's Principle group request funding fell dramatically in the first five months of the 2020–21 fiscal year. If approval of funding in the final months of the fiscal year continued at the same rate as during the first five months, then the total Jordan's Principle group request funding approved in Alberta in 2020–21 would be less than one half of that approved in 2019–20.[446] Figure 3 shows that this steep decline in funding came on top of a 2019–20 approach to assessing Jordan's Principle requests that appears to be have been more restrictive than in any other jurisdiction in Canada. Only 21% of group requests submitted in Alberta in 2019–20 were approved within the fiscal year. In contrast, 85% of submitted requests were approved in Ontario. In Alberta, only 58% of requests submitted in 2019–20 were considered to have sufficient information to be assessed by the end of the fiscal year. Only slightly more than one third of the requests deemed to have sufficient information were approved.[447]

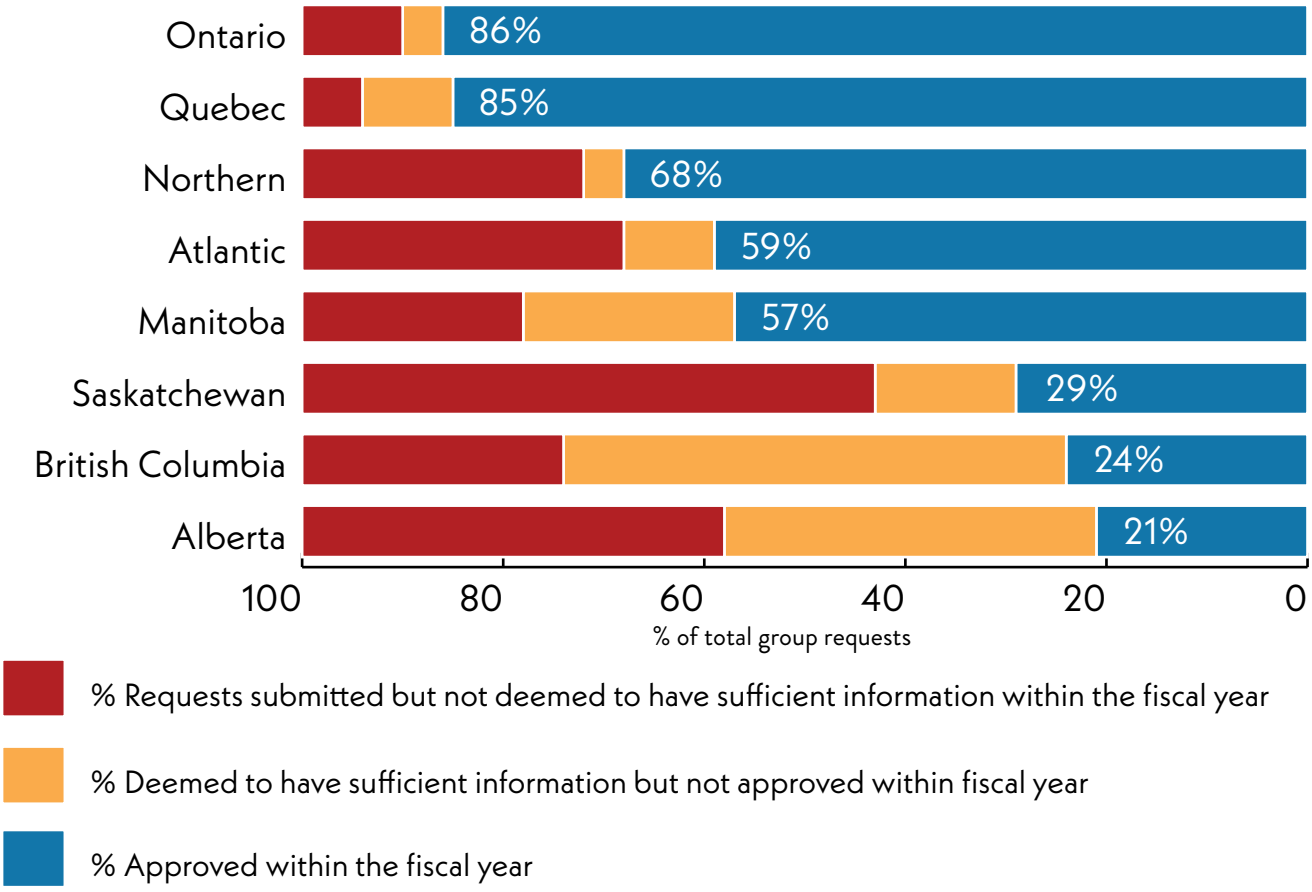
Figure 2 Funding for Jordan's Principle group requests in Alberta, by year



This trajectory of group requests is consistent with the multiple requests for documentation, lack of clarity around Jordan's Principle policies and guidelines, inconsistent explanations for decisions and last minute announcements of temporary funding that KTC Health experienced. It also fits with a larger pattern in the federal administration of Jordan's Principle that has been documented in prior research.[448, 449, 450]

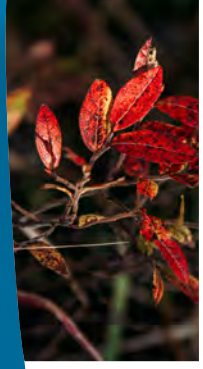
The impact of Canada's short-term and inconsistent approach to Jordan's Principle has been clearly documented in prior research in Manitoba and Alberta. Organizations and service providers working to meet the needs of First Nations children must shoulder the burden of onerous and unclear administrative processes on top of the day-to-day work of providing services. Organizations that operate with Jordan's Principle funding must deal with the uncertainty of building service systems without any clear sense of what level of funding will be available for the next year or whether funding for specific services will be renewed at all. They must do this while also working to recruit and retain qualified staff and contractors. Accordingly, organizations funded through Jordan's Principle accept the risk associated with knowing that, if funding does not

Figure 3 Trajectory of Jordan's Principle group requests, by region (2019–20)



come through, they will be the ones to deliver the news of jobs cuts to their staff and contractors. Finally, these organizations also understand that they might eventually have to notify the children, families and communities with whom they have built strong relationships that needed services will no longer be available. [451, 452, 453]

Jordan's Principle is intended as a mechanism for ensuring First Nation children's rights to equitable services. In the years after the CHRT ordered its full implementation, federal Jordan's Principle funding has provided a means for First Nations to develop and implement services that were never before available. KTC Health has successfully secured and renewed funding for a broad range of services. However, in doing so, it has faced unclear and inconsistent Jordan's Principle policies as well as a lack of information about the services that could be supported by Jordan's Principle, and the time frame for availability of Jordan's Principle funds. This shifting federal approach affected KTC Health's ability to meaningfully engage Nations and other organizations in the initial Jordan's Principle application. It also forced KTC Health administrators to bear the burden of revising and redrafting multiple funding requests amidst a climate of uncertainty and risk. This burden compounded the substantial work needed to create a new system of services for children and families in the KTC member Nations; we focus on the development of this service system in Chapter 3.





Ayaman Osihchikewin
(A Difficult Creation)
Developing the Children's Resources team

Chapter 3





Upon the receipt of initial Jordan's Principle funding, in 2018, KTC Health set about building a system of children's resources to meet the needs of children and families in the KTC member Nations. Feeling pressure to extend services while time-limited Jordan's Principle funding was available, KTC Health administrators prioritized service delivery over organizational development. The organization acted quickly to build and expand services by recruiting qualified staff and supporting the development of an expanding team.

By March of 2021, the Children's Resources team provided individual (one-on-one) services to 86 children, with over 300 children participating in group services. With the focus squarely on extending services as quickly as possible, the development of internal policies and procedures were approached on an as-needed basis. A sense of "building the plane on the runway" continues to inform KTC Health's development as time-sensitive and ever-changing federal directives create uncertainty in services.[455] By 2020, the need for more systematic attention to organizational development and for interorganizational development within the complex context of KTC member Nations was clear. In this chapter, we first briefly present the Children's Resources team as it existed by the end of 2020 and then explore the development of the Children's Resources team over time. In the final section of this chapter, we examine issues of organizational and interorganizational development by exploring both progress made and challenges left to address.

Services and children served (2020)

By 2020, the KTC Children's Resources team provided a diverse range of services across the KTC member Nations. These included: speech language pathology, occupational therapy, physical therapy, referral and family support, respite care, early childhood psychology and behaviour supports, youth suicide prevention, mental health, wellness activities, counseling, fetal alcohol spectrum disorders (FASD) and autism assessment. In addition, the team provided support for Maternal Child Health workers, Head Start workers and Nation-employed

mental health workers. Over the summer of 2020, services again expanded when the KTC Children's Resources team worked in partnership with KTC member Nations to develop and implement a summer camp. The camp served 41 children and adults who participated in person, and 14 families who participated virtually. By the end of 2020, an audiologist was also on contract.[456] This diverse team began offering services informed by their specialized training.

The Children's Resources team offers services using a mix of individual and universal, or group, strategies. Examples of individual services include counseling for mental health needs, child-specific occupational or physical therapy sessions to address motor development, or speech and language supports that specifically address a child's unique linguistic needs.[457, 458] Individual services are offered in shared spaces in Health Centers, Head Start Centers, or other community spaces across the KTC member Nations. Children's Resources team members work to find empty offices and carve out quiet spaces in which to offer individual services.

Universal strategies require service providers to participate in activities with children, and to integrate strategies to address diverse needs within these activities. During universal work in early childhood settings, for example, Children's Resources team members model different approaches to ensuring smooth transitions between activities, suggest creative ways to increase physical activity given site-specific constraints in play areas and equipment, or provide group activities that address specific needs identified by on-site staff.[459, 460, 461] A Children's Resources team member described different examples of universal supports that are common in a Head Start setting:

> *So, for example, if we were creating a lesson or a repeated routine-based lesson plan on dressing, we would list the kind of, the subject would be routines, and we would also have maybe some outcomes or some objectives regarding that. So, for example, to teach kids to sequence steps of dressing, to help kids learn how to manage clothing fasteners, to help kids develop self-help skills. And then you might have some developmental milestones...where kids may be at in terms of their dressing skills at the three to four-year-old range, and then what we would do, within that lesson plan, is break down the steps of how you might teach and implement dressing routine of children.*[462]

Universal strategies offer a means for children and families, as well as Nation-based service providers, to get to know Children's Resources staff and contractors. These relationships enable the Children's Resources team members to identify children and families who may benefit from additional supports. Trusting relationships, which can develop through universal activities, are also key to Children's Resources team members' abilities to assess family needs, support families in coordinating appointments, and build awareness of the services that are available in the different Nations.[463]

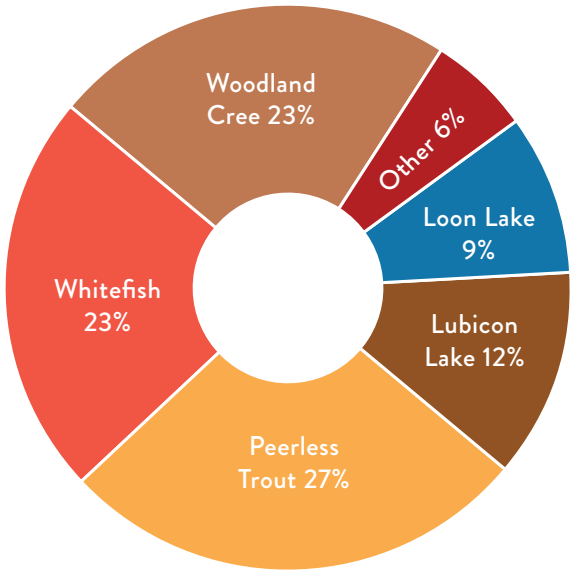
In 2020, the provision of services by the Children's Resources team was heavily impacted by COVID-19 related events and restrictions. KTC member Nations experienced two separate periods of COVID-19 outbreaks and community lockdowns. The lockdowns required Children's Resources team members to work from home or from external offices. Contact with families and children was maintained using text, phone and online platforms.[464]

The Children's Resources team also used periods of lockdown to complete special projects, such as creating informative social media messaging specific to their expertise and developing a Head Start curriculum and summer camp.[465]

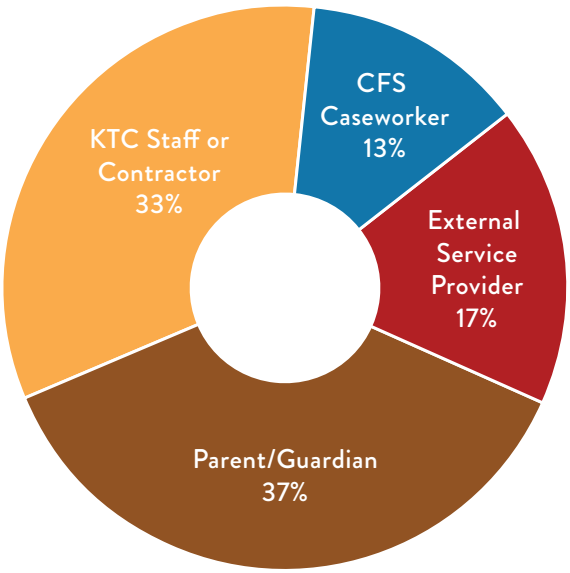
Children and families served

As demonstrated in Figure 4, children in need of individual (one-on-one) services were referred to the Children's Resources team from across the KTC member Nations and beyond. In keeping with a Children's Resources approach, in which each team member seeks to build relationships and serve as an initial point of access, the majority of referrals for individual services came from Children's Resources team members. Additional referrals came from parents/guardians, CFS caseworkers and other service providers.

Figure 4 Referrals for individual services, by community of residence and referral source



Community of Residence

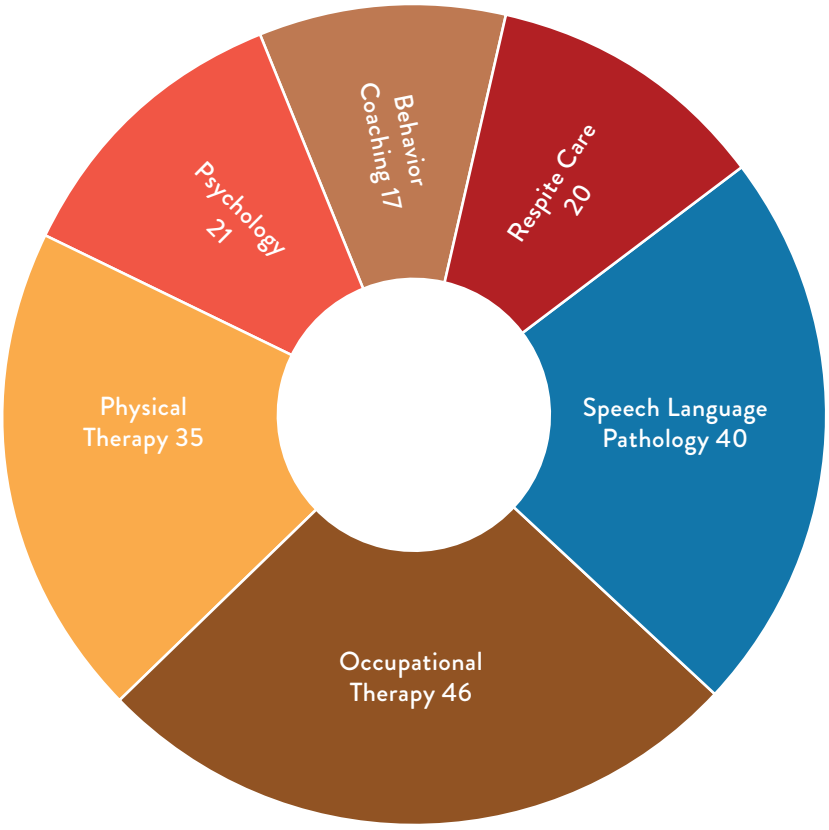


Referral Source

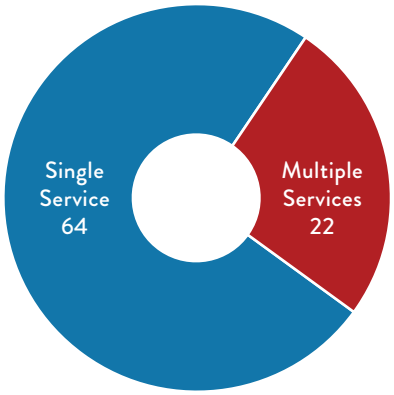
The Children's Resources team provided individual service to 86 children; 25% of these children received multiple services from the Children's Resources team. As depicted in Figure 5, taking into account the children receiving multiple services, 40 children received individual speech language pathology services, 46 received occupational therapy, 35 received physical therapy, 21 received psychological services, 17 received behavioural coaching and 20 received respite care.

In addition to children who received individual services from the Children's Resources team, many more children participated in group/universal activities with Children's Resources team members. Roughly 55 children participated in activities at daycares and Head Starts that were supported by allied health professionals on the Children's Resources team. Alongside many adults, 237 children and youth participated in activities—such as young women's/men's groups and sessions on grief, loss, managing anxiety and depression—that were facilitated by mental health/wellness staff/contractors.

