COMMISSION ROYALE SUR LES PEUPLES AUTOCHTONES

ROYAL COMMISSION ON ABORIGINAL PEOPLES

NATIONAL ROUND TABLE ON ABORIGINAL HEALTH AND SOCIAL ISSUES

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"for the record..."
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Vancouver, British Columbia

--- Upon resuming on Thursday, March 11, 1993
at 8:45 a.m.

DR. LOUIS T. MONTOUR: Good morning, ladies and gentlemen. I would like to officially call this meeting to order.

The first order of business is to ask our Elder, Mr. Glen Douglas, to do the opening.

--- Opening Prayer

DR. LOUIS T. MONTOUR: Thank you, Mr. Douglas.

I would just like to go through the program for Day 2. Our first event is a panel presentation of four community social initiatives which will be chaired by Mr. Alwyn Morris.

We will have a break at about 10:30, since we are 15 minutes behind.

We have a panel presentation of four community medical initiatives which will be chaired by Mr. Peter Ernerk.

We will have lunch, with a keynote speaker, Professor Robert Evans, from 12:00 to 1:30.

We will then have an afternoon panel presentation of discussion papers which will be chaired

and moderated by Dr. Jay Wortman.

Then we will have our second Round Table of the conference, moderated by Alwyn, and then a closing Plenary Session.

I would like to charge the meeting hall today and the three presenters, and one to come. We have here today what the Commission feels and what we know to be a gathering of the experts in Canada on health and social issues. We are very much searching for your individual suggestions, recommendations and visions and ideas on solutions.

We know what the problems are. The papers that have been written eloquently and adequately document the travails and the difficulties we, as Native people, have been through over the last 500 years.

We had examples yesterday of individuals sharing intense personal pain. This was valuable and moving, but it does not get us farther ahead. We need to focus on where we go from here. We have the people here who have direct firsthand knowledge, experience in the field, who work with Native people every day and who can help us forward this process.

We will be asking our presenters this morning to explain and describe their initiatives, where

they work, to give us the background for five or ten minutes and then to spend five minutes on your suggestions and your solutions.

Two of our presenters this morning will be presenting entirely in French, so I will ask you at some point to make your way over to the back of the room to get headphones for simultaneous translation. Our first presentation this morning will be in English, so you will have time at some point to make your way over.

The first presenter on your program, from the Mathias Colomb First Nations, Puktawagan, Manitoba, has unfortunately met an untimely death, Mr. Derek Decook. Myrtle has been in touch with his family, and she was very happy for us to ask the audience here to please stand for a moment of silence in memory of Mr. Decook.

--- Moment of Silence

Our first panel presentation is being chaired by Mr. Alwyn Morris. Alwyn Morris is a friend, neighbour, colleague, fellow paddler when I was older a bit and he was a young, skinny kid. He is also the same age as my wife, and they shared lockers next to each other at Howard S. Billings.

Alwyn, I think, is an inspiration to not

only the youth of Kahnawake but, I think, the youth of Canada and the United States. He is our first Canadian-born, Native Olympic champion. He won a bronze medal in the 500-metre K2 and a gold medal in the 1,000-metre K2 in the 1984 Olympics. His is an achievement unrivalled so far but, hopefully, it will inspire others among us to do the same.

I would now like to call on Mr. Alwyn Morris to moderate this morning's session.

ALWYN MORRIS: Thank you, Louis T.

This morning we have our four presentations. We have changed the program around a bit, as Dr. Montour has suggested. Our first presenter this morning is going to be Carolyn Pettifer, the President and founding Executive Director of the Métis Child and Family Services in Alberta. This organization is an urban-based social service organization, culturally-sensitive to Métis needs. It will be her challenge to rise up to Dr. Montour as the Chair, to try to keep us on track and give some background and some solutions. I am sure we will enjoy her presentation.

Ladies and gentlemen, Carolyn Pettifer.

CAROLYN PETTIFER: Good morning, Commissioners, Elders, ladies and gentlemen in the

audience. The name is Carolyn Pettifer. I am President of Métis Child and Family Services and have been the founder of the agency since its inception nine years ago. I also sit on the Premier's Council in support of Alberta families in Alberta, and I am presently the Social Services Sector Advisor for the Métis Nation of Alberta.

It is quite a challenge for me right now because I expected to be up here to do a 20-minute presentation and it has been cut down to 10 minutes. I thought 20 minutes was not enough time to get into a lot of the issues that we deal with on a day-to-day basis, but I will try to get the best bang for my buck, as they say, during that short 10 minutes.

I have been working with the Métis community in Alberta for the last 10 years. I am originally from Ontario and have been involved in the field of community involvement and working with children and families for over 20 years. I started working in the young offenders system, working with youth, and I have been involved in various organizations. I have been involved with the initiation of a non-profit housing agency in Sudbury, Ontario, and I have worked for the provincial government for three years in Ontario and for a year with the federal government.

My biggest challenge is working with the community. I love working with the community. I would much rather work outside of the system as opposed to inside the system because I feel that changes need to be made to really take on some focus and some real direction to work with our children and our families. There are a lot of issues, and those have been discussed, I am sure, over a number of workshops that the Commission has held, so I don't want to get into the issues facing children and families. I want to focus more on the process for participation and involvement of Métis in terms of directing their own future and for working with both provincial and federal governments.

One person that I really admired and had a lot of respect for, and I have come to work with in the last 10 years since I have been in Alberta, is a man that I admired really well. His name is Larry de Milles. He was President of the Métis Nation of Alberta. He died a couple of weeks ago. One of the things he always told me was: "Carolyn, get out there and push process. We have to be involved and we have to participate in the design and the development of programs that affect our community." So that is what I want to focus on.

Our agency is one that has been out there

struggling. We do have a political mandate from the Métis Nation of Alberta. We are a provincial agency. We are not an urban-based agency; we are an agency that meets the needs of the Métis children and families right across the province.

Although a lot of our services have been focused in the last nine years in the city of Edmonton, we have been working on getting those services out to all of the communities across the province. For us to do that, we have to be involved in a process whereby we can open the doors with the provincial government and with the federal government to allow us to participate and to enter into agreements to do our own work in the communities.

We have a framework agreement with the Province of Alberta and a subsequent Memorandum of Understanding with the Alberta Family and Social Services. That is to allow us to do joint planning, joint initiatives, talking about partnerships, talking about how we as the Métis community and the province can work together in better meeting the needs of Métis children and families across the province.

It is a process, as well, where we can be involved very much more closely with the federal government.

I think it is really important that an agency out there that is delivering services has a political mandate to deliver those services, especially when we are talking about entering into agreements with the province and/or the federal government.

The way the funding arrangements are designed right now, our agency basically works on only fee-for-service arrangements, and that is not good enough for us. We don't need to be involved with government when the programs and the directions are designed at the senior levels of provincial and federal government and we don't have any involvement in the design, when the Métis community doesn't have any involvement in the design and the development of those programs. The funding really limits us in terms of what we can do.

Our agency has about five different kinds of agreements: one with the City of Edmonton; two or three, I believe, with the province; and a couple with the federal government. We spend so much of our time and energy in seeking the sources of funds that we need to do our work.

Our approach is basically wanting to do a holistic, integrated approach to working with children and families. A lot of the work that we are doing is with

families with the child welfare system, mostly in the area of support services. The funding arrangement there doesn't allow us to be involved in the way that we would like to be in doing the work with children and families.

In that sense, I think that being involved with changes to legislation, to regulations -- to make change with any government requires politics. Politics is what makes change. So we feel very strongly that the work that we do with our politicians and the support they give back to us is really crucial for allowing us to take on the directions, to be involved in those changes.

We have had a lot of struggle with our agency, when we are talking about seeking the recognition by government to allow us to participate and involve ourselves in those changes.

With the Royal Commission here, I really feel there should be a lot more Métis participation in some of these workshops, and I do look forward to the Royal Commission making a special effort to put on a round table on Métis. The ten minutes I have up here to speak does not allow me to give the kinds of insight that we have seen, the kinds of struggles that we have as a community in dealing with the federal and provincial governments.

I would like to get into those, but the time doesn't allow me to do that. So I look forward to the round table on Métis, if the decision is made to proceed with that.

The Métis community has a lot of human resources. There is an abundance of people that we have to work with. Our people have been brought up and exposed to all of the social ills faced by other Aboriginal people around the country. A lot of us have survived and overcome and are successful, but we have been exposed and we know the conditions, we know the problems and we know the issues. We know the kinds of things the families are feeling -- the pain and all the social problems they go through. I think a lot of us, because of exposure, can relate to those and, as a result of that, we can share some of our pain, some of our healing processes with those individuals.

Feelings of self-worth, self-identity are all very important. The basis for a healthy, supportive environment is a strong family, our children being brought up with strong feelings of who they are and self-esteem. Those kinds of things are what need to be instilled in our children and in our families if we are going to be healthy mentally, physically, emotionally.

Those are just some of the areas we are

working in with our families -- the holistic approach. But, as I said, we can't operate in an integrated, holistic way without the funding arrangements that go with that.

If I can give one solution to the whole issue, it would be to say to all of those federal government departments that piecemeal funding is not the way to go. Let's take all of those pieces of funding from all of those governments, federally and provincially, and put them in a pot. Sign a federal-provincial agreement with the Métis community, and you can rest assured that we will come up with our own solutions and our own unique approaches to working with children and families. And we will be successful.

If you are looking for a solution, let's involve the Métis community in the process and in a manner that we agree to how we should be participating, not in a manner that the federal or the provincial government chooses or decides how to involve us. Allow us the opportunity to talk and dialogue and talk about a process for participation and our involvement and partnership.

Thank you.

ALWYN MORRIS: She did really well. We are actually a little ahead of schedule, so she certainly

rose to the challenge.

Our next presenter -- and I was asked if I could do a little of this en français, but I am afraid I am not going to be able to do that. In any case, our next presenter is a gentleman named Richard Kistabish. He is the Health Program Co-ordinator for Grand Lac Victoria Band Council, health and social services in the Algonquin milieu.

The Algonquin project is to restore the community's social, spiritual, physical and cultural health, utilizing all available health and social services in the region. The project incorporates the Algonquin culture and philosophy, with the objective of restoring a sense of pride and responsibility for self and community.

Ladies and gentlemen, Richard Kistabish -- and his presentation will be in French.

RICHARD KISTABISH: (Native language)

Since I have been colonized by French, I have to use that language. If my message is not clear enough in French, we will have an opportunity afterward to ask questions and to answer those questions.

Je voudrais d'abord remercier la Commission royale de nous avoir invités pour venir parler des projets qui actuellement prennent place dans la

communauté du Grand Lac Victoria.

J'aimerais préciser ici que le Grand Lac Victoria est une communauté qui n'a pas de réserve comme telle, qui n'a pas le statut légal d'avoir une réserve. C'est une communauté qui est encore nomade. Donc ils ont des maisons et des cabanes un peu partout sur le territoire et ils se ramassent dans un endroit déterminé durant la période d'été.

Ils sont toujours les gardiens de ce mode de vie là et, par conséquent, lorsque tu pratiques un mode de vie traditionnel, des fois tu as beaucoup d'objections de la part des gouvernements pour l'approvisionnement ou l'accès à des ressources ou des services.

Depuis 1980 que le Grand Lac Victoria avait essayé d'obtenir des services en matière de santé, des services sociaux ainsi que d'autres services. On leur a toujours dénié cet accès-là parce qu'ils n'étaient pas sédentaires et vivant sur une réserve.

Je dois vous dire aussi que, par conséquent, il n'y a pas de services courants, comme l'électricité et l'eau courante, dans les maisons. Cependant, la majorité des familles ont utilisé des génératrices au cours des dernières années, de sorte que la télévision est quand même bien ancrée dans les

communautés. En même temps ils ont accès à des vidéos, de manière à pouvoir s'occuper aussi durant le temps qu'ils ont à perdre.

En 1980 le chef de la bande du Grand Lac Victoria, qui s'appelle Donat Papatis (PH), est venu me voir alors que moi, j'étais le président du Conseil algonquin. À cette rencontre-là il m'avait demandé de l'aider à obtenir des ressources pour donner un coup de main à la communauté, parce qu'il voyait qu'ils étaient dans une situation assez lamentable, mais il ne savait pas par quoi commencer, par où commencer. C'est de là qu'on a utilisé aussi une approche pour essayer de régler ces problématiques-là, une approche qu'on peut appeler une approche biculturelle; de temps en temps aussi on peut utiliser le mot "holistique". On essaie d'utiliser le mot "holistique" depuis le début hier à toutes les sauces. On peut aussi utiliser le terme "systémique".

Lorsque tu utilises ces termes-là il faut nécessairement préciser lorsqu'on veut se faire comprendre. Lorsqu'on utilise les trois termes que je viens d'utiliser, ça veut tout simplement englober tout ce qui nous entoure, tout l'environnement dans lequel la communauté peut être placée, autant ses valeurs culturelles qu'elle peut véhiculer que les valeurs

culturelles qu'elle a rencontrées lorsqu'il y a eu la rencontre d'une autre culture, la culture dominante.

On est finalement arrivé à conclure qu'avec la rencontre des deux cultures des problèmes sociaux et des injustices se sont installés qui ont créé finalement des problèmes majeurs et sévères dans cette communauté-là. C'est pourquoi le processus de guérison qui avait été adopté était d'utiliser toutes les ressources possibles, que ce soit de l'autre culture ou de la nôtre. C'est pour ça que les démarches du Grand Lac au cours des dernières années ont été mises surtout sur l'accessibilité à des personnes ressources telles que les travailleurs sociaux, les psycho-éducateurs, les psychiatres si c'est nécessaire.

Grâce à cette approche-là la communauté du Grand Lac a réussi à mettre sur pied une équipe qu'on appelle "multidisciplinaire", multidisciplinaire dans le sens qu'une fois par mois nous nous rencontrons, nous nous assoyons toute la "gang"; nous sommes 27 personnes intervenantes dans la communauté. À part les trois travailleurs sociaux qu'on a, on a un agent de liaison pour les services sociaux, on a un aide conseil, qui est pour aider la coordonnatrice de tous ces services-là.

On a aussi accès à des programmes

auxquels toutes les autres communautés ont aussi accès depuis un certain nombre d'années quand même -- malgré toutes les normes d'accessibilité, parce qu'on n'était pas une réserve -- comme le programme de lutte contre l'abus d'alcool et de drogues. On a un RSC, le représentant en santé communautaire, et les programmes aussi pour aider le monde qui ne savent pas utiliser la langue française ou la langue anglaise dans la communauté, parce que le Grand Lac est quand même composé aussi de personnes qui sont unilingues algonquins.

Finalement, on a aussi essayé d'obtenir des fonds en éducation; les enfants, il faut qu'ils aillent à l'école. Je reviendrai un peu plus tard sur cet aspect-là de l'école.

On a aussi finalement obtenu des maisons qui appartenaient à la province de Québec dans ce temps-là pour pouvoir aménager des points de service. On a créé un dispensaire qui est plus ou moins conforme à ce qui pourrait être considéré comme critère. On a aussi une maison communautaire qui abrite le conseil de bande. Donc on a besoin de personnes pour faire le ménage aussi de tout ça et l'entretien de tout ça.

Nous avons aussi des agents de liaison. On a une infirmière sur place qui est payée directement

par la province de Québec. On a deux médecins omnipraticiens et on a un médecin de santé communautaire. On a pu obtenir aussi les services d'un pédiatre, d'un psychiatre, d'un pédopsychiatre ainsi que la venue de deux psycho-éducateurs, d'un agent de prévention sociale pour l'école, d'une organisatrice communautaire.

Nous avons aussi mis sur pied des programmes pour lutter contre la violence familiale par la venue d'un psychologue qui traite des hommes qui sont des agresseurs, des violents; aussi, nous sommes en mesure de donner des services aux femmes qui ont été violentées. Nous avons aussi un psychothérapeute.

Ça nous donne 27 personnes qui oeuvrent dans le milieu juste dans le domaine de la santé et des services sociaux.

Certains nous disent que ça coûte cher, que ça coûte très cher, ce genre d'approche. C'est vrai que ça coûte cher. Mais quand on regarde un peu l'histoire passée de notre peuple, c'est vraiment pas cher comparé à toutes les ressources naturelles qui ont été prises. On peut commencer par la forêt, qui a fait des milliardaires avec ces multinationales que sont la CIP, la Domtar et autres. On peut vous parler aussi d'Hydro-Québec qui vient faire des barrages là-dessus et qui récolte des

milliards de dollars là-dessus.

Nous avons aussi une chose bien importante aujourd'hui, qui sert de base pour l'aspect monétaire dans le monde: l'or. Nous avons de l'or chez nous, sur notre territoire. Il y a beaucoup de compagnies, beaucoup de personnes qui se sont enrichies de ces ressources-là tout en nous ignorant complètement.

Lorsqu'on parle de donner un coup de main à une population de ce côté-là, ce n'est vraiment pas cher. C'est du petit change qu'on demande.

Je pense que, dans les parts de solutions qu'on a à suggérer tout à l'heure, il est important pour les décideurs et pour tous ceux qui ont à légiférer pour changer des affaires de tenir compte du passé. Si on ne tient pas compte du passé, c'est certain à ce moment-là qu'on n'aidera personne dans notre communauté, surtout ceux qui ont été privés de tous ces argents qui étaient les leurs.

Dans cette approche de l'équipe multidisciplinaire il a fallu aussi tenir compte des facteurs qui étaient à contre-courant, surtout pour la question, admettons, des services sociaux. Cette institution-là préfère avant tout garder l'enfant dans le milieu. Je pense aussi que c'est une approche qui est

adoptée au niveau national de garder l'enfant dans le milieu. Sauf qu'au Grand Lac, garder l'enfant dans le milieu, il était complètement irresponsable et inconcevable de le faire de cette manière-là, au moins lorsqu'on met en branle le processus de guérison.

Je n'ai pas besoin de mentionner ici toutes les fautes qui ont été commises envers les enfants durant un certain nombre d'années, pour ne pas dire durant des dizaines d'années. On a fait les manchettes des journaux il y a deux ans et il y a trois ans aussi, par le Journal de Montréal, à cause que nous avons demandé à la Commission de la protection de la jeunesse du Québec de venir entreprendre une enquête sur la non-accessibilité des services sociaux pour la communauté du Grand Lac. On a demandé aussi de venir voir comment était la situation des enfants dans cette communauté-là. À la grande surprise de tout le monde -- de ceux qui étaient là, sauf nous autres -- on a pu démontrer qu'il y avait effectivement beaucoup d'agressions sexuelles qui étaient pratiquées sur des enfants. Les journaux jaunes raffolent de ce genre de publicité-là, et cela a sorti plus qu'autre chose, ce genre de situation-là.

La situation était tellement déplorable à ce moment-là que l'enquête a permis finalement, de

concert avec le ministre de la Santé et des Services sociaux du Québec, M. Côté, que je remercie d'ailleurs aujourd'hui pour son intervention dans ce milieu-là, de nous dépêcher un médiateur pour venir replacer les gens à la même table -- les intervenants dans le domaine social ainsi que les représentants de la communauté -- et à ce moment-là s'asseoir pour commencer un plan, soit un processus de guérison, mais aussi un plan d'intervention qui pourrait coller plus à la réalité de la communauté.

Durant les premières années -- et encore aujourd'hui ça se maintient -- il faut sacrifier certains aspects fondamentaux, comme de maintenir l'enfant dans le milieu. On ne peut pas la pratiquer actuellement, cette affaire-là, à cause justement du milieu dans lequel l'enfant a été élevé, et qu'on laisse l'enfant finalement dans les mains de ses agresseurs continuellement. On a été obligé de décentraliser, de tout exiler les enfants durant la période scolaire. À ce moment-là on rencontre les parents aussi, dans ce processus-là, et on leur donne des responsabilités pour s'occuper de leurs enfants, pour ne pas que ces situations-là puissent arriver.

Cela a amené aussi la dénonciation de certains enfants vis-à-vis leurs agresseurs. Lorsque le processus de guérison est établi pour les enfants dans

la question des agressions sexuelles qu'ils ont subies, nécessairement, dans la thérapie qu'ils ont, il y a cet aspect-là: la dénonciation. À ce moment-là la justice vient embarquer dans le processus.

Il était important au début, lorsqu'on avait commencé ce processus-là, d'obtenir une collaboration avec les administrateurs de la justice. On a établi, malgré la crise d'Oka en 1990, une bonne collaboration avec la SQ, la Sûreté du Québec, pour la question des dénonciations que les enfants étaient prêts à faire. Il y a eu une équipe qui a été mise sur pied par la Sûreté du Québec pour aider la communauté à non seulement trouver les coupables pour les amener en prison, mais aussi envoyer un message clair à la communauté que les agressions sexuelles, que ce soit fait sur les enfants ou sur les femmes, c'est fini; on n'en veut plus, de ça.

Cela a été une volonté populaire de la communauté qui a été à ce moment-là exprimée lors d'une assemblée générale annuelle que la communauté a tenue. Par conséquent, cela a aussi été une volonté politique.

Cela a toujours été considéré, la question de la volonté politique, comme une partie importante dans le processus, parce que lorsque les

intervenants, comme nous autres, on allait faire des représentations à différentes instances gouvernementales, on se faisait toujours demander si le conseil de bande était d'accord avec tout ça. Je pense que cette manière de recevoir les interventions des communautés, qu'ils soient chefs ou pas chefs, ou membres du conseil ou non, quand il y a une intervention, une volonté de vouloir dénoncer des choses qui se passent dans une communauté, que le conseil de bande ou non soit d'accord, il faut absolument être attentif à ces plaintes-là.

J'en sais quelque chose, parce que lorsque j'ai commencé moi-même à dénoncer, en tant que grand chef, ça n'a pas pris tellement de temps pour que je perde ma job en tant que grand chef, parce que politiquement il ne fallait pas intervenir dans le domaine social. Ça, c'était chez nous, chez les Algonquins de l'Abitibi-Témiscamingue. La volonté politique de vouloir changer les affaires est un facteur important, j'en conviens, mais je pense qu'elle n'est pas nécessairement essentielle pour aider des gens à s'en sortir. Il y a trop de mauvaises expériences que ces gens-là ont vécues pour pouvoir y arriver.

Il y a cependant aussi, lorsqu'on met

une équipe multidisciplinaire comme celle-là... je vais être obligé de sauter des affaires, parce que j'ai 10 minutes et je ne peux pas entrer dans tous les détails. Là, j'ai cinq minutes de solutions maintenant.

On vise cinq objectifs avec tout ça. Notamment, il y a la question de la santé et des services sociaux - on met ça dans un élément -- et c'est de pouvoir arriver à contrôler tous ceux qui oeuvrent dans ce domaine-là. On doit absolument, d'abord et avant tout, lorsqu'on commence un processus d'ordre social comme celui-là, éliminer tout ce qui est microbe physiologique, tu sais, les "bibittes", les mauvaises affaires; on peut soigner ça à l'hôpital pendant une couple de jours ou une couple de semaines, dépendamment de la maladie.

Un exemple que je pourrais vous donner, c'est: Au tout début, lorsque la communauté avait commencé ce processus-là, 65 pour cent des enfants de la communauté du Grand Lac avaient des otites, des bobos dans les oreilles, de sorte qu'à l'école, ayant des fois des enfants qui n'avaient pas de tympans, ils n'arrivaient pas à comprendre ce que le professeur disait parce qu'ils n'entendaient pas. On les classait comme débiles ou comme arriérés pour que les Affaires indiennes puisse donner des subventions plus grosses parce que c'est un cas plus

difficile.

Mais quand on a analysé vraiment la problématique de ces enfants-là, on a découvert que 65 pour cent des enfants, leurs oreilles coulaient. Donc ils n'avaient pas une bonne oreille, si vous voulez. Cela a créé finalement des situations vraiment embarrassantes pour les commissions scolaires lorsqu'on a dévoilé ces affaires-là au grand jour.

L'aspect spirituel, l'aspect traditionnel, l'aspect de la langue et de la culture, à cause de l'approche qu'on prend, je pense qu'il est important de remettre d'abord de l'ordre social là-dedans. La spiritualité, pour ma croyance personnelle, sert uniquement à faire du développement de ta personnalité, mais aussi un développement communautaire.

La spiritualité d'autrefois n'était pas utilisée pour guérir des agressions sexuelles. La spiritualité d'autrefois servait à faire du développement de la personnalité, du développement du caractère pour aller chercher des bonnes choses, pas pour guérir des affaires.

Il y a aussi le domaine de l'éducation. Il va falloir que ce soit repensé, parce qu'une communauté qui est nomade, lorsqu'elle entreprend la prise en charge

de son éducation, nécessairement, on la sédentarise, on la "parke" dans une place et elle doit rester là parce que l'école est comme ça. Il va falloir l'adapter, l'école, aussi.

Le quatrième objectif qu'on vise là-dedans aussi, c'est de restaurer l'économie. Si on arrive à faire toutes ces affaires-là sans tenir compte de l'aspect économique, on va tout simplement donner une béquille de plus à la communauté.

La dernière chose qu'il faut considérer, et la plus importante probablement aussi, c'est l'environnement. Je pense qu'il est important qu'une fois que tu vas avoir entrepris le processus de guérison, de te respecter toi-même avant tout et de respecter ton voisin, de respecter ta famille, ta communauté et finalement ta nation, à partir de là aussi, par l'effet d'entraînement que ça fait, tu vas finir par respecter la terre.

Vous m'excuserez, Monsieur Alwyn, mais il y avait des affaires que je voulais mentionner absolument.

Une des parties les plus importantes à corriger est l'entente de 1966 concernant la livraison des services sociaux dans les communautés. C'est une

entente qui date de 1966. Elle n'a jamais été renouvelée quant à la livraison des services de santé et des services sociaux dans la province de Québec. C'est une vieille affaire qui traîne. Elle n'est plus du tout adéquate pour pouvoir répondre à ça, et la révision de ça doit tenir compte aussi de l'implication des représentants des communautés.

Il y a aussi les programmes SAFFI, qu'on appelle; moi, j'appelle ça "Sophie". C'est le Service de l'aide à l'enfance, familles indiennes. Il va falloir qu'il soit encore plus flexible, celui-là, parce que la communauté du Grand Lac ne peut pas être admissible à ce programme-là. Elle est trop petite, pour commencer; par contre, les problématiques sont tellement immenses, je pense qu'il faut en tenir compte de ça.

La dernière affaire sur laquelle je voudrais revenir aussi, c'est la question de la santé mentale, que le gouvernement fédéral a actuellement en main. C'est incroyable, la manière de gérer la santé mentale.