Figure 5 Number of children receiving individual and group services, by service area



# of Children Receiving Individual Services By Service Area



# of Children Receiving Multiple/Single Individual Services

# of Children Receiving Group Services By Service Area

Textbox 5 Making a difference—Jordan's Principle and services in KTC member Nations

Many of the services funded through Jordan's Principle were historically unavailable to children living in KTC member Nations; the sudden expansion of programming offered through the Children's Resources team provided accessible, local services. An administrator who works for one KTC member Nation described the challenges in accessing services for children and families prior to the development of the Children's Resources team:

> *We're pretty isolated and that does have its benefits, and also it's a challenge [laughter] for services, like for service providers. Our nearest medical facilities are about—it's about a three-hour drive one-way, so that's one of the biggest challenges...*

She noted that, now, many more services were available and identified the next step as ensuring that service providers visited the community more frequently.[466] A practitioner who worked with KTC member Nations prior to the implementation of the Children's Resources team reflected on the needs in the Nations and the ways services have shifted the practitioner's response to a child's needs:

> *I was spending, and I still do spend a lot of my time, you know, on the mental health of my communities. Because there is a significant problem with mental health in our communities, and... it starts...at youth. A lot of it is underdiagnosed or misdiagnosed ADHD okay, and obviously, the FAS that goes along with it... So having [KTC Health] start this program and getting [mental health supports] and all these other guys up here on a regular basis to me is a huge thing. And to be able to have the child quickly assessed, effectively assessed, have a full assessment done on them, and to know where we are going with this child in the long run is great.*[467]

Another clinician highlighted the ways a multidisciplinary team has been able to support a small group of children with high needs who, historically, would have been unable to access supports and services in their Nations:

> *We have a multidisciplinary wrap around team that would actually sit down with that person and actually talk about what the challenges and the circumstances and...the strengths that that individual has and actually, with them, create an action plan and implement that action plan. And so that wrap around stuff, it's low incidents, it's very intensive, it's time intensive, but I think by doing that you can start supporting these really complex situations in community in a manner in which that person is then able to be healthy and well, contribute [to] their family, contribute to their community instead of the perpetual sort of cycle.*[468]

Textbox 5 Referrals for individual services, by referral source and community of residence

...continued

While a comprehensive review of child outcomes is beyond the scope of this report, the KTC Children's Resources team members noted positive outcomes for children and families during the first years of service provision. When discussing the impact of having services available in the Nations, Children's Resources team members pointed to examples of changes in children; for example, children who initially screened as high needs have screened out of services after a year of group-based occupational therapy supports.[469] Team members also discussed outreach from families seeking services, which indicated to them the development of the relationships and trust needed to support engagement with services.[470, 471, 472]

In addition, 15 children and 26 adults participated in the in-person summer camps that the Children's Resources team sponsored in partnership with KTC member Nations; an additional 14 families registered for virtual summer camp.

Developing Children's Resources

In order to provide a broad range of services by 2020, the Children's Resources team had to develop and expand very rapidly. In the summer of 2018, following the immediate crisis response discussed in Textbox 6, KTC Health hired a consultant to draft job descriptions and began recruiting through public postings and formal networks.[473, 474] These postings generated minimal response from qualified candidates. Recruitment was eventually facilitated through the pre-existing professional networks of the staff and contractors who had already joined the Children's Resources team.[475] By the end of 2018, the Children's Resources team was taking shape—it included a Child First Initiative manager, a clinical supervisor, a respite care coordinator, two community-based workers focused on the provision of specialized supports and FASD assessment, a youth mental wellness worker, an occupational therapist and a psychologist.[476]

In December of 2018, KTC Health made an initial attempt to develop a basic organizational framework for the rapidly expanding Children's Resources team. A document developed at that time outlined roles, responsibilities, internal organizational values and a clear team mandate.[477] This draft document was further edited to incorporate feedback following a large Children's Resources team meeting in February of 2019.[478] Beyond that, however, the decision was made to address additional organizational development on an ongoing, as-needed basis.[479] KTC Health made the decision to focus on the provision of direct services to children and families; the organization was under pressure to use the initial year of Jordan's Principle funding to demonstrate impact, which was necessary to secure ongoing funds.[480]

Textbox 6 Initial focus—Responding to crisis

The initial focus of KTC Health's Children's Resources team was responding to a youth suicide crisis that was heavily impacting KTC member Nations. Reflecting on the losses suffered by the communities, a KTC team member noted:

> *People grew up together; whenever there is a loss or suicide, it's devastating. The whole community is just devastated, they go into shock. And when there is another, there is more shock, more shock, and people don't know how to handle that. They really don't.*[481]

In collaboration with KTCEA, the Children's Resources team initiated a crisis response that focused on immediate safety planning. This collaboration supported the planning and implementation of summer recreational programming that would ensure youth were engaged and connected throughout summer vacation and school closures.[482] The recreational programming has since evolved from a crisis response to on-going youth services that are unique to each Nation.[483]

KTC Health administrators hired a consultant with many years of experience in suicide prevention in May of 2018.[484] The consultant immediately began developing programming focused on providing gatekeeper ASSIST trainings, which supports the identification of people at risk of suicide and immediate actions to mitigate imminent risks until formal follow up can be provided. Early and on-going efforts also included information dissemination to community and team members, and fulfilling training requests from people working in the KTC member Nations. Training topics include crisis intervention, self-harm, grief and loss and mental health first aid workshops.[485]

During the immediate crisis response period, the approach taken by the Children's Resources team was shaped by the impacts of trauma. One Children's Resources team member noted:

> *It was a difficult time, especially for two of our communities. We temporarily suspended the notion that we need to let community drive some of the response to those events. When we are in trauma, we are incapacitated in how to respond. So, we suspended the idea of going into the community to ask how to help. It changed to "These are things I can do for you." We have shifted back to the self-determined place for mental health. We have built some capacity for mental health, but that philosophical shift has for sure changed.*[486]

Moving beyond the initial provision of therapeutic supports and training, the KTC Children's Resources team began to focus on building networks that could strengthen the community moving forward. The Children's Resources team developed a directory of people who have taken trainings in order to facilitate access to a support network in moments of need.[487]

Textbox 6 Initial focus—Responding to crisis

...continued

Interagency meetings were also initiated to facilitate communication and relationship building within the Nations. Participants included the RCMP, healthcare workers, victims' services and workers affiliated with public works projects, among others.[488] One Children's resources team member noted that these meetings were a way to bring actors within the Nations together:

> *It's the community role to help build themselves, find their space, find their place.*[489]

When reflecting on this work, one Children's resources team member emphasized the importance of community strength and self-determined approaches to suicide prevention:

> *The success is that they can talk to each other, and they can say we can help our community ourselves. You know. We're from here, we are probably the best people who can do it. In my mind, I believe that community has the capacity to take care of themselves, and they just need the knowledge and skills to do it.*[490]

KTC member Nations continue to note a high need for mental health treatment and supports. Services are provided through a complex and fragmented structure that involves provincial, federal and Nation based services, which creates significant access barriers for children and families.[491] In 2019, KTC Health embarked on the Valuing Mental Health research project, which highlighted barriers to seeking services, including: limited confidentiality, stigma and limited availability of mental health supports (See Appendix 2).[492] Building on the results of this research, KTC Health is working to develop mental health services that are self-determined by Nations with centralized management and support by KTC Health.[493] Over time, KTC Health hopes to support the development of comprehensive and culturally grounded mental health, substance use and co-occurring substance use and mental health services for children and families in KTC member Nations. KTC Health intends to ground service expansion in a "two-eyed seeing" approach which seeks "To see from one eye with the strengths of Indigenous ways of knowing, and to see from the other eye with the strengths of Western ways of knowing, and to use both eyes together."[494, 495]

An administrator reflected on the decision to prioritize the provision of services and build internal infrastructure and guidelines as the organization developed:

> *We knew we could get in quick and make a difference, then identify the challenges and work backwards determining max hours per month, funding, things like that. We need to make sure we are focused on supports for families, and we can't all sit in an office because I am not sure that is going to make a huge difference for families.*[496]

The focus on direct service provision was in keeping with KTC Health's mandate, which required the organization to complement and support Nation-level services. This focus also fits with KTC Health's strategy of leveraging an economy of scale to better serve the five KTC member Nations. However, the direct provision and administration of services was a significant departure from KTC Health's past approach, which emphasized capacity development, training and other supports for local services.[497] Historically, KTC Health's role in direct service provision was limited to the coordination of primary care contract services—such as nursing, physician and dental care—when requested by Nations. The development of the Children's Resources team represented a departure from this emphasis of past KTC Health work.[498] An administrator discussed KTC Health's historic role in direct service provision.

> *So that's really tricky for people. It is confusing … Pre–Jordan's Principle, besides nursing, pretty much all of the services that KTC [Health] provided were [… things like] coordinating a dentist, where leveraging the economy of scale across five communities made sense to attract a doctor. So, the communities have to agree that that's going to happen. KTC [Health] can't go and just do these things. They need permission to do it on behalf of the Nations.* [499]

The administrator continued, providing a description of how responsibilities shifted for KTC Health.

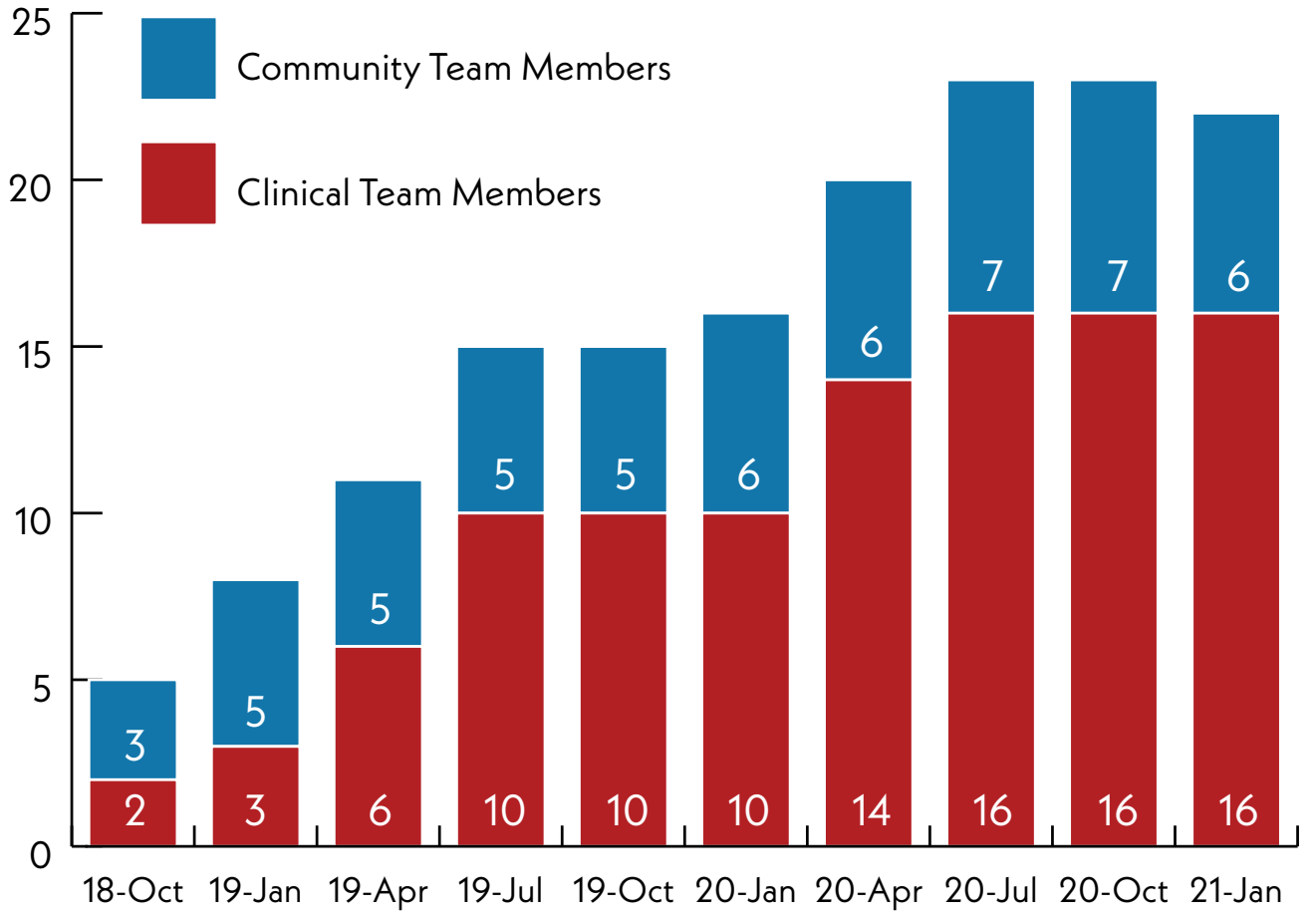
> *Until Jordan's Principle, a lot of it was programming that was either regional, as in Alberta regional, or Treaty 8-wide. So the Treaty 8 wellness consultant is a Treaty 8-wide position that also provides support to [National Native Alcohol and Drug Abuse Program] NNADAP workers in KTC communities.*
>
> *And it was always sort of that, like advisory kind of types of roles. So, the frontline… services of the [Children's Resources] team is newer for [KTC Health], to be providing that kind of frontline support, where the work is actually with the public, as opposed to us working to support the workers who are at the health centre, based on the Nation.* [500]

Expansion and structure of the Children's Resources team

In order to adapt and meet the requirements of this new, direct service provision role, KTC Health prioritized recruiting and retaining highly qualified and experienced staff and contractors. Recruitment efforts focused on attracting people who could help build an effective service system, adapt to an evolving organizational context and meet the unique needs of the children and families in KTC member Nations.[501, 502] Staff and contractors engaged as part of the Children's Resources team grew and diversified over time. As shown in Figure 6, the number of Children's Resources staff and contractors grew from five in the fall of 2018 to 23 by the summer of 2020.

As shown in Figure 7, the growth in the Children's Resources team was driven largely by the hiring of part-time staff and contractors. The number of full-time staff grew from 3 to 8, and the number of part-time contractors increased from 4 to 14, including three people working quarter-time or less. As will be discussed in the next section of this chapter, the growth in part-time contractors reflects both the challenge of recruiting full-time clinical staff in rural/remote areas and KTC Health's concerted effort to attract and retain qualified clinicians.

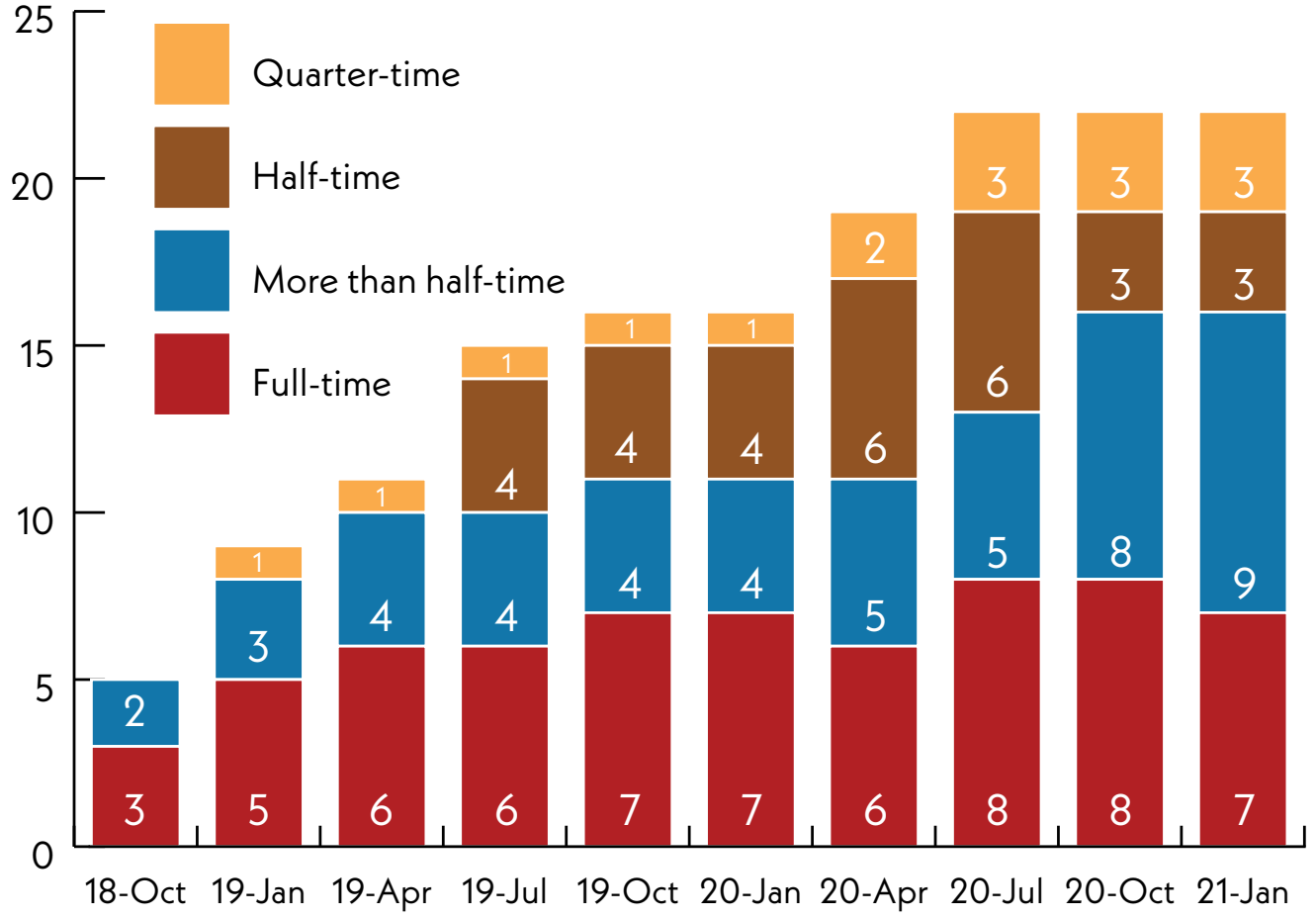
Figure 6 KTC Children's Resources staff and contractors



Structure of services 2020

The KTC Health's Children's Resources staff and contractors are organized into two teams (see Figure 8). The community team serves as the first line of ongoing contact with families and builds the relationships necessary to facilitate referrals, coordinate meetings and work with the family to identify and address emerging concerns. The clinical team provides allied health and mental health and wellness services and supports. The form and function of the clinical and community teams reflect distinct challenges and concerns that KTC Health has sought to address throughout the development of the Children's Resources team. The Children's Resources team also works alongside learning/teaching aides and TAs who are employed by KTC member Nations using Jordan's Principle funding (see Table 5). The connections between these Nation-level workers and the Children's Resources team are essential and highlight the complexity of the structure of services within the KTC member Nations.