Il y a actuellement une politique fédérale en santé mentale qui consiste à payer des thérapies individuelles à des gens. Aussi, ils mettent une limite au traitement lui-même, sans considération

aucune: 750 $ quand c'est prescrit par un médecin omnipraticien et 1 500 $ si c'est un psychiatre qui la prescrit. C'est absolument inconcevable, lorsqu'on entreprend un processus ou une thérapie, surtout dans le domaine d'agressions sexuelles, de laisser des gens dans une situation dans laquelle ils vont aller dévoiler leurs affaires et qu'à un moment donné, pour des raisons d'argent, il faut arrêter. C'est comme si on faisait une opération à coeur ouvert et que tout d'un coup l'électricité manque ou quelque chose manque et il faut laisser le gars sur la table d'opération le coeur ouvert, pas capable de faire la soudure ou le "recousage" pour fermer son coeur.

J'aurais bien d'autres choses à dire, mais j'ai vraiment abusé de mon temps.

ALWYN MORRIS: Thank you very much, Richard. That is a tremendous amount of food for thought.

Our next presenters are Fred and Joyce Johnson who are Band Councillors in charge of drug and alcohol programs in the Alkali Lake region. For those of you who don't know the Alkali region, the Alkali Lake Band posed itself for a dramatic reversal of widespread addictions to almost total sobriety. I invite them up now to speak.

JOYCE JOHNSON: My name is Joyce Johnson, and I am from Alkali Band. I am also a Council member. I have been a Council member for four years.

In the spring of 1992 the Alkali Band received funding from Health and Welfare Canada, through NNADAP, to conduct research. The primary objective of this research was to determine what were the most effective factors in achieving and maintaining sobriety among the residents of our community.

The quantitative research component is entitled "A Study of Sobriety and Aftercare at the Alkali Lake Reserve, 1993." The project also included a separate historical summary of sobriety's movement. It is to be published and made available to other Native communities who have not yet achieved sobriety or started their healing interventions.

The problem that must be addressed is the disease of alcoholism. It is a disease that is medically recognized as having no cure but can only be controlled through abstinence. To deal effectively with this problem and its effects, a detailed knowledge of this disease is required.

One of the reasons that the problem is so difficult to solve is simply that very few people are

truly knowledgeable about alcoholism and how to deal with it. They know little to nothing about aftercare and effective healing interventions which are needed to maintain sobriety. This lack of knowledge about how to deal with alcoholism in native communities is reflected in the shocking statistics on Native social problems.

The suicide rate for Native youth is six times higher than the national average. The number of Native children in care and the number of Native adults in jail are also six times higher than the national average.

While many Native communities have made substantial progress and reached high levels of social, economic and cultural development, there are many others still caught in a trap of poverty, hopelessness and alcohol. It is for these communities that this research was conducted.

In 1985 a film was produced entitled, "Honour of All: The Alkali Lake Story", which has been seen throughout North America. As a result, we receive phone calls and letters on a regular basis, usually from people who have seen the film and for whom a spark of hope has been ignited. They want to know how Alkali Lake accomplished this and "can you send us something more."

This study was conducted in two parts.

Part I is a historical summary that documents the excellent interventions used by Andy and Phyllis Chelsea to turn the community around, and parallel events were portrayed in the film. Part II presents the quantitative research done of Alkali Lake. It focuses on the disease of alcoholism itself and what people found to be helpful in sobering up and maintaining their sobriety through an aftercare program.

In this study the subject of sobriety and the maintenance of sobriety through aftercare has been distinguished through the action of ceasing to consume alcohol. Quitting drinking and maintaining sobriety are presented as two separate and distinct subjects.

In Alkali Lake the first step was to place it on a community level. Through the authority of the Band Chief and the Band social worker, the second step was undertaken on a personal level during the healing process that is required to maintain sobriety. The Alkali Lake experience has shown that both these stages are necessary. The community level interventions and the personal aftercare program are both essential to the community healing process.

Based on the historical study of the interventions used at Alkali Lake and the data gathered

in the 1992 research, the following is concluded:

1. Confrontation intervention was used on a wide scale between 1972 and 1980 to get people to stop drinking. This intervention was very effective.

2. Aftercare treatment alone is not sufficient to maintain sobriety. Many aspects of aftercare must be developed to facilitate a healing process. Without attending to aftercare, the risk of relapse is high, or the person remains a dry drunk. Their behaviour, while being sober, would be like it was during drinking.

From the historical studies the personal growth training undertaken in 1981 was significant in moving people past the plateau stage, out of the dry drunk syndrome and into individual programs of personal healing and personal growth. It was after the personal growth workshops that the community reached 95 per cent sobriety.

The healing must be an ongoing intensive process, and it must occur in the community.

3. Alcohol and Case Work: Based on the effectiveness of the confrontation intervention and the success of aftercare initiatives at Alkali Lake, we feel that people in the helping professions should have training in alcoholism and know how to work with an alcoholic client.

Our research submits that the alcoholic client and the alcoholic community is not a hopeless situation, but can respond to a combination of sober leadership, structured interventions, and resources for healing and aftercare.

4. Family support: The statistics show that family was the biggest factor in people's decisions to quit drinking.

Recommendation: We recommend that social workers must have more understanding of holistic models.

5. Spiritual support: The historical research showed that there was no practice of Native spiritual ceremonies in Alkali Lake prior to the late 1970s. It is estimated that today approximately 100 people participate in traditional practices such as the sweat lodge and the pipe ceremony. The practice of the traditional spiritual ceremonies was purposefully revived and relearned from outside resources during the past 15 years at Alkali.

We believe that this type of specific planned intervention to revive and relearn Native spiritual ceremonies played a significant and substantial role in the recovery of the Alkali community.

In our research data, quantitative research was conducted during the summer of 1992. The population of Alkali Reserve is approximately 500 people, with about one-half being under the age of 18 years. A democratic profile and interview was completed of 188 Alkali Lake residents over 18 years of age. During the interview people were asked the following questions:

1. Which interventions did you use to become sober?
2. Which interventions were most effective?
3. Please explain why.
4. What significant event or thing caused you to want to be sober?
5. What has helped you to stay sober?
6. What has been the most effective factors in the aftercare program?
7. What barriers did you see in your recovery?

The findings from the data collected in the quantitative research is summarized as follows:

Question No. 1: family support, 25 per cent of responses, and personal growth 20 per cent, were the two main interventions used to quit drinking; treatment

centres, 12 per cent; and AA groups, 11 per cent, were also used.

Question No. 2: The most effective factor identified in the interventions used to quit drinking were self, 24 per cent, followed by family, 17 per cent.

Question No. 3: The reasons for effectiveness were stated: spiritual support, 28 per cent; and family support, 23 percent.

Question No. 4: The reasons for wanting to become sober were identified as family, 48 per cent; and spiritual, 31 per cent.

Question No. 5: The factors used in aftercare to maintain sobriety were spiritual support, 25 per cent, including AA and sweat lodges; and support groups, 18 per cent.

Question No. 6: The most effective factors in an aftercare program were spiritual support, 34 per cent, including AA and sweats; and support groups other than AA, 19 per cent.

We do have the study. If you have need to see this, we will be here.

Now Fred will come on.

FRED JOHNSON: My name is Fred Johnson

of the Alkali Lake Band Council and the Drug and Alcohol Council.

I would just like to talk a little bit about sober leadership in our community. Just before I talk about that, I would like to thank Joyce for coming up and doing her presentation.

When I first sobered up, I used to take Joyce to all the Band Council meetings and all the different business meetings. She was struggling to stay sober. I just let her know that one day she was going to have to be a leader.

I am proud of her. I guess that is why it is important for our leadership in our communities to be sober, so that we can be role models to our community. I would like to recognize the person from Davis Inlet. I understand.

I think another reason -- I am very nervous and kind of shaky, so you will have to excuse me. I think another reason for sober leadership -- coming from a community that had 100 per cent alcoholism, when we sober up as a community, our community expectations of community leaders are high.

From what I heard yesterday and from what our community experience is, there is a lot of work to

be done in our communities. One of the biggest things that I see as a leader in healing is that sobriety is just one step. Healing is another step. One of the biggest things that I think helps our community members is when our leaders can stand up and talk about their secrets that they carry for, I guess, a lifetime, that we don't have to hide the fear of the residential experience or sexual abuse or family violence. If our leaders can do that, then we can have understanding of our community members.

As a leader, I couldn't understand why a lot of people were standing on the streets until I looked at my own sexual abuse issues. Then I understand why our people were on the streets killing themselves. I guess that was a type of suicide.

I prayed. I asked the Good Spirit to give me strength. I said, "Fred, don't cry." But I guess however it comes out, it comes out.

I understand today why our Indian people, like my people, are standing on the street in Williams Lake, killing themselves with alcohol and drugs. I understand today why our young people are hurting themselves with drugs, until I deal with my issues.

I was in Canim Lake two days ago, and I thought I had dealt with my residential school issue,

but when I hear about it, I cry. It seems like a lot of our people -- our young people that are hurting themselves today, didn't go through residential school, but their parents and their grandparents have passed on their behaviour to our young people in our communities.

I guess that is why it is so important for our leaders to be sober, so that we can understand our people, so that we can go the distance in helping them out.

In regard to funding and looking for funds for healing, I have had that experience. If we don't deal with our issues, sometimes when we have to deal with sexual abuse or family violence funding, we don't try hard enough to get that funding. I have experienced that in our leadership, and I guess that is why it is so important for our leadership to be sober and also to be in healing, to understand what we have to do for our people.

I have two minutes here, and I don't know how else to say it in such a short time.

I would like to say that the expectations of our Band Council are high. I don't know if it is my place to say this, but I am going to say it -- I have said it before, and I am going to say it again. With the people that we deal with, at whatever level of government, we

expect the people out there also to have respect for alcohol when they deal with Indian people. I guess I am talking about people who sit on committees in funding, that they also be sober and in healing to understand our people. I know that is a high expectation, but with the people we deal with we have been through hell and we want you to respect that. That is how our Band Council -- and I am only talking for the Alkali Lake experience.

I just have one short little thing -- I must have about 30 seconds left. I never heard it in here yesterday, and I hope the Commissioners find a way. I hope the people here find a way. There is one more hurt that my people need to deal with, and that is the land issue. I guess people call it land claims.

I find my people have a lack of pride, are ashamed to be Indian, and I was ashamed to be Indian. I think that little reserve we stay on we are ashamed of. My traditional Shuswap territory is a large area; yet, we live on a little piece of land.

As I say, I hope the Commissioners here are listening and can do something about that in Ottawa, so that we can stand up proud and bring the pride back to our people. I think our children need a future. If we can address that one issue, I think it would help us

in that holistic healing, as we call it.

I would like to thank you very much.

ALWYN MORRIS: Thank you very much.

Le prochain présentateur est M. Louis Hanrahan, qui était directeur de la Santé et des Services sociaux pour le Conseil de la nation Atikamekw.

Monsieur Hanrahan.

LOUIS HANRAHAN: Bonjour. Je voudrais commencer par remercier la Commission de nous donner l'occasion de venir parler de l'expérience chez les Atikamekw.

Je me sens un peu mal de venir vous faire une présentation un peu froide, finalement, après toutes ces présentations qui sont beaucoup plus émotives d'une certaine façon mais plus collées à la réalité. Je me dis que peut-être que ça montre un peu les limites de l'intervenant non autochtone dans le milieu autochtone et les limites de notre participation au vrai progrès chez les autochtones.

Il est possible que, comme moi, vous vous soyez posé certaines questions hier sur comment passer de cette idée d'une approche plus holistique, intégrée, si on veut, à la pratique; comment structurer une organisation et un modèle de dispensation de services qui

répondrait à ces préoccupations-là. Ce que je vais vous présenter aujourd'hui, c'est un peu une expérience, si on veut, de réponse à cette question-là qui a été vécue chez les Atikamekw. Je vais donc donner un regard critique sur l'implantation, c'est-à-dire à quel point on a réussi à faire ce qu'on avait prévu de faire par rapport à un modèle qu'on avait développé au début. Ce n'est pas un regard critique sur tous les services chez les Atikamekw, et ce n'est pas non plus un regard sur les résultats cliniques obtenus. Si on veut, c'est plus un regard d'un point de vue de gestion, comment on gère une approche holistique intégrée plutôt qu'un regard sur les résultats d'une telle approche.

Je vais commencer par vous situer rapidement aux niveaux historique et géographique. Deuxièmement, je vais vous donner un aperçu du modèle, vous décrire ce qu'on voulait faire et comment on entendait s'y prendre. Finalement, je vais regarder des facteurs non facilitants, des facteurs qui ont peut-être nui à ce qu'on voulait faire, et aussi des facteurs qui ont été facilitants, qui nous ont aidés, et les impacts de ces deux facteurs-là. Si jamais j'ai du temps -- et j'en doute fort -- je vais tirer quelques conclusions.

Pour vous donner un peu d'information,

vous présenter mes billets personnels, si vous voulez, vous avez peut-être constaté que je suis non autochtone. J'ai travaillé chez les Atikamekw pendant six ans. J'étais le directeur des Services de santé et des Services sociaux, comme M. Morris vous l'a dit. Donc je vous parle d'une expérience qui se situe entre 1984 et 1990 de façon générale. J'ai un peu de recul avec le temps, mais je ne peux pas prétendre à l'objectivité. Je ne fais pas une présentation académique et objective. J'ai été là, j'ai fait partie de tout le processus de développement de cette approche-là; alors vous pourrez corriger en fonction de ce que je vous dis.

Aussi, la directrice actuelle des Services de santé et Services sociaux chez les Atikamekw, M^me^ Joanne Moore, est ici, si jamais il y a des questions plus tard qui vont plus loin que 1990, si vous voulez savoir ce qui se passe présentement.

Au niveau de la situation, les communautés Atikamekw sont situées au centre du Québec. Il y en a trois. Elles représentent une population d'environ 3 500 personnes. Ce sont des communautés relativement isolées; même si elles ne sont pas au nord, elles sont tout à fait au centre, et il y a des distances d'environ deux à cinq heures de route dépendamment des

conditions. Ceci fait que ce n'est pas évident de donner des services à partir d'un point central.

Du côté historique, en 1983-1984 les bandes Atikamekw se sont regroupées pour se donner un organisme qui s'appelle Comité de coordination Atikamekw pour organiser et se donner des services. Entre autres ils ont annoncé leur intention de prendre le contrôle sur les services de santé et services sociaux.

Les trois bandes ont essayé de faire passer des résolutions du conseil de bande leur donnant le droit de gérer et de dispenser des services de santé et des services sociaux... surtout des services sociaux à l'époque. Une des bandes a réussi à faire passer cet article-là. Les deux autres, cela a été refusé par le ministère des Affaires indiennes. Mais les Atikamekw considéraient que c'était de leur droit et de leur juridiction de donner ce genre de services là. Ils ont décidé d'aller de l'avant, même sans l'approbation complète au niveau légal. Ils ont obtenu un financement des Affaires indiennes, une entente qui finalement faisait en sorte que tout l'argent qui allait être dépensé pour des services sociaux pour la population Atikamekw devait passer via le Conseil de la nation Atikamekw. Cela a été très important, parce que cela a

empêché le développement de services compétitifs, si on veut. Par ailleurs, les programmes PNADA, les programmes de représentants en santé communautaire aussi étaient déjà pris en charge par les bandes et ont été transférés au Conseil de la nation Atikamekw.

Initialement on a développé une équipe de 12 personnes qui ont développé des services plus de type volontaire. Mais, finalement, avec les problèmes qui existaient, on a commencé à donner des services reliés à la protection de la jeunesse, les jeunes contrevenants, et caetera. J'y reviendrai. De toute façon, ce qu'on a essayé de développer dès le début, c'est une approche plus intégrée avec les représentants du côté santé et services sociaux.

On a donc, avec cette approche-là, essayé de trouver une façon d'organiser les services qui serait appropriée à la culture et à cette volonté de donner des services de façon plus holistique; on n'utilisait pas ce mot-là, mais c'est effectivement ce qu'on faisait.

Il y avait certains principes. On voyait que la question d'aider les autres n'était pas nécessairement réservée à des professionnels -- ce n'est pas une activité professionnelle, c'est une activité de partage, si on veut -- et que les problèmes auxquels

faisaient face les individus atikamekw n'étaient pas nécessairement des problèmes individuels uniquement, que la résolution de ces problèmes-là était aussi une responsabilité collective et que tout le monde qui avait un rôle à jouer dans la solution des problèmes devait travailler ensemble et avec la population.

On pensait aussi que les communautés avaient les ressources pour faire ce genre de travail là à l'intérieur, que les Atikamekw aussi avaient certains droits, si on veut, qui était entre autres le droit de faire les choses à leur façon, le droit de faire des erreurs aussi, leurs propres erreurs, et le droit de décider de leurs propres prioritéS. Finalement, ça devait se faire sans ingérence politique.

On a donc structuré l'organisation. Au niveau de la prise de décisions la communauté devait participer à la prise de décision. Il y a des conseils de santé et services sociaux qui ont été organisés dans les trois communautés qui devaient donner avis aux conseils de bande. Il y avait aussi un rôle de feedback, si on veut, pour nous donner de l'information sur la performance des travailleurs. Au début on pensait qu'ils joueraient un rôle dans la gestion des cas comme telle, mais ça ne s'est jamais fait.

Au niveau de l'imputabilité, les services de santé et services sociaux étaient imputables à la direction du Conseil de la nation Atikamekw, indirectement au conseil de bande via les conseils de santé dont j'ai parlé tantôt. On pensait aussi être capable de mettre en place un conseil de santé national pour les trois réserves, mais ça non plus, ça n'a jamais été fait.

Au niveau administratif les services de santé et services sociaux étaient sous le contrôle du Conseil de la nation. Les questions politiques, les questions de finances étaient la responsabilité du Conseil de la nation. C'est plutôt au niveau de la programmation et de la gestion des cas que les services de santé et services sociaux avaient une certaine marge d'autonomie.

On pensait donner des services, finalement, qui étaient basés sur une clientèle qu'on définirait de la façon la plus large possible. On essaierait de faire un focus sur la communauté en premier, ensuite sur la famille élargie, la famille plus restreinte, et finalement sur les individus lorsque nécessaire. On allait jusqu'au point d'ouvrir des dossiers pour les familles plutôt que les personnes.

Au niveau des travailleurs professionnels on ne pensait pas que c'était des

travailleurs vraiment avec une haute spécialisation professionnelle qui seraient appropriés. On pensait plutôt que des travailleurs communautaires Atikamekw avec une formation générale en développement communautaire devraient être la force motrice ici et qu'il y aurait, finalement, un peu de formation complémentaire dans certaines disciplines comme les services sociaux ou la prévention.

Ceci ne veut pas dire qu'il n'y avait pas de formation, parce que c'est tout à fait le contraire. Il y avait un programme avec l'Université du Québec à Chicoutimi géré par un organisme autochtone, qui s'appelait l'Institut éducatif et culturel Atikamekw-Montagnais. Il y avait un programme de trois ans, un programme de bachelier en intervention communautaire bâti autour de trois cours de base en intervention communautaire et finalement une spécialisation dans les deuxième et troisième années.

C'est certain que cette approche de façon plus intégrée était basée sur une approche multidisciplinaire qui demandait qu'il y ait de la planification des services, que l'intervention spécifique soit planifiée et même faite en équipe.

Ce que ça donnait comme avantage, c'est

qu'on pouvait utiliser des travailleurs en santé communautaire pour suivre des cas de protection de la jeunesse dans des cas de conflit d'intérêts avec la famille, et caetera. C'était mieux si le client se sentait plus à l'aise avec quelqu'un qui n'était pas, disons, le travailleur social. Cela a aussi permis de mettre en place un programme d'urgence sociale 24-7, en principe en tout cas.

Au niveau des obstacles, avant 1988 on a été capable de fonctionner sans entente très claire au niveau légal, au niveau de la juridiction par rapport au Service de protection de la jeunesse. On faisait tout le travail, finalement, et de temps en temps, lorsque nécessaire, lorsqu'on n'était pas vraiment capable de solutionner un problème au niveau local de façon volontaire, on faisait appel au tribunal et à l'Agence de protection de la jeunes, le CSS; sauf que c'était des ententes cas par cas, et nos travailleurs continuaient de faire le travail.

En 1988 on a été obligé de signer des ententes avec les CSS, ces agences-là, et à partir de ce moment-là on a perdu, d'une certaine façon, le contrôle. Il fallait rendre des comptes à toutes les étapes à l'autre agence, finalement, parce que le gouvernement du Québec

ne permettait pas de signer des ententes qui reconnaissaient l'agence comme telle.

Un gros problème, finalement, qu'on n'avait peut-être pas prévu, c'était la sévérité et à quel point l'incidence des problèmes... les problèmes étaient beaucoup plus sérieux et il y avait un beaucoup plus gros volume qu'on pensait à l'époque. Ceci permettait de questionner: est-ce que c'était assez, une sorte de semi-spécialisation, chez les travailleurs? Même s'ils avaient un bac, ce n'était peut-être pas assez de connaissances professionnelles pour intervenir dans des cas très, très lourds.

Il y avait aussi une limite au niveau des objectifs. On n'avait peut-être pas planifié assez loin. On n'avait pas d'objectif santé. Les objectifs, finalement, en l'absence d'objectifs clairs et bien définis, étaient plutôt la solution de problèmes. C'est certain qu'il y avait un problème là sur lequel on n'avait pas tout à fait le contrôle, dans le sens qu'on n'a jamais eu de l'argent pour structurer cette affaire-là. Ça s'est fait à mesure qu'on travaillait. On essayait de s'organiser. On n'a jamais eu d'argent pour vraiment évaluer les besoins et structurer une réponse en fonction de ces besoins-là.

Finalement, peut-être qu'un autre problème, c'était la relève. Le programme de formation sur lequel on misait beaucoup, qui permettait de former ces gens-là, qui avait une perspective intégrée, a duré pour un bac et après ça des complications avec l'université ont fait que ça n'a plus été possible de continuer. Ceci veut dire que la relève, les nouveaux travailleurs... c'est sûr qu'il y a un certain roulement. Le roulement n'a jamais été aussi élevé qu'on avait pu penser compte tenu des problèmes, mais il existait quand même.

Par rapport à des affaires qui ont favorisé -- et certains de ces points-là peuvent être critiqués; c'est une approche qu'on a essayé de développer -- finalement, le personnel de Santé et Services sociaux s'est beaucoup impliqué au niveau personnel, comme bénévoles dans la communauté mais même comme élus au conseil de bande. Cela a permis de d'amener les préoccupations santé et services sociaux de l'avant et leur donner une certaine priorité.

Je pense que je ne pourrai pas tout finir. Je finirai peut-être par un point que je trouve important, et c'est que tout ce qu'on a essayé de faire, finalement, a été beaucoup et grandement compliqué par le fait qu'on n'avait pas un contrôle total. Il fallait

vraiment se plier, au niveau des finances, à toutes sortes de conditions, différents budgets. On a voulu gérer, au niveau financier, de façon intégrée, faire un budget global. Ce n'était pas possible parce qu'il fallait rendre compte de différentes façons à un paquet d'agences de financement qui avaient des conditions différentes.

Aussi, au niveau du contrôle sur le judiciaire, il n'y avait pas de contrôle sur le judiciaire et c'est possible que, comme on essayait d'éviter de judiciariser le plus possible pour garder le contrôle sur nos interventions, on ait donné trop de pouvoirs finalement à des intervenants individuels. C'est gens-là, il n'y avait personne qui les surveillait d'en haut, si on veut. Finalement, quand on regarde ça avec un certain recul, le pouvoir qu'ils avaient sur certaines familles d'enlever leurs enfants ou de ne pas les enlever, ça allait un peu trop loin.

Je pense que l'approche qu'on a essayé de développer aurait été beaucoup mieux si on avait pu la jumeler avec une prise en charge du système judiciaire en même temps, au moins partielle, pour les services de protection et de jeunes contrevenants.

Merci.

ALWYN MORRIS: Merci beaucoup.

I would like to give an opportunity now for the audience to ask questions of some of the presenters. May I ask that the current Director, Joanne, to come up to the front.

In addition to asking questions, we might want to hear some of your own solutions to some of the issues that you have experienced. Certainly, the themes in all these presentations is that the community has to take control and move things forward. Certainly, the leadership and the political will to do such a thing is an important aspect.

I will keep a record, and we will start with microphone No. 2.

JEAN AQUASH: Good morning. I was really quite interested in the young man who spoke from Quebec and from Alkali Lake.

I know that in the past alcohol and drug treatment programs have been very important and still are and still will be. In the training about alcoholism and the behaviour of dysfunctional families, all of that is very important -- all the training programs that go with that. I am interested mostly in the aftercare and the spiritual foundation of the aftercare.

As the one speaking about the programs

that were opened for them in Quebec, I work with a Native program in group therapy work, with these past issues that all of us have -- the secrets of the past. As I understand, we are as sick as our secrets. If we can unload those, we can go on and walk in the light of God.

If we could do that without provisions of the government -- you have to have a Ph.D. to do that. I don't think that is necessary. I think Indian people can help Indian people without conditions.

What I would like to see from the Royal Commission is that the funding be open to Native people across the land for therapy, to get that kind of help from each other. It has to be under training programs. In the ones I work with, we go under training programs to be better facilitators and better healers in order to walk them through from their garbage into unloading their garbage and to finding their real selves. All of us are bigger than what we see ourselves to be.

That is what I wanted to share.

I have with me today my friend and my mentor. She helps facilitate people to train in facilitating group therapy. I know that it can happen and it is happening. Some of the things that the old people say is that we, as a people, with our spiritual foundation,

are the ones who are going to help speed up the healing process so that we can speed up the healing of the surroundings around us -- Mother Earth and all things around us. I believe in that.

I have some pamphlets from my helper. She helps me to be where I am at, to really recognize my own human dysfunctions and to look at myself, how to blend and work in group dynamics, which I didn't know before. I have some pamphlets from her if I could leave them at the desk. I would like that permission. Thank you.

ALWYN MORRIS: Thank you very much.

When you come to the mike, please identify yourself. Microphone 3.

KIM SCOTT: My question is directed at Richard Kistabish.

You have the advantage of being a part of the community and being able to instrument change from within the community. What I am wondering is: There are a lot of other communities in Quebec where virtually 95 per cent of the children are at risk because of the widespread addictions in those communities. What suggestions do you have for people from outside the community to change those situations?

RICHARD KISTABISH: It happened one time in the community of Grand Lac that they had their Annual Assembly. On that occasion the elder people allowed the children to speak up and also to address their concerns and their aspirations. From that point, I guess the community changed the whole direction and orientation, the way they wanted to control what was happening to their lives.

Everything was concentrated only on children since that. Every intervention that we do, any action that we do, we always have to keep in mind the children.

It is not an unusual way to proceed. Most of the societies, even the bands and communities across the country, don't allow kids to speak out at an annual assembly or any assembly. I never saw a general public meeting in any community in my region that allowed kids to speak out, and also to consider what they have to say.

One of my dreams is to have the AFN allowing kids to be part of their annual assembly and to keep them as voting members also. It is very, very challenging and it is very important, because you are working toward the future and you don't want to make any

mistakes about the orientation that you are taking, when kids address you on the way things should be done.

ALWYN MORRIS: I don't have anyone else at the mikes at this time. Are there any additional comments with regard to the presentations and/or other solutions?

Microphone No. 1.

ELDER GLEN DOUGLAS: Thank you. Glen Douglas again. Good morning everyone.

That gentleman from Quebec has just answered the question about the participation of the youth. It is like the women. Half of the population are women. We often all our children and our youth our future, our most important resource, but we oppress and suppress them. They are to be seen and not to be heard.

We have learned to be paternalistic through that Indian Act, that repugnant piece of genocidal legislation that I spoke of yesterday. That is why, and it is the same with the women.

We do not have the same regard and respect and honour, caring and sharing for these women, even though we pay lip service by mentioning Mother Earth and how she takes care of us. But we turn around and mistreat our mates and other women, as we do the children.

As I said yesterday, we are all role models. We are either a good one or a bad one, and there is no halfway in between. It is like being half-pregnant.

A comment for my brother, Mr. Johnson, from Alkali Lake, and his last closing words about the land. In my studies in anthropology we had a world-renowned anthropologist speak to us. Her name was Margaret Mead. She said: For a dominant society to dominate and defeat another weaker society, all they have to do is two things: destroy the economy base, which is our land, destroy it by controlling it; and the other is to destroy the language, and you have defeated them.

The residential school system has been almost 100 per cent successful in that area. That's all they have to do, and they continue to oppress us and suppress us in this area by imposing certain legislation, such as Bill C-31, in which we wanted to control our own destinies, our own membership. I speak of it as citizenship rather than membership, because I can belong to the Canadian Legion and I would have to pay so much a year. The price we have to pay to be a member of a Band is all of the resources that are extracted from our ranches, our territories.

Thank you.

ALWYN MORRIS: Thank you. Microphone 1.

CONRAD SAULIS: Conrad Saulis of the Native Council of Canada.

I want to echo and support the wise words of our Elder with regard to our youth and our children and our women.

Over the past two years, I have had the honour of travelling across this country heading up a national Commission on Aboriginal Child Care. I have had the honour of being able to sit and listen, along with the Commissioners, and to hear from people in large urban settings like Vancouver and smaller places like Prince George and Lethbridge and right across the country.

We do leave our children behind. We don't think about the future. We do need to think about the future ourselves, as Aboriginal people, and quite paying that lip service to our children, saying that they are our future. It's time that we put action to those words and started doing things proactively as Aboriginal people ourselves.

I have heard Aboriginal people from my generation and older generations saying, "We want to be responsible for ourselves. We want to develop and provide

those services for our children. It's our responsibility. They are our children. We need to do it. We want to do it." There is only thing that is missing, and that is the proper kind of resources that are required to develop and design those kinds of services. It is not to be a further tax drain on the Canadian public or on federal and provincial coffers.

The reality is, like for anybody else in this country, that it does take money to develop the kind of services that Carolyn Pettifer has developed in Edmonton, that Ken Richard has been able to develop in Toronto, and the kind of services that are being developed here in Vancouver.

The onus is on us, as Aboriginal people, as the leaders, as the parents, as the uncles and the aunts, to do that kind of work. We need to look at our communities and support the kind of drive, the kind of desire, that is out there. I have heard it from the people. They want to do it themselves. There is no doubt it. We are intelligent enough; we are creative enough; we are strong enough. There is only one thing, as far as I can see, that is missing, and that is the proper kind of resourcing.

How to get by the federal/provincial jurisdictional squabble, I don't have an answer

unfortunately. Hopefully, the political leaders of the national and provincial organizations will somehow be able to talk with the people who can resolve those kinds of thing. Without that kind of resolution happening, and with the disparity that is ongoing from the federal government with regard to the on-reserve focus only, the people who are living off-reserve in this country, the lives of our children, the hundreds of thousands of children who are living off-reserve in this country, will continue to be forgotten.

"Brighter Futures" is a prime example of that. $160 million has been put aside for on-reserve. Fine; that's great. Where is the money for the off-reserve Aboriginal children? There is none. There is no money there. It is supposed to be under protocol agreements. There are no protocol agreements being signed.

The lives of our children in the urban setting and off-reserve across the country are being left by the wayside. Nobody really wants to take responsibility for that, because it means too much money on the federal and provincial side of things.

There are so few examples of real things happening; yet, the desire is there. We need to do

whatever we can to support that, to put those words into action. Our children are our future. Think and do the things that we need to do together and get beyond the squabbling and quibbling over the limited resources that are there and make sure that we can develop and design those programs that will benefit our future -- and that is our children.

I thank you for your time. There are more things I will say later.

ALWYN MORRIS: Thank you very much. Microphone 2.

LYNN CHABOT: I was just depending on timing. I didn't know if you were going to let any more people talk.

ALWYN MORRIS: I am going to give you 10 more minutes, and then I am going to close off.

LYNN CHABOT: My name is Lynn Chabot.

I was really interested in some of the comments that were made about the need for political will in the area of health and social services. In fact, some statements were that it is essential.

I am curious as to whether any of the panel want to comment on the issue of political will versus

political interference. I think a lot of communities are facing that problem. I am curious about the definition of "political will" when it comes to these issues of child welfare. What is the dividing line in terms of Band Councillors or others that are interfering with care-givers doing things in the area of child welfare? I don't know who might want to comment on that.

CAROLYN PETTIFER: Political will is absolutely essential to ensure that we take on and assume delivery of services and the design and development of those services. However, it is just as essential and even more crucial that there be no political interference in the implementation of those services.

What we have done in our organization is that we set up self-government institutions. We consider ourselves a self-government institution of the Métis Nation of Alberta. We have a Board of Directors who are appointed by the Métis Nation of Alberta Board who are, in turn, accountable to the Métis community in the province. We have a separate agreement that there will be no interference in the ongoing operations of the agency.

So far, for us, that has worked. We have by-laws such that our appointments to our board are

guaranteed for the time of the appointment. There are very strict guidelines in terms of why and how people should be removed from the Board of Directors. We have guidelines for the kind of people that we have on our board. The guidelines for nominations are based on resumés; we do background information on our Board of Directors; we do criminal record checks; we do child welfare investigation checks.

The expertise that we pull to our board is not limited only to the Métis community. We call upon the non-Native community and the Indian community to provide us with that kind of direction on our board. So our board doesn't have only Métis people; we have professors from the university; we have one Indian person on our board. The majority are Métis, but the Métis people we have on the board are people with a lot of background and experience and are sympathetic to the kinds of issues that we deal with on a day-to-day basis.

It is really important that your by-laws ensure that you have those kinds of protection and that the political support is there so that, when you do take on issues and when you do take on services, the role of the politicians is that you provide them with the information. They are there to support and do the lobbying

on your behalf, and those kinds of things.

ALWYN MORRIS: Thank you. Microphone 1.

CHARLENE BELLEAU: My name is Charlene Belleau. I am from the Alkali Lake Band and am working with Canim Lake Band right now.

I would just like to respond from the First Nations' perspective on what we mean by political will. When I think back to the history of our people and where we have come from, the Indian Act and everything that everybody talks about, I think history has shown us that the policies, legislation and everything that was designed for us hasn't worked. We have said that time and time again.

To me, the political will is something that we need to establish even today. I say that because I sit on a provincial and a national committee right now where we are looking at the new initiative called "Brighter Futures" that was announced by Health and Welfare recently, a five-year, $170 million initiative.

People get excited when they talk about $170 million over a five-year period. At the same time, what governments are doing, which First Nations haven't fought enough yet, in the way the policy is implemented

they take a high percentage off the top for operation and maintenance, funds to staff more positions within Medical Services. They are challenging and holding back a certain amount of money for national initiatives, when we are saying at the First Nations level that we want those funds at the community level.

Even if we might have recognized 25 years ago the way the governments put out funding to First Nations, 20 years later in 1993 we are still dealing with the same attitudes that come from the top down, from ministers who think they know what is better for Indian people.

They have opportunities today to correct how they have been working with First Nations people, and I think it is really important that that political will that we are talking about comes from the top levels -- from the Prime Minister's office to the Minister's office to the Deputy Ministers to the ADMs and everybody coming down the line. I think it is really important to consider that.

The other issue that I look at when we talk about political will is making sure that all of those funds get to community level. I think research is important, but a part of the stalling tactics by government

is to do more research. I think First Nations people are saying that we know and we recognize and we accept responsibility and are looking at the issues around suicide and everything else. We need the funds at community level, not for the majority of it to be skimmed off the top to have more government people trying to find solutions for our community members.

Coming from Alkali Lake, you heard from Fred and Joyce that a lot of the solutions to the community problems came from within the community. I swear, if we waited for professional psychologists and psychiatrists, people would still be drunk -- and I am not saying that to be rude to professionals. Really, a lot of the issues that were dealt with at the community level came from within the people and empowered the people and the Band Councils at that level.

Thank you.

ALWYN MORRIS: Thank you, Charlene.

This will be our last question as we approach our time line. Microphone 3.

COMMISSIONER ALLAN BLAKENEY: My name is Allan Blakeney, and I am a Commissioner. My question is directed to the Johnsons from Alkali Lake.

I listened to that story and I thought

it was a remarkable story. I was, of course, familiar with it in general terms, but I think we all benefited from hearing the details this morning.

I am aware of communities that have achieved sobriety, a number. I am aware of very few that have achieved it over a sustained period of time. You have done something that few communities, Aboriginal or non-Aboriginal have achieved.

My question is: Is there any organized teaching program so that you can teach to others the way you achieved your success? Is there any way that, through your teaching, that success could be replicated in other communities?

FRED JOHNSON: I hope I can answer your question in a very satisfactory way.

Hopefully, the research that has been done in Alkali Lake can give you an outline of some of the things we have done. I find that question very hard, and I have heard it over the past 20 years. It is very hard, even in our research, to put down.

When our community started combatting alcohol abuse and other abuse, it was that sharing and caring that comes from two people and spreads across the community. I don't know how you could teach that. As

I told you, I carried around my sister to different meetings, and I guess that is what we all need to do in our communities -- to share and care for each other in every way, support in every way.

I don't know if I am answering your question. Hopefully, the research that we have can help out in that way when you look at it. We have Joyce and myself and we have a lady over there and Charlene. I don't know if Charlene or Carol want to attempt to answer that question.

I find it very hard. How do you teach sharing and caring? Thank you.

CHARLENE BELLEAU: I just want to expand a little and thank Fred for giving me the opportunity.

I had the opportunity to spend two years as Chief of the Alkali Band and then six years on Council with people like Fred. Again, my sobriety comes as a result of people like Fred. Fred has been sober for a lot more years than I have been. When I was down struggling on the reserve, he was the one that saw in me the leadership skills and really supported and helped me through sobriety. So I really admire Fred every time he has to get up. He might not have written what he has to say, but he sure feels it, and that impact on you is better than anything

that is ever going to be written. I really admire Fred for being so sincere and so open as to who he is and what he has to offer.

In response to that question about how you help other communities or how you might assist other communities to achieve what Alkali has, I think one of the biggest problems, in looking back on the history of Alkali Lake, is that there hasn't been a lot of documentation about what has happened. People are almost afraid of documentation and non-Native people or other people abusing that instead of using it in a good way.

The only documentation, when we have a chance to travel across the country or in the States or internationally for that matter, has been the video, "The Honour of All", that was made on Alkali Lake. The three-part series that you have there is one set of documentation.

The research that Carol has co-ordinated through the Social Services Program is another piece of information that will be helpful to other communities.

I know there needs to be more resources developed on how Alkali Lake has succeeded. Again, hopefully, that process doesn't get so complicated when people really are trying to find what that secret is.

It was really simple, when you look at the process at Alkali Lake. As Fred was saying, it was sharing between one another; it was caring between one another, and a lot of that you can't document. You can't tell people how to do it; you just do it. You are sharing and you are caring. So some of those things may be difficult to document.

I think there is a simple process there. If governments, whether they be provincial or federal, were to invest more funds in assisting the community to document its success, it would be helpful to other First Nations communities across the country and in other parts of the world as well. I sit and think and I know that it is not only Alkali Lake that has been successful; other communities are succeeding, and we now have non-Native people coming to the community and to First Nations people to ask how you do it. They recognize the failure of the criminal justice system, the failure of their own health systems, the failure of a lot of different things, and are asking how we do it.

It is a real pleasure to be involved in a process that can show some vision, not only to one community but to First Nations across the country and to the world.

Thank you.

ALWYN MORRIS: Thank you, Charlene.

With that, I would like to thank the presenters today and the people who have participated by coming up to the microphones.

I will turn you to your Chair.

DR. LOUIS T. MONTOUR: On behalf of the Royal Commission, I would like to thank Alwyn Morris for his moderating, and the presenters, Mr. Richard Kistabish, Carolyn Pettifer, Joyce Johnson, Fred Johnson and Louis Hanrahan. C'est un grand plaisir d'avoir l'opportunité d'écouter la langue française ici. Nous sommes très loin de la province du Québec. C'est un plasir d'écouter toujours la langue française ici.

It was a pleasure to be able to hear the French language spoken here in Vancouver, quite a long way from home in Montreal. Our reserve is principally anglophone, and there are very few Mohawks who can speak French. So I don't often have a chance to practise it.

We will now break until 11 o'clock. I ask you to please return your translation units to the recorder before you leave. Thank you.

--- Short Recess at 10:47 a.m.

--- Upon resuming at 11:07 a.m.

DR. LOUIS T. MONTOUR: I would like to

call the meeting back to order.

The next order of business is a panel presentation of four community medical initiatives. The moderator for this session is Mr. Peter Ernerk. Peter, as you will recall, is the Executive Director of the Inuit Cultural Institute.

I will turn it over now to Mr. Ernerk.

PETER ERNERK: Thank you, Mr. Chair. Good morning to you, ladies and gentlemen.

We have four speakers this morning, and we will go until 12:30 when we will break for lunch. The first speaker I would like to introduce to you is Mr. Keith LeClaire. His paper is called "Kateri Memorial Hospital Centre
- The Kahnawake Mohawk Experience - The Responsibility to Control Our Own Health Care Services."

Mr. LeClaire is a Kahnawake Mohawk, a husband and father of two children, with a strong sense of community involvement. Keith has been employed in the Indian health field since 1980. He has extensive experience in the local, regional and national Indian health care spectrum. His experience includes advocacy, policy development, community development, and he is presently the Director of Administration in Canada's only

and unique Indian-controlled and operated hospital.

Would you please welcome Mr. Keith LeClaire.

KEITH LECLAIRE: Thank you very much, Peter.

Mr. Chairman, invited guests, ladies and gentlemen, I want to take the opportunity to express my sincere appreciation to the Royal Commission for being here and for extending Kateri Memorial Hospital Centre the honour to address this Round Table.

Before I start, I would like to make a special congratulation to all of the people who work here, especially Myrtle Bush and the staff of the Royal Commission. A lot of times we fail to acknowledge those people. They have done a very good job of registering us in, giving us a hand. In fact, I think a lot of time we should make sure that those people are not forgotten.

When I say, I also include the people who are doing the videos as well as the people in the translation booth. Without them, this meeting wouldn't be the way it is.

Let me move on now to Kateri Hospital.

Kateri Hospital opened in 1905. Kateri is located in the territory of Kahnawake, and it is

approximately nine miles from downtown Montreal. We service all people. Mohawk and non-Mohawk clients are welcome, and our staff are a mixture of Mohawk and non-Mohawk individuals.

Kahnawake being so close to Montreal, we are fortunate to tap into other health resources when it benefits our clients. We have a 43-bed in-patient capacity which presently has a 96 per cent occupancy over the last year, and we service 18,000 out-patient appointments annually.

In our Mohawk traditions, four major themes are always central to the Great Law of Peace. The Great Law of Peace provides guiding principles to our interactions with people. The four themes are: peace; respect; being of a good mind; and responsibility.

Peace basically implies that you must be at peace with yourself and with your surroundings. Respect implies that you must respect yourself and respect others, from the perspective of who you are, how you act and what you do. Being of a good mind implies that you must be positive and creative in all of your thoughts and in all of your actions. Responsibility implies that you must act in a responsible manner and be accountable for your actions.

In developing this presentation, I had originally entitled it "Kateri Hospital - The Mohawk Experience - The Right to Control Our Own Health Care Services." I was reminded by others at the hospital, when I started developing this paper, that in fact the word "right" was not appropriate. So I took this advice and I consulted a person whom I respect. The bottom line was that "responsibility" has more significance in our culture and, hence, it is the focus of this presentation today. Responsibility is an obligation that we can take or we can leave.

In 1955, which is 50 years after the founding of our hospital, the organization administering Kateri went bankrupt. Closing appeared to be a reality. At this point the Kahnawake community did not accept this decision. Our people were fed up with hearing about closing the hospital.

The community and its members chose to take our responsibility to continue servicing our people with or without others' help.

As I reflect back, Kahnawake's attitude is simply not to accept an administrative decision from the outside. We will take our responsibility, and we will get things done.

To other communities we recommend the following:

No matter how long it takes, if you want to improve the health of your community, you can do it. Make this attitude adjustment. You have the responsibility to make things happen. You can either accept this or you can allow somebody else to basically determine your community's health future.

In 1955 we were told that there would be no government funding. In 1955 our community volunteers did everything. They brought food in; they washed the beds; they acted as orderlies and nurses' aides; and of course this was done under the leadership of a Mohawk woman, so we know this was done. At this time, I would like to mention and praise Miss June Delisle for the work that she has done at Kateri Memorial Hospital Centre.

Eventually, over a period of time, we built up our credibility by going from almost nothing to a hospital centre today that is continually expanding. This, in turn, has developed a solid working relationship with the major funding sources. Presently it is the Ministry of Health and Medical Services. Kateri Hospital is still here, and we are still going to get better.

In the 1980s another event happened.

We needed a new building, as the existing one was falling apart. We needed to make this dream become a reality.

The Board at the time, composed of 11 members, agreed to a strategy to allow communities to understand the need for a hospital building. Who was going to fund this project was the community's biggest concern. This came at a time -- and let me put it in perspective with Quebec. Quebec had introduced restrictive language legislation for non-francophones. It had imposed eligibility requirements for schools. It had just completed, unfortunately, a salmon war in the Restigouche First Nation and, more at home, a provincial police officer had shot and killed a Kahnawake resident in his own front yard. In short, the community did not want any involvement with the province.

It is within the context of these events that the task for community acceptance would be difficult.

Our hospital board strategy involved four steps. The first was to create awareness that the federal government would not fund this. We were looking at 100 per cent funding from the federal government; in fact, it was clear through the present legislation that that could not be done. Awareness was needed with the

community.

Second, we had to get members of our board of directors directly elected to the Council.

Third, we were going to get the Council to be given community authority to enter into negotiations with the province.

Fourth, we were then going to negotiate an agreement that would respect the political will of our community and maintain the political aspirations of the Parti Quebecois government in power under the Prime Minister, René Lévesque.

That is exactly what we did. We ended up with a nation-to-nation agreement respecting all political positions. Kateri is not a corporation; it is an unincorporated First Nations institution. Our hospital has a reporting relationship directly to the Mohawk Council of Kahnawake, and that goes through our board of directors. Our Council appoints a member to our board, and our Grand Chief, Joseph Norton, acts as an ex officio member of the board.

Our First Nations institution did not surrender the land upon which the hospital is located. Basically, that is a requirement under the present provincial legislation. Our First Nations institution

does not fly the provincial flag on the building within our territory. That is almost a requirement if you receive funding from the province. Also, our First Nations institution does not integrate into the provincial health system of Regional Councils. Our First Nations institution maintains a direct tie to the Office of the Minister of Health.

Our rationale for not integrating into the provincial health system is simple. We argue that responsibility and, hence, the accountability is more to our Mohawk community than to the needs of a regional structure. We argue that local community control would be more useful without the regional structure. The Parti Quebecois Cabinet in power agreed.

Our discussions are carried on now with less bureaucratic stumbling blocks.

At this time I would like to acknowledge the three board members from our hospital that went on to become members of our Council. They are Myrtle Bush, who is basically working here with the Royal Commission; Franklin Williams who is working with the Assembly of First Nations now; and Mr. Donald Horne who is the Administrator of the Social Services component in Kahnawake presently.

In short, the board strategy was a very

long, hard process to get the community to accept this. I believe a large number of people felt very uncomfortable with it in our community, and some unfortunately ignored the guiding principles of the Great Law of Peace. In fact, some of them became very, very uncomfortable, and they showed that uncomfortableness to those three individuals. However, the three individuals endured and so did the hospital board.

How is Kateri Hospital perceived? Let me share with you my impressions from a federal, provincial and community perspective.

At the federal level Kateri Hospital is perceived as a provincial hospital. Why? Presently 92 per cent of our funding officially comes from the province and only 8 per cent of it is a direct federal fund from Medical Services. Medical Services presently supports the community health nursing unit. Existing policy indicates that the federal government has no wish to maintain full, 100 per cent federal responsibility for Indian health. The federal government, I believe, fears provincial backlash -- plus it is in the legislation, and it is going to take one heck of a time to change.

Nevertheless, I believe Indian health should be a full federal responsibility.

At the provincial level, Kateri Hospital is perceived as successfully meeting its health responsibility to our community members.

At the community level, Kateri is perceived as a major Kahnawake institution. Community members recognize our responsibility to have and control a hospital which is based on our demonstrated ability to provide quality care and proven operational capabilities.

In our awareness campaign for community acceptance of provincial funding of the hospital funding, we invited representatives from the Medical Services Branch as well as from the Department of Indian Affairs officials, to allow them to come to a community meeting. What they did was state their department's position about funding a hospital. The bottom line was current legislation: We cannot fund a hospital.

It was only after this message was received through these representatives that, in fact, the community accepted the idea of direct community/provincial negotiations. The Kahnawake position and our Mohawk position stems from the fact that the federal government is channelling federal funds to the province through the Estimated Program Financing Act and the Canada Assistance Plan financing arrangement.

The Mohawk Council and Kateri Hospital both perceive that the Medical Services Branch's present transfer initiative is simply our Chief and Council acting as administrators on behalf of the federal government for the delivery of only federally-funded health services. Transfer implies that we, as First Nations representatives, deliver the pre-set policy and regulations. The federal government formulates, controls and, when necessary, can limit both policy development and regulations as to what can be administered.

This administrative devolution is not the type of control we want in Kahnawake.

With the Medical Services Branch transfer initiative, do we talk about holistic medical health? No. Do we talk about holistic health administration? No. Do we talk about the delivery of treatment services and their administration? No. You cannot control treatment because treatment, as I said, is under the provincial responsibility under the regulations in force.

Do we talk about administering the non-insured health benefits component of Medical Services? Hold on, now! Transfer initiative does not include all federal health services. Who picks and chooses the

programs that are transferrable? It is not ourselves as First Nations.

Based on our experience, there is little to gain from the holistic health perspective of the health transfer program. Therefore, transfer or administrative devolution can allow First Nation health administrators to transfer program funds. For example, if you in a community wish to use community health representative funding to cover off an alcohol need under the NNADAP program or a nursing need or any other type of perceived health need, you have the authority to transfer funds from one pigeonhole to another pigeonhole of a program.

Both Kateri and the Mohawk Council are not interested in this type of arrangement.

From another perspective, let's look now at what works well at Kateri Hospital.

Kateri works well because we have a participatory management system in place. Our department heads play a major role. Our department heads assume their responsibility to plan, to manage and to supervise their respective areas within established departmental priorities set by ourselves.

Second, Kateri works well because we have developed our Mission Statement, our philosophy as

an institution, our goals and our annual objectives. These are developed at the department head level. The directors fit what is developed in the whole hospital perspective, and the board reviews and approves the work and the direction we take.

In the past two years Kateri has internally restructured our operations. We have now implemented changes that will be leading toward hospital accreditation.

Third, Kateri Hospital works well because we have continued to focus on communication. I was very happy to hear that mentioned again yesterday. There is a need to make sure that there is good communication. At the hospital level, that is also very, very important if you are going to service your community.

Emphasis at the hospital now is on monthly departmental meetings as well as monthly department head meetings of the leaders of the those departments.

We also have an Education Co-ordinating Committee, a Nursing Procedures Committee, a Charting Committee, and a Quality Improvement Committee that focus on strengthening our standards and criteria upon which we operate.

Good communication improves services. In our hospital centre there are 130 staff members, 12 departments, four directors -- and I would like to compliment Louis who is our Director of Professional Services -- and, most important, a nine-member board of directors which is composed of a majority of our own community members.

Another point where Kateri works well is that we continue to explore our employees' skills enhancement. I was also very happy to hear that yesterday. If we can make our workers more knowledgeable, they become better people. Better people become better workers, and that is the philosophy we see at Kateri.

In short, the four areas that work well, which I have mentioned, are participatory management, clearly developed direction, communication and employee skills enhancement.

With regard to Indian health, I also see two improvements which I would like to share at the federal level. First, I am a strong advocate that the federal government accept Indian health as a federal responsibility. There is a need to stop First Nations communities from being shunted between federal and provincial jurisdictions and funding sources. I was very

happy that Conrad Saulis mentioned that in his presentation just before the break. It is very difficult when you have two different people, two different levels of government, each one with different regulations. As we have seen already, how do you develop a holistic approach?

Second, I also believe Indian health policy needs to be made and formulated by First Nations people. How many of our people are there formulating Indian health policy in Medical Services today? If you answer that, I will rest my case on the improvement at the federal level.

At the community level, I see four improvements to make Indian health better. This is at the community level.

First, when there is no political action at the community level, you must make it happen. You must develop the attitude that, should there be no political support from anywhere, you will do it by yourself until you can develop a strategy to get that political support.

Second, you need to develop and nurture a core group of community Indian health advocates to deal with the federal, provincial and community levels. You need a strong tie-in with community people and health professionals. In Kahnawake we are very fortunate to have

all our Indian health managers of federal programs on what we call a Health Consultation Committee. Basically, the committee is able to undertake health planning from a holistic community perspective. That is needed, and it is so essential in our communities.

Third, you have to have your community people strengthen their skills. Specific areas that need to be strengthened, from our perspective, are the need to be assertive when you are approaching funding sources; to be able to know how to plan -- if you have failed to plan, you are planning to fail; also, to be able to outline competency needs for your staff; to be able to outline training and development needs; and also to be able to develop an evaluation systems design, which is so important.

If your people strengthen their skills in these areas, definitely you are going to have better service provided to your community.

Fourth, you must ensure that outside policy-makers know that you are able and prepared to do whatever is required to make things better. In short, you must walk the talk. You must earn your credibility.

Within Kahnawake's community level, our own health infrastructure allows me to see four

improvements at the hospital level:

First, to strengthen our staff and community rapport. You have to outline the basic expectations of what is achievable and what is totally out of your league. Unreachable expectations lead to failure; lack of achievable objectives leads to failure. Failure does not reflect well on anyone, and it is not positive.

You must meet community expectations or you must clearly define what you can accomplish so that it is clearly understood by community members.

Second, are human resources consistent with organizational needs? If your priorities change, can your people meet this challenge? Do you have the balance between clinical and non-clinical staff?