Figure 7 Growth in part-time Children's Resources staff and contractors



Clinical team

Members of the clinical team have diverse clinical specializations, including physiotherapists (PT), occupational therapists (OT), therapy assistants (TA), speech language pathologists (SLP), behavioural specialists, psychologists and, most recently, an audiologist. The clinical team is composed primarily of part-time contractors who commute to KTC member Nations from Edmonton or, in a few cases, Peace River and High Level. From the fall of 2018 to the summer of 2020, the number of clinical contractors increased from 2 to 16; all but one of these team members was a part-time employee. Figure 9, shows that the growth in Children's Resources part-time contractors was driven by the hiring of new members of the clinical team. The contractors that make up the clinical team are managed by seven different organizations, which are organized around different service specialties. The clinical team is also supported by a clinical supervisor who provides coordination and clinical support. The clinical supervisor troubleshoots emergent challenges, oversees FASD assessments, supports the recruitment of new staff and contractors and helps to shape the development of the clinical team.[503, 504, 505]

Table 5 Jordan's Principle position in KTC member Nations

	Loon River Cree Nation	Lubicon Lake Band	Peerless Trout First Nation	Whitefish Lake First Nation #459	Woodland Cree First Nation
Therapy Assistant(s)	1	1	2	2	2
Learning Aids for Head Start / Daycare	2	2	3	3	4
FASD Family Support Worker	.5	.5	1	.5	1
Accessible Van Driver	.75	.75	.75	.75	.75
Community Connections Youth Wellness Worker	1	1	1	1	1

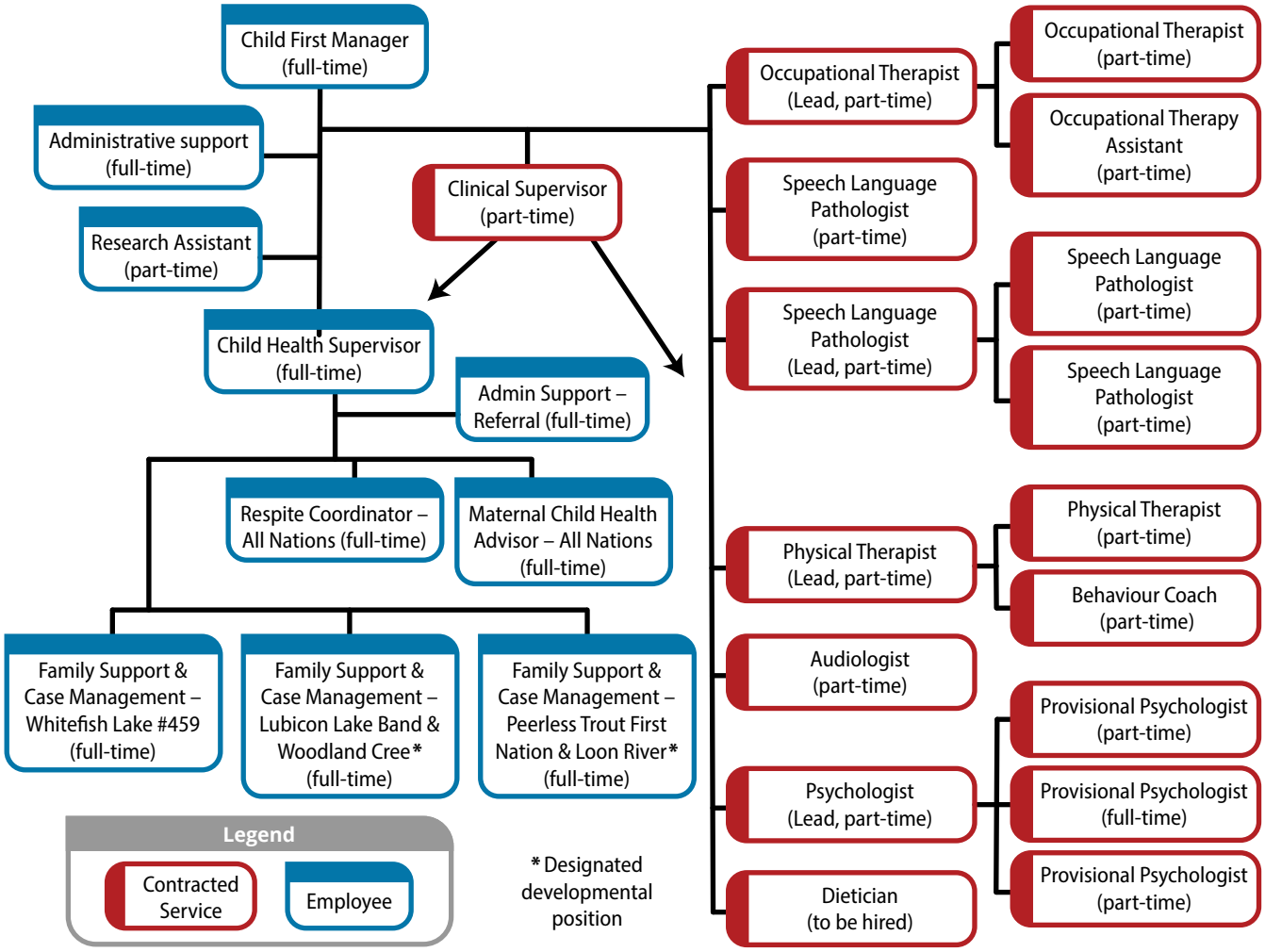
Blue—filled position Red—unfilled position Grey—status unknown

The structure of the clinical team reflects both the shortage of qualified clinicians in rural and remote communities, and the creativity and persistence that KTC Health has shown in recruiting contractors. Nationally, allied health professionals tend to be concentrated in urban centers; only 10% of Canada's physical therapy workforce is employed in rural communities and the percentage is even lower for OTs, SLPs and audiologists.[506] Similarly, approximately 4% of psychologists work in rural and northern settings.[507]

In order to attract and retain clinicians, particularly those with prior experience working with First Nations, KTC Health has been persistent and resourceful in recruitment. Offering flexible, part-time employment and job sharing was a primary strategy when recruiting clinical contractors. KTC Health also ensured that salaries matched the highest Alberta salary standards and budgeted for recruitment incentives when needed. Employment flexibility has been achieved by bringing clinicians on as contractors, which allows them the possibility of taking on additional contracts with other employers. Contractors have, in turn, helped recruit other qualified clinicians within their respective professional networks. A contractor reflected on her appreciation for flexible scheduling and job sharing:

> *I guess maybe this is a success for me, but I really enjoy the flexibility in my work, in terms of ok, well it doesn't work here, but we can*

Figure 8 Organizational chart

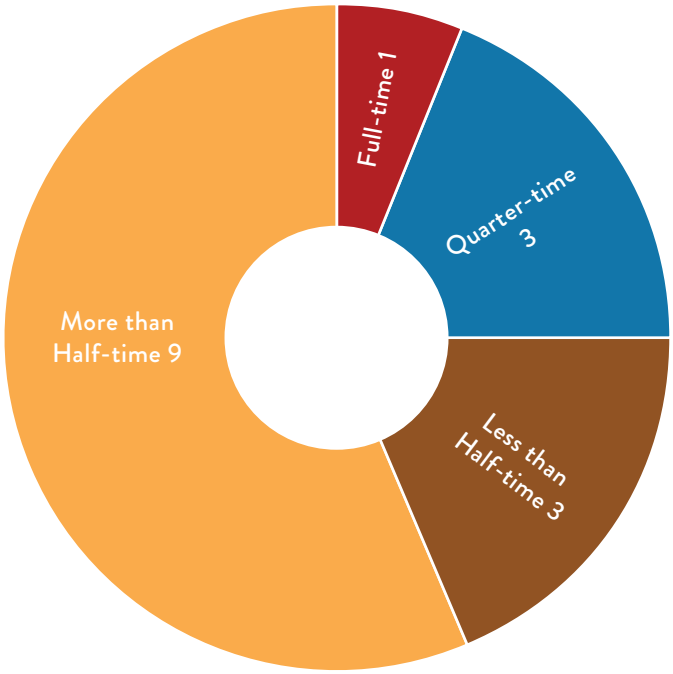


make it happen on Saturday/Sunday, and you know, still have the event move forward or have the session happen.[508]

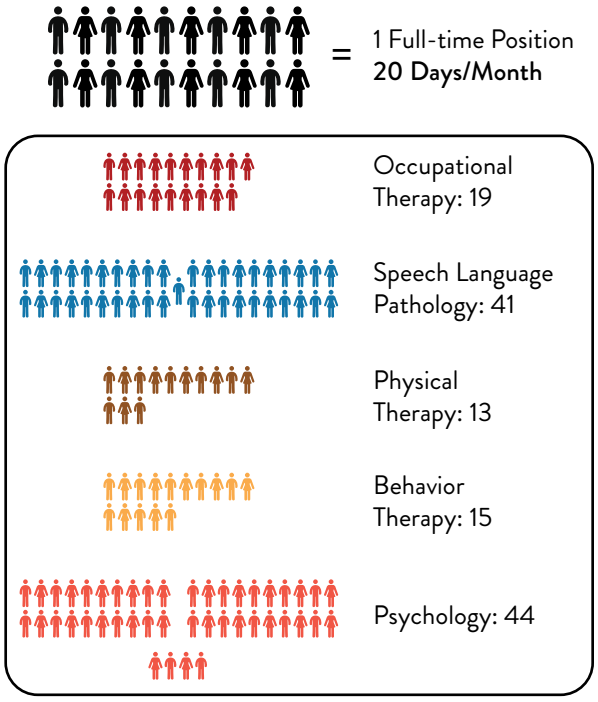
While a flexible approach to recruitment and retention has been key to retaining clinical team members, it comes with strong trade-offs. The clinical team has a complex service structure in which subcontractors are recruited, hired and supervised by seven independent contractors.[509] These contractors provide on-site supervision to maintain standards in services, but Children's Resources Team members pointed to a need for role clarification. Team members asked, for example: whose responsibility it is to ensure new subcontractors are provided appropriate cultural training; who is responsible for training new staff on pre-existing resources and services; who is responsible for community introductions and supporting the development of relationships within the community; and who will support new contractors in their professional development? [510, 511]

Figure 9

Full-time/part-time status of clinical contractors, and total full-time position equivalent by service area (2021)



Full-time/part-time status of clinical contractors



Total full-time position-days per month equivalents by service area

A worker reflected on how the reliance on multiple contractors has created communication and collaboration challenges in the team:

> *Yeah, I've worked in other [contexts] and [team members] were...all subcontracted by the same company. So, that made it a lot easier to share information, because we were all under the same umbrella. I think that KTC [Health] has hired amazing contractors, so that helps a lot, because we have personal working relationships that allow us to work really well together, but I could see there's...a couple of contractors that if you don't have that personal work relationship or they like to do things differently, we don't know what's going on with them. And that makes it, when you're sharing a child and you're like "Oh, what's going on with this? What's going on with that?" and it makes an impact on your treatment.*[512]

To support team collaboration, clinical staff schedule multidisciplinary meetings as needed with all staff involved in a case. At times, Children's Resources staff and contractors will schedule a round table with the Health Directors and community-based staff. These multidisciplinary meetings are intended to

create a shared space to communicate the child's needs, while also discussing what services have been provided and how services might shift to meet evolving needs.[513] A Children's Resources team member reflected on the ways joint meetings can support awareness of different providers' skills to facilitate collaboration across specializations:

> *So, and we've also had meetings at some of these Health—the Daycare Head Starts, with just the staff there and their director and then all of us as a team, like, and doing some round table about some of these kids and how we can support them together. And it's easier when all of us are there together, because then they can...we can all hear—we all hear the same information and can work with them to kind of get the best picture—a program for these kids.*[514]

However, this type of collaboration is inherently complicated by the geographic distribution of clinical team members who commute from Edmonton, High Level and Grande Prairie. The commute for these individuals can vary from two to five hours one way, with at least a one hour commute in-between each Nation. As will be discussed in more detail in Chapter 4, the combination of part-time work and long commutes mean that clinical team members have limited time to spend in the KTC member Nations, meet with colleagues and complete other work. Time limitations impact the provision of services in terms of the pace of work and the approach to relationship building, which staff identify as being central to their work. In-person communication can also be limited with regards to achieving more concrete tasks, such as ensuring that families are informed about and able to attend appointments and meetings.

The travel and accommodation expenses incurred under this model are also significant. For example, mileage is reimbursed at $.55/km, and the average cost for return travel to a community is around $500. In addition, in a region where accommodation choices are very limited, accommodation and food average around $200 per day.[515] The cost of the geographically dispersed clinical team was amplified when appointments booked in advance were cancelled due to miscommunication, the closure of an office site due to a funeral or community event, or lack of transportation for the family.[516]

Community Team

The Children's Resources clinical team works alongside the community team, which plays a vital role in supporting families through a diverse range of responsibilities. The community team is under the supervision of a Child First Manager, who also oversees the administration and development of the Children's Resources team. In late 2020, a Child Health Supervisor was also hired to provide supervision and day-to-day support to the community team.

Community team members fulfill complex responsibilities, including administrative duties, providing referrals, helping families to navigate services and providing psychosocial supports to families of children with disabilities. They also provide direct support to families by being a trusted "go-to" person who understands the family's situation and can help broker connections to other resources. Multiple members of the Children's Resources team highlighted the role that community staff play in supporting families, building connections to services and ensuring access to services:

> *The specialized community supports, we are often connecting with them because they are often our link to the home, and the parents sometimes depending on circumstance…So it will be connecting with specialized clinics that might be following the children that we might be working with, and trying to just figure out where their support services are, and if they have any recommendations, and trying to help families plan to get to Edmonton, cause that is a big trip and takes a lot of logistics sometimes. And, again, that's connecting with [community-based staff] and understanding the funding, transportation and all of those supports.* [517]

Community team members work very closely with service providers to broker relationships with community members and follow up with families as needed.[518] To ensure consistency and open communication, they attend weekly team meetings where they provide updates, highlight successes and discuss challenges of the week. These meetings allow the team to develop meaningful relationships with each other, celebrate their successes, brainstorm solutions to emerging challenges and avoid duplication of services within the team.[519]

In contrast to the clinical team, for which recruitment across a geographically broad area was required, Children's Resources team leaders emphasize the benefits of hiring community members or local employees in community positions.[520, 521] They describe the positions as being a good fit for individuals with experience or training in the area of social work, rather than the allied or mental health credentials that are in short supply in rural and remote areas.[522] Still, recruitment and retention for these positions have come with their own challenges. The Children's Resources team received limited applications from residents of KTC member Nations, and the applications received have often not been a good fit with the job description and requirements outlined by KTC Health. As a result, key community team members are currently located outside of the KTC member Nations.[523] A Children's Resources team member summed up the complexity of filling the community positions:

> *We're going to have to take people who…show some initiative and these other kinds of soft skills, where we think that they're going to be a good fit, and then train them up into those positions. The question is, what do you do in the meantime, because you can't have all your positions training up. You need to have the capacity to cover the work, until those people get trained up.*

And then you also don't want to bring in a bunch of—like, you don't want to bring in a bunch of social workers who don't come from that Indigenous lens, who are then leading the program in this direction, while you're trying to train up Indigenous workers who are going in this direction...these are complexities that I think about.[524]

The community team positions have also been less clearly defined than those of the clinical team. This is partly because the work of community team members is not explicitly regulated by professional orders like those that define the work of the clinical team. In addition, the understanding of the community team's roles and responsibilities has evolved over time. A worker reflected on their observations surrounding role clarity, team expansion and the community team:

I think some of the challenges are that when—I think I talked before about some of the HR and supervision challenges that we were experiencing. And I think when your team grows, that those challenges multiply themselves. So we [have] definitely seen a lack of clarity with some of the team members on the non-clinical side around how, like what is their role. And of course, they started a new job without a job description, which is particularly challenging.[525]

For example, the specialized supports coordinators positions were originally envisioned as being focused on FASD. Gradually the specialized supports coordinator role shifted to a much broader provision of service to children with disabilities, which required the workers to provide referral and service coordination support to a wider range of children and families with diverse needs.[526] The complexity of the specialized supports coordinator role is reflected in ongoing discussion of the most appropriate approach to staffing and managing these positions. A Children's Resources administrator explained the complexity and challenges that occurred in this type of position:

In the perfect world, I would rather have those kinds of family support positions be people who are from the Nation, living in the Nation, who know the community, know the services, are able to be there.