If you have a nurse without a community health representative, what would be the priorities? Conversely, what if you went to a community where they had just a community health representative without a nurse? Would those priorities be the same? A healthy balance of human resources is needed in order to make greater strides.

Third, do you have the proper space allocation to allow people to be productive in their work?

The more cramped people are, the less productive they become. Since 1986, when we moved into the new building, we have seen a 35 per cent increase in the number of out-patient appointments. Hence, our responsibility is to determine if we can increase space allocation or decrease the services to possibly diminishing the quality of services that we offer. Space allocation is also a key to our success.

Fourth, consider the feasibility of developing a fund-raising arm. Two years ago, Kateri Hospital developed the Kateri Memorial Foundation. What we found is that we need greater financial support outside of the traditional funding sources. If we go with just the traditional funding sources, we are just doing the basics. We have to be able to look forward, and looking forward requires funding from other sources.

Let me reinforce the development at the personal level for both skills enhancement and attitudes. You need those in order to have holistic health.

As Kateri Memorial Hospital moves toward total quality management, we realize that, to be successful, all staff and board members must be involved and be aware. Holistic health and Indian health are our responsibility. Kateri Hospital appreciates that it is

a long, slow process that requires all of us to work together in a spirit of peace, respect, being of a good mind and assuming our responsibility. That is a part of Kateri, and that is a part of our traditions as Mohawks.

In short, I really welcome anyone who wishes to speak further about it outside of this context here. I will be happy to answer any questions.

The one thing that I always remember very, very much is that on an August evening back in 1956 I was born, and my journey in life began in Kateri Hospital. It began with a physician from our community and with a nurse from our community. I am very proud to say that that came through. It is my hope that, when I pass on and I go on my other journey, I will be able to start it again at Kateri Hospital.

On behalf of our First Nations institution of Kateri Memorial Hospital Centre, I wish you all the best on your journey toward taking responsibility for your communities' health.

Thank you very much.

PETER ERNERK: Thank you very much, Mr. LeClaire.

The next speaker I would like to introduce to you is Mr. Richard Watts, Chairman of the

Nu Chah Nulth Health Board. Mr. Watts is from Port Alberni, British Columbia.

There is a slight change in our program, ladies and gentlemen. The next person that I would like to introduce to you to speak to you this morning is Annie Tuluguk. She is going to speak on the Innuulitsivik Hospital.

I am quite tempted to speak on this issue as well myself. It is an issue that I care a hell of a lot about, from the Inuit point of view, especially from the Keewatin Region. This must be a very proud moment for Annie Tuluguk. It's a good program, as I understand it, and it's really an exciting program, especially on the part of the Inuit of northern Quebec.

Ms Tuluguk is the Director General of the Innuulitsivik Hospital and Social Services Centre in Povungnituk, Quebec.

ANNIE TULUGUK: (Native language) Thank you, Peter.

I have promised the midwives back home that I would present their slide show so that everybody from across Canada can see who they are and get an idea of what they do -- a real picture.

My name is Annie Tuluguk, and I am very

honoured to be asked by the Royal Commission on Aboriginal Peoples to present our midwifery program from the Innuulitsivik Hospital. We are very proud to be here.

Innuulitsivik is a 25-bed hospital. It is situated in Povungnituk on the Hudson Bay coast. We serve seven Inuit communities on the Hudson Bay coast in northern Quebec, for a total population of about 4,000 people.

When we, the women of Hudson Bay, heard that there would be a regional hospital built on our coast under the James Bay and Northern Quebec Agreement, the women were determined that the hospital would not serve to further deteriorate our culture, our values and our traditions. We were determined that it would help to serve us, as a tool and as a stepping stone toward our participation as full partners of health and social services.

We were dealing with many issues -- women's, men's and family issues -- that we were very concerned about, and we wanted the hospital to help us to learn how to deal with those issues. We had a high rate of unwanted teenage pregnancies. There were cases where several young girls were getting pregnant by one young man. We had a high rate of STDs, and we had abuse.

We were dealing with many issues, and we wanted the hospital to help us to learn to deal with those issues.

This is the Hudson Bay coast. We serve seven communities, from Sulri (PH) down to Great Whale River.

We wanted the hospital to help us, women and men, to understand our bodies, to teach our women about pregnancy, family planning, nutrition, mother and child care, labour and childbirth, as well as about STD prevention and to be a refuge for abused women, to be a welcome place for abused women, for them to be able to talk about what is going on in their families. We wanted the maternity to be involved in our lives.

This is a picture of the hospital. These are the midwives. Presently we have two white, professionally-trained midwives who are, in turn, training Inuit community midwives. Those are the three Inuit women who are actually taking training in midwifery. This picture was taken at the time that one of the white midwives was leaving and transferring responsibility to another white midwife. We have two white midwives and one Inuit community midwife.

First, they start as community midwife trainees. They progress to community midwifery, and then

they become midwives. This is a white midwife working with a patient; a white midwife training an Inuit community midwife; the Inuit community midwife seeing a patient. They learn to do all the examinations in the gestational periods, and everything about pregnancy.

These are the women who are involved in the actual training. They are trained in many areas that concern mother and child.

They have a training program for the Inuit women who are pregnant. Every Friday afternoon they have a two-hour training program with the Inuit women who are pregnant. At that time they teach about nutrition, about STDs, about childbirth, about labour, and whatever else the women want to learn, about family planning. At that time they have a little refreshment.

This is at the maternity ward. As much as possible, we invite men to participate in the delivery and in all the education around pregnancy. We involve them in the family planning. We have an arrangement with the airline company so that any man whose wife is coming to our hospital to give birth can come in and have a half-price air fare.

This is a picture of a woman giving delivery. It is quite dark.

This is an Inuit community midwife helping a woman deliver.

Because there has been so much violence against women, even during pregnancy, and because of the non-respect the men have for women, we find the opportunity, when the woman is pregnant, to involve the man as much as possible, as early as possible.

We also like to involve, as much as possible, our elder traditional midwives. The elder woman is a traditional midwife, and the training of the community midwife is done both in the modern hospital way and the traditional way. There is a balance as much as possible between the two, so that the community midwife retains the traditional values.

These are women -- that is the parka to carry your baby on your back. There is the baby going home.

That's it for my slide show.

The program is designed to teach Inuit women in midwifery, but inside the program we give them the opportunity to train other women -- pregnant women, the community. We teach them communications skills, how to do presentations, how to teach, how to talk on radio programs, how to answer questions. We give them skills

on the outside, how to do work on the outside as well.

I wanted to also speak a little bit about the structure of the midwifery program, the maternity program.

Midwives are full-fledged members of the Council of Physicians, Dentists, Pharmacists and Midwives. Under Quebec law, CPDP is an advisory body to the board of directors of health care establishments, responsible to oversee most processes and issues related to quality of care and the appropriate distribution of services.

Within such a structure, the midwife does not act in subordination to other professionals, i.e. the physicians, but under the authority of the Council which determines the status and privileges granted to its members. The Innuulitsivik CPDPM -- we call it CPDPM because we have midwives -- recognizes the scope of practice of midwives and sets the rules, regulations and protocols that pertain to perinatal care. It is the Council's Credential Committee that reviews applications and recommends appointments, just as it does for physicians, dentists and pharmacists. A midwife also sits on the Council's Executive Committee.

The white staff, the professional staff, must focus on training and learning the needs of the Inuit

personnel. Skills and interests toward teaching, as well as adaptability to our cross-cultural work environment, has always been important selection criteria in our hiring process for midwives and other professionals.

The Perinatal Committee is a statutory subcommittee of the CPDPM. This committee, chaired by a midwife, regroups the physicians, midwives, Inuit trainees and the nursing staff involved in the care and follow-up of pregnant women. It must meet each week, and its functions include:

1. The review of all perinatal files, routinely around the thirty-second week of pregnancy, but also at other times at the request of the primary care-giver, to outline the general care plan for each during the third trimester.

2. The elaboration and periodic review of clinical practice protocols.

3. The review and evaluation of the training program.

4. The establishment and review of goals and objectives for our perinatal programs.

In order to try to answer some of the questions that were being asked in the fundamental questions concerning the program, we find that we need

a real commitment from the people, the Inuit themselves, in the communities. The people must be willing to work at the maternity and they must put the energy that it takes, themselves.

We are not allowing any obstacles to prevent us from doing what we feel is important and is required and necessary for our people's health and what will help them to achieve a better social life.

When we hire the white staff, they must come to the hospital expecting to teach us. They must teach their skills to us. Also, the Inuit, our people, must take the responsibility and they must be willing to take the responsibility to learn.

As to how we can measure whether this program is going well or not, are people happy with it? Are people achieving a better health because of the program? If the people are happy with it and we are achieving a better health for women and children as a result of that, then we feel that the service is appropriate.

The community has to understand that they must support their midwives. The family has to support the woman who is coming in to work in the middle of the night when a client is in labour until the delivery, which can be hours. The family has to understand that

it takes time, and they must support the woman who is working.

We have problems, of course. We know that most universities and training institutions would be willing and receptive to our needs in terms of training our people, giving us better education programs, but we feel that the educational system in northern Quebec is not receptive to what we are doing and what we need from them. Neither is the Regional Council of Health and Social Services.

We find that we need boards of directors who are truly democratic so that they can discuss real issues, what is important, what is the priority of the people, how we can best achieve what needs to be achieved in terms of health and social services for our people.

We feel that the services must make efforts to develop special custom-made programs. There must be a willingness of the people to learn.

Establishments like ours, a regional hospital, have the responsibility to give to the people as good a service as can be achieved under the circumstances. We feel that is what we have tried to do.

Thank you.

PETER ERNERK: Thank you.

The next speaker is Priscilla George. Ms George is the President of the Board of Directors of the Anishnawbe Health in Toronto. She is an Ojibway from the Saugeen First Nations.

Ms Barbra Nahwegahbow, who is the Executive Director of the Anishnawbe Health Toronto and also a member of the Whitefish River First Nation will be answering questions during the question and answer period.

Ms George, please.

PRISCILLA GEORGE: Commissioners, Elders, Mr. Chairman, invited guests, ladies and gentlemen, I would like to thank you very much for the honour that Anishnawbe Health has to present some of the things that we have been doing.

I am often asked how I would like to be introduced when I speak at gatherings, and I say that there are only three things that are really important to me. The fact is that I am an Ojibway, an Anishnawbekwe; I am from the Saugeen First Nation; and I am from the Turtle Clan.

In our Anishnawbe tradition, my name is Ningwakwe(PH) which is Rainbow Woman. If you think about that, a rainbow has no light of its own; it gets its light

from the sun, and it reflects, refracts and disperses that light. What I am about to present to you today is not mine; this is the work of the people who are committed to Anishnawbe Health, and all I am doing is reflecting, refracting and dispersing what they have been doing.

I would like to start my presentation with a quote from Art Solomon, an Ojibway Elder:

"There is no simple way to talk about healing without going into a long story. Healing means being in total balance and harmony -- physically, emotionally, psychologically, spiritually. It doesn't necessarily mean that we have no pain whatsoever; it means getting into harmony with the rest of Creation. It means getting to know something about the power and the beauty and the sacredness of Creation ... It means getting back into balance between men, women and children."

Now I would like to share a little bit with you about our Vision Statement that we have just put together this year.

From the beginning of Creation, everything necessary for human existence was provided. The first humans were surrounded with foods, waters and medicines. As we grew and developed, we were given teachings to help us understand our place on Mother Earth

and within the universe. These ancient teachings and directions continue to hold true to this day. Anishnawbe Health Toronto affirms these teachings and the directions as the basis of our organization and as the mandate for our work.

Anishnawbe Health Toronto is a culture-based, multi-service health organization located in downtown Toronto. It is only in the past year that we have determined that it will be culture-based, as opposed to being merely culturally-sensitive or culturally-appropriate. We have determined that our values, our traditions and our beliefs, which include the traditional Native approach to healing, will be at the core of our organization, that these will be the driving force behind everything that we do.

This represents significant forward movement on the part of Anishnawbe Health.

The process of taking stock of what Anishnawbe Health was doing and engaging in a re-visioning process was precipitated by a crisis in the leadership and management of the organization. This crisis in leadership, in turn, led to a certain loss of confidence by the community and the funders. A change in leadership and management, a hard look at the organization's

deficiencies and strengths, and an evaluation of organizational programs and practices have resulted in profound changes in the organization philosophically and otherwise.

Before we discuss what we do and how we do it, we will tell you a little bit about our board, our staff, our community and our funders.

We were incorporated as a non-profit organization and began providing health services in 1989. We are governed by a nine-member board of directors elected from and by the Native community. We have 26 staff, which include administrative staff, street workers, three registered nurses, an AIDS educator, two physicians, and other program and clerical staff. All of our staff are Native with the exception of the two doctors.

Our core funding comes from the Ontario Ministry of Health. This year additional funding for projects is provided by the City of Toronto and the Ontario Ministry of Citizenship.

When we recruit board and staff, we now look for a belief and a commitment to the Native traditions. The community we serve is large, diverse and scattered over a huge geographical area. Estimates of the Toronto Native population put it at somewhere between 50,000 and

70,000. Many different Aboriginal nations from across Canada are represented. They could be Okanagan, Micmac, Cree, Ojibway, Mohawk, Métis and Inuit, to name just a few.

Some are long-time residents of Toronto; some were born there; some are newly-arrived. Others travel from First Nations communities outside Toronto on a regular basis to participate in some of our traditional programs. Our clients come from a wide range of economic and social circumstances. They could be homeless street people; they could be people who live fairly comfortably.

But the people we serve have something in common. They are looking for a sense of identity and belonging. They are looking for a Native identity, Native belonging. They are suffering from the effects of the oppression that we have lived under for too long and which is manifested in many different ways -- physically, mentally, emotionally and spiritually.

In order to facilitate healing and empowerment, we do two things at Anishnawbe Health. One, we help people gain an understanding of our history as Aboriginal people, our political, economic and social situation. Two, we help people learn our traditional ways.

In the initial proposals for Anishnawbe Health and during the first three years of operation, the focus was very much on the provision of western medical practitioners -- that is, physicians and nurses. There was a lot of discussion about providing culturally-sensitive, culturally-appropriate programs and services. It was briefly mentioned that Anishnawbe Health "will promote the use of traditional holistic methods in health assessment and treatment -- understanding the Native traditions of balance in mind, body and spirit," and further that "Elders/Traditional Healers shall act in the capacity of consultants to ensure integration of Native values and cross-cultural teachings."

In the early years an inordinate amount of time was spent by staff in cross-cultural training for health professionals, medical schools, nursing schools, et cetera.

The difference between being culture-based and providing culturally-sensitive services is vast. Being culture-based means that the organization's vision, philosophy, programs and relationships are rooted in the traditional Aboriginal values. For a Native health organization, it means that

traditional healing approaches and traditional healers are at the core of the organization, and they provide the primary methods of healing our people. It means that western medical practitioners, such as doctors, nurses and psychologists, play a secondary role and act as support or helpers to the traditional healers.

Being culturally-sensitive, on the other hand, means merely that the organization provides programs and services that acknowledge, make allowance for and compensate for cultural differences. A culturally-sensitive health organization is not grounded in traditional values. While Native health professionals may be providing the service, they do not necessarily or consciously use or make use of traditional healing approaches.

For Anishnawbe Health, because we are a Native place of healing, it is imperative that we are culture-based. As noted previously, this is a new development in our organizational consciousness. Thus, our model of culture-based urban Native health care is an emerging one, an evolving one and an exciting one. It's a process of experimentation, of innovation and creativity, of looking to our past to secure our future.

The Board of Directors undertook a

formal visioning process in January and developed a Vision Statement. This is now being taken back to the community for their reaction and input.

We would like to discuss some of the programs that we have developed in the past few months, as well as some which have been in existence for a greater length of time.

The first is the traditional healers. We have brought in an Ojibway medicine man from the United States on two occasions for five days at a time. This individual is able to diagnose as well as to treat problems of a physical, mental, emotional and spiritual nature. Informal promotion of his visits was done through word of mouth, telephone calls to other Native organizations in Toronto, and other personal contacts by both the board and the staff.

On each occasion, he treated approximately 150 people, some of whom travelled from out of town from different First Nations communities. It struck us as somewhat ironic that people would travel hundreds of miles from reserve communities to see a medicine man in downtown Toronto. It is worth mentioning that among the Toronto residents who came in to get doctored were many who had never ever used the services of Anishnawbe

Health before, so this was our first contact with them.

This experience was a clear demonstration to us that there remains a great belief in and a tremendous need for traditional healers. He also went to hospitals.

Many of the people that he saw had been misdiagnosed by doctors and, in other cases, doctors had failed to pinpoint the problem. We also found that many were being over-medicated.

Using a medicine man is certainly cost-effective. We cover his travel costs, and we give him an honorarium. It works out to a cost of about $30 for each person that he doctored. When you compare that to a visit of a doctor, it is quite different. Other cost savings, to name a few, were cancellation of scheduled surgery, shortened hospital stays, no prescription drugs, no costly and invasive tests, and no referrals to specialists.

Traditional healing empowers the individual and his or her family because then they become active participants in their healing, such as gathering and preparing their medicine.

We have held a number of ceremonies as a result of the treatment that the medicine man has

prescribed. For example, he recommended a doctoring sweat lodge for some women. We brought an Elder in from out of town to conduct this for us. For some people, he recommended that they get their Anishnawbe names. We referred them to an Elder. We have held Naming Ceremonies for these people. We also have Memorial Feasts for those who have gone on, and we have ceremonies to help people with the grieving process. These bring people together and build and strengthen our community.

The staff perform a number of functions in relation to traditional healing. They will educate community members in the protocol to be followed when approaching a traditional healer or an Elder for assistance, or when holding or participating in ceremonies. More and more of our staff are becoming familiar with what is required to ensure that assistance is requested in a traditional and respectful manner.

Staff also help when people are feeling apprehensive about seeing a healer or an Elder for the first time. They may be asked to accompany someone into a doctoring session or a sweat lodge. They may be asked to assist in gathering the medicine that is required. They will also deal with the bureaucracy so the healer can go into a hospital. They will help patients to

exercise their rights to see a healer.

The biggest limitation that we suffer from with respect to traditional healers and medicine persons is the scarcity of these resources. There are very few medicine people and even fewer who are willing to leave their home communities to come and doctor Native peoples in a city like Toronto.

The role of Elders in Native communities is an important one. They are the teachers, the keepers of our traditions, and the counsellors. In an urban community, with our people often isolated from their home communities and their families, we feel it is crucial for them to maintain contact with the Elders. The Elders will work with them on an individual or a group basis to pass on the teachings.

Once a month, for five to seven days, we have an Ojibway Elder who is available to do individual counselling sessions. She is available for ceremonies and for Native Women's Circles. This individual has been working for us for about eight months and now has a regular clientele of about 50 people. In between visits she is available by telephone to anyone who needs help. She is becoming well-known in the Toronto community as a good listener, a traditional advisor, and the demands on her

time are increasing. It will no doubt become necessary in the very near future to increase the amount of time she spends at Anishnawbe Health.

Traditional Talking Circles for both men and women are held once a week. Women's Circles are held three times a month. Men's Circles will start in April. One of our traditional teachers, Avis Archambault, describes the Circle in this way:

"The Traditional Talking Circle is a very old way of bringing Native people of all ages together in a quiet, respectful manner for the purposes of teaching, listening, learning and sharing. When approached in the proper way, the Circle can be a very powerful means of touching or bringing some degree of healing to the mind, the heart, the body or the spirit. One could call it a very effective form of Native group therapy."

With the exception of the once-monthly Native Women's Circle, all Circles are open to both Native and non-Native people.

One of the effects of the oppression that Aboriginal people have suffered is the loss of our language. Providing opportunities for people to learn their languages is deemed by Anishnawbe Health to be an important part of the healing process. It renews pride

and self-confidence. It is as important as proper nutrition, exercise and Talking Circles. To this end, we have instituted an Ojibway language program that is being taught by an Elder. Within the next month we will be adding Cree which will also be taught by an Elder.

In addition to the Women's Talking Circles, we have undertaken other initiatives to facilitate the healing and empowerment of Native women. Writing workshops, which are six to eight weeks in length, have been conducted by a Native woman writer. They have focused on the exploration of our collective and personal histories. Discussions have centred on oppression and the internalization of oppression, so that the women can start to gain a greater understanding of their own experiences and our collective history.

Weekend workshops for women have focused on traditional teachings, the role of Native women in contemporary Native society, violence against women, and issues such as fetal alcohol syndrome. These workshops have been well received and have help to break the social isolation of Native women living in the city.

Future workshops will deal with female sexuality and healthy relationships.

The deaths of several Native street

people prompted the establishment of our Street Patrol program three years ago. Currently, we have six street workers. They patrol the Toronto streets nightly, providing food, clothing, blankets, condoms and needle exchange. I believe, at last count, we had approximately 200 volunteers who would go out with them as well. The street workers also go out on afternoon foot patrols. Approximately 600 people are seen per week by the Street Patrol.

Long-term, stable funding is required for this program. It is currently being funded through short-term grants from the City of Toronto.

Information workshops are held for the Native community, and educational materials are developed and distributed on AIDS prevention. Posters, coasters, pamphlets, condom jackets and a video which includes an Elder talking about AIDS have all been developed through this program which is funded by the City of Toronto.

We carry out other activities related to this area for which we receive no funding. We are a designated anonymous HIV testing site. We provide pre-test and post-test counselling. We also provide supportive counselling to people who are HIV positive. These are important activities, but we are stretching our

staff resources in order to provide them.

We also work with the Medical Services Branch. We have a contract with them to provide a clerical function on their behalf for the Native people in Toronto. We have approximately 125 contacts per week, mainly by telephone, with clients and suppliers.

There are two full-time doctors on staff who provide primary health care at our Centre, and on a regular basis they hold clinics at other Native agencies in the city. Clinics are held at Wigwamen Terrace, which is a seniors apartment complex; at Council Fire which is a drop-in for street people; at Na-Me-Res, which is a residence for Native men; and at Pedahbun Lodge which is a residential treatment centre for Native people with a history of substance abuse.

The doctors are on call after hours and on weekends. Our nurses provide family support services, community outreach, hospital and home visits. They also run groups for young mothers and an after-school program for children. They make use of our traditional resource people in their work.

Those are some of the activities and programs that we are carrying out. In total, an average of about 2,500 people use our programs and services on

a monthly basis.

With the declaration that Anishnawbe Health is a culture-based organization, the staff and the board recognize the need for an ongoing staff development program. This was needed not only to increase the awareness and understanding of traditional values, beliefs and practices, but to look at how we could incorporate these into our personal lives and into the life of Anishnawbe Health.

Regular in-service training has been taking place since July with traditional teachers, healers and Elders. The focus of the training has been on our cultural teachings, our history of oppression and how to break that cycle, personal empowerment and empowerment of our community, living out our traditional values and maintaining our cultural integrity as individuals and as an organization. The training has been intensive. It has led to tremendous personal growth and has helped to strengthen the relationships amongst the staff.

This training has been crucial in our endeavours to build a culture-based organization. A three-day staff retreat, where we will be able to hold ceremonies, is planned for next month, and a retreat for their staff and their families is planned for the fall.

Staff are encouraged and supported to attend ceremonies, and many do so on a regular basis. The healers and the Elders who come to Anishnawbe Health are also available to the staff for individual consultations. They are also available to the board. I use them.

Just recently, we started Staff Talking Circles which take place one afternoon a month. One of the staff has been given the responsibility for holding these, and he has taken the initiative of involving other members as helpers so that everyone gets the opportunity to learn by doing.

It is an absolute necessity that the staff and the board of AHT make a commitment to their own healing. If we are not empowered, how can we facilitate the empowerment of the people we work with?

One of the biggest challenges that we face is uprooting the medical model which really took hold at Anishnawbe Health during its first three years of operation. Anishnawbe Health functioned as a medical clinic, and the doctors became the point of access for all clients. Traditional healers were not being brought in. Elders were invited in on an ad hoc basis. Traditional healing seemed to have a low priority, whereas

the provision of western medical services had a high priority. This could be attributed to several factors:

1. Fear of the unknown -- of traditional healing, what it is, and our memories of what the state and religious institutions said it was, the devil's work.

2. It is much easier to get funding to pay doctors than it is to get funding for traditional healers. For example, our funding for the traditional healing program is $43,000 annually, while funding for physicians is almost $300,000.

3. The high value that society places on doctors and the low value placed on people who don't have a high level of academic training. Sometimes we, as Native people, tend to devalue our own experts and our own healers.

4. Scarcity of traditional resources -- that is, legitimate medicine people and healthy Elders who know the teachings.

5. Unfamiliarity with appropriate protocol when dealing with traditional healers and Elders -- that is, how to treat them, how to compensate them, et cetera.

Obviously, accessing the funding to

provide traditional healing has been a challenge for us. There is no question that the need and the demand is there.

In September of last year, we began accessing Medical Services Branch Traditional Healing Program which covers the cost of healers to travel to Native communities. We were also using it to send our clients to healers. However, due to lack of sensitivity in that department and a seeming lack of trust in the credibility of our Health Centre and what we do, we have now been advised that we have to utilize local resources. What that means is that, if a Native person from Okanagan were living in Toronto, he or she would be unable to exercise his or her right to see a healer from his or her own nation unless they could afford the travel costs. It also means that Anishnawbe Health would have to find the money elsewhere if we want to continue using a healer with whom our community has built a good and trusting relationship.

Medical Services Branch has also recently requested that we submit the names of the patients who see the traditional healers at our Centre, along with their diagnosis. For us, this constitutes a breach of confidentiality. As well, in view of the persecution that our people have suffered when following traditional ways, we don't feel comfortable submitting information of this

nature.

Clearly, the federal policies need to be re-examined and changed to meet the needs of our Aboriginal communities.

Because we are an urban health centre, the other issue that requires immediate attention is federal responsibility for status Indians living off-reserve. Our own political leadership needs to ensure that this gets put on the agenda. Historically, those of us who make our homes in urban areas are forgotten in political negotiations. We sometimes feel that our rights get sold out to make concessions for our brothers and sisters on reserves. But, like them, we need to assert our Aboriginal rights so that we can regain our political, social and economic health.

There are many more issues that we would like to discuss, but time is limited. So I will close my presentation with another quote from Art Solomon:

"Healing then is accomplished by respecting and honouring all Creation, including men and women and children, for each one is a created being and a vital part of Creation, and each one is special and unique, with their own gifts, and each one given a free will that is so special that no one, but no one, has the

right to impose on that free will, not even radio and television announcers."

Meegwitch.

PETER ERNERK: Thank you very much to all the speakers. We have at least six minutes for a question period, five or six minutes. Are there any questions from the audience?

Just before you go on, Katie Rich, Simon Reed is going to be the first speaker this afternoon at two o'clock. I understand there will be some more questions which you can ask later in the afternoon during the Plenary Session this afternoon.

Microphone No. 3. Identify yourself.

KATIE RICH: My name is Katie. I am from Davis Inlet in Labrador.

A couple of weeks ago some government officials came to our community, and we presented the seven-point proposal to them. The seven-point proposal came from the community, from our Elders and from our children. We received a letter a couple of days ago and also today that the plan has been rejected by Premier Wells.

I will be reading a press release that will be sent out to the media today.

"David Inlet Chief and Innu Nation Shocked by Ignorance

Shown in Clyde Wells' Letter.

Innu Nation President Peter Penashue and Chief Katie Rich replied to Clyde Wells' letter of March 5, 1993 in a joint letter today. Chief Katie Rich is representing her community before a round table of the Royal Commission on Aboriginal Peoples in Vancouver, while Peter Penashue is involved in a community workshop in Sheshatshiu today, but both found time to develop their joint response. They noted that it was difficult to respond to the Premier's letter: 'We feel frustration, shock and anger. Your letter shows surprising ignorance, and instead of allowing Newfoundland, Canada, the Nushuau Innu Council and Innu Nation to work together, with the involvement of the Assembly of First Nations, you are trying to split the parties apart, meanwhile our people suffer.'

Assembly of First Nations National Chief

Ovide Mercredi responded with his own letter yesterday, stating that he was 'shocked and disappointed by your government's ill-informed and confrontational approach to the situation in Davis Inlet.'

Premier Wells has accused Innu Nation and AFN of 'using' the current plight of Davis Inlet, implied that the community developed 7 point plan had been imposed on the community, and rejected the plan and the document Hearing the Voices: Government's Role in Innu Renewal without any discussion or consideration.

Rich and Penashue demanded that the Premier, as a gesture of good faith, commit to attending the Minister's meeting in Davis Inlet where Hearing the Voices will be reviewed and commitments given by government. MInisters Siddon, Bouchard and Clark would also be involved. If Wells makes that gesture of good faith, Rich and Penashue wrote

that they would 'ignore and forget' the Premier's ill-advised letter."

I would like to ask the panel what advice they would give Davis on how to make positive changes and to stop our children from dying.

Thank you.

PETER ERNERK: Thank you. Is there any response from the panel?

KEITH LECLAIRE: Now that we have heard this, it tends to go back to the whole concept of holistic health. The whole point is that an approach has been made to a government system. If the Province of Newfoundland feels that your application is not worthwhile, maybe they need to look at it at a community level, from a community perspective, to try to develop some activities within with the youth.

When I look at Kahnawake, we have a large number of youth. When we try to focus in on what we are going to do, I know the NNADAP prevention workers, most of the time, are not able to access all of our youth. In fact, they get a core group started. Once the core group is started, of four or five individuals, that starts the ball rolling and things can get done.

I think what is needed right now in your

community is to be able to develop -- because we are talking about youth and the loss of youth, there is a stronger need to make sure that some type of training program be developed to allow some community activity where their minds are not idle. That is the important aspect that I would suggest to you, Katie.

PETER ERNERK: Thank you, Mr. LeClaire. We will have one more question. Microphone No. 3.

COMMISSIONER MARY SILLETT: My name is Mary Sillett. I am an Inuk from northern Labrador. Inuk is singular of Inuit, and Inuk is different from Innu.

My question is directed to Annie Tuluguk. I just want to say that I think the Inuit of Nunavik deserve congratulations for Innuulitsivik. The formal recognition of midwifery in this country has been under discussion for a long time. The recognition of midwifery in Innu communities has also generated much discussion.

While I was the President of the Inuit Women's Association, we fought very hard to receive funds from the federal, the provincial and the territorial governments to produce Ikayuti (PH) which is a film produced by the Inuit Broadcasting Corporation and which looks at the whole issue of Inuit traditional midwifery.

In fund-raising we met with a lot of resistance from those people. Why? Because the potential funders and others were concerned with the lack of legal protection afforded to Aboriginal midwives. They were concerned that, if a baby was born with the assistance of a traditional midwife and if it died, they were concerned with who assumed that legal responsibility.

Also I think there is a lack of recognition of the value of traditional Aboriginal healing practices and, clearly, a reluctance to recognize the value of Aboriginal healing knowledge.

I am just wondering, in the Innuulitsivik experience, if you have encountered similar obstacles and what you have done to overcome these obstacles.

ANNIE TULUGUK: First of all, anybody who comes in to work at the hospital, whether it is a doctor or anybody else, they have to understand that this is the way things work at this hospital. They have to accept that, and they have to work with it. We don't give them any choice. If they want to work for us, they have to work the way we want things to be done.

When the hospital was set up, there was money in the global budget for obstetrics and the maternity

ward. Instead of getting professional obstetricians, we hired trained midwives to train our people. We turned the money around. In fact, our maternity work has never been funded by the government until they decided to do a pilot project a couple of years back. Now we are recognized in the law as a pilot project, but in fact we are not. We are carrying on the work. It's a daily activity for us.

PETER ERNERK: Thank you.

Ladies and gentlemen, I would like to thank on your behalf the four panelists who were speaking on the community medical initiatives this morning and this afternoon. Thank you very much.

DR. LOUIS T. MONTOUR: On behalf of the Commission and the audience, I would like to thank Peter, as well as Annie Tuluguk, Priscilla George, Barbra Nahwegahbow and Keith LeClaire.

We will now break for lunch. We have a guest speaker, Professor Robert Evans. It is downstairs in the same ballroom as yesterday. We will reconvene here at two o'clock. Thank you.

--- Luncheon Recess at 12:30 p.m.

LUNCHEON ADDRESS

Professor Robert Evans

DR. LOUIS T. MONTOUR: I would like to present our luncheon keynote speaker.

Professor Robert Evans is a professor in the Department of Economics at the University of British Columbia. From February 1990 to November 1991 Professor Evans was a Commissioner with the British Columbia Royal Commission on Health Care and Costs. He is a national health scientist with Health and Welfare Canada. He is a Fellow of the Canadian Institute for Advanced Research, and he is a Director of the Institute's Program in Population Health.

The topic of his discussion today is the illness care system and the holistic view of health.

Ladies and gentlemen, Professor Robert Evans.

ROBERT EVANS: The title of my talk was made up about 15 minutes ago. It struck me as something I would sure like to hear. One of the ways in which academics try to learn about things is to undertake to talk about them and then, hopefully, when they are through, they may have learned something from their audiences.

I think that is an important point as backdrop to this talk. I am not a specialist on Aboriginal issues. I cannot tell you the kinds of things that you really do need to know.

What I propose to do is to provide a sense of what I think the overall background is nationally and internationally that has a powerful impact on both the constraints and opportunities on what it is you are trying to do here. That I do have some awareness of and have spent some time thinking about. Then I think it clearly is up to you to translate that into doing things and not doing things and achieving results.

It would be both arrogant and naive for me to pretend that I could tell you your business. Although, as a professional economist, I have my share of both of those qualities, I am not prepared to get into this in quite that way.

When I was a member of the B.C. Royal Commission on Health Care and Costs, studying the B.C. health care system, again we were all acutely aware that the problems in this particular area were of extraordinary complexity and largely beyond our reach and required another commission to deal with them, and here you are. You have another commission. I guess that's a way of

passing the intellectual buck.

The two parts to the title that I gave this talk reflect what, to me, seemed to be -- I suppose one hesitates to use the phrase "two solitudes" -- two separate administrative intellectual trends that are going on in health care, really quite separate from each other and with not a great deal of overlap. There are some very interesting and very important things going on in what I have called the illness care system, and there is a separate discussion and a separate evolution of ideas and, to some extent, policies going on in response to the WHO definition of "health" and the notion that the promotion of health requires a much more holistic concept of the individual in society. The phrase "new paradigms" floats around a lot, although one of the things that makes it so popular is that nobody knows what it means -- the notion that there is something more to health and something more to the promotion of the well-lived life than simply supporting the illness care system.

That notion, I think, is developing and evolving really with not a great deal of contact with what is going on in the illness care system.

What I want to do is I want to start by describing, obviously far too briefly, what I think is

happening in the illness care system, and I think that has powerful implications for what may and may not be optimal strategies for trying to pursue broader definitions or broader concepts of health. So I will start with the illness care system that I can actually get some numbers on, and then try to switch over and say, "Okay, so what."

The first point that I would make is that I do not use the "illness care system" label in any critical sense. It is my experience with people in the holistic approach to health that they tend to use that as a epithet, as a slur. They say, "It's not a health care system at all; it's an illness care system," as if that is something you should be ashamed of.

I do not myself think there is anything to be ashamed of in providing care to people who are ill. That seems like a perfectly decent and proper thing to do. It would be a good idea if, in addition, you did things that actually helped them to get well, but that often happens. Critics from outside tend to concentrate a great deal on the shortcomings of the illness care system, but I think we need to recognize its very real strengths and effectiveness as well.

That is not a criticism, but it is a

statement, I think, that the illness care system is good in taking care of illness. It's a good thing to do. You shouldn't expect it to do everything that is involved in the promotion of health. There are some real risks there that I will get to a little later on.

The illness care system, as we know it -- the sort of conventional, mainstream, what calls itself the health care system in Canada and we mostly call it that, too -- is, of course, as you all know, in crisis at the moment. This is not a surprise. It has been in crisis for as long as I can remember -- and I have been in the field for about 25 years. I expect it always will be.

Being in crisis is part of the negotiation process whereby the people who provide health care in a society and, to some extent, the people who use it, negotiate their claims with the rest of society. In a publicly-funded system, which means virtually all of them in the modern world, there is a continuous dialogue with the rhetoric of crisis that could be described -- one of my colleagues, Jonathon Lomas at McMaster, has claimed the phrase "orchestrated outrage." It is the continuous outrage of the people in the system at the inadequacy of the resources they have gotten.

In the last 30 years we have expanded that system in real terms per capita four times, so it is now 400 per cent larger in real terms than it was 30 years ago. That has had no impact on the crisis rhetoric. The rhetoric is just part of the normal operations of the system, I suggest to you. If you think back, you will certainly see that it has been around for a long time. And it turns up in almost every other system as well, perhaps every other system in the developed world.

However, that being so, I think we are at a time when something has changed in Canada and in the rest of the world. All across Canada we have had within the last five years major commission reports, inquiries, Premiers' Councils, a wide variety of investigative agencies which have recommended major reforms -- and this hasn't happened in 20 years. This is a new event, at least new in recent years.

It is interesting that exactly the same thing is happening all over Europe and in the South Pacific. The Americans, of course, are trying to reform their system, but then well they should. In those systems which actually run reasonably well, there is the same process in the same time period happening everywhere, so there is nothing unique to Canada. All of a sudden, within about

the same five-year period, every country that has had a reasonably effective, universal, comprehensive, relatively cost-controlled system is suddenly getting very interested in reform. So we are dealing with a phenomenon which is obviously something broader than simply the present Canadian experience.

We are very much part of this general trend, but I think we need to reflect upon the fact that we are part of something that is happening everywhere, and very recently, quite suddenly. Something has changed, and it isn't something within health care systems themselves. It is something outside it. And the something is not very far to seek.

If you want to see what is really causing the crisis in health care, you look at the data on the general economy. You can look at that in Canada, or you can look it all across the western European world, and you find that somewhere around 10 years ago there were some quite significant changes in the level of economic growth in most of those economies. The British are an exception, but then their growth was so low in the earlier years that you couldn't see much of a drop. But in western Europe, as well as in Canada, something changed.

I want to show you some images of that.

They are very simple, and they are remarkably stark. They surprised me when I started fooling around with these charts. If everything works well, we will now switch into the visual part of the entertainment.

As is appropriate for an economist in the forecasting business, I am very shortsighted, so I have to check my transparencies. I can't see them as well as you can.

What that shows -- this is just straight StatsCan data, straight out of the publications. That shows real output, domestic product, total output for Canada, "real" meaning adjusted for inflation, "per capita" meaning divided by population. That is your basic measure of the economic resources available per capita in Canada and how they have been evolving over time.

I have plotted a trend through them from 1960 to 1980, the simplest possible plot, a log linear trend -- and anything who knows anything about this game will realize the low intellectual level I am working. If you fit the trend from 1960 to 1980 and project it through to 1991, you get the nice smooth curve there. The remarkable thing is that the reality lies bang on the curve for 20 years. That is a long time to be that tight on the curve. Then the next fun part is what happens in the

early 1980s. We come off the curve and we don't get back on. We manage to get back in parallel with it for a while, and then we hit another recession. By the end of that period, the actual is about 25 per cent below the trend value. That is the external economic reality, the external environment we are working in.

You can do a lot of qualifications to that. All statistics are, to some extent, false. But that is the kind of broad outline.

If you put on the next transparency, it tells you exactly the same story but in an even more dramatic form. This is the actual value of output per head relative to its trend value. You can see that over the 20-year period it bounced around within 5 per cent either way of its trend value, then it collapses in the early 1980s and then it collapses again at the end of the 1980s.

That has something to do with funding difficulties for new programs, because that is your overall economic base in the country. It doesn't say that new programs of various sorts shouldn't be priorities; it just says that the competition is getting tough.

If we now relate that to health care -- this is all just straight Department of Finance stuff.

If we relate that to health care, a very common statistic which is used by the people who say that health care costs are out of control is that we are spending more and more of our income on health care over time. Well, there is some truth in that but, as usual, it is far too simple.

With the next transparency, I have said: What did happen to health spending relative to income and what would have happened if we hadn't gone into the collapse of the early and late 1980s? The upper line is the reality; the lower is what would have happened if we had continued on our previous growth path.

You can see that the reality was a steady growth here, flat in the 1970s and then, with the recession, an explosion of share, levelling out, another big bounce with the new recession. If there hadn't been those two recessions, if we had stayed on the previous trend, not much -- a pretty well-contained, not doing anything terribly special kind of health care system. Don't quote me on that. It was doing lots of special things, but it wasn't doing anything special in terms of its economic impact. That is what I meant.

That is total health care. Now let's focus on hospitals and doctors alone, not because they are all that matters but because they are what is funded

through the universal public insurance systems.

This goes back to the post-war, and it does that because the data go back. If there had been data available, I would have plotted the other one back, too.

Now you see the really dramatic, stead increase from the late 1940s all the way up to 1970, flatten out, drift off, and it would have kept on drifting slightly downward except for recession, recession.

The reality happened. There is no getting around that. But the point about it is that what we seem to have here is an external environment that deteriorated markedly and an illness care system which did not respond to that change, which continued to behave as if it were still in the high growth environment. There seems to have been enough inertia built up into that system over the previous 20 years -- and, if we had time, I could go through some of the details of what that inertia is, what forms it takes. Enough inertia built up that the health care system has not adapted to the new environment.

That means a lot of conflict. That means that the control processes, the attempts to limit that growth, have to be imposed tighter and tighter as the overall economic environment deteriorates. Even

trying to do that, you can see the realities; you have these pressures. In a sense, this is Glen Clark's case, I suppose, although these are national data. This is the dilemma of the Minister of Finance of a health care system in which expectations are very powerfully driven by past performance and past experience that says we have to keep on growing and the economy is supposed to be there to help us keep growing. If the economy is inadequate to help us keep growing, we just have to expand our share of what is there.

That is, as you see, what happened during the 1980s, and I think that is what powers the recent pressure for reform throughout the health care systems of Canada and, indeed, of most of the OECD world. I am not going to take you through one of these sets of transparencies for every one of the 18 countries in the OECD because you probably don't want to stay here until tomorrow morning. They would look sort of similar. I think the Canadian ones are particularly dramatic.

I will give you a flavour of the international environment. Here are the two outlines, the U.S., the country of the cost explosion, the U.K., the country of the Chief of Nasty, and in the middle the average of all OECD countries -- all western Europe,

Australia, Japan, New Zealand, us, the Yanks, all averaged.

Parallel to the U.S up to the late 1970s, flattens out, parallels the U.K. from then on. The Europeans figured out how to limit their costs; they decided to do it, and they did it. The Yanks didn't; they haven't yet. They are trying to place every disaster to us. The British were always Chief of Nasty -- my background is British. Canada following the U.S. right down the line, just a little colony of the U.S., goes into universal health care; everything changes; we flatten out; we hit the OECD average; and then we come unglued with the recessions.

What is the relevance of all this? The relevance of all this is that I think the mainstream system is going to be tied up for some time to come, wrestling with its own problems of restructuring. You don't have to go much farther than this morning's news programs on the closing of Shaughnessy.

What that says is: In this kind of environment, how do you do new things? How do you go out as a Commission, for example, as we did, and get told by all kinds of people about priorities for different, new and important things to do in an environment where it is very unlikely that the overall globe is going to be able

to go?

The answer is: You are going to have to manage better the resources that you now put into the illness care system and you are going to have to transfer them, if you really want to, out of that system and over to other sorts of community-based programs. That was essentially the message of our Royal Commission and, in one way or another, I think that has been the message of all the royal commissions. You translate that to where the rubber meets the road -- the Commissioners have all gone home by then -- and it says that you close Shaughnessy. Suddenly, there are a whole lot of people who work at Shaughnessy. They have jobs.

Every dollar of spending in health care is, by definition, a dollar of somebody's income -- an accounting definition. That is not an estimate. That is not an economist's viewpoint; that's an accountant's viewpoint. That is reality -- that's a stretch right there, isn't it? It really is the case; trust me on this one.

If you want to change priorities which is a nice phrase, redeploy resources which is a nice phrase, what it means is that you have to take employment away from somebody and give it to somebody else, or you have

to tell somebody, "The job you have been doing for some years and feel reasonably confident at and know what you are doing and, by the way, happens to be where you like to live, doesn't exist any more. There's another job opening up somewhere else, that will be quite different. You're going to be nervous as all get-out figuring out how to do it, but that's what we really want done and, if you want to work in this system, that is where you are going to have to go."

Those kinds of statements don't resonate with a lot of the people in the system already. They would be much happier to say, as they have said for 40 years, "There are new needs, of course, but there are also old needs. So keep on funding the old needs and also add on more resources to do the new important things." We have done that for most of the history of our system, and we are probably not going to be able to do it any more. That's the message here.

That was why in the B.C. Commission we said, "Business as usual is not sustainable." We don't know that; that's a statement about the future. But it does look like the world has changed in a way in which that is going to be very tough.

So how does that flip over into the

second part of my talk, holistic health care and all that? There is a very important distinction, I think, that needs to be made here between broadening the definition of health and broadening your concepts of the determinants of health. I will try to run through that carefully.

The WHO back in the late 1940s defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity -- in other words, virtually all good things. This is the well-lived life.

In some sense, you could call a healthy life a well-lived life. I am not going to argue with the philosophy behind that, but I am saying that that is really pretty difficult to operationalize, and it is not at all clear that the illness care system, either in its present form or in some extended form through funding preventive interventions by clinical people or something of that sort, is an appropriate mechanism for achieving that. It's likely to be very expensive and it's likely to be ineffective.

Take a very clearcut, unambiguous, well-known to everybody example. It is now pretty well agreed -- and there is a recent report out from LCDC in Ottawa to confirm -- that there has been virtually no

pay-off to the research done and the treatment done on most kinds of cancer, particularly lung cancer. Huge resources go into this area; not much comes out in terms of benefits.

We know why most people get lung cancer; they get it because they smoke -- back of the room smoking tables. What we don't know is a whole lot about why they smoke, although we know there are some very interesting correlations with social status, sense of control, empowerment or non-empowerment -- nice and controversial stuff, but really some pretty powerful stories coming through. We also know it has something to do with whether there are people in the business of trying to addict children to smoking, which is when most people take it up. Yet, what we do is we spend our money on supporting bio-medical researchers in our universities. What's the point?

When that came out a week ago, the coverage in The Sun was: Hey, we gotta do more about prevention but, of course, we certainly shouldn't cut back on bio-medical research because that is good; that is a good thing to do. It doesn't happen to do any good in terms of outcome, but, gee, we should keep it going anyway because there are folks with white coats and neat looking

labs and we've got to do those things; it's important. God demands it.

That is what I meant about the difficulty in addressing the obvious, saying, "Look, if this is not working and that looks like it might work, maybe we should close some of this down and move the resources over there." It is very hard to get that thinking going.

What I think has happened in the holistic area, in the sort of new dimensions of health care -- sorry, that was a very important Freudian slip; I did not mean to say that -- the new dimensions of the determinants of health, the things that matter to your health are very narrowly defined, not only in the WHO definition but things like mortality and morbidity are conventionally defined. What we are now learning is that they depend far more on your social environment, also on your physical environment obviously, on your social status, on your sense of where you fit into your community.

The hard evidence is now coming in in terms of not fuzzy things like people feel good and report it on a questionnaire, but whether they are dead or alive. Mortality rates actually depend on things like social status and social networks, and stuff like that, and you can pretty clearly show that and you can replicate it in

animal experiments. You can go into the lab and show the same darn thing, and it is really quite remarkable.

So what do you do about that? I think the real danger is that you take this new perception that a much wider range of determinants affect health, narrowly defined -- if you take that understanding; don't get drawn too far into very broad definitions of health that are too difficult to get agreement on. Stick to very narrow ones where nobody can deny where nobody can deny we are talking about health. We are talking about very narrow mortality and morbidity measures that are dependent upon very much broader conditions than simply the health care system.

The trouble, I think, is that the people who are worried about holistic health have tried to define conditions and problems as diseases. Alzheimer's was invented as a disease about 10 years ago. It used to be just senility, and then it became a disease. Once it was a disease, it was eligible for bio-medical funding; it was eligible for public support in a whole variety of ways. Alcoholism -- is it a disease or not? People insist it's a disease. Why does it matter? It's a hell of a problem. It matters because, if it's a disease, then it comes under the health care system, under the illness care system.

It becomes eligible for different kinds of funding; it becomes eligible for different public attitudes.

Defining a problem as a disease looks like a very good way of raising its status and raising the resources that go to it, but there is a price to be paid for that. The price to be paid is, first, that it falls into the standard illness care framework of who gets to define the problem, who gets to identify its dimensions, and who gets to be paid for providing the solutions. You maybe didn't want that. The example of lung cancer, it seems to me, is a good one. It is clearly a disease, but we are not addressing it in a very effective way.

The thing I am adding to that with those transparencies is that it may not be such a hot idea in the future, as it has been in the past, to try to get your very real problem classified as an illness. The sharks are getting pretty hungry in the illness care system; things are much tougher there than they were 10 years ago, and that is going to continue. There is no real reason to believe that we are going to get back on that growth trend.

I think what it says is: Be awfully careful about defining problems as diseases in the hope that that will elevate their status and get you better

results. It may well not. It may well backfire on you.

Secondly, be pretty careful about defining health itself too broadly. I think you can get a lot of mileage out of defining health pretty narrowly, but really focusing hard on the very broad determinants of that health. The evidence really is good on that, that you can now start to say: Look, the things that matter for people's health, in the narrowest sense -- not the aery-faerie sociologist sense, but in the narrow sense of who lives and who dies and in what condition they do that. The things that matter are far, far broader than the illness care system, and the problem is to try to hold that system under some kind of control so that you can free up resources to do other things.

That was a little over the five minutes.

DR. LOUIS T. MONTOUR: That was fantastic.

ROBERT EVANS: Thank you.

I think we are going to take some questions. I always like somebody who refers to my talk as "fantastic." There is a prime ambiguity to that.

DR. LOUIS T. MONTOUR: What I meant was that it was a very hard-hitting and fast-paced presentation. Thank you very much.

We have time for one or two questions or comments. Does anyone care to challenge his economic statistics?

UNIDENTIFIED SPEAKER: I don't really care to challenge your economic statistics. What I am concerned about, though, is the fact that since November of 1991 everybody talks to Elders and Chiefs and Band Administrators, and many of the First Nations people concerned about their views and how they feel about the delivery of Native healing programs throughout the province of B.C.

On several occasions and even as recently as the announcement of the Brighter Futures Program, there have been certain Elders who have stood up and made their comments on the use of the word "Aboriginal" to describe First Nations people. I wonder why and whose idea it was.

If we identify ourselves as First Nations people when we are talking nation to nation and to the federal government and any other government body, if we start calling ourselves "Aboriginals", then that is taking away our position as nation people. Once we lose that, then we lose a lot more of our identity.

Part of the health of our people is being

recognized. In my position, my people were given their languages by the Creator. We were told to call ourselves Anishnawbee, which means basically "the people." The people on the Queen Charlottes, when they were given their language, were told to call themselves Haida which translates into "the people." We are the First Nations people.

Why and whose idea is it to turn around and call us "Aboriginals?" I am a First Nations person; I am an Anishnawbee, and I would like to know why that came about.

DR. LOUIS T. MONTOUR: Thank you for the question. I don't think that is quite the subject material for Professor Evans' talk, but thank you for the question anyway.

We have time for one more question.

UNIDENTIFIED SPEAKER: Is it true that an economist is somebody who doesn't have the personality to be an accountant?

ROBERT EVANS: Yes.

DR. LOUIS T. MONTOUR: We will end on that note.

I would like to call on Judge Dussault. He has a presentation on behalf of the Commission for

both Professor Evans and Dr. Kuhnlein. Would Dr. Kuhnlein come forward as well, please.

CO-CHAIR RENÉ DUSSAULT: I have a very pleasant duty to perform.

First of all, I would like to give, as a token of our consideration, a gift to Professor Harriet Kuhnlein for her very enlightened speech.

What we are giving is a logo of the Commission.

I would like to thank on behalf of everyone in this room and also the Commission Professor Bob Evans for his very interesting speech. I think it was down-to-earth. He succeeded to really give us a good understanding of the overall economic environment under which our health system works. Certainly his long-term visions and also the insight he gave us will be remembered by all of us.

Thank you very much.

--- Presentations to Dr. Kuhnlein and
Professor Evans

DR. LOUIS T. MONTOUR: I want to thank Professor Evans for catching my double-entendre there. I didn't realize I was quite so witty.

I would like to thank the ADM, Marie

Fortier, for pinch-hitting with the slides.

We will now end the session, and we will reconvene at 2 o'clock -- two minutes from now.

--- Upon resuming at 2:11 p.m.

DR. LOUIS T. MONTOUR: Try as I might, I probably could never speak as fast as Professor Evans, so you will have to bear with me.

This afternoon's panel presentation of discussion papers is being chaired by Dr. Jay Wortman. We have an addition to the program from this morning. In the panel presentation of four community medical initiatives, the Nu Chah Nulth British Columbia presenter kindly consented to delay his presentation until now, for time reasons. That will now be presented first by Simon Reed, and we will follow with the four papers.

I will now turn it over to Dr. Jay Wortman. Thank you.

DR. JAY WORTMAN: Thank you, Louis, and hello again. Welcome back to the afternoon session.

I will just review for you what we are going to do this afternoon. We are going to hear from four speakers. The first speaker is left over from the morning session, and that will be Simon Reed, whom I know quite well from his work with the Nu Chah Nulth Health Board.

Simon will present some of the community action that has gone on at Nu Chah Nulth. That is a

slightly different presentation from the ones that will follow. The ones that will follow are papers that have been included in your conference materials. The following speakers will speak very briefly about essential issues and focuses on solutions from those papers.