However, she pointed to the difficulty that KTC Health has faced in recruiting from within the KTC member Nations. She also highlighted a need to avoid the types of challenges that Community Connectors, who are now part of the Nation-level Jordan's Principle staff, faced when they were employed by KTC Health but working in their Nations:

> *It was difficult for them because they kind of felt like they had these two masters. [The staff] weren't really sure what that line of communication was. And, of course, communities leverage their workers in however they need to, so they were sometimes being drawn into other things and were [not] able to focus. But our system was, like, relying on there being a person there. And so that wasn't working well.*[527]

The challenge of defining community staff roles was further complicated when different positions evolved in similar directions, blurring the division of responsibilities that initially existed. Overlap between some community team positions sometimes resulted in parents being contacted by two different team members about the same topic. One community team member discussed this type of overlap:

> *I don't know. Honestly, right now, I do not know what is happening in between our roles, because I find that I'm doing phone calls and [my co-worker is] doing phone calls. They're following up. I'm following up. Like, I even told my supervisor, "I don't think there's any clear division there." I think it's similar in the role, you know, so that's something I'm still trying to clarify with them to see, "OK, is this what I do and compared to that?" To me, up to this date, I still don't know.*[528]

By early 2020, Children's Resources Team leaders determined that restructuring and revision of the community team was required.[529] The specialized supports coordinators contract positions were not renewed. These staff were among the first Children's Resources team hires, and the responsibilities attached to these positions shifted significantly as additional services were implemented. Other positions were also reshaped and redefined. A Child Health Supervisor was brought on to oversee the restructuring, provide day-to-day supervision and support the community team.[530] The size of the community team fluctuated in 2020 as the KTC Children's Resources team worked on the restructuring. Three members of the community team were let go, left the team, or did not have their contracts renewed between 2019 and 2021, and three new people were hired by the start of 2021.

By late 2020, a new vision for the community team was emerging, with a clearer division between administrative, case management, capacity building and clinical support roles. This vision also included a more specified understanding of the qualifications and training needed for each role, and plans to integrate training as needed in order to support team development. The new structure relies on positions with skill sets similar to community-based social workers; a priority will be placed on hiring people who possess Indigenous cultural competency skills to support families on an ongoing basis. Additional qualifications include case management skills and the ability to provide administrative support such as billing and appointment booking.[531, 532, 533]

Nation-level Jordan's Principle staff

In addition to the staff and contractors who are part of the KTC Health Children's Resources team, Jordan's Principle funding also supports a number of positions that are based in KTC member Nations. As summarized in Table 5, these positions include community connectors, TAs and learning assistants. In 2020, Jordan's Principle funding for Nation-level positions included: 5 community connections/youth wellness workers, 3.25 Van drivers, 3.5 FASD family support workers, 14 learning aids for Head Starts and daycares and 8 TAs. As discussed in Chapter 2,

Jordan's Principle funding in the prior years also included support for Elders in each Nation to provide oversight, input and implementation support for community programming. The funding for Elder positions was not renewed in 2020–21. The structure and development of these Nation-based positions highlights the complexity of the relationship between the Children's Resources team and other service providers in the KTC member Nations.

As discussed in Chapter 2, KTC Health secured Jordan's Principle funding for Nation-based positions and worked with leadership in KTC member Nations to ensure the transfer of funding for these positions directly to the KTC member Nations. Accordingly, KTC Health played a large role in developing the Nation-level positions. KTC Health also supported Nations in filling positions by providing job descriptions, facilitating job postings and regularly following up to enquire about recruitment progress.[534] Still, at the end of 2020, more than 20% of positions were unfilled.[535]

For the positions that were filled, the relationship and connection between Nation-level staff in these positions and the Children's Resources team varied greatly. Some Nation-level workers had little interaction with the Children's Resources team. Others, such as some community connections workers, collaborated closely with the Children's Resources team. Team members spoke positively and appreciatively of collaborative relationships with staff in the community connections positions:

> *In one community, there is [community connections staff] who I've been working with for a number of months now and [this person] sort of brings the information together. [They] know what others in the health centre are working on, and so [they] provide information to me. [This person] sometimes coordinates my involvement in other events and also supports any events or experiences…that I'm involved in…So, to me, personally, I think that the [community connections staff] is kind of, has a critical role in the work that I do in the communities.*[536]

The Children's Resources clinical team also provides a variety of supports to TAs and learning aides that are hired by KTC member Nations. While clinical team members do not have direct supervision responsibilities, they do support skill building, model developmentally appropriate strategies for working with children and provide training supports as requested by Nation-based staff.[537] A Children's Resources team member reflected on the collaborative approach that is taken when modeling developmentally appropriate strategies:

So what we often do is take like a bit of a modelling approach, so instead of, you know, saying, like, "Oh, actually this is what children this age should be able to do. You should be doing it this way," and being very frank about it, we end up modelling similar activities that are more at [the child's] level for staff and then we encourage staff to kind of join in. And by doing that, we can kind of engage them in a collaborative conversation about what the approach that we're taking is. And then, more often than not, usually they will ask for the resources, and then we can kind of facilitate or navigate it that way.[538]

The same team member further reflected on the role of providing support while being unable to provide direct management and clinical supervision:

Lots of these positions are new, so they don't even know what could be part of the roles. So, part of it is just educating them and helping them understand, like, too, with the supervisory relationship, we're not there often enough to act as a supervisor. So yeah, just making them aware that that kind of arrangement doesn't quite fit. We can kind of advise, but we can't, like, supervise, especially when it comes to therapy assistance, just with, like, clinical boundaries and insurance and all of that fun stuff.[539]

The relationship between Children's Resources team members and Nation-level staff is one that has required ongoing attention and clarification. At the Nation level, some service providers maintained an understanding that the Children's Resources clinical team members were to provide support and direction for Nation workers. In contrast, KTC Health maintained the understanding that there was never the intention or agreement for the Children's Resources team to supervise and manage these positions.[540, 541] As a result, workers were left to build shared understanding and agreements on a case by case basis. Children's Resources administrators, clinical team members, as well as Nation-level service providers pointed to confusion around who was responsible for directing and supervising Nation-level workers:

The [Nation-based staff] don't know what's going on. The staff themselves were calling me and asking me, "Am I moving over to the school? That's what I was told." And I said, "I'm not the supervisor of your program. You know...health gets the funding, but it flowed through over to the daycare. So, [the daycare director) is the one that's in charge of all of that, and she has her own set

of challenges with understanding the programs as well. My understanding is the workers get their direction from the Children's [Resources] Team. They get their direction about the services they are to provide from [professionals] employed by KTC Children's Team. They get their guidance from there. The daycare director is the person that just oversees them in terms of administrative...but in terms of direction with how they carry out their duties, that expectation is that that comes from the KTC Children's Team...I feel like they're not actively taking an active role with some of the things that they need to take an active role on. Because they're the professionals, we're not. I don't have that training.[542]

A Children's Resources team member summed up the confusion:

So, the therapy assistants are hired by the Nation, so they're not KTC employees. Both the therapy assistants in all Nations, and the health directors in all Nations, and [people at KTC Health] have struggled through how that looks...shouldn't [KTC Health] be providing direction for these positions?[543]

Other staff noted the administrative framework that surrounds Nation-based staff and highlighted the complexities of providing funding for a position over which KTC Health provides no supervisory authority. Supervision is provided by the Nations to ensure that the positions best reflect the self-identified needs of the community.

The framework really from just a governance and finance perspective is we don't really have any authority over those positions, we're providing the funding to the community. But, then we do have a reporting function right, in terms of reporting the efficacy of those positions and also the money that's been spent.[544]

The need to clarify the administrative framework that surrounds Nation-based staff, specify the type of supervision that each organization provides and identify direct, on-site supervisors was highlighted across interviews.[545, 546, 547]

Moving forward: Catching up to rapid growth

The Children's Resources team grew rapidly, extending a remarkable number of new and expanded services across five remote and rural Nations in less than two years. The exceptional nature of the system of services extended by the Children's Resources team was highlighted in a September, 2020, presentation by the regional FNIHB office.[548] The presentation noted that only 11 First Nations, which accounted for 24% of First Nations in Alberta, had used Jordan's Principle funding to establish a system of allied health services comparable to those provided off-reserve, through the province. Only 11 First Nations had established mental health and wellness supports with Jordan's Principle funding. In both cases, the KTC member Nations served by the Children's Resources team appear to comprise five of these 11 Nations.

The Children's Resources team was able to extend needed services to communities despite the uncertainty, burden and risk imposed upon the organization by the federal approach to Jordan's Principle. However, in order to do so, KTC Health had to cross into new roles, adapt to new needs and prioritize service provision over organizational and

inter-organizational development. In part, the lack of sustained attention to organizational and inter-organizational development was an unavoidable outcome of rapidly implementing and developing an entirely new stream of services. KTC Health was, itself, involved in an iterative process of learning about the range and structure of services that the communities required. However, administrators also made a purposeful decision to focus on extending services right away and to attend to aspects of organizational development as they arose. Administrators described this process as "building the plane on the runway."[549]

Making sense of Children's Resources

Across interviews, respondents emphasized the way in which the rapid expansion of services left families, other service providers, and even members of the Children's Resources team, confused about the structure of the Children's Resources team, the range of services provided and the relationships between the Children's Resources team and other services within the Nations.[550, 551] One Nation-level service provider, for instance, noted that it was a challenge for community members to make sense of the services provided by the Children's Resources team:

> *Community members, to know that the services are there, like what exactly will they do? And are the community members aware? Do you know, it's something of a—it's a bit overwhelming at first—because there's all of a sudden, we have nothing, and all of a sudden we have, oh, you know you can get an FASD test in the community, which before we [would have to travel to another community] before we could get an actual referral. Versus now we have the team actually coming out to the community. So, we are still trying to educate the community.*[552]

Others identified a need for greater clarity about the structure of the Children's Resources team and the services offered, noting basic questions about when, and how often, clinical team members were in the community and about the role of some community team members.[553] A KTC Health administrator also noted that much of the necessary work to support service delivery was invisible to Nation members:

> *The tremendous amount of work and coordination that happens behind the scenes, that isn't seen necessarily…they don't realize that having this fine-tuned running system of competent allied health workers showing up on the right days, doing the right referrals with the right partners, that is an unbelievable amount of capacity that is able to make that happen in such a short amount of time.*[554]

A Children's Resources team member noted that feedback from families in KTC member Nations confirmed that the behind-the-scenes labour required to provide services was not evident to families:

> *What I'm hearing from the family is…that they see the amount of funds that KTC Health is giving. But they're just not seeing the outcomes of it. People are very much, "This is how much money is at play, but we can't even get this." So, that's one thing I'm hearing. The other one is, "Oh, you have all this staff. I don't even know who half of them are. KTC is getting bigger and bigger and bigger, but you're the only one we see. How is this possible?"* [555]

Giving structure to work within Children's Resources

Children's Resources team members also noted a need for ongoing work to develop internal procedures and policies. A staff member reflected on the differences between their previous work environment, in a provincial service system, and KTC Health:

> *It's just so different...it [experience with a provincial organization] just seemed like, so systematic and so put together, and you knew exactly what the organizational structure was, and then you come to KTC and it's just like this web...with different communities, and different workers, and it's all in flux. It's kind of a bit exciting because it's so new and it's like, you know I feel like, I don't know, just exhilarated to kind of work with such a thriving, growing, piece of educational work that is so unique. But at the same time...I don't really know how it all comes together, or who does what, and what goes where.*[556]

The result of this "flux" was an approach to the development and provision of services that heavily relied on individual staff and contractors to dive in and make sense of things on their own. This was apparent in Children's Resources team members' discussions of their initial introduction to KTC Health and KTC member Nations when beginning their positions. Team members noted the lack of shared documentation or internal communication around the organizational mandate, philosophy, values or history of the team. For instance, one team member discussed seeking information from the organization's website to inform their role:

> *I really wish that they would have had an organizational work plan. Like, I haven't even seen a mission or mandate statement or anything to help guide me. So, what I did was I went onto the KTC website, and they had some stuff that they want to promote so I took those and I kind of used them in the work plan as goals and how my role would fit to meet those goals.*[557]

Children's Resources team members also identified the importance, and absence of, onboarding materials that supported development of an introductory understanding of KTC member Nations. The material they sought included: detailed, printed maps to facilitate travel between sites that had limited network connectivity; basic information on the history and context of the five Nations; an introduction to important Cree words

such as greetings, expressions of thanks and other common phrases; an introduction to family systems and parenting styles in the different Nations; and in-person introductions to service providers and respected people within the Nations.[558]

Children's Resources leadership was able to develop organizational infrastructure to respond to some emerging challenges over time. This includes the development of consent forms and procedures, as well as the adoption of new tools for sharing and tracking case information. For example, the Children's Resources team had been using a commercial file sharing program, Sync, to share case files and information. In early 2021, this system was replaced by the case management database APRICOT to better meet the needs of the team. A referral form was also developed in collaboration with the KTC Education Authority (KTCEA) and KTC Child and Family Services (KTC CFS). Children's Resources leadership were also able to slowly incorporate improvements in onboarding. By the end of 2020, a new staff member described the reformed on-boarding process:

> *I was really lucky, because [my coworker] was familiar with it. So the first time I went up, I went up with her and it was an introduction. And [my supervisors] gave me like a Zoom introduction, where we went on Google Maps and I labelled everything and that was hugely helpful. And [my supervisor] said that was the first time they did that with anyone, based off of...feedback, and I can't imagine not doing that ahead of time. So, I thought that was really helpful.*[559]

However, staff noted that work remains to be done. For example, one staff member pointed out that, in late 2020, that key organizational policies that could serve as guides to issues such as communication, supervision and dealing with conflict were not in place:

> *[The] policies and procedures are not solid, there's no step by step. It's really left up to the discretion of your supervisor...I think that has been my biggest challenge and frustration.*[560]

Team members understood this compromise as unavoidable given the organizational focus on providing services, or simply doing the work, in advance of organizational structuring or policy development:

> *Yeah, I think it's still a secondary thought in terms of HR policies. Because I think what they fail to realize is that once you get into community, you're so busy trying to serve community and put out fires, you don't have time to build those policies and procedures, and it probably should have been something to do first. Because you're not having staff work effectively, and you have no way of ensuring they work effectively, you're not going to be able to provide services anyway.*[561]

Accordingly, staff and contracts indicated that a purposeful shift in approach and commitment to prioritizing organizational development may be required.

Navigating a complex organizational context

The need to focus on clarifying roles and procedures, and to develop infrastructure, also extended to the inter-organizational context within the five KTC member Nations. As discussed in Chapter 1, the complex organizational structure which the Children's Resources team must navigate reflects colonial policies

that created silos between health, education and child welfare organizations. Each Nation has its own health services provided through a mixture of federal, provincial and Nation organizations. They are also served by the KTCEA and KTC CFS. Both KTCEA and KTC CFS have recently experienced substantial increases in funding and have, as a result, expanded services. The siloing of health, education and child welfare services impacts organizational responses and affects children and families seeking services. Across interviews, people identified a need to focus on developing structures, policies and practices that break down silos and facilitate collaboration.

A Children's Resources team member provided an example of navigating a complex service context, in which multiple organizations were operating, when reflecting on the crisis response to multiple youth suicides:

> *There's so many parties involved in a community. There's KTC, there's the band itself, there's—when I first got there, because of all the stuff going on and the crisis that they were in, there was, like, 10 different agencies developing and delivering programming. And it was chaos. And that's not happening right now. So, there's more opportunities to kind of do different things.*[562]

The "different things" attempted in the ensuing period included the development of interagency meetings intended to develop stronger networks amongst service providers. One Children's Resources team member reflected on the purpose of the interagency meetings and what they have generated to date:

> *So, interagencies are ways that people begin to start working together and establish partnership and provide updates. So, in our meetings we do two things: we do updates, and then we do a brainstorming activity of what's needed, and then we try to meet those goals throughout the year…So, every time they feel like there is an issue they want to talk about, it's our job to make sure that happens and try to advocate for it. For me, I try to make sure I am not in charge of what's happening here, but I am making sure it continues on.*[563]

Another team member spoke of joint trainings that were intended to build collaboration across organizations during COVID-19 community lockdowns:

> *So we don't have a lot of formal things in place, but one of the things [my coworker] and I decided to do is, we had—just before the social distancing measure came to place—we had an early learning series scheduled in communities which we postponed, and that has been rescheduled for the second and third week of June, where we can bring back and bring together some of our clinical staff, and some of the staff in daycares and Head Starts to...reconnect, learn together, and just make sure to get them thinking about those best practices so...I guess this is an example of something we formalized...in terms of trying to create those connections again.*[564]

Such efforts were driven by a shared understanding, voiced across interviews, of the importance of coordination between organizations in KTC member Nations, but also by recognition of existing tensions. Children's Resources team members noted the potential for duplication or inefficiency of efforts. Team members also spoke of the creation of burdens and delays in services that complicated the development of trust and the assurance of continuity and coordination of services for families. Team members viewed collaboration as a means of enhancing services and addressing these tensions.[565, 566, 567] Several people highlighted the relationship between KTC Health and KTCEA as one with the potential for increased collaboration:

> *I think the other thing in terms of teaming [up] that I should maybe add as a barrier, although I think it's getting better, is the health and education connection...It is just a little bit different, and I think [health and education] are starting to talk little bit more which is great, 'cause it is quite fluid for [some staff]. So, for example we might see a little one at school and help support school programing, but know through talking to mum they might need some support at home in terms of home equipment or other supports so...[we are] trying to connect those teams, and we are realizing that education doesn't know about all of the community resources through health either. Like, they are still learning about that so...I think that is one that has more room to grow, and I know they are working on it to establish that connection a little bit better.*[568]

Important steps have been taken to address this disconnect. For example, KTC Health and KTCEA developed a service delivery protocol that serves as a framework to support a more seamless continuum of supports for the children, youth and families that the organizations serve.[569] The protocol highlights and attempts to clarify areas of confusion regarding service delivery between the two organizations, such as the provision of services over the summer or for children transitioning out of school. However, despite such steps, some interviewees pointed to ongoing tensions between organizations, and called for a much more coordinated approach in order to facilitate a greater shared understanding of services, effective referrals and more coordinated family supports:

> *I feel that there is a real power struggle between KTC Health and KTCEA, in terms of those types of services and who should be providing what. And at the end of the day, I don't think there should be a power struggle. I believe that we're supposed to be looking out for what's in the best interest of those children and how—and to ensure that there is a continuity of care as they move from preschool into the school.*[570]

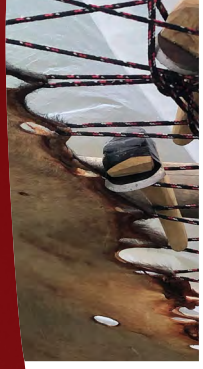
Some interviewees further highlighted the difficulty of understanding the structure of organizations serving the KTC member Nations and specifically questioned the value of having two separate KTC-level organizations to address health and education needs. Reflecting on the relationship between siloed organizations, one Children's Resources team member pondered the impacts of systemic racism in a colonial model of service provision. The team member drew a parallel between their clinical work and their observations of the interorganizational context in KTC member Nations:

> *And, you know, I just see these systems as exactly the same. They never get the feeling of safety…if they could have a part of that organization where the foot was firmly in safety and the people felt calm and under control, then the organization itself would have that kind of grounding. So then they could, they could think yeah, let's venture out and think about this group over here that are really struggling right now, and let's support them, and, you know, and why do we think this way, why are we so scared of health right now, why are we scared of telling them anything? Well, it's probably because we got burned in the past, and so there's a whole bunch of us here that are scared to do that.*[571]

The team member continued, positing that the way forward lay in continued efforts at relationship building:

> *And it's just so important for us to keep highlighting that, that they need to talk, otherwise there's this inefficiency that happens in the, you know, where the traumatized system starts pushing away, everybody pushes each other away, and then I'm going to keep myself safe in my little place just, you know, harmful…*[572]

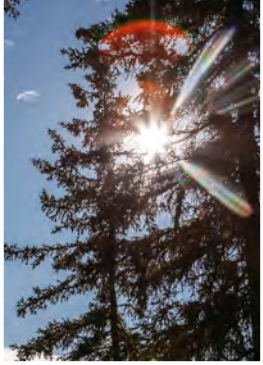
The Children's Resources team will soon be entering its fourth year of operations, and, as it does, a major challenge will be to finish building an "airplane" that is now in the air and flying. Interviewees highlighted a need to clarify roles and responsibilities, to develop clearer policies and procedures and to establish more consistent internal and interorganizational communication mechanisms. KTC Health has successfully extended a system of services to KTC member Nations in a very short period of time. Moving forward, key steps must be taken to develop: clearer ways of articulating the system of services provided by the Children's Resources team; more explicit policies and procedures to guide the work of this team; and ongoing ways of engaging with other organizations serving the KTC member Nations in order to build strong collaboration and shared understanding. In Chapter 4 of this report, we seek to contribute to these efforts by outlining the key features of the Children's Resources team's approach to service provision.





Nîsohkamatowin
(Supporting Others)
An emerging Children's Resources model

Chapter 4


Given KTC Health's decision to prioritize direct provision of services, a Children's Resources services model has not yet been formally created. However, team members consistently identified key elements of a commonly embraced approach to practice. These elements comprise an emerging model of service delivery by the Children's Resources team. Central to the emerging model is relationship building, which requires that staff take time to learn about and connect with children, families, service providers and the diverse KTC member Nations in advance of providing direct services. This approach increases engagement with services over time and is seen by team members as a necessary precursor to meaningful work with families and children. Another core element of the Children's Resources team's emergent approach is providing services through both universal and one-on-one supports. An overarching emphasis on following the lead of children, families and community members is also central to the Children's Resources team's approach. Finally, team members emphasized the importance of collaboration between service providers, families and children.

In addition to identifying key elements of a unifying approach to practice, Children's Resources team members also noted challenges in the emerging model of service provision. One key challenge was navigating the geographic distance between Nations without having dedicated physical space in which team members could work. Another was working cross-culturally; team members identified a need to learn to recognize cultural differences, integrate culture and address power imbalances in their work. These challenges are discussed in the final section of this chapter.

Building trusting relationships

The Children's Resources team centers the notion of "building relationships" in their emerging approach to service delivery. Trusting relationships were identified as the foundation for clinical work and are understood as being necessary to overcome distrust linked to colonization, stigma and racism within healthcare.

Trusting relationships were also seen as necessary to: support people in making sense of services; enable people to determine their own needs and interests with regard to services; and foster ongoing engagement with services. A Children's Resources team member succinctly summarized the central role relationships hold in service provision:

> *The relationships are why we can offer services in the first place.*[573]

The factors identified as supporting relationship building varied across interviews and involved both interactions with community members and one-on-one service provision. At the community level, staff note the importance of having someone known to people within the Nations to provide initial introductions.

> *[The KTC Children's Resources team] were very generous, and on my second week here they took me to every site where there was psych or mental health, and they tried to introduce me to as many people as they could. So that put me in another positive position with people in the community.*[574]

Some clinical team members identified the development of connections with staff in other organizations as key to building trusting relationships with caregivers. For example, staff at Head Starts, daycares and health centres can introduce Children's Resources team members to community members and service providers, accompany Children's Resources team members to onsite visits, help to facilitate referrals and secure consent forms from caregivers. Children's Resources team members more broadly highlighted the ways in which relationships with other Children's Resources team members, staff of other KTC-level organizations and members of the KTC Nations also contribute to building trusting relationships with children and their families. These different relationships facilitate engagement with services by creating multiple avenues for information sharing and referral to the KTC Children's Resources team. As demonstrated in the Textbox 7, on consent, taking time to build trusting relationships in the Nations also allowed other service staff and families to learn about and make informed decisions around a child's on-going care with the Children's Resources team.

When it came to relationship building, Children's Resources team members also highlighted the benefits of simply being available in shared spaces within the KTC member Nations:

> *I tried to meet with all the Health Directors and…with some of them I would just go in, and I would ask to see the Health Director, and sometimes that will happen and often times, they are very busy people with a lot going on. So, they would be too busy, and they would have somebody else for me to talk to. And then, you know, you would sit in the staff room waiting, and you would meet five different people that would walk through there.*[575]

Children's Resources team members emphasized the importance of "just being there," and demonstrating consistency in order to gain the trust of community members and staff in Nation-based organizations.

Textbox 7 Consent—A challenge and a success

In healthcare or social service settings, informed consent is an ethical and legal imperative that requires practitioners to give information about services to adults and children before services are provided. Following a conversation about the services and potential benefits and risks, the person can make an informed decision about their participation, or the participation of a minor. The process of securing informed consent respects the autonomy of individuals while fulfilling services providers' legal obligations to inform people about the efficacy and overall processes of services.[576]

The KTC Child Resources team's approach to securing consent from children and families has changed over time. In the first year of programming, staff and contractors identified a variety of factors that impacted the ability to secure informed consent, including hesitation to seek services due to negative past experiences with healthcare workers, having limited time to build trusting relationships with staff, lack of information that specified services were free, stigma around accessing services and the lack of culturally relevant consent documentation. A Children's Resources team member reflected on the importance of understanding consent from a relational lens in order to develop practices that reflect First Nations caregiving traditions:

> *It's the Euro view of things. We work in bureaucracies where we have these things lined up… But we've got this cultural relational lens that we have to tend to. In our clinical work I would always get a signed consent from the legal guardian, and that's just not relevant in a lot of our communities. Legally I need consent, but ethically it's "who is the caregiver"? We developed a familial consent [for] situations [where a child is] looked after by an aunt or uncle. We take their consent for services as if they were a parent or guardian. Someone could challenge us on this, but ethically things are solid… So we've had to feel our way through that from the beginning.*[577]

Textbox 7 Consent—A challenge and a success ...continued

Alongside culturally appropriate approaches to consent, practitioners also identified the importance of providing information by attending community events. Children's Resources team members identified informal conversations at these events as building trust and understanding. A clinician summarized the importance of building relationships and sharing information with families in advance of attempting to secure formal consent:

> *I think just trying to be present at as many of the community events as possible has been helpful, like I've attended all the Teddy Bear Fairs...in all the communities, and I think that's been huge, because typically parents bring the kids in, and then you are able to connect with them. And then, they are usually a lot more open to services and, you know, willing to make appointments and stuff like that. Umm, whereas, you know, you are trying to send a consent [form] home from a Head Start...you just don't have the connection with the family that you would like, and your informed consent isn't, I don't feel, as informed as it could be.*[578]

Across interviews, staff and contractors identified the importance of relationship building to create connection, understanding and trust in informed consent. A Children's Resources team member reflected on their experience working with Nation-level service providers to secure consent:

> *There was an instant connection about, you get us, you get what we are dealing with. And so, by the next time I came, they had consent in place. They had actually phoned a parent that had withdrawn their child because of their behaviour and said [big breath] "we have somebody, bring him back! We're ready for him!" So they got excited about what I do and how I could support them and support the kids. So they were instantly getting, umm, consents, and they were, like "other kids!" like "We have other kids!"* [579]

When opportunities for relationship building have been unavailable, Children's Resources team members have noted fewer consents are provided by families.

Planned meetings that fell through or event cancellations were understood as opportunities to build meaningful relationships and develop trust through community engagement, or by providing services for other community members:

> *Sometimes I would get to the community, and [the child] wouldn't be there. Then I would spend that time in the classroom, with the teachers and the students, modelling strategies and kind of fielding any questions that they had with their kids just generally, or the specific kids as well.*[580]

Another team member summarized the importance of just being there by describing it as being the core of their work:

> *That's part of your job just to...be in the health centre, and sit there and visit with the people that come by—I have that experience... I got [a cancellation] on one of my interviews, and there is, you know, just a couple of the workers there [at the site] that sat down and started talking about their own kids. And I don't know, it's just—that's a good thing... If we can get [everyone] on the team to see that and to feel it and then be, like, OK, I got stood up today but my job right now is just to be with these people... Half of our job right now is for people to notice that we're there and to feel, you know, our presence and know this is not going to change.*[581]

Team members reflected on the development of relationships and identified gradual changes that occurred over a period of years, not weeks or months. One team member suggested that time is needed to overcome community distrust that is informed by a historic lack of services:

> *I would say it's a gradual build. Building trust with the community, all these new faces, people are sitting back waiting to see [if] these services stick around. I also think these communities haven't had services ever, and they've been getting by. It's almost like a bit of a shock that there are services available now. So, just changing the mentality that there are no services, to there are [services], is a bigger challenge than I ever anticipated.*[582]

When attempting to gauge the development of trusting relationships, Children's Resources team members identified Nation-level service providers and parents seeking out services from the Children's Resources team as an indicator of success. One team member reflected on communication between a mother and the clinicians who were involved in her child's care as an example of how relationship building provides the foundation for service provision overtime:

> *I think one of the biggest things is just seeing how much more comfortable parents have become with us, just by having a consistent presence in the communities—like this is our third year now, which is really exciting. And just as we know, relationships are so important, and I don't think that they have had the opportunity to have people visit consistently. There's many times where they say, "You're back already?" And they're so pleasantly surprised, and it's almost sad to me, they're so shocked that we're back already. So, just specific examples that come to mind. Like, I have one mom who will text myself as well as other members of the team and send little videos, little progress updates of the children. Yeah, it's really sweet. And she'll say things*

> *like, "Oh, the [kids] are so excited to see you,"... And historically, this was a parent who was quite closed off, just very nervous and apprehensive around health professionals. So I think that is absolutely huge... She's also just taken on a lot more active role, in terms of she's always been a good advocate for her kids, but throughout the [COVID-19 lockdown] we were able to send some little activities and then she would send pictures of [the kids] like carrying them out... Yeah, I think just being able to see some of those relationships, just building on them, and have them be a little bit more long-lasting, I think it's just opening up so many more doors and then people are starting to become a little bit more forthcoming with information, and obviously that just puts us in a better position to support them and help the children.*[583]

As discussed in Chapter 2, recent changes in the federal government's approach to Jordan's Principle funding require that services be tied to specific children, with an emphasis on individual service provision. Administrators in the Children's Resources team have expressed concern around these federal guidelines, highlighting the fact that the time required to build trusting relationships in communities can be difficult to represent in terms of child-specific services. In the case of the Children's Resources team, relationships often took upwards of a year to establish. Spending time in community health centres, attending community events and taking the time to engage with Elders or local service providers were highlighted across interviews as necessary activities that helped generate community interest, investment and willingness to seek individual services.[584] Relationship building activities are a vital foundation for the provision of child-specific services. Accordingly, funding models that do not account for the importance of time-consuming community-based engagement fail to account for the needs of First Nations children, families and their communities.

Universal strategies alongside one-on-one work

Children's Resources team members build relationships and provide services through both one-on-one and group-based strategies, also referred to as universal strategies. Children's Resources staff and contractors indicated that universal strategies provided them with opportunities to connect with children, youth and other community members in an open and flexible way. Universal strategies allowed staff and contractors to work with children and youth in ways that team members identified as non-stigmatizing; universal approaches can also be implemented without individual consent forms, which allowed concerns to be addressed more readily due to the time required to secure consent. In settings such as daycares and Head Starts, the use of universal strategies allowed Children's Resources team members to model skills and techniques that were of interest to the organization's staff. Universal strategies were employed in tandem with individualized approaches to assessment, referral to concurrent services and the provision of one-on-one sessions that provided tailored supports to meet children's specific needs.

Some positions in the Children's Resources team were created specifically to ensure that universal approaches to community wellness were undertaken alongside one-on-one supports. Members of the clinical team who were hired to provide mental health services with a community wellness focus

spend significant time on universal and group-based activities that promote belonging, safety, positive relationships and role modeling. The decision to emphasize universal services was also partly informed by feedback from KTCEA staff, who identified individualized services as disruptive and stigmatizing to students who had to be removed from class to attend counselling sessions. Limited space and the goal of minimizing educational disruptions also informed the emphasis on universal strategies. A KTC team member detailed the universal strategies she is attempting to share with individuals through group settings:

> *You know, I go into the classroom, I do a lot of activities that center around mindfulness... [trying] to understand the basis of emotional regulation and support to students that way. So, I build activities and things that promote positive relationships and role modeling and all kinds of different things around creating a positive atmosphere in the classroom. Creating safety is really important...which we know in the learning environment is one of the most important things. So, I guess in terms of a goal, that is one of my goals in the classroom—to create safety.*[585]

Over time, KTCEA has expanded the universal mental health strategies offered through the school, and fewer Children's Resources team members provide services in school settings. The universal approach remains common in daycare, Head Start and other community settings. Universal approaches include family wellness events, developmentally targeted strategies for young children with high needs, and craft nights or after-school activities.

Children's Resources team members working in Head Start settings also highlighted the ways that universal strategies can provide support and safety to children when one-on-one strategies cannot be offered:

> *You know, not necessarily having a consent to do one-on-one with one kiddo, but to have the opportunity in a group to be able to model certain skills, and actions, and strategies within a group. For some of the staff and caregivers, they didn't necessarily feel comfortable to be singled out to, you know, try certain things or do certain things, but when you're in a group of people like that, you know, it's safer and easier when you're with your peers and your friends to maybe try some of those things that aren't in your comfort zone.*[586]

Children's Resources team members also applied universal and individual approaches in collaboration with Nation-based staff who worked at Head Starts. Contractors who provide occupational therapy services commute to the site and observe the children in attendance while discussing concerns identified by Head Start staff. Following these conversations, KTC Children's Resources team members use universal strategies to teach and model tools, such as techniques which children can use to calm themselves, which also support classroom management for Head Start staff.[587] Depending on the level of trust and the availability of space on site, individual targeted strategies can be provided to address the needs of specific children. When KTC Children's Resources team members are not on-site, Nation-based staff play a key role in continuing to implement strategies with children on a daily basis. This consultative model, which responds to the needs of both children and staff, helps ensure continuity of care. A team member who provides support in Head Starts reflected on the results from universal and individual strategies over time:

> *Well I guess one thing that was kind of nice, it was a good surprise, is that [the team] saw a few kids in one Head Start last year, like quite a few kids, and they had pretty significant struggles, and this year [a team member] saw them in the school setting and they actually screened out as average, which was pretty cool. That was surprising in a good way. I guess, I feel like some of our work is definitely having an impact, which is good.*[588]

"Following their lead"

The concept of "following their lead" was discussed by Children's Resources team members when they reflected on their work with individual children or families. At times the concept of "following their lead" emerged in tandem with discussion of the importance of building trusting relationships. In addition, some, though not all, Children's Resources team members were able to clearly articulate the ways in which key elements of their approach to practice, such as engagement and the development of service plans, centered on following the lead of children and families. A focus on "following their lead" also extended to the relationships between Children's Resources team members and staff affiliated with other Nation-based services. For example, Children's Resources team members working in daycares and Head Starts follow the lead of Head Start staff, even while sharing strategies and skills they gained through specialized training. Children's Resources team members spoke of an approach in which they focused on building trust and creating space for daycare and Head Start staff to raise concerns, which were then followed-up with skills modeling for Nation-based staff and universal strategies to address the needs of children.