I will introduce Simon as the first speaker, and we will proceed from there. We will listen to all the speakers, as we have done in the other panels, and then we will invite questions from participants from the floor.

We are hoping that we will be able to maximize the time available for the participants. I know this has been a problem up until in terms of the scheduling of the program, that there hasn't been enough time for you to participate. We value your experience and expertise, and we want your participation, so we will going to try real hard to keep this program moving along now and make that space available at the end of this session.

Without further ado, I would like to introduce my good friend and someone I have a great deal of respect for for his work with the Nu Chah Nulth, Simon Reed.

SIMON REED: Thank you, Jay.

I would like to begin by acknowledging

the Salish Chiefs on whose territory we stand today and by thanking the Commission for the invitation to Nu Chah Nulth to present here.

I would also like to convey the apologies of Richard Watts who was scheduled to do this presentation. Those of you who know him know that he is usually not caught short for words, and he asked me to express his apologies.

I am not used to public speaking, so I am not sure how this is going to come out. If it goes well, it is a tribute to people like Richard who taught me as much as I know about it.

I am not going to talk about the history of Nu Chah Nulth; it is not that different from any other First Nation in the country. I am not going to talk very much about the conditions the way they are now; they are also not that much different from any other First Nation in the country.

What I want to focus on is the process of change which is what the Nu Chah Nulth Tribal Council is about. To begin that, it is important to recognize that the Nu Chah Nulth Chiefs have never signed a treaty of any kind with the Canadian government or any other government which recognizes the basis of co-existence.

That is still an open question as far as the Nu Chah Nulth Chiefs are concerned.

The Tribal Council has had one focus on that issue over the last 30 years since its inception, and the other focus has been on building our communities and the capacity for self-government. Today I am focusing on the health program, but it is important to recognize that this is only one aspect of the self-government which the Tribal Council has worked for. It also includes control over family and child services, economic development, control over resources and any of the other government issues. The Tribal Council is working on all of those.

The health transfer, which is described as a Health and Welfare initiative, happened to fit into a strategy the Tribal Council has pursued for many years. The original direction to go after something like that came in 1981. I guess the simplest basis for pursuing it is that it was felt that a Nu Chah Nulth-controlled program would be better than a program controlled from outside the Nu Chah Nulth territories, and anything which moves a step closer to that is better.

In taking control of the services, there are three major issues that we confronted. The first is

that we have five generations of colonial-style government to undo. Apart from the trauma which has been described repeatedly -- and I will only mention one statistic, just to put a focus on that. In the past 12 weeks our staff have dealt with 42 suicide attempts in a population of 3,000 people. I am happy to say that only one of those was completed.

We have a legacy of five generations of healing that has to be taken care of.

The second issue has to do with the reconstruction of wellness in the communities. The remains of the traditional system are there, but they are only a skeleton of what they used to be. They still provide a framework which can be built on, but there is a lot of work to be done in rebuilding that.

On the professional side, it starts right in the home with the upbringing of children. Their success in the school system and their ability to get into professional careers is another major issue.

The final major issue we have had to face is the whole patchwork of federal-provincial jurisdiction and the multitude of funding sources. Although most of the NTC funding now is in one major agreement, there must be a dozen other subsidiary agreements with federal and

provincial governments. An awful lot of time and energy goes into trying to make that process work.

We have heard quite a bit over the last few days about traditional ways of healing. I think perhaps Dr. Montour summed it up best when he said that it is a way of life. If we strip away all the professional credentials and the organizational structure, what our staff and workers in the communities are trying to do is encourage people to seek out their own life path, drawing on what they can from their Elders and, if they do not have surviving Elders with that knowledge in their own families, to go to their neighbours and any others who can supply it to them.

Of course, in going through that process, they confront their own issues. So we have a role in helping them to deal with some of the secrets that have been buried over the last few years -- I should say generations.

We are encouraging people, through the health program, to try to get back to the traditional view of health -- not necessarily all the practices, but to understand the philosophy and the way of life which underlies that.

On the professional side, we have the

shortage of trained professionals. There are no physicians from Aboriginal communities in B.C. I know Jay is here, but there are no qualified physicians from the First Nations of B.C. at this time. The first graduate is going to be this spring.

In the nursing profession, there are perhaps 10 per cent of the number there should be. I know of five qualified Nu Chah Nulth nurses, but we have only been able to draw one back to the west coast to work in our program. So that is an issue.

Related to that is the importance that those people also have grounding in their own traditions. If they learn the other system only, they will not be able to help recover what has been lost.

The health program and, through the transfer, some of the things we have been able to do -- we have started with some career material aimed at elementary and junior high school students to encourage them to look at those careers. We have a series of posters intended to go into every home to supplement the cultural teachings of the Elders. We offer scholarships for post-secondary training in health careers. We have developed a six-week basic training program for all of our human services workers in the communities.

Those were immediate needs, but we are looking forward to going beyond that. In the next short term, some of the issues we expect to deal with are control over non-insured health benefits, because we can see that funding being used much better. We want control over some of the provincial services which go to our urban reserves at the moment. We want to see home care available in the communities; that is something which is not available at the present time, but is available off the reserves. We need to do follow-up work on residential school issues.

We are in the process of a major process to take the variety of programs which have been taken over from various government agencies to try to integrate them following the Nu Chah Nulth philosophy of caring for the families, to develop family support system rather than program support systems.

Finally, we see a need to develop better co-ordination of urban services for our urban members. Fifty per cent of Nu Chah Nulth people are off-reserve.

In the longer term, we see the present criminal justice system as an obstacle to the healing that needs to happen in the communities. As long as disclosure of some of the abuses that have taken place ends up in the courts in a confrontation between members of families,

there is going to be great reluctance to deal with it openly. We say that knowing that there is a great deal of healing required to restore the traditional forms of justice, but that, ultimately, control over justice has to be within the communities themselves.

Finally, the treaty negotiation process which is just becoming a reality in British Columbia ultimately will provide the resource base that is needed to sustain the health of the Nu Chah Nulth communities.

I would just like to close with a comment that was made about five years ago by a Nu Chah Nulth Elder, the late John Thomas. He was describing the training which he received 60 years ago from his Elders. Their advice to him was that, when you are attempting to cross a strong flowing river, you test each step before you place your weight, because sometimes the stones that look the safest are the ones that roll out from under you unexpectedly.

That was a word to set your goals but to proceed cautiously toward them.

Thank you.

DR. JAY WORTMAN: Because Simon was actually part of the morning panel, it may be appropriate at this point to invite a question or two directed to Simon and his description of the Nu Chah Nulth project, before

we move on with the other presentations which are the scheduled ones for the papers that you have in your materials.

If there is anyone who has a question they would like to direct Simon, there is an opportunity to do that now. Of course, if you want to wait until the end of the panel, Simon will be here at that point as well.

It looks like we are going to move on.

It is with great pleasure that I introduce our next speaker. I think she is known to many of you because she is a senior policy analyst with the Commission, Kim Scott. She has been very instrumental in much of the work with the Commission, and I have had some dealings with her in that regard and find her to be a very impressive person.

Prior to this she worked with NNADAP, and prior to that she was a Director of Health and Social Services in Kitigan Zibi Anishnabeg.

Without further ado, please welcome Kim Scott who will present Discussion Paper E on how programs, policies and funding arrangements can be changed to respond better to the holistic health challenges and health promotion.

KIM SCOTT: Good afternoon, everybody.

I would like to thank the Musqueam and the Squamish for hosting this important event. I feel comforted by the number of familiar faces in the audience, and I also feel comforted by the calibre of my new allies whom, I am sure, require no speech about the importance of prevention and integration.

I was reading an article the other day about a project in Arizona called Biosphere II. Human beings are living in a contained environment where they have to grow their own food and their restricted access to hamburgers and hot dogs, of course, has led to a reduced amount of fat in their diets and they have leaner body mass indices and a better sense of well-being. The scientist in me thought, "Gee, isn't this wonderful. This argues for preventive nutrition." Preventive nutrition, of course, results in reduced incidence of diabetes and all of the other chronic diseases, as I am sure you know. Then my excitement settled. The Anishnawbekwe in me said, "I am really horrified that the scientists are actually preparing for the inevitable destruction of Biosphere I."

I thought to myself: Yes, prevention is really important on an individualistic level, but look around you. There is prevention on all fronts that we

have to participate in. Integration and prevention is our challenge.

In the paper that you have in your package, I chose not to talk as much about prevention and integration because I believe you are all converted to believe that that is important. I chose, rather, to talk about the peculiarities in the distribution of "health wealth" in Canada and, by that, I mean the particular pieces of legislation that govern the distribution of "health wealth" in social services and in health services.

The first that I want to talk about is the Canada Assistance Plan, or CAP. When we look at social service delivery for indigenous health authorities, again we find a very narrow focus. We find that we don't have the same range of services that is provided for by provincial social service agencies. If we look at what CAP funds, we see that it includes work activity projects, community development efforts, institutional care, and on and on and on. Generally, the range of services for indigenous health authorities is almost always restricted to child and family services. So that is one peculiarity.

The second peculiarity about CAP is that there is a Part II in CAP which, I am sure, is an attempt to reconcile the federal government's responsibility for

Indians on reserve and the provincial responsibility for the establishment and extension of social services. Part II allows the provinces to enter into agreement with the federal government so that the federal government will pay 100 per cent of social service delivery on-reserve. The problem is that all of the provinces have rejected entering into these agreements.

That creates several problems. There are exceptions to the rule. Ontario and Alberta do have arrangements which ensure some level of comparability between community-based social service agencies and provincial social service agencies, but they aren't comprehensive and they are not under Part II. In other words, the federal government isn't supporting 100 per cent of the cost.

I maintain that it is here where funding policy double standards can develop. It is extremely complicated, and I hope I am being clear. I trust that all of you have read the paper and that there is a clear presentation there.

What happens is: If the province has not entered into agreement with the federal government to extend social services to Native people on-reserve, then we have a situation where the reserved-based

communities are not receiving the quality and the range of services that is provided to Canadians generally. Where the federal government is meeting their responsibility and they are funding communities to provide social services, they don't necessarily do so by the same formula as provincial agencies.

If we look to Established Programs Financing for health care, we see a different scenario. There isn't a Part II there; in other words, Established Programs Financing for health care is supposed to cover medically necessary treatment or insured health benefits for all Canadians generally. That isn't the case. Some hospitals are being primarily funded by the federal government, and some hospitals are being primarily funded by the provincial government. Again, double standards can develop.

The federally-funded hospitals do not necessarily operate under the same funding formula that the provincially-funded hospitals do. I think it is very important to illustrate that.

I present grounds for change to these two particular pieces of legislation and how they govern "health wealth" distribution in my paper. I would refer to that now because I do have restricted time here. I

wanted only to plant the seeds of why there needed to be grounds for change.

Given this context of "health wealth" distribution in Canada, I would like to turn now to the administrative transfer initiatives of federal and provincial governments. The first one I want to consider is the transfer initiative under Medical Services Branch.

This is a progressive step. I think this is an important and progressive step because this administrative transfer initiative offers programmatic flexibility. It offers some moral independence. Communities can set priorities, and many communities have seized the opportunity to do so, my community included.

However, there is no evolutionary flexibility afforded with administrative transfer arrangements under the Medical Services Branch model. The first question I pose is: Are provincial agencies be asked to stay with the same funding resources that they had in 1987 into the 21st century?

I think it is inappropriate not to have evolutionary flexibility in the post-transfer scenario for several reasons. One is that we don't know how AIDS is going to impact our communities into the 21st century. Second, we have an age cohort of children who are affected

by FAS and FAE for which we never had resources to begin with. So I think, especially in the post-transfer scenario where you have the most culturally and linguistically sensitive group in control, there should be some evolutionary flexibility.

The other criticism that I have heard widely about the transfer initiative is that it is not comprehensive. Two of the major branches which are not included in the transfer initiative are the Health Promotion and Protection Branch and Fitness and Amateur Sport. Here are two prevention-oriented budgets which we cannot access through the Medical Services Branch transfer initiative.

The other really big pot of money that is not available under the transfer initiative is non-insured health benefits. Just to give you an idea of how important this could be to community control of health services, the non-insured health benefits amount of money flowing into any particular community represents at least as much as what is going on in health programs. In other words, if you had the whole pot of wax, you would have half for health programs and half for non-insured health benefits.

Non-insured health benefits was not on

the table for a lot of reasons. It's a demand-driven funding formula that guides non-insured health benefits. In the demand-driven scenario, costs have been escalating dramatically. I present a table in my paper that argues for the community-based program controlled scenario which illustrates how cost effective it can be. Without flexibility, however, to move this remedial symptom-centred, demand-driven budget into a more program-controlled scenario, the costs, of course, will continue to escalate.

The other thing that I wanted to point out is that administrative transfer is also occurring within the Department of Indian Affairs, Social Development Branch. Indigenous communities are now allowed to assume responsibility for child and family services.

The apparent problem there is that the most isolated and the smallest communities, with 250 children or less, are not eligible to qualify. So, given what I have presented to you earlier about the fact that, if the province isn't assuming their responsibility for the establishment and extension of social services, there is no mechanism to ensure that the federal government is doing so and if the federal government will not do so

because you don't have more than 250 children, it appears that some way or another these children are not entitled to protection.

There needs to be a reconciliation of those federal and provincial responsibilities.

When I spoke to people who were in urban-based centres or operating Métis health organizations, their complaints about administrative transfer were much the same. Administrative transfer came with strict, imposed subscription to provincial legislation; it came with rigid programmatic guidelines; it came with remedial, symptom-centred, service volume funding policy. To illustrate the lunacy of that, some of these agencies were being funded by the number of children in care. That seems to me to provide no incentive to keep families together.

I know 15 minutes doesn't allow me to illustrate all of the solutions. I have presented some in the paper, but my task really was to stimulate your minds about the solutions and to draw from you or extract from you the kinds of solutions that we are seeking.

Your challenge is to develop mechanisms which would ensure more equitable distribution of "health wealth" without imposed subscription to a Euro-American

notion of what health and social development is all about.

What I would like you to do, and I strongly urge all the Round Table participants, is to look at the questions in Discussion Paper E and prepare written submissions to me before March 20, so that I can include them in the eventual publication of this discussion paper.

Thank you very much.

DR. JAY WORTMAN: Thank you for an excellent presentation, Kim.

Our next speaker is Bill Mussell. Again, Bill is very well-known to many of you and probably doesn't need an introduction.

He is a researcher and author and works in community and curriculum development and works as a trainer. He is a member of the Skwah Band of the Sto:lo. He is probably best known, at least to me in my experience with him, for his work in training the CHRs in this province.

Bill is going to present Discussion Paper F: What are some of the workable models that allow Aboriginal individuals and communities to take responsibility for health?

WILLIAM MUSSELL: Thank you, Jay.

Commissioners, distinguished Elders,

Presenters and Learners -- I assume you are all learners by being present. I am a bit concerned that there isn't much interaction in regard to what is being covered. My perception of a Round Table was that there would be lot of chances for people to share their thoughts and feelings about respective issues. I am hoping that there will be adequate time later in the afternoon to begin to do that.

I have Roda Grey helping me. I scribbled out some drawings because a picture is worth a thousand words, and I want to refer to them as I attempt to deliver something in 10 minutes that I would like to take about three hours to share with you.

What I have discovered as an educator of indigenous background is that it is very important to understand what the big picture is before we attempt to begin to make meaning out of the details -- very, very important. I discovered as a learner in the educational system that most teachers don't present you with the big picture; they present you with the details. I always found it a bit of a challenge trying to figure out, "Why is the teacher talking about this now when we are supposed to be dealing with something else?" but later discovered that it all fit together into a big picture.

What I have done there is trace from a

historical perspective -- this is a similar diagram to the one I did in the paper. The main point here is that, as Elders have taught most of us, if we don't know where we've been, we don't know where we're going. Our friend from Kahnawake talked about planning this morning and the importance of planning.

Traditional teachings, as I understand them, help us to begin to recognize that talking about the past, present and future are really very arbitrary kinds of distinctions. If we can look at things as a continuum, if we look at the importance of inter-generational teachings, for example, there is a very strong continuum. What has happened in our history is that there has have been tremendous forces applied to our lives as collectives of indigenous communities which have been trying to disjoin, to break down, to discontinue that flow of continuity.

I think the challenge facing us is what I have drawn at the bottom of the diagram, and it is this: As traditional communities, which consisted primarily of extended family units, we were both the agent and the client. We looked after our own needs. They were one and the same, and people fulfilled certain kinds of roles and responsibilities that made it possible for us not only

to survive but to grow and develop.

What has happened over the last 100 years or so is that there has been a tremendous breakdown which has resulted in the separation of the agency from the client. What we have today are external orders of government, the first and second orders of government, the federal and provincial levels, who in fact are making most of the decisions, as you have heard many times over the last day and a half -- most of the decisions about the programs and services that they think we need.

What I see us striving to do is to bring together again the agency and the client, to the best of our ability. I thought the example given by the speaker from Toronto, who is with the clinic there, provided some wonderful examples of strategies they have employed to begin to demonstrate the importance of bringing together that agency and client.

When I look at the papers that have been written and discussions regarding self-government of indigenous nations in this country, what I think they are really talking about is the importance of bringing those two functions together. The challenge, then, is to figure out how we can do that.

What I have at the top here, called

"Reciprocal Interaction" is a strategy, I think, that must be employed in order to succeed in bringing together the two functions of being agency and client. This is where we have a lot of frustration.

Since about 1967 we have been subjected to what is called "consultation", started by the Liberal government. I sat through a number of those meetings, and what I saw was a one-way process. It wasn't even a process; it was a one-way exchange of information. It was us telling the government what we wanted in terms of changes to the Indian Act and in terms of what we saw as being the needs, but there was no reciprocal interaction. The government did not have agents doing the consultation who would sit with us and explore our thoughts and our feelings about what it was we were saying and what it was they were thinking about what we were saying.

If that process is not undertaken, there will be no change in terms of level of understanding. There will be no greater working knowledge, which is necessary to begin to identify and describe the strategies that are necessary to bring the outcomes or the results that we are working toward.

I am very concerned that we have our own organizations doing something similar. Now it is them

coming to us and saying, "What do you want; what do you need?" We are at a meeting like this -- and this is a very good example of a meeting where there really isn't much time for reciprocal interaction. So you are going to leave with whatever you think I am sharing with you without having a chance to check with me and giving me the chance to elaborate further on what it is you are thinking I am thinking about someone else's thoughts. That process is very, very important.

I just did some work in Fort MacPherson, and one of the things that some of the speakers said there and that came up this morning is that we, as parents, do that to our own children. We, as Chiefs and Council members of our Bands, do that to our own Band members. We don't give them the opportunity to pose questions, to share their thinking, and to share their feelings about the things that are going on. A 12-year-old's perception of reality is very different from a 35-year-old's. Someone who is 70 years old has a very different perception of that reality compared to that 35-year-old and the 12-year-old.

Why is it we don't take the time to begin to interact in ways that will result in increased awareness, understanding and knowledge? It is only

through that process, as I see it, that real change is going to come about. It is only through that process that we are going to begin to better define alternative strategies to deal with very critical issues.

We can apply that top model to relationships between parent and child, between brother and sister, between husband and wife, between Chief Councillor and Band Manager. Any human interaction process can be characterized in that way.

What we have struggled to do -- and I a former Chief and I have worked as a Band Manager for many years. What we have struggled to do with the Department of Indian Affairs is to get into a reciprocal interactive process, and then it is resisted like crazy.

I think it was well-demonstrated in the first panel this morning, where we had our friend from Alkali Lake being quite emotional about the things that concern him, and his colleague from northern Quebec who was very cerebral; he was very, very cognitive; he was very cool and he was calm and he was collected, and he reported things. As I listened to him, I had a hard time figuring out who that person really was in that uniform, but I had a good sense of who our friend from Alkali Lake was because of the way in which he communicated.

I would like to have seen some interaction between the two of them. Would that interaction have resulted in greater understanding, or would it have resulted in greater frustration?

I think that, in a sense, models a major problem in terms of our relationships with people from the outside, in particular the representatives of the first and second orders of government, the federal and provincial governments.

If you look at the old, unworkable model, the way I see it, thanks to teachings that I learned from having studied with Paulo Freire, is that, when we assume the role of expert -- and I am concerned that our Chairman uses that label. I know he has no ill-intent in using it, but I do have problems with it. If we are serious about finding solutions together, then no one is more expert than the other person. That means that our relationship should be characterized by respect, which means that we truly value one another's life experiences -- all the things we have learned for as long as we have lived.

Through that respect, which is the essence of sharing a traditional cultural value that is still very strong in our societies, we would begin to create

the kind of understanding that will result in some creative alternatives for addressing very serious problems.

When we look at that old model, then, if someone assumes they are expert, they are treating the other party as being an empty head. It doesn't matter what that person feels or thinks. Isn't that what many of the women in our communities have said? Isn't that what many of our children will say in terms of how they are treated in our communities and even treated within our families: It doesn't matter what we think. We try, but no one listens. No one hears us.

I think if were to pay much closer attention to what people with less experience or with a lot more experience are attempting to share with us as workers and leaders and so on, I think we would begin to learn some very, very important things. It is this on which we must first model change ourselves. Once we know what that change is, we can better appreciate what it is that the people we are working with and wanting change, are in fact going through. I think that is very, very important.

The old model maintains the status quo. Things stay as they are. There is no personal or social change. It applies within our communities and certainly

applies, as I said, in relations between our leaders within our communities and leaders of government agencies outside, as well as local governments or municipal governments, and it also takes place within families.

I think that is where the new strategy really has to focus, and that is why I think many of the speakers today, for example, have been stressing the importance of having resources that make it possible to undertake education and training which better prepares and equips those workers not only to heal themselves but to undergo personal growth experiences. Only with those first two conditions fulfilled satisfactorily can those people create the cognitive knowledge which is necessary as working tools to carry out whatever the challenges are.

Just quickly on the information wheel, what we have learned over the years is not our perceptions of our reality as descendants of the original people, but what we have been subjected to over and over again are the outsiders' perceptions of us. When you study Canadian history, what do you learn about us and our forefathers? There are efforts being made to change that, but it is extremely difficult to create the curriculum necessary to help us begin to feel much more positive about what we have been and what we are and what we can become as

long as we don't have the research to produce the documentation and the stories and the drawings and whatever else is necessary for us, in terms of the present generation, being able to clearly appreciate what it was our people saw when those immigrants started coming to this land. We don't have the benefit of that.

But we certainly have the benefit of what some of those immigrants thought about the Iroquois and other First Nations people of this country. That is the reason I share this particular drawing. Again, regarding how we communicate, I really think there is a major difference in the sense that we are more holistic because communication is something more than just the words that we are able to project, based on what our brain is telling us; we are very sensitive to what our heart is telling us as well, and our spiritual self as well as our physical self.

I think there really needs to be much greater appreciation of our respective strengths. If we all were to grow and develop holistically, we shouldn't have any trouble interacting and being emotional or cognitive or spiritual. I am concerned that many people on the outside tend to become afraid when they are interacting with us and we tend to become emotional about

what it is we are addressing.

This model is a really important one in terms of where it is we are at. It is a model which stresses the tremendous significance of personal life experience. That which we know best is what we have experienced.

If we are going to work together to create change, then it is important that we have the ability to interact and genuinely communicate so that, in fact, each of us are able to better integrate new information, which may have to do with thoughts or feelings or perceptions, whatever it might be. Again, that takes time.

Another main point here is that each of us creates our own knowledge. We can't give one another knowledge. Although that which I was exposed to as a student in the educational system was the very opposite: the teacher was the expert, and I had to learn what the teacher told me. If I learned it well, I got 100 per cent -- and I was that kind of student. But when I got to university, I thought, "My goodness, learning how to learn is far more important than memorizing information." This model is very much oriented toward learning how to learn.

When we talk about the need for

concentrating on the needs of infants and children in regard to preparing them to learn how to learn, to be able to maximize their life experience by the time they get into the school or pre-school, then we are talking about a tremendous need because of that culture devaluation process that we have suffered for the last 100 years.

A final point regarding culture. I am always concerned when I hear people of our communities saying, "We have lost our culture. We don't have a history," and culture being identified with sweat lodges and with various kinds of ceremonies, and so on, and not being seen as encapsulating every decision we make each day as well as every decision we choose not to make. Culture is dynamic. It's living. It means we are moving forward if we have some functionality in our lives.

My concern is that we have been taught the opposite, again through the perceptions of those who are outsiders looking in, very often outsiders who didn't understand the abstract nature of culture. They could only address the concrete aspects of our cultures.

My belief is this: Each of us, as workers and leaders today, should strive to become as well as we can in a holistic sense. In fact, we have the best opportunity to enrich the transmission of culture to the

next generation and to generations thereafter.

Therefore, I fully support what has been said so far with regard to the importance of healing, which includes grieving, dealing with those issues which, in a sense, run our lives for us and are related to alcoholism and various other kinds of problem, and, following that, being able to experience personal growth, education and training that help us to get to know our inner lives. The western world around us seems to pay very little attention to the importance of that inner world or that inner environment. Their emphasis is on the world around us, the external environment. Again, I think there is little need for me to elaborate on that because of the kinds of examples we have had in the presentations this morning.

What about models? I think what is important is that the models that we attempt to employ are models that are going to make it possible for us to interact in reciprocal ways so that we expand our experience and, through expanding the experience, in fact to begin to find alternative ways to bring health and wellness to our communities.

I think sometimes we are misled when we want to look for solutions. What we are dealing with is

a brand new area in terms of human experience that requires healing and wellness. If we can look at alternative ways that are based upon some vision that we have for our future, I think we will be much more successful in eventually finding the answers that we need to health and social issues in our lives, not only as Native people but other human beings of the world.

Thank you.

DR. JAY WORTMAN: Thank you very much, Bill.

Our final speaker for this panel will be Alma Favel-King. Alma will be presenting Discussion Paper G which is in your materials, which deals with: How will community control of services and the recognition of treaty rights to health affect holistic strategies to maintain and restore health?

Alma comes from Saskatchewan where she works with the Federation of Saskatchewan Indian Nations, where she is the Executive Director of their Health and Social Development portfolio. I enjoy my visits to Saskatchewan where I occasionally run into Alma. We crossed paths just this last week, although I missed you while I was there.

Please welcome Alma.

ALMA FAVEL-KING: Good afternoon, members of the Royal Commission, Elders, ladies and gentlemen.

Before I begin, I would like to acknowledge one very special person who has been part of our Commission ever since I got involved with the FSIN. Chief Scott, Chief of the Kinistin(PH) Band is here with me to provide me some moral support, and I want to publicly thank him for that. He is shy; he has his head down.

First of all, as Dr. Wortman mentioned, I am with the FSIN Health and Social Development Commission. I have been involved in health and social issues, working either with or for First Nations people in my home province, since 1971. I don't profess to be an expert in treaty issues, but I would like to give some points in this Round Table discussion.