Children's Resources team members identified the "following their lead" approach as involving complex processes and informing their approaches to both service delivery and building relationships with children, families and the KTC member Nations. One team member connected "following their lead" to being a guest in the KTC Nations:

> *Like, right now we are in Treaty 6, and when I work in the North I am in Treaty 8... I need to know my status to the land... I know the responsibilities that I have to the people.*

And so, because I am not from the Treaty areas I am not one of the people. I am a guest, so it is important for me to know my responsibility is not to boss people around, or tell people what to do... It really directs my relationship to the people, and how I support them, and support their endeavors.[589]

When reflecting on how awareness of being guests in the Nations informed their actions, Children's Resources team members also spoke of taking a support role to centre leadership and participation from community members, instead of stepping in and assuming what needs to be done:

Taking their direction on how they want me to focus my time. So that is through relationship and understanding them, identifying their needs, and I provide that, rather than me just going in and taking over responsibility for all that stuff.[590]

Multiple workers highlighted the importance of storytelling and listening as the starting place of providing support, from which the self-identified needs of the family and child can guide service provision:

I think when you go into any community that you are not part of, you have to stop and listen. And you have to do that in a way that you know it is just not traditional active listening, like western active listening. You have to try even harder; put yourself aside a little bit.[591]

Another team member built on the importance of listening to families:

Because when you start asking them, well what are some of the supports that you require? That's when some of the stories come out about well this is what's happening in my life. This is some things that I would like to see. From there on, as we get the story, then we can kind of see some of the things that could possibly help them.[592]

Listening to community members was also identified as a dynamic process through which Children's Resources team members learned to follow the lead of children, their families and their Nations. Team members discussed listening as something that supports needs identification, self-awareness and being responsive to systemic failings at the individual level where team members can use their discretion to modify services:

I think when you look at the history of medical services or therapy services when it comes to Indigenous populations in Canada, a lot of it has been very like medical model and hasn't really taken their needs or the historical context into

consideration. So, we're really trying to bring that forward in terms of supporting them to tell us what they feel like they need and...in what way, in what format, that's going to be most comfortable for them.[593]

Though less commonly mentioned than the child or family level, some Children's Resources team members extended the concept of "following their lead" to the community level. Team members highlighted the critical importance of employing staff from within the community, emphasized the need to be guided by community perspectives and priorities, and questioned the level of engagement with leadership in the communities served.[594, 595, 596]

Collaboration

Collaboration across different organizations that provide services in KTC member Nations was also highlighted as being integral to the work of the KTC Children's Resources team. Head Start staff were identified as important clinical collaborators who support building relationships with families by taking time to discuss services with parents in advance of children receiving one-on-one support. The collaboration between Children's Resources team and Head Start staff supports continuity of care for children, helps ensure Nation-based staff can provide services independent of the Children's Resources team and supports the professional development of Nation staff.[597, 598, 599] Projects that address the needs of both children and the Head Start staff who work with them on a daily basis have developed through this collaborative approach. A staff member described an example of a collaborative project to develop a Head Start curriculum while KTC member Nations were locked down because of COVID-19:

So occupational therapists...took on like the art subject [to] address some fine motor skills, and then the physical therapist took on like the physical literacy so they could go gross motor, the speech language pathologist took on the literacy where they could chime in with language-based examples in some of the pre-literacy skills. So it really was a collaborative group effort and next step really, because we were hoping we could do a [professional development session] with all the staff in order to help train them or just explain and brief them on it. But, with the sites being at various stages in terms of re-opening, we kind of took a step back a little bit.[600]

Collaboration also occurs within the Children's Resources team. Due to the extensive commuting and part-time schedules of most team members, over-the-phone consultation between the clinical team lead and clinical and/or community team members is the most common form of collaborative clinical support. However, regular clinical and community team meetings also provide a space in which team members can discuss concerns and identify solutions. In addition, within some areas of specialization, Children's Resources team contractors created opportunities for informal collaboration by planning for their schedules to overlap when they visited specific Nations, or by driving to the KTC Nations together. Within one area of specialization, for example, team members discussed a strong sense of collaborative teamwork that was supported by an experienced co-worker who served as a mentor. Collaboration also occurs between clinical and community staff and contractors who work together to facilitate direct referrals, complex case management and clinical support. Community and clinical staff also collaborate closely to share the needs community members identify and to plan, coordinate and implement community wellness events that are informed by these needs.[601, 602, 603, 604, 605, 606, 607]

Case management also occurs on an as-needed basis. Case management involves the collaborative identification of barriers and possible solutions to these barriers to support resolving the needs of people seeking services. Case management tends to involve a single coordinator who supports the documentation and follows through across collaborating professionals involved in a single case by advocating, providing assessments and developing a treatment plan.[608] A team member reflected on the number of collaborative partners involved in a single case of a child with complex needs as an example of the resource-intensive nature of case management:

> *This case also really brought everyone together in terms of respite services and what KTC provides, what Treaty 8 provides, how that looks different, and what the family would be eligible for, and what our role would be in terms of helping get approval for that so that was really good... So just in this one case, for this one little girl, it really required really everybody to be on board and also liaising with a full team of medical, like eight different people, at [a major hospital] so that's been interesting.*[609]

Despite the clear value that team members ascribed to the case management process, the Children's Resources team lacks the resources to support ongoing case management, and case management occurs on an as-needed basis.

As described in Textbox 8, the Children's Resources team has also focused on inter-disciplinary collaboration around complex needs such as Fetal Alcohol Spectrum Disorder (FASD) assessment, and has responded to community need by building an inter-disciplinary FASD assessment team.

Textbox 8 Fetal Alcohol Spectrum (FAS) Assessments

A need that the Children's Resources team initially aimed to meet was providing assessment for Fetal Alcohol Spectrum Disorders (FASD) in KTC member Nations. A Children's Resources team member explained the complexity of seeking FASD assessment, which requires coordinating across different sectors including a family doctor, audiology, occupational therapy, Non-Insured Health Benefits (NIHB) for transport support and the Band office, amongst others:

> *Yeah, so for FASD without the team being set in place now, they would have had to sit there and go and see somebody five different times, five different clinical professionals...even to just get a diagnosis or an assessment done for FASD and it's been taking up to 12 months, 14 months, 16 months.*[610]

Another team member noted that a lack of follow up and the absence of local services also caused families to be hesitant to seek support:

> *There's a huge fear of kids being labeled, so talking about diagnosis and assessment is very challenging, because it's an assumption that bad things will happen. Historically, screening or assessment has taken place without any follow up.*[611]

In response to these challenges, KTC Health sought and received Jordan's Principle funding for the services required for FASD assessment and supports. Having all necessary services located in KTC member Nations circumvented complex cross-sectoral referrals that required families to travel hours to access. A Children's Resources team member reflected on the rarity of locally based services of this type:

> *It's out of the norm... This is one of the first models that they've been doing this way under the Jordan's Principle, because it makes sense right. Why, for so many years, keep taking everybody out of their communities...when it would have been easier to put those funds and bring somebody into the community?*[612]

Over time, the nature of the supports provided to families of children with FASD shifted, from a focus on assessment to addressing broader family needs through long-term follow-up. A Children's Resources team member reflected on this evolution:

> *Yes, we are still focusing on that FASD, those referrals, assessments, and diagnosis but it's broader... It's helping the families... They don't just...need a diagnosis or assessment, it could be just helping them get supportive services and reaching out within their own communities as well. And then being flexible with the whole needs of the family. So, sure maybe with one of the families it may have started out with an assessment, but then all of a sudden getting to know the family, the family dynamic, all of a sudden there are other needs. So, we are able to help guide the family into the services that will help them grow, strive, develop. Or just basically have day to day life.*[613]

Ongoing tensions

Amongst a number of successes, the Children's Resources team continues to encounter a range of tensions that emerged while developing an approach to services. One key tension had to do with the geographic dispersal of the Children's Resources team members and the lack of dedicated space for the Children's Resources team within the KTC member Nations. A second area of tension was tied to the cross-cultural nature of KTC Health's work.

Space and Geography

The work of many members of the Children's Resources team requires commuting from Edmonton or from smaller northern towns such as High Level or Grande Prairie. The commute for these team members can vary from two to five hours one way, with at least a one-hour commute between each KTC member Nation. Seasonal challenges can extend commute times due to poor road infrastructure, with many routes becoming impassable outside of the winter season:

> *So the distance is a barrier sometimes, and having to travel so far... It is kind of an extra challenge, 'cause that road is really tricky. It is good right now, because it is all frozen, but in the fall, spring and summer it is kind of, it is a really tough drive. So, that's difficult.*[614]

A team member who lived more locally reflected on the amount of commuting entailed to access multiple service sites that are spread across five different Nations:

> *A lot of my job has to do with traveling. So, when I meet at the Atikameg office, which is our main office, I leave there at nine am. By the time we get to the first location, it's an hour away. So, I log maybe five hours in the community.*[615]

The combination of long commutes and part-time contracts limits the time in community, particularly for clinical team members. Time limitations reduce the opportunities for connecting with children, families and staff who work in other organizations such as health centres, daycares, or Head Starts. These factors also impact relationships and collaboration within the Children's Resources team itself. Clinical contractors typically schedule their days in the Nations months

in advance to keep a semi-consistent schedule for themselves and to facilitate consistency for children, families and Nation-based staff. However, that schedule varies across service providers, and, as a result, there is limited overlap between team members. In order to carve out shared time, some service providers purposely commute together and use that time to connect as a team. Long shared commutes are also used to conduct collaborative case conferencing to discuss children who receive multiple services across different specialized providers on the clinical team.[616, 617, 618]

The challenges posed by physical geography are compounded by the shortage of available office and accommodation space in the Nations. Most Children's Resources team members provide services in existing community facilities within the KTC member Nations, including health centres, daycares and Head Starts. Team members noted that working in these shared spaces played a key role in supporting the relationship building that is integral to the team's approach to services. One team member reflected on working in collaboration with pre-existing service providers and the way the physical layout of buildings can either present barriers to or facilitate relationship building:

> *The first site that I went to…I very easily connected and broke the ice with the staff because it was the cold snap. And so there were no students, it was just adults, and so I could be humorous and engaging… And the staff just thought that was delightful and so there was an instant connection about, you get us, you get what we are dealing with. And so, by the next time I came they had consent in place… So at [the first site] there's one room that I dealt with, I just deal with the Head Start room. At [the second site] there's a toddler daycare room, there's a daycare room, and then there's a Head Start room. So realistically, you're not connecting with all the people you need to connect with. So, at [the second site] although there's more kids that need my support, direct support, I don't have any consents. Because I haven't had that opportunity to engage the staff in a really meaningful way yet.*[619]

Working within existing service centers also posed other challenges. These centers have limited office space in which Children's Resources team members can provide uninterrupted, one-on-one services to children or families. Team members also noted that available spaces for one-on-one sessions were located in facilities that community members sometimes hesitated to enter because of experiences of stigmatization and breaches in confidentiality.[620, 621] An example of the limitations of shared space was identified by a team member who reflected on the ways confidentiality can be affected in a small community:

> *[Community members] all complain about [the lack of confidentiality], you know, "if I can get into the back door, if I got a [health care provider] that would open the back door and let me in that way." You got what you need in the [sign in book at reception] because some people are going to see that too, and then they will figure out that you have a problem with your wife or something, or one of your family has a drug problem or something. Everybody is going to talk about it.*[622]

Finding ways to meaningfully engage with community by working in community spaces, without getting diverted into the work of the host organization, was also identified as a challenge, particularly for

the community team.[623] Accordingly, Children's Resources team members indicated the need to continue working in shared office space *and* the need for spaces in which they can maintain the confidentiality of individual children and families.

The combination of long distances and a lack of dedicated, private work space also added significant time and effort to the work of Children's Resources team members. The lack of secure storage space means that packing for extensive commutes to and in-between Nations requires meticulous organization of specialized equipment and toys for Head Starts. Alongside equipment, team members also transport documentation such as "family notes" that are shared with caregivers to encourage trust and transparency; these notes outline the goals, tasks and progression of children in services.[624] Because the administrative work of KTC Health is done from offices in Edmonton, or from a crowded shared space in the KTC Health building in Atikameg, Children's Resources team members also have very limited access to printers and confidential shredders. As a result, they sometimes face time consuming back and forth commutes to Red Earth to ensure families have timely access to sensitive documentation. A member of the clinical team discussed the impact of extensive commutes and the delivery of time-sensitive confidential documentation on her work:

I type all my notes to make it so that there is a copy, or I have apps where I can scan it in. So, if I want a copy, I would have to print it out. Some people bring their printers up with them. So, I could print it out there or I would have to print it out at home and then bring it the next time I come up. But there's not a private, confidential printer that we can access where we're staying. So, let's say I spend an hour to an hour and a half with the family, then I'm spending 30 minutes to an hour to write a documentation note, and it probably took me an hour to get there and an hour to get back.[625]

The "hour to get there and hour to get back" refers to time driving between the community and a Red Earth hotel, where clinical team members often stay. The hotel is an extra one to two-hour drive to the KTC member Nations; Children's Resources team members noted the impact that this, more local, commute had on their work:

> *I'm driving a lot. I'm mileaging out my vehicle and...all of the commutes are over an hour long. Although it's only 63 kilometres from Red Earth to Peerless, it takes an hour, and the road is the worst road, literally, the worst road I've ever driven on... I work maybe a couple days here, and then I have to go to a different community, and then backtrack. So, I'm putting a lot of miles on my vehicle. And so I stay, usually in Red Earth, but there's accommodation in Peerless as well. It would be really helpful if there was accommodation in Atikameg, but unfortunately, they don't have any space at this point. So, I guess if there was accommodation in each community, it would make it a lot easier. Did I mention the wear and tear on my vehicle?*[626]

The same team member noted that, when in Red Earth, not all clinical team members stay at the hotel. They may also stay in one of multiple trailers owned by KTC Health or the clinical companies it contracts with; however, space in these trailers is very limited and advanced booking is required.[627] The absence of shared accommodations poses an additional challenge to building relationships between team members:

> *Oh I would be there and not really know who else was in Red Earth at the same time as me. So, I stay in a cube trailer...then KTC apparently has two trailers. I've never seen either one of them... I don't think I'm allowed to stay at the KTC...trailer. I'm not sure, I don't know what the situation is. But I think that if I was allowed to stay there as well, those connections [between co-workers] would be made.*[628]

Shared accommodations were also highlighted as a potential mechanism to build mutual support within the Children's Resources team by reducing isolation and creating opportunities to simply be together as co-workers:

> *I think that can contribute sometimes to that feeling of isolation too... I'd go into these trailers and if you're sitting there all night by yourself with nothing to do, that's a weird feeling...You know, when you think about things that could be improved, how do you get the people who go up there to support each other and be together?*[629]

Over time, and particularly during periods of COVID-19 related restrictions on travel, team members have developed stronger systems for communicating and collaborating via text, email, Zoom and a shared filing system. Still, geography and space limitations continue to constrain opportunities for building the strong relationships that are central to the Children's Resources approach to practice.

Engagement with cultural awareness, cultural competency, and cultural safety

A final tension was tied to Children Resources' team members' efforts to understand and address the connections between the unique cultures of the KTC member Nations and their work with children and families within the Nations. Children's Resources staff were all engaged in a process of learning about the KTC member Nations and cultivating their abilities to understand how cultural differences can inform service provision. However, the focus of their engagement with these questions existed across a continuum in which some people were learning about the cultural differences between themselves

Textbox 9 Cultural awareness, cultural competency and cultural safety

- **Cultural awareness** indicates the service provider understands there are cultural differences between themselves and the person seeking services.[630]
- **Cultural competency** suggests the service provider is aware of cultural differences and able to understand the ways these differences impact a person's needs and engagement with services. Cultural competency also indicates that the service provider attempts to modify how services are provided to best meet the unique needs of people across different cultures.[631]
- **Cultural safety** requires service providers to be aware of power imbalances between service users, service providers and organizations. This awareness is then applied to change how services are provided to centre the self-identified needs of clients. Cultural safety is a process in which power is consistently transferred to people and communities who seek services. The extent to which cultural safety is enacted can only be assessed and verified by the people and communities seeking services.[632]

and the children and families with whom they worked (cultural awareness), others were focused on modifying services to fit with the cultures within the KTC member Nations (cultural competency), and still others were focused on ensuring that people within the KTC member Nations shaped the work of the Children's Resources team (cultural safety). Brief definitions of cultural awareness, cultural competency and cultural safety are provided in Textbox 9, and examples of the questions and tensions that Children's Resources team members encountered in each of these areas are discussed below.

Cultural awareness

Children's Resources team members expressed cultural awareness in multiple ways and spoke of their attempts to be respectful of difference. At the most fundamental level, team members expressed enjoying the process of providing services and learning about the cultures of KTC member Nations. Team members engaged in developing cultural awareness focused on basic features of their interactions with communities, including reflecting on their personal body language, facial expressions and documentation practices. A team member reflected on the experience of learning about Cree culture from Cree peoples, identifying this experience as fundamentally different from workshop, text, or school-based learning:

> *I really enjoy learning about the culture...when you immerse yourself in those [sites] you get to see...the Cree culture and the environment... It's just neat to be immersed in it. It's so enriching and valuable rather than reading it on the internet or in a book, or learning it at a workshop. You are actually in it.*[633]

Examples that indicated a tension in cultural awareness emerged in the language used by staff to describe the Nations. Across interviews team members reflected on their appreciation for the Nations, the natural beauty of Treaty 8 territory and the meaningful process of relationship building. However, in some interviews team members also expressed unspecified discomfort that can be a part of working cross-culturally and in unfamiliar environments. Some used language like "scary" or "rattling" to describe their initial introduction into KTC member Nations, identifying the challenge of overcoming negative perceptions of First Nations that developed before spending time in KTC member Nations:

> *I'd never been north of Edmonton, and so I was like "oh my god, it's so scary." And I was like, I definitely was not going to take the position. But then after being out here and seeing how it was OK, and it was safe, and how kind and just, like, supportive [my supervisor] was, I was like how can I not?*[634]

Another staff member reflected on their first two weeks in the KTC member Nations:

> *Those first two weeks, it was a little bit rattling. And then there was also that unknown of, if I did get lost or if...my car became immobilized, would anybody stop to help me? Just because... there's a cultural difference clearly between me and the, the bands...and so would they feel like, oh well what are you doing out here? And so I had some worries and some concerns, but since I have been in the communities, I am convinced that people would stop. And that it would be totally safe and okay.*[635]

Some team members also expressed concern that, due to a lack of awareness, they might offend or disrespect community members while providing services and supports. For some, these worries were tied to guilt around historic processes of colonization:

> *I think a challenge for me is just when I didn't know the culture at all, I was really trying to watch what I'd say, and I was really worried about offending someone, or not fitting in, or what they thought of me. But I've realized that the people I've met are quite forgiving. And, I don't know, it's just awkward coming in and thinking these people have been colonized by probably my ancestors, and so I just felt—you feel guilty and you kind of have to get over that and just be like, I'm here to help. So that was definitely a challenge.*[636]

These examples point to the importance of supporting Children's Resources team members by scaffolding their introduction to KTC member Nations. Staff expressed interest in having training on the cultural practices, traditions and norms of KTC member Nations:

> *I think that one thing I wish that [the Children's Resources team] would provide would be like an Elder or an education session regarding Indigenous people and Indigenous culture and...the cultural differences between the reserves... Just on my end to be more respectful and conscientious of what's going on, I think that would have been really helpful, and I think that was totally lacking in the education.*[637]

Across interviews, workers reflected on their limited knowledge of KTC member Nations and requested additional training. Children's Resources team members also requested more opportunities to spend time in communities by attending important events or by simply being available in public spaces:

> *My wish list would be...having more time in the communities. And engaging more, more engagement, more collaboration, because it's the communities we are working for after all, right. And then, you can tell the different dynamics from each community. Even though they are all First Nations, and they are all in the one area, they still have their differences of how they conduct themselves.*[638]

As discussed in Chapter 3, KTC Health's limited development of onboarding procedures and internal policies to support the ongoing work of the Children's Resources team was a result of time-sensitive federal funding applications. The limited development was also informed by an organizational decision to prioritize rapid extension of direct services. Children's Resources team members engaged in building cultural awareness highlighted the importance of onboarding procedures that could support: their learning about the cultures of the KTC member Nations; their efforts to overcome stereotypes about First Nations; and their progress towards modifying their provision of services to meet the unique needs of children and families within the KTC member Nations.

Cultural competency

Team members also discussed their engagement with questions of cultural competency, and their efforts to modify services in order to incorporate and adapt to the cultures of the KTC member Nations. For example, they highlighted the inclusion of Cree-based animal cards in an early education curriculum developed by the Children's Resources team. When discussing the development and implementation of the cards, the team members reflected on the limit to which people from outside the community could implement culturally competent services without guidance or direction from a community member:

> *One of [my co-workers] found these like Cree-based animal cards, so they have animals on them, and they have the Cree name for the animal associated with the card. And then, so what we did was we started to plan—originally, they were kind of more intended for movement breaks, so they would have a rabbit and it would be jumping or whatever. But we started to add specific content, kind of by [need and*

specialization]... And we also are wanting to ensure that, just because there is some cultural components, that we're just vetting that the curriculum with an Elder in the community. And so, [an administrator] indicated that we would want to...have the Head Start staff identify a specific Elder for that community.[639]

Another team member reflected on the feedback community members provided around the cards, highlighting the importance of collaboration and community engagement in the development of culturally relevant services:

Things that I just noticed off the top—specially with the AniMoves, with the Cree words, is some communities are like "That's not the word that we use for that animal" and some communities are like "This is how I would say it." So, the Cree dialect or the Cree words that are used are different. And I don't know which communities, but I've heard some communities are more of like Cree culture and Indigenous, whereas other communities are like "That is not part of our culture anymore." Like, Christianity is the most important thing, and they look more at different religions. So, I think if I knew which community focused on what, that would be really helpful. Because I'm just pushing all these Cree words, and they're like "We don't want the Cree words."[640]

Team members also discussed modifying services according to "what works best" for families as one approach to ensuring developmentally-sensitive services were delivered in a culturally relevant way:

It's different not just with English and First Nations but any other kind of language or culture—how we talk to kids is very different and how language is developed within that system is very different. So, having to be very aware and cognizant of how I'm presenting information to families and making sure that it's sensitive, culturally sensitive. Because trying to get them to talk nonstop to their children, like English speaking parents often do, doesn't work. Cause it's against what they normally do culturally. So, having to come up with different ways to improve language in those kind of situations is often a process that we work through with the families, to try to figure out what works best for them.[641]

Well, yeah, yeah I would love, especially parts of [assessments], I would love to be able to throw out. The problem with the whole thing is you—then what you do is you then handicap the people that you're working with because they don't have this kind...report that they can use to bend the majority of society a little bit to their way. They have to have it. It would be great if there was culturally appropriate stuff... But...if you have autism, if you have FASD and somebody has come out and stated that clearly, then you get certain benefits now. And if it's loosely done...then you've screwed things up for the very people that shouldn't have, you know, that already are disadvantaged in so many ways.[642]

When reflecting on integrating culturally specific needs into service delivery, team members identified challenges in modifying services while still conforming to professional guidelines and requirements. An example that was discussed at length in multiple interviews was assessment. Children's Resources team members described the limitations of assessments that are not culturally tailored, while acknowledging the function assessments can play in ensuring access to health and social services, across the lifespan, within existing service systems. When prompted to discuss the role of assessments and the limitations of modifying assessments, a team member identified the tensions of applying cultural competency in a structure of health and social services that is tailored to the needs of Caucasian populations within a colonial context:

Children's Resources team members who were focused on the cultural competence shared examples of the ways in which their modifications to services were informed by the cultures in the KTC member Nations. They also discussed tensions around clinical training, professional guidelines and implementing culturally relevant services.

Cultural safety

Some Children's Resources team members focused on thinking about the power dynamics within their work and ensuring that the work of the Children's Resources team was shaped and driven by children, families and KTC member Nations. However, team members differed in their ability to connect principles of cultural safety to concrete features of their work. Differences in the understanding and application of cultural safety were sometimes a source of tension, with specific disagreements occurring around differences in approach to assessment and diagnosis.

Team members identified practice examples that reflected an applied awareness of cultural safety in direct service provision, including an awareness of non-verbal communication, communication in groups and self-reflection. For example, a team member reflected on the power dynamics of non-verbal communication:

> *I always keep that in my mind...and try to be really self-aware of how my body language and how I am positing myself around [children]... I always want to try to be kneeling on the ground if they're on the ground, or if they're sitting in a chair I don't want to always be standing because I don't want there to be this power differential... I always try to just be really mindful of that to help build that relationship and that connection. Through some of my previous work I just know that you need to have a relationship in order to get any work done or in order to facilitate change. And that relationship piece is like, so important, like first and foremost.*[643]

Team members spoke of applying a cultural safety approach in group contexts and identified ways of communicating that engaged humility and an observational approach:

> *I like to go into the community and be quiet and watch. So, I'll sit in the interagency and I'll just take minutes. And there's lots of times I could say something, you know, but no that's not my role. It's the community role to help build themselves, find their space, find their place. You know...but I am not going to go in and say this is the way it has to be. I don't think our team really does that. And I don't think we quite understand...where we are supposed to be in that place.*[644]

The most important [thing] I think is humility. Like if we can have, train everybody in humility so they stop and they listen and they wait before they talk too much [laughs], when they go up north that would be a good thing.[645]

Team members also identified self-reflective questions that guide their practices and create self-awareness around power dynamics in service provision:

Our role is to have these conversations. What is my impact? And what is the influence I have on the community and on the people? And that is a difficult question to ask. Because for people to realize, whether you are Indigenous or non-Indigenous, once you realize that hey, even though I have good intentions here I could actually be perpetuating the process of colonization.[646]

Children's Resources team members who were focused on cultural safety raised questions about how to more systematically and consistently centre the perspectives and voices of KTC children, families and community members. In so doing, they raised critical questions about both short and long-term priorities in structuring and expanding the work of the Children's Resources team. For example, they pointed to time limitations and limited pre-existing service capacities as challenges to cultural safety in service provision, especially in the moments of crisis and crisis response, such as the youth suicide crisis discussed in Textbox 6 in Chapter 3. One team member identified the imposition of generic crisis response programs as something which limited engagement from Nation members, while also communicating inaccurate messaging around a Nation's capacity to help members:

When you bring in a generic suicide prevention program or a workshop, that is good. But what other messages are being sent? That you are incapable of helping your own people, that you need to be dependent on a specific program? Where does the consultation to the people come in? Where does that conversation happen? Instead of just quickly throwing out ideas and not thinking about it, quickly putting in this workshop and that workshop and not thinking about what is the messages being sent, what is the impact of that? One of the things that I have read through the whole process that in delivering the programs is that people have not been so responsive to...ummm...really heavy terminology...like "trauma workshop." No one is going to that. [The things] that people are really responsive to...are preventive...like we are baking tonight. We can build relationships, we can have conversations about serious issues in a safe way. [It] doesn't have to be called "trauma workshop" or "healthy relationships." That is what I have discovered.[647]

Some Children's Resources team members also pointed to the ongoing challenges in recruiting people from within the KTC member Nations for Children's Resources team positions as concerning. Though KTC Health made concerted efforts to hire people from within the KTC member Nations, applications were limited. The shortage of team members from within the Nations was amplified when funding for two positions filled by people from within the KTC member Nations were not renewed. Some Children's Resources team members identified the limited number of staff and contractors who were from KTC member Nations as a source of concern:

You know I think if agencies who work for Indigenous community don't have the voice of the Indigenous people, then how can we really say that we are providing a service that is for them? Because you have a different world view, your world view is different than mine. Same with the people who are not from those Nations. So...am I doing a disservice by not representing what their needs are, and do we have enough knowledge and training so people can be open enough to know what to do in those areas?[648]

The prevalence of non-Indigenous people in leadership positions was also raised as a concern and identified as an important organizational question:

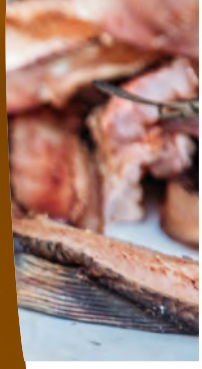
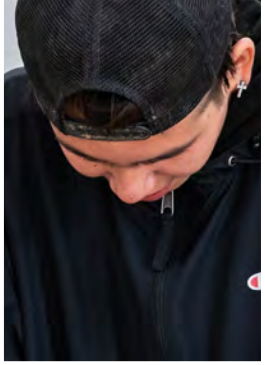
Often we see non-Indigenous leaders in Indigenous communities and, I don't know. Should we change that? Should that be something that we take a closer look at? I guess that would be a question for KTC.[649]

Team members also reflected on the potential for the Children's Resources team to support the development of service provision capacity within the KTC Nations, highlighting professional development as a key to ensuring members of the KTC Nations drive the work of the Children's Resources team:

I would've loved to talk to members of the Tribal Council and knowing about their goals and expectations were... Just talking more... with people in the communities and knowing what their expectations are, I felt like we just swooped in and I would've loved to know more what the goals were in the communities and what they would like. I think, and I don't know if this is because of COVID, but there's so many opportunities for community education and professional development within the communities and empowering people in the community to do a lot of the roles that we're doing right now... There's lots of really capable

> *people in the community that could take over some of [the Children's Resources] roles. Where we could help provide education for that, that could make a big difference so it's not always people from the outside coming in.*[650]

Children's Resources team members have varied levels of experience, understanding and comfort with application of cultural awareness, competency and safety. Multiple team members identified long-term relationship building as experiences that, over time, could shift the ways service provision engaged with a cultural safety approach. Team members also requested trainings to support the Children's Resources team in developing an applied understanding of cultural safety across diverse disciplines. The challenges that members of the Children's Resources team identified are inextricably tied to: colonization; the federal siloing of health, education and social services; and on-going challenges in Jordan's Principle implementation that are raised in earlier chapters of this report. In the concluding chapter of this report, we outline four key recommendations intended to address the complex challenges identified by Children's Resources team members and others that we interviewed. These recommendations are provided to support the Children's Resources team in moving forward with the long-term implementation of a service model that supports KTC member Nations, families and children.


Conclusion





Since 2018, KTC Health has worked to develop a Children's Resources team that provides allied health, mental health and wellness, early childhood education and disability-related supports and services to children and families in KTC member Nations. KTC Health has been able to build and expand the Children's Resources team using funding made available through the Jordan's Principal Child First Initiative (CFI). Accessing Jordan's Principle funding required extensive work because of continually evolving Jordan's Principle policies. The Children's Resources team has worked to adapt proposals and services in order to comply with changing funding justification requirements and the shifting parameters of services that can be funded through Jordan's Principle.

Funding continues to be allocated annually, with no assurance of renewal until just before the new fiscal year. This has left KTC Health and the Children's Resources team uncertain about continued funding, even as they worked to build up a system of needed services. In 2020–21 overall funding for Jordan's Principle group requests in Alberta appeared to decrease dramatically. Funding decreased even though only 11 Nations had been able to establish Jordan's Principle funded allied health and mental health and wellness programming by the fall of 2020.[651] The Children's Resources team lost funding for key mental health, wellness and cultural supports. Consequently KTC Health will, again, have to work to justify reinstatement of funding for these positions.

As a result of working within this tenuous funding context, KTC Health sought to offer services directly to children and families as quickly as possible. By early 2021, the Children's Resources team provided individual level services and supports to 86 children in the KTC member Nations and supported group activities for over 300 children. KTC Health administrators adopted a flexible approach in order to quickly build the clinical team needed to provide mental health and wellness supports as well as allied health services and supports to the families of children with disabilities. This resulted in a complex organizational structure with responsibility for training and overseeing clinicians distributed across multiple contractors. The work of these clinicians is supported by a community team that plays a leading role in building relationships with KTC families and Nations and also provides logistical and administrative support. Understanding of community team members' roles

has emerged over time; KTC Health is currently restructuring the community team and recruiting with the hopes of hiring KTC Nation members in the newly defined positions.

The focus on rapidly extending services meant that the development of organizational infrastructure and interorganizational protocols and policies has been approached on an as-needed basis. Three years into development of the Children's Resources team, team members indicated a need for formal onboarding procedures and more extensive organization policies as well as clearer pathways for communication. Interviewees also identified a need for greater interorganizational communication and collaboration in order to clarify the roles and relationships of different service providers working within the KTC member Nations and more clearly define the role of the Children's Resources team. This interorganizational work takes on urgency within a context in which a long-standing, siloed approach to services is being challenged by expansions in the range of services being offered by KTC Health, KTCEA and KTC CFS. As each organization expands beyond its historic boundaries, the work of these three KTC-level organizations increasingly intersects.

While the documentation of a defined practice model is part of the organizational work that remains to be done, Children's Resources team members articulated a clear, shared approach to service provision. At the core of this approach was an emphasis on building trust and on following the lead of children, families and community members. Trusting relationships are seen as a necessary foundation for addressing family needs. The Children's Resources team combines universal approaches, that provide opportunities to model support strategies for allied service providers and caregivers, with individual strategies that offer the time and space to provide support for specialized needs and assessments. Interviewees also emphasized the importance of collaboration, both within the Children's Resources team and with other service providers, as being essential to ensuring that children and families receive quality care.

Children's Resources team members also clearly identified areas in which team members were, themselves, learning and searching for solutions, strategies and best practices. For example, they were searching for ways to mediate the tensions arising from long commute times for clinical team members and the necessity of working in shared health center, daycare and Head Start spaces within the KTC member Nations. The long commutes limited the time that team members had for relationship building. The use of shared spaces facilitated relationship building, but it also complicated the work of team members who could not count on having appropriate space to meet with individual clients, store confidential files, or collaborate with colleagues.

A second area of tension was tied to the cross-cultural nature of KTC Health's work. Children's Resources team members engaged in different practices that responded to the social and cultural contexts within each KTC member Nation. However, while some team members were focused on the initial process of learning about the KTC member Nations and their cultures, others were developing concrete ways to integrate culture in their work. Still others emphasized the importance of striving for cultural safety, which involves the consistent transfer of power to people and communities accessing services. Differences across this continuum of engagement with culture were sometimes a source of tension within the Children's Resources team, but all team members expressed a desire for additional supports to facilitate learning about and centering culture in their practice.

Recommendations

Based on this formative evaluation of KTC Health's Children's Resources, we make four key recommendations. The KTC Children's Resources team has already taken important steps to advance progress towards each of the recommendations.

1 We recommend that KTC member Nations and organizations advocate for the transformation of Jordan's Principle from a short-term 'initiative' to a flexible, long-term funding stream that can support a systemic approach to service delivery.

Jordan's Principle has introduced expansive new funding for services to First Nations children and supported the development of First Nations led services that are tailored to the context and needs of specific communities. However, funding for Jordan's Principle is still short-term and federal policies and expectations around Jordan's Principle have been inconsistent. In Alberta, funding for Jordan's Principle was more limited and restrictive in 2020–21 compared to prior years, and it appears that the approach to Jordan's Principle funding in Alberta is more restrictive than in other regions. We recommend that KTC leadership join with other First Nations and First Nations organizations to advocate for a revised federal approach to Jordan's Principle. The new approach should maintain the current flexibility and emphasis on locally generated proposals, but it should adopt more consistent guidelines and policies in combination with long-term funding commitments, including funding for infrastructure and capital costs. Within Alberta, advocacy might be carried out in partnership with the First Nations Health Consortium, HCoM or AoTC. At the national level, key forums where this advocacy can occur include:

- The Jordan's Principle Action Table (JPAT), which brings together representatives of First Nations organizations across Canada, may be a primary forum for this type of advocacy. The former Director of KTC Health secured a seat at the JPAT, and the Assistant Health Director continues to participate.