I was very humble and pleased when the Commission approached us to prepare the discussion paper on the Treaty Right to Health. Where I come from, treaties are an important part of our lives, and we try to maintain our rights to a number of treaty promises as best we can.

The question in the discussions with the Commission was to prepare a discussion paper on how the federal government transfer process, enabling community

control of health services and the recognition of treaty rights to health, may impact on the future health status of First Nations people. That was one question. The second question was: Will the process facilitate a holistic approach to health maintenance, and how will this be achieved, and how will the role of the federal and provincial health agencies change?

Looking at those questions and the fact that the treaty right to health has not been recognized or practised by the federal government or the provincial government, we wanted to bring some light from our perspective of the difficulties in First Nations asserting their rights to health services under the treaty-making process, and that is how we tried to define it within the context of the paper.

We have been told by our Elders, our grandfathers and a lot of people around us, that our forefathers entered into a treaty-making process to ensure the long-term survival of First Nations people. That was one of the reasons why there was the movement in getting a treaty right to health recognized.

Part of the difficulty, I think, is probably with the translators 100 years ago. There is no word in my language, Cree, which says this is what health

is. We talk about (native language) which means a state of well-being. I think part of how that got translated into the Treaty 6 is probably from the health practices 100 years ago where they talk about a medicine chest. That is primarily, I think, where the definition of the treaty right to health becomes really cumbersome and hard to come up with a common definition.

Again looking into the historical perspective, Indian Affairs used to maintain all responsibilities for all services for First Nations people. In the 1940s the responsibility for health services was transferred to Medical Services. I think it is fair to say that the transfer occurred without any recognition of treaty rights and how we access those rights.

Within the Indian Affairs system, though, they retained some portions of services that have a direct impact on health status and health indicators. I don't really need to go into this. All of us who are First Nations who have worked at the Band or Tribal Council level or even at the regional level are all aware of those. Such things as water and sewer systems are not part of the Medical Services budget. Those have a direct impact on health status. They are administered under Indian

Affairs under different guidelines, under a different formula, and I don't think there have been ideal working conditions between the two departments up to this point.

That is on a service level. When you talk about treaty rights -- and we have been trying to get some movement in getting a treaty right to health recognized within our province, and we have been tossed back and forth between Indian Affairs and Medical Services. In my paper I quote a letter that we received within the Federation from Medical Services, and I would like to take this opportunity to quote that:

"-- the responsibility for discussing treaties on behalf of the federal government resides with DIAND. Where DIAND has received a mandate to discuss treaty matters with First Nations, and if the treaty matters to be discussed include health, the Department of National Health and Welfare, through MSB, will participate in that substantive discussion. MSB participation will be subject to the overall DIAND mandate and framework for

treaty discussions."

Up to this point, I am not aware of any one instance where Medical Services and the Department of Indian Affairs have agreed to sit down together to resolve the treaty right to health issue.

Within the Medical Services programs, there was some mention this morning of transfer of the Indian health policy, so I won't take time to go into those issues. However, the short-term evaluation of the Indian health transfer, which was just completed last year -- and I quote from the paper:

"-- people involved with transfer repeatedly point out ... the lack of recognition of Treaty Rights to Health."

That was consistent throughout the evaluation process of the transfer projects.

What we have been finding in our own experience is that our treaty rights to health are being defined by federal policies, where you are restricted to your non-insured health benefits, you are restricted to a number of -- eyeglasses, for instance, once every, I forget how many years.

We had one instance where we had a 95-year-old person who lost his hearing aid. When we asked

for a replacement, we were told he had to wait five years until his five years were up. That's fine, but he might not be alive in five years to enjoy what he thinks his forefathers agreed to as a treaty right. Those are just some examples of the kind of difficulties First Nations people have in having the federal government recognize its obligation for the treaty right to health.

Not only are our treaty rights being defined by the federal government; there is also downsizing occurring between Indian Affairs and Medical Services, who are supposed to be there for our best interests or to keep our interests at hand. They are downsizing. The people who are there purportedly to serve are the ones who suffer the brunt of all the reorganization within the federal system.

Part of the process in terms of having the treaty right to health recognized, I think, is in coming up with a common definition of "health." We heard discussions yesterday and today about First Nations' perception of what health is, and health being more than just the absence of disease but, rather, the whole body, mind, physical, emotional and spiritual harmony.

Medical Services up to this point has delivered a purely western European medical model of

health. There have been some changes from First Nations who have taken the transfer initiative in terms of redefining what their priorities were, based on their understanding, but up to this point most of the delivery has been from a foreign definition of "health."

We heard through other presentations the present conditions in our First Nations communities, and I am not going to spend a lot of time on that. However, given the fact that our health status is far below that of the other population and a ping pong approach is being used by the federal government with respect to responsibility for the treaty right, we have a number of recommendations for the Commission to consider.

First, the recognition of the right to self-government.

Second, the Constitution Act, 1981 was declared which reaffirmed treaty and Aboriginal rights. There has not been any visible movement on the part of the federal government to provide the leadership to do some work in recognizing that they have a treaty obligation to health services.

Third -- and Jean Goodwill mentioned this yesterday. Indian Affairs and Medical Services and other agencies who have services for First Nations are

all operating separately. Part of the solution, I think, might be to have all those programs and services under one umbrella.

Fourth, an office of the Federal Treaty Commissioner or Treaty Ombudsman be established which would monitor and be a watchdog over how the federal government meets its treaty obligations to First Nations.

The recognition of the right to self-government -- and we went on to describe what the impact of those recommendations would be. With the history of the past several months and with the constitutional debate, I interpreted the results that the Canadian population in general did not have any difficulty with First Nations' aspirations to self-government. I am not a lawyer, but I think there are ways to achieve self-government with a constitutional process.

Self-government at the First Nations level would provide the First Nations with some law-making authority, some powers to pass legislation, and how their healing process could begin and some standards.

The one area that I really want to stress is the reorganization of the federal government. People always talk about how much this is going to cost us, and I think the resources exist within a number of systems.

In order to facilitate community healing in a holistic way that we have been talking about, I think the federal government has to restructure itself in a holistic way as well.

We have some instances where, if you are looking at adult care, you go to Indian Affairs, you go to Medical Services, you go to Manpower for training. You spend so much time running around that it gets so cumbersome.

Part of the benefits from having one federal department having responsibility for Indian services would be that the lower administrative costs could be channelled back into the First Nations communities. Each of the departments have their own administrative structures, they have their own policies, they have their ADMs, they have their RDGs, RDs and all the initials in the alphabet, and the benefits of all those things are not felt by the people at the local level.

The establishment of a federal Treaty Ombudsman or a Treaty Commissioner, I think, is important to ensure that the federal government abides by its respective responsibilities around a common understanding and a treaty understanding of the delivery of services to First Nations people.

The recognition of the treaty right to health and the development of legislation and jurisdictions within a self-government framework and the co-ordination of federal government activities are essential if First Nations are to truly address health and social issues in a manner which is responsive, culturally appropriate and acceptable to First Nations consumers. Only if the health and social approaches are integrated, community-based and multifaceted and respect the inherent rights of our First Nations will the health status improve and wellness be achieved.

Thank you very much.

DR. JAY WORTMAN: Thank you very much.

You will recall that yesterday during the Elders' Panel one of the Elders made what I considered a very sage comment, that it is absurd to ask someone to compress what has taken a lifetime to learn into 15 minutes. I would like to commend our panel of speakers for compressing a lot of knowledge and expertise into a very short time, thus allowing us an opportunity to entertain some questions.

We will open up the floor for questions. You may direct questions to any of our panel members,

including Simon Reed who spoke to us from the panel this morning.

I will just remind you that we like you to keep your questions brief and focused on the issues that were discussed in these particular papers. I am also asked to encourage people who haven't yet spoken at the microphones to please feel free to do so. We want to hear the input of everyone here, obviously. There are some time constraints, but we will try to favour those who haven't had an opportunity to speak yet.

Bill Mussell would like to make an additional comment.

WILLIAM MUSSELL: I neglected a very important responsibility, and that was to share with you my thoughts about what self-management is. I knew, as I was leaving, there was something I left out, and I promised Marie Bergeron that I would address that.

I personally like the notion of self-management. I actually found a definition for it in the Webster's Unabridged Dictionary. It says: "such persons collectively regarded as a distinct social group with special interests, characteristics" -- and I add "purpose." So there is a definition for that.

I like the notion of self-management

because what it suggests to me and to many of my students I have worked with is that, when we consider aspirations for self-government, it is very important that we, as individuals and families, have the knowledge and ability to manage our own lives, to make our own decisions in ways which really show that we are making our own history. Others are not making our history for us.

What I see as preceding that in the process of becoming self-governing is the importance of having the ability to interact in ways that are characterized by the word "co-reliance." If individuals in a family can rely upon one another as responsible human beings, in terms of fulfilling the various duties and responsibilities, that family will not have any difficulty surviving and growing.

I think that is critical, particularly given the common characteristic that we all share as indigenous peoples, and that is that sharing is valued. Sharing really means being able to give and receive in an interactive fashion. It is not just giving. It is giving and receiving, and that can be applied to many different levels.

A major problem that we have today, as we have identified, is passive dependence. We are afraid

to make decisions. We are afraid to share what we think and what we feel. Many of us, as adults, have those fears, and certainly many children do.

When we have that kind of fear, we permit someone else to control us. Someone else is running our lives for us.

So the notion, then, of self-management, I think, is a very useful one because it can be applied to individuals, families, other social groups and communities of people. I think, if we are able to know that as the majority of families in a community, we really would have no difficulty being self-managing or self-governing. Being self-governing is really the point I want to make.

That completes my responsibility, Jay. Thank you.

DR. JAY WORTMAN: Thank you very much.

It appears that you have exhausted your questions and comments at this point of the day. I sort of feel like the auctioneer; when I go to bang the hammer the last time, it may spur another bid.

We have somebody at Microphone No. 2.

HARRIET KUHNLEIN: Harriet Kuhnlein

from the McGill Centre for Nutrition and the Environment of Indigenous Peoples.

I would like to put a question forward to the panel, in particular to Mr. Bill Mussell. I would like to reiterate a bit from what Dr. Isaac Sobol said yesterday so eloquently, when he asked several questions concerning the will that exists amongst Aboriginal communities for the documentation of traditional medicines.

What I would like to do is to extend that to the question of the documentation of Aboriginal traditional food systems and, further, to look at the documentation and research on how people feel that these food systems can be used for health promotion and the stimulation of cultural pride and self-identity and all those things that are important for holistic health promotion and, in particular, for the link that people have with their environment.

I find that there has been very little discussion related to the relationship that people still have, or want to have, with the land, and traditional food systems clearly fit into this picture. Is the reason why this discussion isn't so great around these few days because it is not so important any more, or is it because

the people who are represented here don't have that relationship any longer?

I also want to ask the question as to whether maybe this is becoming more of a women's issue, the provision of food to families and the fact that maybe the men are no longer so involved in a relationship with the land and the providing of traditional foods. For example, someone in the corridor this morning was telling me that they have a hard time convincing the men to stop playing golf and going to find their traditional foods by way of hunting or fishing.

Also, further to Annie's comment yesterday in response to my presentation about having a hard time getting the men to bring the seal and so forth into the hospital, my question is really: This kind of documentation or recording of knowledge is really not very difficult to do. It's a matter of finding out what people still use, why and how much, and where to find it and at what season of the year. Some work is probably still needed on the chemical composition of these foods, and certainly the technology for that is available -- how people feel about the foods and appreciate their taste and, most important, how this knowledge can be used for holistic health promotion.

From the panel and from other participants perhaps, is the will there to do this kind of documentation? If it is the case that it is there, then I put the suggestion forward to the Commission that there be some recommendation for funding to be in place so that communities can take up this activity as they wish to take it up.

DR. JAY WORTMAN: Thank you for your question. I will direct it first to the panel members. Does anyone here want to make a comment in response to that?

WILLIAM MUSSELL: I will kick off the response.

Perhaps the importance of the land, which really is the culture, has not been addressed as we kind of assume that it is understood, that it is a truism. Again, because we are not all of a similar culture, it is an oversight, at least on my part, for not bringing it into my summary.

We made a film in B.C. about 25 years ago called "The Land is the Culture." What that film did for a number of people was to begin to see very clearly that our identity is anchored in that land.

When you look at the names of the

cultural groups, the traditional names in our own languages, you will discover that those names are directly related to the land and the features of the land. My group is called Sto:lo, meaning people of the river. We live along the Fraser River, and it has a great deal to do with that land and, therefore, the importance of preserving that land -- not in terms of the laws that are very much based upon individualism, but based upon the fact that we in fact are the keepers of the land for future generations. That is still a very powerful value, and it is one that is very, very different from the western way of perceiving land and the importance of land.

I am concerned that people buy and sell land all the time. If they destroy the community around Chilliwack, they don't live there; it's not home to them, and they will move somewhere else.

But we are not a transient people. There have been many relocations attempted and have very seriously failed. I think it is because home is that home territory; it is where our ancestors are in terms of the sacred places they are buried, and that kind of thing.

It is still a powerful value, although I must mention this: There are gradually increasing numbers of people in our bands who are buying into the

values I identify with individualism, who would love to be able to own the land and sell it or exploit it in terms of gravel pits and mining and garbage dumps, and so on. But those who are into that are very, very small in number.

DR. JAY WORTMAN: Thank you, Bill.

Because we do have other speakers lined up -- and I know you extended your question to the participants -- I would suggest that further comment could be made during the Plenary Session at the end of the afternoon, if there are participants who want to respond to that question.

We will go now to Microphone 3.

DR. ED CONNORS: My question is directed to Bill, as well as to the first speaker.

In light of the last comments you made, Bill, regarding self-government and self-management and the first speaker's comments regarding the position of your community with respect to dealing with abuses within the community, I would like to make reference to Professor LaRocque's paper and her position. I think I am reading it correctly, but I may be wrong and I would need to check with her. I think I am reading her as saying that the way to deal with the cycle of violence within our communities is to increase the severity of punishment that

is doled out by the larger society -- in other words, to make the punishments for sexual abuse crimes and other crimes of violence more severe -- and that we should, in a sense, leave it to that system of corrections and justice to deal with the cycle of violence within our communities in that manner.

I think she also implied that the attempts by communities such as Hollow Water to develop a community response and a community approach perhaps may not be very effective. I don't think she says it is not effective, but certainly raises a number of questions about the degree of effectiveness of the communities' efforts to break the cycle of violence.

I would be interested in your comments regarding that position.

DR. JAY WORTMAN: We are running close to the end of our allotted time which has been shifted ahead. What I will do is declare that the last question and allow the panel to respond and remind the other speakers that there are opportunities after the break to ask further questions.

Panel members, please respond to the question.

SIMON REED: To respond to that, I think

I will reply to the previous question as well.

The Nu Chah Nulth understanding of wellness is embodied in the term "flemuxti", and that captures emotional, spiritual, physical, mental health, the things that are often talked about. But the other important aspect of it is the context, and that includes both the environment, the natural resources on which all life depends, and also an individual's position in the family. That position in the family is vital to their identity as a person and as a community.

If the post could be set aside and we could say that all the abuse that happened yesterday and in the years before, that there could be an amnesty against criminal trial of that type of thing, then perhaps now turning to that justice system would have a hope of working. But there is so much abuse still hidden in the communities, still secret, and if affects so many individuals, either directly or because their immediate relatives are affected, that the consequence of taking that into the criminal justice system now is to rip apart entire families and, ultimately, the basis of the communities.

So the only solution which has a hope of working is one which recognizes that structure in the communities. I am not saying we have the answers to that

yet, but if that is the goal, then we have to work within the communities to create that climate, not through the external justice system.

DR. JAY WORTMAN: Thank you, Simon. Bill has the final comment.

WILLIAM MUSSELL: I agree with Simon's comments. The justice system on the outside doesn't work for non-Native people; why should it work for us when we are culturally different? Because we are still very much anchored in the family as a primary institution, I think it is very important that we do everything we can to work through the strengths of the family and to build the strengths of the family at whatever time we can.

One of the ways of building it, as I see it, is to find alternative ways of helping people who express themselves through sexual abuse to become a positive contributing member of that family system. We have not given those alternatives ways a fair testing.

When we do and when we begin to re-establish the norms that are necessary to be able to police and monitor our own behaviours as families and relatives and so on, I think we will be very successful in doing it. We are still communities, much more than the societies around us.

So I am quite hopeful that we are going to be successful in finding those strategies.

DR. JAY WORTMAN: Thank you. I am going to bring this session to a close. We have a break at this point, and we are much beyond our scheduled time. There will be another opportunity for participants to ask questions and direct comments after the break.

I am sorry, I have to close the session now. I am going to turn you over to our Chairman, Dr. Louis Montour.

DR. LOUIS T. MONTOUR: I would like to thank Dr. Jay Wortman, Mr. Simon Reed, Kim Scott, Bill Mussell and Alma Favel-King for their participation.

I would like to declare a 10-minute recess, for a short 10 minutes, and then we will reconvene. I will ask the participants in the Round Table to please come back to the Round Table immediately as you come back from the break.

Thank you.

--- Short Recess at 3:30 p.m.

--- Upon resuming at 3:45 p.m.

DR. LOUIS T. MONTOUR: Our next item of business is our second Round Table discussion on fundamental questions.

Before I go on, the young lady who wanted to address us at the end of last session, Cecilia Weiss, is from the Squamish Nation. She wished to give us a message from her Native sisters that a survivor of the Koordair(PH) Residential School in the Yukon died this morning of HIV. He was not in favour of continuing the cycle of abuse he and others suffered at that residential school.

Thank you.

I will turn it over to our moderator, Mr. Alwyn Morris.

ALWYN MORRIS: Thank you, Louis T.

Just some housekeeping before we go on. We have a francophone who is sitting at our table here, so I would urge that the audience go and get their translation machines.

What I will do is follow in the footsteps of yesterday's Round Table and basically let the participants introduce themselves. If we can keep the introductions relatively short, we can get into the discussions. I will read the question after you have done your introductions, to spur on some discussion based on the question.

With that, I will start in my Iroquisan

way to my left-hand side and follow the sun.

RICHARD JOCK: I am Richard Jock. I am Director of the First Nation Health Commission. I am Mohawk from Akwasasne.

SHEILA GENAILLE: I am Sheila Genaille, President of the Métis National Council of Women. I am a Métis from Edmonton, Alberta.

JUDY MOSES: Judy Moses. I am Cree from James Bay. I work with the provincial government's Ministry of Health as Director of Aboriginal Services in the Alcohol and Drug Program.

STEPHEN CHASE: I am Stephen Chase. I am with New Brunswick Department of Health. My involvement is federal-provincial and Native relations.

RON GEORGE: I am Ron George, President of the Native Council of Canada.

HUGUETTE SAUVAGEAU: I am Huguette Sauvageau from the Ministry of Health and Social Services in Quebec. I am a nurse, and I work as liaison with the Native community.

MARIE FORTIER: I am Marie Fortier, Acting Assistant Deputy Minister for Medical Services Branch, Health and Welfare Canada.

MICHAEL SIMS: I am Mike Sims. I am the

Director General of Program Policy for Indian Affairs.

JANE GOTTFRIEDSON: I am Jane Gottfriedson from the Okanagan Similkameen Nation. I am President for the Aboriginal Women's Council and B.C. Native Women's Society.

LOU DEMERAIS: Good afternoon. My name is Lou Demerais. I am the Executive Director of the Vancouver Native Health Society.

DR. MARLYN COX: Good afternoon. I am Marlyn Cox. I am a family physician from Cross Lake, Manitoba. I am a Cree from Grand Rapids First Nation.

DR. CATHERINE COOK: Good afternoon. I am Catherine Cook, Métis from Manitoba. I am a family physician with the University of Manitoba, and I work with a fly-in physician in some nursing stations in northern Manitoba.

DAVID NEWHOUSE: My name is David Newhouse. I am an Onondaga from Six Nations. I am a professor in the Department of Native Studies at Trent University and I serve as the Chair of the Joint National Committee on Aboriginal AIDS Education & Prevention.

PATRICK JOHNSTON: I am Patrick Johnston from the Canadian Council on Social Development in Ottawa.

ALWYN MORRIS: Thank you very much. I will read the question, and then I open the floor to participants.

Aboriginal communities and individuals are assuming greater responsibility for health. What policies can facilitate that process? What are the recommendations for implementing a holistic strategy?

With that, participants, the floor is yours.

JANE GOTTFRIEDSON: First, I would like to welcome all of you to B.C., especially to this beautiful valley in the Vancouver area. I would like to let you know that also with me in the audience are members of the Aboriginal Women's Council who are the Professional Native Women's Association, the Aboriginal Women's Council, the B.C. Native Women's Society and Urban Images for Native Indian Women.

We had prepared a short presentation for you.

I will do my best to tell you what we, as Aboriginal women, are doing to resolve the issues you are interested in. I hope that in my voice you can hear our Aboriginal women, youth, Elders and men, that you will see in our creation of organizations, in our scrappling

together of the few resources available, how we work on a daily basis to improve our social and economic conditions, finding for our recommendations what we need for today and tomorrow.

Our organizations have been established by grassroots Aboriginal women. Each is mandated and controlled by the grassroots.

The solutions we have designed reflect the direction of our memberships. Here are some examples of our work.

The Professional Native Women's Association does advanced healing training workshops. The fundamental purpose is to train people in healing, and these people, in turn, train others in healing. In this fashion, the healing knowledge is passed through the Aboriginal population and on to future generations.

The healing traditions that were greatly reduced by the residential school system are now being revived and, in fact, used to heal the survivors of the residential schools.

The Aboriginal Women's Council have the responsibility of being the umbrella group for the Aboriginal women's organizations of B.C. The Aboriginal Women's Council is developing a lay counsellors handbook

for distribution to individuals throughout B.C. This handbook will contain basic information that will empower the concerned or caring family members to address situations of family violence, alcoholism, substance abuse, AIDS, et cetera.

As a preventive measure or until professional help becomes available, by information and self-education, we hope to empower individuals to help themselves, families or friends. This is necessary because there is simply not sufficient available professional or other resources to meet the needs of Aboriginal peoples.

The B.C. Native Women's Society has been in existence for 23 years. For the past 14 years a program titled "Native Outreach for Women" has been operating. Clients have received employment, education and training services. The project has made a great difference in the labour market through sensitizations of non-Native employers and through the visibility and public relations.

We have also been involved in the literacy program which offers basic skills to students with approximately Grade 2. This work is very involved, and we continually will work with grassroots people on and off the reserve.

The Urban Images for Aboriginal People, previously termed Urban Images for Native Women, has for over eight years provided training for the severely employed disadvantaged. Urban Images has expanded its training from a focus on Aboriginal women to a holistic program of the family.

Preparing Aboriginal people for employment is not teaching computer skills. It involves preparation of the person holistically, their mental, spiritual, physical and emotional well-being.

These are examples of work that we do today. The Aboriginal members of our organizations and friends have worked countless hours, many times under trying circumstances, to help each other and to rebuild our people. The challenges that face our people are very grave, as in our long history of struggle. We cannot ease our work; if we do, then the terrible statistics of mounting numbers of suicides, family violence, substance abuse and social and cultural destructions will grow even larger.

To lead the world in numbers of suicides of people is an unacceptable situation for any people, as are the other deplorable statistics attached to us as Aboriginal peoples. If Canada is serious about helping us, then here are our recommendations:

1. The lasting solutions can only be developed by adequate levels of financial resources under the control of Aboriginal peoples. 2. The Aboriginal peoples be hired to help Aboriginal people in the development of the needed federal legislative policies, budget estimates, Treasury Board minutes, programs and systems, to ensure adequate financial resources reach the grassroots people who need it the most.

Aboriginal people must have direct input at the highest decision-making levels to ensure that Aboriginal health issues are addressed. Without Aboriginal involvement, the issues and problems that exist today will increase and continue tomorrow.

3. To incorporate and implement into the government programs the Aboriginal philosophies, principles, practices and culture that ensure holistic approaches are taken to address issues.

4. To seek out and remove the foundation of thought that created the 1969 white paper policy that crystallized aggressive policies to eliminate Aboriginal peoples as distinct peoples under the cloak of a Nielsen Task Force Report.

5. Change the policies related to Indian self-government that currently means transfer of

government responsibility but with no resources to Aboriginal people.

6. Address the longstanding issue of specific and comprehensive claims with separate and new allocation of funds. Do not continue the current practice of transferring the funds from programs for health, education and economic development.

7. To develop two-year budget estimates with Aboriginal involvement and agreement from the grassroots level to tribal level, regional level to national budget total. Involve and have Aboriginal approval of one-year budget adjustments and annual targets sent to Ottawa. Involve Aboriginal people in the allocational decisions after budgets are set and through the Throne Speech.

8. Establish the data bases used for budget projections, using actual Aboriginal needs at the community levels.

9. Funds, programs and resources allocated for Aboriginal people must be increased and accessible by Aboriginal people, both on and off reserve.

10. The current policies, programs and funds must be changed to reflect the following:

(i) the population growth of the

Aboriginal community; and

(ii) the cost of living increases; and

(iii) the reality that the massive multi-generational and widespread destruction by the residential school require unique and distinctive solutions that cost money to resolve.

Thank you.

ALWYN MORRIS: Thank you, Jane.

We have 14 people sitting at our table here, so we would like to keep our comments related to the discussion.

RON GEORGE: Thank you, Mr. Chairman. I would like to say hello to all the Elders and special guests and everyone I have been able to meet. At least the Royal Commission affords us a chance to visit and meet new people.

The issues I would like to bring forward in answer to the two questions in the discussion we are having -- the answer for the Native Council of Canada in regard to how to facilitate the responsibility for Native health is obviously to have enabling legislation, short of constitutional change which is something that we didn't succeed with on October 26. What the Native Council of Canada is proposing, especially for off-reserve groups,

is legislation which we call Authorities Recognition Act.

There are numbers of authorities off-reserve dealing with health, but, at best, they are all ad hoc. There is no clear policy in any government, be it federal or provincial, as to who would bear the responsibility for people living off-reserve. It has been mentioned already here today, but it bears repeating: The Community Futures Program, which has $170 million allocated for Aboriginal children, is being used strictly for on-reserve children now. It should be noted that the statistics used to arrive at this $170 million were derived from all Aboriginal children, whether they were on or off-reserve, but now they are only being applied to on-reserve.

The response we get from Mr. Bouchard's department is that they are working on protocol arrangements between the federal and provincial governments in relation to off-reserve interests for the children under Community Futures.

This, following on the heels of the Charlottetown Agreement where we agreed that the three equal access clauses for off-reserve people to their self-government rights to negotiate their own agreements, equal access to Aboriginal and treaty rights, and equal

access to treaty renovations, doesn't really follow along the spirit and intent of that agreement when the Health Department is negotiating with the provinces without any discussion with off-reserve groups at all.