- National Jordan's Principle summits and gatherings sponsored by AFN and/or the federal government provide opportunities to learn about Jordan's Principle initiatives in other jurisdictions, connect with other First Nations and First Nations organizations doing Jordan's Principle-funded work and participate in conversations about Jordan's Principle policy. KTC Health has previously presented information about the Children's Resources team at this type of forum.

2 We recommend that KTC member Nations and organizations prioritize, engage in and fully support an effort to transform the current, siloed approach to service provision.

We recommend that KTC leadership mandate KTC Health, KTC Education and KTC CFS, as well as health, early childhood and social services at the Nation level to work together to develop:

- Clear systems for ongoing communication and information sharing,

- Shared understanding of roles and responsibilities,

- More open, trusting relationships across organizations,

- Clearly articulated, shared values,
- Common standards and expectations for service provision and,
- A coordinated strategy for educating/engaging other organizations about work within the KTC Nations.

Important steps towards ongoing collaboration have been made in the past few years. These include, but are not limited to:

- The development of a joint protocol which details guidelines for KTC Health and KTC Education's work in areas of intersecting responsibility.
- The establishment of interagency meetings that regularly bring representatives of different agencies serving the KTC member Nations together to build relationships and shared understanding of roles and responsibilities.
- Work to streamline and facilitate information sharing between health and education, including the creation of consent forms that include permission to share information between the two organizations.
- Consultation and collaboration around the development and submission of Jordan's Principle group requests.

These steps represent significant progress, but there is still work to be done. Moving forward, we recommend that:

- Work to break down silos be mandated and prioritized by Chiefs and Councils of all five Nations, rather than being left to the initiative of individual organizations or organizational directors.
- Collaborative work be initially coordinated by a professional, outside facilitator who can help to mediate tensions or conflicts and support the development of trust and shared understanding.

3 We recommend that the leadership of KTC member Nations prioritize and collaboratively develop initiatives that support Nation members in building on their strengths, skills, language, culture and knowledge to better address the needs of children and families.

We recommend that KTC leadership mandate the development and implementation of a comprehensive and coordinated approach to capacity development. KTC Health, like other organizations has invested in capacity development for its employees and has also supported the development of training for early childhood development workers. Recent efforts include computer literacy and team building workshops as well as Cree language classes for staff. KTC Health also facilitated formal early childhood development certification training for Nation-employed staff of Head Starts and daycares; the organization also provides a yearly ECD workshop series that is widely available to Nation-employed staff working in Head Start, daycare and Maternal Child Health or FASD programs. However, the necessary capacity development efforts must extend beyond current employees of organizations providing services in KTC member Nations and focus on the KTC population as a whole. The goal should be to nurture the development of future service providers and leaders by supporting new capacity across different levels of education, training and service domains.

Potentially useful examples of capacity building and training programs developed by other First Nations organizations include:

- The Manitoba First Nations Education Resource Centre (MFNERC) Training Institute, which provides training for educational assistants and special education teachers and has also supported specialized programs and initiatives for training First Nations psychologists and speech language pathologists. For additional information, please see: https://mfnerc.org/category/events/training-institute/
- The Indigenous Perspectives Society (IPS; British Columbia) Training series. IPS provides a broad range of brief training workshops which span the areas of community and family support, leadership and governance, justice and equity, cultural perspectives and Indigenous social work. For additional information, please see: https://ipsociety.ca/training/

Conclusion

4 We recommend that KTC Health and Children's Resources team administration prioritize organizational development with a focus on centering cultural safety throughout its policies and processes.

We recommend that KTC Health and the Children's Resources team intensify their focus on organizational development, including (but not limited to) the development of clearer and more comprehensive human resource policies, communication mechanisms and onboarding procedures. Through this organizational development process, KTC Health and the Children's Resources team should strive to develop a stronger, shared organizational culture which prioritizes and systematically pursues the engagement of and transfer of power to KTC member Nations and its members at every level of Children's Resources service development and provision. The clear articulation of a two-eyed seeing approach to mental health in the *Valuing Mental Health Report* (see Appendix 2 for the recommendations of that report) was an important step towards realizing this recommendation.[652] However, ongoing work is needed to establish clearer and more comprehensive organizational policies and procedures that include, but are not limited to:

- Onboarding practices that include cultural training and purposeful introduction to community,
- Systematic processes for introducing new staff and newly developed services,
- Consistent practices around recording and sharing of discussions at meetings,
- Transparent mechanisms for staff to provide input and feedback on organizational policy and,
- Exit interviews for departing staff.

New policies and procedures should be tailored to the complex structure of the Children's Resources team, considering application to KTC employees, contractors and subcontractors and (when applicable) other service providers working in KTC member Nations. New policies and procedures should also centre support for KTC staff and contractors, recognizing and responding to the central role that relationship building plays in the development of a stronger, shared organizational culture while also prioritizing skill building and training for the Children's Resources team.

Appendix 1: Report Methodology

Kee Tas Kee Now Tribal Council Administration (KTC Health) partnered with Dr. Vandna Sinha (University of Colorado, Boulder) to document the development of the organization's Children's Resources team and the initial implementation of services in the Kee Tas Kee Now Tribal Council member Nations: Loon River First Nation, Lubicon Lake Band, Woodland Cree First Nation, Peerless Trout First Nation, and Whitefish Lake First Nation #495. The collaboration was formalized on March 27th, 2019 with the signing of a research agreement.[653]

The formative evaluation that is presented in this report was grounded in a participatory mixed methods approach that is presented in Table 1. We drew on multiple sources of primary data, including:

1. Administrative data;
2. Children's Resources team internal and publicly available documents;
3. Participant observation; and
4. In-depth, semi-structured interviews (n=38)

We also drew on publicly available literature, government, and legal documents related to Jordan's Principle, First Nations in Alberta, and the Alberta health, education, and social service systems. Primary qualitative data, such as interviews and participant observation, were collected and analyzed between March 2019 and March 2021.

The research team transcribed, coded, and analyzed this data following an iterative process of validation with the Children's Resources staff, partners, and with the larger literature related to this report.

At the core of the participatory approach to this evaluation were regular, bi-weekly meetings between the research team and the Children's Resources Child First Manager, who oversees the administration and development of the Children's Resources team. These meetings served as a forum for sharing updates on developments around Jordan's Principle, the Children's Resources team and KTC member Nations. The meetings also provided a space for information verification and discussion of emerging themes and challenges.

The evaluation was also informed by an Advisory Committee, which was composed of key staff from KTC Health, the Children's Resources team, representatives from KTC Child and Family Services (CFS) and a Director of Education from one of the KTC member Nations. Regular meetings with the Advisory Committee served as a forum for sharing and discussing data collection and emerging narratives, and for soliciting valuable input on the best way to approach and adjust the study in the midst of the COVID-19 pandemic. As required by this agreement, this report was reviewed and validated by members of KTC Health's administrators and the Advisory Committee prior to its publication.

Table 1 Primary data collection: Types of data, data sources and types of information collected

Type of data	Data source	Types of information collected
Administrative data	Basic case data, documented in an information management system April 2018–March 2021	Number of Children's Resources team intakes, services requested, services provided, referral to other organizations
Review of KTC Health documents	KTC Health public and internal documents, presentations and communication with ISC regional and national office employees March 2019–January 2021	Information regarding Jordan's Principle policies and the process of submitting a Jordan's Principle request
Participant observation	Field notes based on participant observation in Children's Resources team meetings and events; other meetings and events September 2019–January 2021	Information regarding KTC Health's vision, organizational and service development, relations with partners
In-depth unstructured interviews	Transcripts of interviews with 37 Children's Resources staff, administrators and partners. One round of interviews was conducted in late 2019 and a second in late 2020	Information about the development and evolution of Children's Resources, successes, challenges and daily practice

Appendix 2: Recommendations from Valuing Mental Health Project[654]

Recommendations Toward an Integrated Mental Health Support System

This report outlines a number of recommendations for improving mental health and additional services within KTC member nations. Recommendations have been organized into themes which include:

- PART A – Communication & Community Determinism
- PART B – Specialized Services
- PART C – Comprehensive Health & Wellness
- PART D – Service Improvement
- PART E – Governance & Finance

PART A – Communication & Community Self Determinism

Recommendation 1 – Promote a positive view of mental health and addiction support

The challenge most often discussed during consultations included the obstacle stigma presents in limiting the likelihood that someone in need might access support for mental health and/or addiction. Included are suggestions for battling the stigma often associated with mental health addiction support with the goal of eliminating this significant obstacle for people accessing service.

Recommendation 2 – Develop protocols to support effective communication and collaboration

Communication challenges were a common theme with the community members, staff and third-party service providers we spoke to. Developing protocols to support effective communication and collaborative care between all services providers will elevate the effectiveness of mental health and addiction services.

Recommendation 3 – Create a KTC advisory committee on mental health and addiction

The mental health and addiction support needs of individuals and communities evolve. Taking advantage of quality improvement requires an organization to revisit services and ensure these services meet individual and community needs. The development of a KTC advisory committee on mental health and addiction would continue the work started through this report to ensure mental health and addiction services are always relevant for those who need them.

Recommendation 4 – Advance community mental health action teams

We talked with a number of community members who wanted to harness the power of community to help support mental health and addiction. We met passionate people concerned about the challenges of mental health such as depression and addiction were having on their own families. Advance community mental health action teams for establishing community based action teams who direct those in need to the services they need and also serve as champions for mental health and addiction.

PART B – Specialized Services

Recommendation 5 – Develop a collaborative care process for mental health and addiction

Complex mental health and addiction challenges are resistant to positive outcomes according to our discussions with almost all groups we met. We

heard many challenging stories of people not getting the help they need, or receiving one-off supports that lacked the comprehensive wisdom required to resolve complex challenges. Develop a collaborative care process for mental health and addiction which includes a multi-disciplinary process for community members whether they live in the community or not. This collaborative care process initializes appropriate care by helping to determine the challenges an individual and/or family is experiencing, developing an action plan in collaboration with them and professionals and then executing an action plan.

Recommendation 6 – Improve crisis and critical incident response

Crisis and critical incidents within the community, particularly the loss of life for community members to mental health and/or addiction add significant stress and challenge to the community and community services. The development of crisis and critical incident response plans and formal crisis response teams will establish support for crisis in the community along with centralized support for situations that require additional service.

Recommendation 7 – Advance mental health and addiction outreach services

Many of the community members we spoke to had a basic knowledge of the mental health and addiction services available in their community. Many participants commented on the importance of outreach services to raise awareness and bring services directly to those in need. Advance mental health and addiction outreach services includes a number of suggestions for improving awareness and creative service provision which brings services to community members who need them.

Recommendation 8 – Provide community training on trauma informed care

Trauma was accurately identified as a significant issue among those who participated in our discussion on mental health and addiction. The trauma of colonialization, the cycle of trauma it has proliferated and the traumas community members experience losing loved ones is a real and present challenge for everyone. To support the healing of trauma, communities and service workers need to understand trauma and the trauma-informed care that can help heal trauma. This recommendation focuses on the provision of community training on trauma informed care to support real community healing by providing knowledge and evidence-based care.

PART C – Comprehensive Health & Wellness

Recommendation 9 – Develop a wellness framework for elevating community health and wellness

Excellent activities are already being organized to elevate mental health in every community we visited. There are also numerous community-based and centralized services, along with third-party services doing great work with the challenge that these activities aren't coordinated through a common lens of health and wellness. The development of a wellness framework for elevating community health and wellness includes a way of thinking about and planning activities to elevate mental health through consideration of 10 dimensions of health and wellness.

Recommendation 10 – Integrate traditional healing, medicines and ceremony into a comprehensive support system

Participants we talked with shared a variety of things that brought them strength when facing mental health and addiction challenges including family, friends and religious affiliation. What was missing for many we interviewed was the availability and integration of traditional healing, medicines and ceremony into a comprehensive support system. This recommendation includes a number of suggestions for incorporating traditional healing, medicines and ceremony along with the other support systems and psychological supports already available.

PART D – Service Improvements

Recommendation 11 – Improve confidentiality of mental health and addiction service provision

The real and perceived lack of confidentiality community members fear when accessing community services was a major obstacle identified in our discussions. Improving the confidentiality of mental health and addiction service provision improves the confidence people experience when accessing support for mental health and addiction services.

Recommendation 12 – Enhance counselling support options available in the community

Participants provided a number of excellent ideas for further improving the counselling services already available. This recommendation includes a number of suggestions for enhancing counselling services available in the community. This includes improving the availability, options for accessing services such as home visitation for example.

Recommendation 13 – Elevate addiction prevention support and treatment services

Addiction was named as a significant issue by a large number of community members we spoke with. The frustration with the difficulty in accessing treatment and the challenges with family members returning unprepared from treatment were common themes. The report includes a number of suggestions for elevating addiction prevention, treatment and after care services.

Recommendation 14 – Promote education and exposure to vocational opportunities in specialized community services

KTC member nations have a number of service staff who provide various levels of care. There are also non-community staff and contractors providing specialized service as directed by community leadership according to

community need. Community members can see improved health outcomes by being supported by specialized staff who look like them and have similar backgrounds as them. The promotion of community members to vocational opportunities in specialized community services serves the objective of increasing the number of community members who wish to get specialized training and provide professional services back to their community.

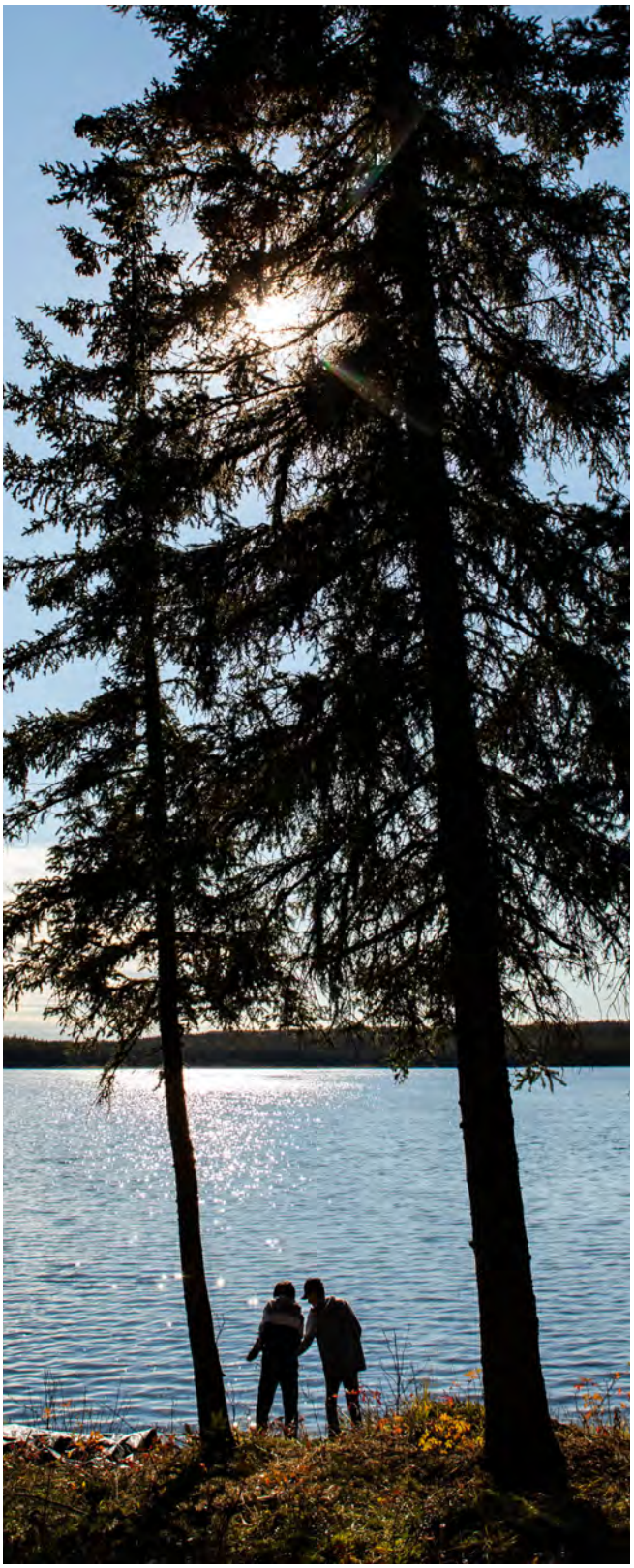
PART E – Governance & Finance

Recommendation 15 – Advocate for enhanced flexible funding for health services

The evidence is clear; when a nation has the autonomy to make their own decisions regarding funding, communities provide clear, connected and creative solutions. Often funding comes with "strings attached" and heavy reporting requirements often mismatched to the core purpose of funding which is to improve health outcomes. This recommendation reinforces the importance that advocating for flexible health services has on improved efficacy.

Recommendation 16 – Develop an integrated mental health and addiction support system

Lastly, it was clear that other KTC organizations spoke with authority and a powerful voice regarding their area of delegated authority. These organizations were able to maintain community decision making but also improve their efficiency through specialized services that were centralized. The implementation of an effective integrated mental health and addiction support system requires careful consideration on two dimensions; (1) Are decisions about support services decided upon by community, centralized support or a combination? (2) Are the services themselves delivered by the community, central service or a combination?



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Endnotes


LOON #476 RIVER
FIRST NATION


WOODLAND CREE
FIRST NATION
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Whitefish Lake First Nation 459


LUBICON - LAKE - BAND
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PEERLESS TROUT
FIRST NATION
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