That would be our first recommendation. Self-government means exactly what those words supposedly tell us. Off-reserve people are the ones who would best be able to design programs that are pertinent to their needs. I say off-reserve because there have been enough people advocating self-government for on-reserve at this meeting, and very little has been stated for two-thirds of the Aboriginal population of this country. The 1991 census says that two-thirds of the Aboriginal population live off-reserve; yet, we are the ones who have no policies that delineate any government's responsibility.

Obviously, our first choice would be to have constitutional recognition of off-reserve authorities, but in the interim, given the political climate and the leadership conventions that we are dealing with, we would urge an official Authorities Recognition Act to cover off the policies and the cracks in those policies through which our membership continually fall.

There is much more I could say about that, but to give other people a chance I would like to

refer to the holistic strategy.

The one thing I learned from the Charlottetown process was that there is very little in this Aboriginal movement that can happen without the involvement of women. We heard that message loud and clear, and I don't think we can continue to disregard that message. There has to be a concerted effort for political groups to make way for women to have a voice. I speak from the office of my hereditary chieftainship. I am a hereditary Chief of the We'Suwet'en Nation. My name is Tsaski(PH), and I am bringing that up because that hereditary system is a matrilineal one where the women are the ones who maintain the hereditary lines in our nation. We know the value of the participation of women. So that would be number one.

Number two would be the involvement of youth. There is really no attention paid to youth -- and I know it has been brought up a number of times over the last day and a half, that youth especially need attention to develop. There have been suggestions that there should be more recreation, et cetera. Whatever, they must be involved in any political discussions that lead to any solutions.

Last but not least are the Elders. The

Elders have to be present to guide all of us -- youth, women and everyone who is concerned.

Those are the two points I would like to make right at the outset.

Over and above all the other concerns that people have been raising, over the last two years, the off-reserve housing programs have been cut down by 60 per cent. It strikes me that one of the first needs of Aboriginal people, wherever you live, but especially off-reserve since we are without a land base, is to upgrade the standard of living. With a 60 per cent cutback in the off-reserve housing program, if we weren't in a crisis situation before, we certainly are now.

Resourcing, of course, is something that Jane brought up, and a number of other people did. Right now, as I mentioned, with the Community Futures program, there is zilch, nothing, that off-reserve groups can access except in ad hoc arrangements. There is nothing there unless we are able to negotiate it for specific projects. We need, again, something like an Authorities Recognition Act so that the federal and provincial governments quit using us as political footballs.

You wonder why bureaucrats are doing studies. That's all they can do. There isn't anything

there to guide them as to who is to be responsible for the different jurisdictions. The Charlottetown Constitution debate was all about who is responsible for Aboriginal people. The feds are saying that they are responsible for people who are status and living on reserves, and they are trying to foist the responsibility to the provinces. The provinces, of course, are reticent to admit any responsibility to off-reserve Indians because that translates into financial responsibility. That is why that Charlottetown Accord was so important, to do away with that grey area as to who is responsible.

The law says that the feds are supposed to be responsible for Indians and lands reserved for Indians, but they interpret it in the narrowest terms and only apply it to status people who live off-reserve.

Finally, I would like to correct an error a lot of people are making when they speak about treaty rights. I heard someone say that the treaty rights are being administered by the Department of Indian Affairs.

One of the biggest problems that we have, especially in the prairie regions, is that the government treats treaty rights as being synonymous with status. In other words, they would like to say in the same breath that, if you are status, you are treaty. There is no

connection whatsoever. There are treaties that were written before the Indian Act was even dreamt of. Those treaties were what we call pre-Confederation treaties. There have been many of them in the Maritimes. The reason I mention that is because the federal government is treating "treaty" and "status" as one and the same. That gives a lot of difficulty to our off-reserve members in the Maritimes.

On the other end of the scale, in B.C. there aren't any treaties, and that policy affects us. If we are non-status or status living off-reserves, and the Department of Indian Affairs has jurisdiction over administering treaty rights and they interpret it as being equivalent to status, of course, you can see what goes on. We are left out yet again.

If anybody would like to correct their delivery in future, treaty is not the same as status. That is a legal distinction, and it is a real distinction. So, be careful. It makes a big difference in the interpretation of policies.

Thank you.

ALWYN MORRIS: Thank you, Ron. I am keeping a speakers' list, and I have Patrick Johnston next, please.

PATRICK JOHNSTON: Thank you very much, Mr. Chairman.

At the outset I have to extend my apologies. I am going to have to leave as soon as I make my remarks. I have another engagement that I have to go to, and I apologize for that.

I do want to thank the members of the Commission and the staff for inviting me to participate over the last two days and tomorrow. I certainly appreciate the opportunity and feel quite privileged to be here.

I also feel, in a sense, like a bit of a fraud because I have taken a lot, I have learned a lot over the last two days, but I haven't really given much. I am not sure I have much to give.

Let me make one observation that I hope might have some bearing on the question that we are dealing with at this Round Table.

I was thinking yesterday, remembering a number of meetings I attended 10, 11, 12 years ago, meetings that were sponsored by the National Indian Brotherhood as it was called at the time, the Canadian Indian Lawyers' Association. One of the major social problems that Aboriginal people identified then was the

placement of Aboriginal children in foster families and adoptive families, out of their communities, out of the culture, and very, very often out of the country. Remember, it was 10 or 11 years ago when Manitoba was still placing Aboriginal children in places like Louisiana and Alabama.

What has struck me as interesting is that over the last two days we have heard a lot of discussion about children, but we have not heard so much the concern that was being expressed 10, 11, 12 years ago about Aboriginal children being removed from their own communities and families. I think, and I hope, that is because we have seen over the last 10 years a significant increase in the number of Aboriginal communities who are running and delivering their own child and family service operations and child welfare programs. Increasingly, Aboriginal communities are reclaiming that responsibility. It was always a responsibility. It was taken from them, but they have increasingly reclaimed it.

I think we should reflect on that, because I see that as a positive sign. I see it as a positive development, and I think it suggests hope with respect to the issues that we are talking about today in terms of Aboriginal communities' increasing

responsibility for health.

I started to think about why that happened. Why, in fact, do we have far more Aboriginal organizations running child welfare and family services today than 10, 11, 12 years ago? To what extent was it because policies changed beforehand?

In thinking about it -- and I was also struck by some of the comments that both Keith LeClaire and Charlene Belleau made this morning. It strikes me that the reason that we have seen that kind of change is because Aboriginal people and Aboriginal communities 10, 11, 12 years ago essentially took the action themselves. They basically decided: This is enough; we will no longer allow this to happen; we are going to make sure that our children stay in our own communities and in our families.

I see a number of people in the room -- Jane Gottfriedson and the B.C. Native Women's Society which was very, very active as an organization in pursuing that issue. You saw examples like the Spalmacheen(PH) Band that essentially instituted their own by-law and just said, "This is our responsibility, period. We are not going to wait for it to be given to us. It is ours, and we claim it."

I think that is really why we saw the

change. It is because Aboriginal people themselves just did it. They didn't wait for the policies to be changed and to be put into effect. I am not suggesting that there isn't a need for a change in policies to facilitate that process, but I think we have to be careful that Aboriginal communities don't wait until all the policies are there. In that instance, it may never happen.

I think there are some important lessons that we can learn from the experience of Aboriginal communities in claiming responsibility for child welfare services that apply equally to the health care field.

Thank you.

ALWYN MORRIS: Thank you, Patrick. I encourage the panel to use your time to dialogue on the questions and with one another. We are trying to utilize as much of your experience and your professional experience to help answer the questions and to give us some resolution to thoughts that have been exchanged and, hopefully, come up with some solid solutions.

The next person on my list is David Newhouse.

DAVID NEWHOUSE: I don't know if more money or jumping up and down and saying this is the responsibility of the federal government is going to solve

the problem. There has been an awful lot of money spent in this area in the past decade, and probably in the past 20 years.

I think that we have to stop giving the responsibility away to other people. The responsibility for our health is not the responsibility of the federal government or the provincial government; it is the responsibility of us, as Aboriginal people, as Indian people or as Métis or as non-status. It starts with us.

We have to begin to build a foundation and infrastructure and a set of policies and approaches that work from that foundation. When we give away the responsibility, then we give away our lives.

I am optimistic -- and I don't say this because I don't have any sense of the seriousness of the situation. I am optimistic that we have at least the beginnings of a policy and the beginnings of a change in health conditions in our reserves and in our communities.

In 1972 there were 600 Aboriginal people or Indian people in colleges and universities in Canada. In 1992 there were 23,000 Indian people who are supported by Indian and Northern Affairs in universities and community colleges across the country. That's a tremendous amount of education that is going on, and that

education is going to directly benefit our communities if we act in ways in which we can bring that expertise back within our communities.

We have to begin to do that. We have to begin to ensure that those people who leave our communities begin to come back and use their expertise there.

This Commission is the first commission in the history of royal commissions in which the majority of work, the intellectual work, the thinking, is being done by Aboriginal people. There are eight Aboriginal doctors in this room. There are people here with Master's degrees; there are people here with doctorates and undergraduate degrees. There are people here who know their own traditions, who know their own language, and who have been schooled in universities and colleges and who have blended the knowledge.

In that sense, I am optimistic that we have the human capital to begin a solution. I think that is different from what the conditions were 10 or 20 years ago.

In very specific terms, I think what we have to do is to begin to build in community guidance mechanisms -- health boards, health commissions, health

committees -- that permit communities to develop, guide and change programs without rigid accountability and direction from the federal government. That is where the funds come from for most of the programs.

We don't, in the majority of cases, have a tax base in which we can begin to pay for our own programs. Except for a few on-reserve Aboriginal communities in Alberta, we are poor. We might as well be honest about it. The federal government serves as our tax base and, because they do that, they begin to direct the rules. They tell us how we can spend the money.

We need, to some degree, to break that link and try to break that accountability to the federal government. All the accountabilities that are in place at the present time force our health professionals, the people who are dealing with health and other issues in our communities, to account not to our communities but to account to the federal government.

I can't think of many health boards or health commissions that report to their communities, that are held accountable for results by their own communities. We need to begin to define an accountability and begin to try to define that in a way in which the accountability is to ourselves.

The federal government will say that they can't do that because of the laws which govern Parliament and the way in which money is voted by Parliament. They say that, if Parliament spends money, then the bureaucracy must somehow be accountable for it, and the Minister has the ultimate accountability. But we can begin to work within a system that I don't think is going to change. There are things we can do.

I think we also have to, as Ron has said, begin to sort out the jurisdictional issues, carve out a very clear area of jurisdiction for health. Without carving that out and without enshrining it in some document, perhaps through a Memorandum of Understanding, then we are not going to be able to move very much.

The last point I want to make before I go on is that we need to understand that we are in this for the long term. Short-term solutions are not going to work. We are in this crisis situation for at least another generation, and we are going to have to maintain an effort over that long period of time. Health takes that long to improve.

We are going to have to ensure that we also do two other things. We need to ensure that the standard of housing improves and that economic development

programs begin to raise people's incomes. If you will recall, at lunch time Dr. Evans talked about the environmental determinants of health. All the studies indicate that the physical environment and the social environment have a far greater effect upon individual health.

We need to ensure that, at the same as we begin to talk about health, we begin to talk about housing and begin to talk about economic development so that we begin to raise people's incomes.

On the side of self-esteem, that area has begun to work very well. People are now proud of who they are and can now begin to go forward and begin to devise solutions.

As Aboriginal people, I think we have passed out of an adolescence, in a sense, in which we began to search for our identity that had been taken away from us, or had been beaten out of us in a lot of cases. We now are secure in our identity and we can then begin to build upon that.

ALWYN MORRIS: Thank you, David.

The next speaker is Lou Demerais.

LOU DEMERAIS: Thank you, Alwyn.

I just want to make a few comments

related to funding and so on. It was brought up by David here as well as by some of the other speakers who have spoken before me.

Before that, I just want to tell you briefly -- again, my name is Lou Demerais, and I am the Executive Director of the Vancouver Native Health Society. It is an organization which is community-based here in Vancouver. It is apparently situated in the downtown east side of Vancouver, the poorest area, according to Stats Canada the poorest riding in Canada. A lot was made of that in the press when the results of the latest census were being tabulated, and so on, and being released.

For a while people talked about it, but nothing really happens down there, at least nothing happens overnight down there. We are trying to put some things in place to bring about some better conditions and better health levels, and so on.

We started an organization three years ago, or a little more than three years ago, at the behest of the provincial government. They came around and they met individually with people and organizations and so on, and then they collected us all together and they said, "Perhaps what you people should do is band together because you are all saying the same thing."

Basically, there were four things that we were saying. We were saying that control is absolutely necessary if Aboriginal people are to become involved in improving the health levels of their own people. We began to talk pretty simultaneously about the need for our own institution here in Vancouver. There were a number of other things, such as it is absolutely necessary that the government recognize the need for and the validity of traditional healing as a viable alternative to contemporary western medicine. The fourth one, of course, was that adequate funds ought to be in place in order to allow those things to come about.

So we have set up to incept a healing centre where we see traditional healers working alongside contemporary western medicine. There was quite a bit of talk about that during yesterday's Round Table, and I wanted to say at that time that I am feeling a little ambivalent.

When we discuss the notion of holistic medicine and holistic healing, and so on, and are asking governments to recognize that -- and I realize that maybe I am somehow countering what I just said a while ago and what I have been saying from the outset. My worry is that any time you get any kind of government recognition, you

will also get government regulation. That, to me, would be the death knell of any attempts that we may have to institute traditional healing in a sense that they are then on the same level, I guess, as other health care practitioners.

It may have something to do with the fact that it has been kind of difficult for us to get traditional healers to come forward to work with us. That is a problem we are working on. We have identified a number who are willing to work with us, but I think they want to work with us on the terms of the society as well as their own terms.

I guess what I am saying is that, if we are going to have traditional healers involved in these kinds of clinical settings and these kinds of healing centres that we are trying to build, they have to be self-regulating rather than government-regulating.

In speaking to the other question, what kind of policies are necessary, one of the notes I made to myself was that, in terms of funding, it should be global funding. I take into account what David has said, and I agree with him on those notions. We don't have that tax base, but we still need funding.

I don't have any hesitation in saying

that, as far as I am concerned, both levels of government are responsible for funding of Aboriginal health because they are the people who put policies in place that screwed things up in the first place. I think the churches, rather than taking government money to provide programming, ought to be providing their own money and giving it to us so that we can provide our own services. I think the church owes it to Aboriginal people; I have no compunction about saying that.

I really want to say also that what we need is less bureaucratic interference. I know that is an old saw; I have heard it said many times here in the last day and a half. I have heard it thousands of times at other conferences. If we are really going to get down to putting those things in place that are necessary, we have to have less bureaucratic involvement in the process, as far as I am concerned. At least part of the answer is: Give us the resources; we will report to you, and we will show you that, while we may make a few mistakes along the way, generally speaking, we can't do any worse than your system is doing for us right now.

I want to relate a somewhat personal experience to put this in the context of what I am saying.

We have had a lot of difficulty internally, within the Aboriginal community here in Vancouver, in achieving acceptance. We have also had that same problem in dealing with some of the government bureaucrats that we have had to deal with. When they can't deal with you as equals, they will try to put you in a disadvantageous spot.

What they did with us was that they began to create rumours about us. The rumours went all the way up to the Deputy Minister, and they had something to do with money. They said, "Well, we understand that the President of the organization is on the take and so are all the members of the board of directors, and it's against the law what they are doing," blah-blah-blah. And that was aided and abetted by Aboriginal people on the outside.

So we have this process going on that we don't have any control over. Everyone knows what rumours are all about. They tend to get embroidered and embellished and, before long, we are being accused of everything under the sun. I don't think we were ever accused of being Progressive Conservatives or Socreds or anything that bad, but they were accusing us of mismanaging money.

We didn't have much money to mismanage.

We weren't mismanaging it.

The Deputy Minister got a little afraid of the rumours that were circulating -- and the rumours were being perpetrated by his very people. He created an investigation. We opened our doors and said, "The filing cabinets are wide open. Have a look here at our annual audited statements. Go to it."

That put them in another fix. Then they weren't going to release the results of the investigation back to us, even though they had promised that. So we just more or less forced them. We just said, "Either you give us the results of the investigation, or we'll sue you and we'll take political action." Pretty soon the fax machine fired up and we got a copy of the report.

Once those kinds of thing take root, they are very damn difficult to deal with. I am sorry to have to say that probably the people who do those kinds of thing will go without any kind of punishment, even though we intend to identify those people. We intend to go around and get the required depositions that we need, and we may very well wind up in a court.

It is really stupid the kinds of thing you have to go through just so you can provide services. I will tell you about some of the services, and then I

will shut up.

Right now we operate an evening clinic five nights a week. In the past calendar year, our five evening clinic doctors amongst them saw 1,420 different patients. They weren't all Aboriginal, but the majority of them were.

We just started a day clinic. Both these clinics are for street people or street-involved people. They don't have to have coverage. All they have to do is show up. We don't ask question: Are you status? Are you non-status? Are you Métis? If you have a medical problem, we have a doctor in the back who is going to look after you, or at least look at you.

We know that is only a partial answer.

The day clinic is already getting so busy that we are thinking maybe we need another doctor in there. That is run almost beside another community clinic that has opened down there which will take the same kind of people. What we are getting is that a lot of our people are coming to see us, I think because (a) their own people run the damn place and some of the people who actually are trying to help them are Aboriginal people. In the other clinic they are all non-Aboriginal people.

We have just signed a contract to do some

home health care work with AIDS and HIV patients in Vancouver. We have identified 25 people who are either HIV positive or who have AIDS. We now have the capacity to go right into their homes. When I say "homes", it runs the gamut from your basic downtown flophouse to apartments in various housing complexes, and so on. So we will be doing that, and the doctor will be tagging along two nights a week to do some diagnostic work and some examination work, and so on.

The whole notion is that we think we can prolong these people's lives with somewhat better health care. If we can promote within those people healthier kinds of habits and better dietary habits, perhaps they will live a little bit longer.

From the time that most of our people contact the virus until they die is less than two years. In the white world it is usually 12 to 15 years, so you see the difference right there in what I am talking about.

We also want to do what we can to prevent fetal alcohol syndrome and narcotic addiction syndrome. We are in a partnership program with Children's Hospital, with the City of Vancouver and with Crabtree Corner which is an emergency daycare. The four groups are working jointly to put a program together. We house it and partly

administer it. We think, if we can counsel some of these young ladies as well as help them with dietary supplementation, perhaps we will have some healthier babies.

Right now I can take you down there and I can show you young females who are pregnant, perhaps in their seventh month, selling their bodies. Most of them are intravenous drug users and most of them abuse alcohol. So you get a sense, just from looking at them, what chance their babies have.

We would like to think that, with some intervention, we can change that.

On Monday of this coming week we start our program for sex trade workers. We have a former sex trade worker who has agreed to come in. She has a lot of lifeskills training experience. We have been out there banging the pavement, trying to find some of these young women and men who might be willing to come in and get some lifeskills training.

DR. LOUIS T. MONTOUR: Excuse me, Mr. Demerais, I would just like to request, on behalf of the Commission, that you restrict your comments to questions or commentary to the rest of the panel, please.

LOU DEMERAIS: There was one other

program I was going to tell you about, but I will shut up there.

ALWYN MORRIS: Thank you, Lou.

Just reiterating from the Chair, our question is: What policies can facilitate that process and the recommendations for implementing?

What I am gathering here is that, basically, we have governmental policy that is being directed by political will in existing governments, be it provincial or federal, and that we also have a political arm that is driven by our own communities, through Band Councils and in some cases national organizations. Both policies don't seem to even match.

I guess the question that is in all of our minds is that, if we are moving toward holistic health, will they ever match? I guess what it comes down to is: What steps can be taken so that they do match?

I would like to focus some attention there. We are getting on in time, and I think we all have to come out of here with something that is going to be solid. Is there a way we are going to be able to match both ends, both in the political sphere that has the electorate that votes political people in place and in our own political electorate that votes our people in?

It seems right now that the debate goes around and never shall the two political spheres meet when it comes down to delivery and especially so for holistic health, because our approach to health is far different from that of the non-Native world.

Let's concentrate on that. I want to move now to Marlyn Cox.

DR. MARLYN COX: Good afternoon.

I would say that I would like to thank the Royal Commission for inviting me here, but I wasn't invited. I had to force my way in, and initially was told I was an observer and then gradually changed to a participant over the past week. I am glad I have this white badge on and that I can say my two words.

I am frustrated. In the last two days we have heard a lot of pain and about a lot of anger in our communities, but there is also a high level of frustration. I can feel Lou's frustration, to my right here.

I work as a primary caregiver in a community of over 4,000 people. It is a busy, busy community. We see over 100 patients a day, between myself and the nurses that are in the community. What we ask for, so that we can provide quality medical care and

holistic medical care to those people, is not being listened to.

I go for months without having anything to do with Medical Services Branch. Every time I do have to phone their office, I usually have to deal with more frustration. Sometimes it just pays to just ignore them.

It disturbs me that we are finally starting to get some Native physicians into the Medical Services Branch and that none of them is at this table because their lips are basically sealed. They have the information on money spent and how money is spent within that branch, and they are not at this table because their lips are basically sealed.

Somehow we have to develop a policy that does away with Medical Services Branch, that the money from the Government of Canada comes directly to First Nations communities and not have to go through that department. That is what self-government is about.

I don't have that answer. I don't know what policy. I guess I could ask for a policy to be passed by Medical Services Branch that they will not exist by the year 1997 and that they all start working on that tomorrow. But how realistic is that?

You have heard here for the last two days, for the people here who are with the federal government and for the Commissioners, our people pleading to give us the responsibility and to give us the power to take care of our people in the way we feel they should be taken care of and in the way the people are asking to be taken care of.

First Nations people are big business in the business of health. We use up the most dollars.

I was in Shamattawa, a community of 600 people in northern Manitoba, on Friday. I am sure most of you have heard about that community and the problem they have with solvent abuse. We heard at the public meetings that we were at in Shamattawa that there was over $2 million spent on children from Shamattawa, in different abuse centres throughout Canada and the United States. The people in Shamattawa are asking for a treatment centre. I am sure that $2 million that was spent sending the children away from their community and away from their families -- I am sure the foundation could have been built for $2 million.

When you see all these things happening, you wonder what these people think in these departments.

Every time you ask a question, nobody can give you any direct answer.

I am going to ask Marie Fortier to respond before I leave -- I have to leave by 5 o'clock. I hope you don't say, "I am only acting, so I can't give you a response." That is what I get a lot of when I phone Medical Services Branch. I would just like to ask you if you have heard what the people have said for the last two days and what your department hopes to do to that plea.

Thank you.

MARIE FORTIER: Thank you, Marilyn.

What I intended to say is that I probably should stay acting so that we can indeed get rid of Medical Services Branch faster rather than making myself comfortable in the job and hanging on to it.

I agree with you that the long-term objective of Medical Services Branch should be to get out of existence. However, having said that doesn't really say everything, and I am sure you realize it. We are not the only component of the health system with which you are confronted. We will need to work together to make that possible through a long process, an evolutionary process I think, which involves First Nations, involves Health and Welfare, involves provinces and other federal

departments.

Even if we got rid of Medical Services Branch tomorrow, I don't think that would be the perfect solution. But certainly it has to be our long-term goal; otherwise, we will never get there if we don't start thinking that way.

I would like to respond to your comments about the physicians in Medical Services Branch. Why they are not at this table is probably because the topic was policy. I imagine that would be the reason why someone like myself or someone occupying the position I am in would be expected to speak here. There is no doubt in my mind that the Aboriginal physicians in the branch, as do all the workers in the branch, have something to contribute to these debates at various times and in various places.

I don't know if that responds to everything you would have liked to hear from me. By the way, you are right about the many acting people in the branch; that is something I hope to correct as soon as possible. It is certainly not possible for anybody to make long-term commitments to their own job and to really get involved, as is necessary to do in the kind of work we do, if they are not certain about their own future.

As frequently is the case now, they are

also carrying a load from the other job they occupied before they were put in this one on an acting basis.

Let's hope that that can be resolved within the next few months.

I would like to talk a little bit about the transfer initiative and relate that to the theme of this Round Table which is recommendations for facilitating the process of increasing Aboriginal responsibility.

The current transfer initiative is, of course, as you know, the first generation of the transfer initiative. Its limitations are very real in that it must operate within the current legislative framework that is available to Health and Welfare.

Some of the recommendations that have been made in the papers and by others around this table have to do with different legislative frameworks, different constitutional frameworks or different policy frameworks. Of course, all of these changes, if they occurred, would open up new possibilities for new ways of talking about transfer.

At the same time, it is my impression that we need to learn from what we have done in that regard over the three, four or five years that transfer has existed. The policy was put in place in 1986 or

thereabouts. The funding was put in place in 1989. We have currently 25 transfer agreements involving 69 First Nations, and there are currently 74 pre-transfer projects under way involving 218 First Nations.

That gives us a fair bit of experience to learn from and draw conclusions. In fact, as you are probably aware, there has been an evaluation conducted and recommendations have been put forward. We are in the process of working together with a number of people on following up on these recommendations.

I don't think the result will be a quantum leap in terms of transfer. We will still operate within the current broad policy framework. But if we can make refinements and improve in the short term, I think that will be welcomed by everybody.

The only possible major leap will come from more broad, sweeping changes at the policy level involving the political process. I think that has been alluded to in several presentations, and our Chairman just alluded to that a few minutes ago. That reconciliation of the political agenda at another level has to occur before administrative processes can be altered significantly and spun into an entirely new generation of thinking.

I think this forum is certainly an

opportunity to advance that one step. The Royal Commission, when it reports, hopefully will be making recommendations that will permit even greater advancement in that regard.

Until then, I think what we have to do is work at the community level in very small, bite-sized chunks to bring better co-ordination of all our efforts together. It is interesting to hear from the success stories that that is actually possible. For instance, the experience of the midwifery example which I heard today, and which I had heard before, is an interesting one, where there was a political will to do something in a community and it was, in fact, achieved. It is a situation that is unique in this country.

I am sure you all realize that the practice of midwifery is still not fully approved anywhere in Canada. Ontario has created the legislative framework for it, but they are just starting to train. Quebec has offered to establish a few pilot projects, and everybody is fighting with everybody over that in the province. None of them has really gotten off the ground except that one on the coast of Hudson Bay.

So things can happen within current frameworks, but at the local level. If we, the

bureaucrats, with our colleagues in the First Nations and in the provinces are able to make those things happen at the community level, while broader issues are getting resolved at the political level, we may indeed get the two ends together at some point in time. That is certainly my hope.

I would just like to respond very briefly to David Newhouse's comment about accountability to the federal government.

Certainly, the structure of services delivered by the federal government, by public servants, on-reserve operate within that context -- and I don't think that is what you were referring to. That is understandable. Public servants providing service report to another public servant who reports to another public servant, et cetera.

Within the context of transfer, if that impression still exists, that a transferred program remains accountable to the federal government in the same old way, that is unfortunate. That is certainly not the intent.

Accountability to a community for the delivery of a program, for its quality, for its appropriateness, for its scope, is certainly possible.

It cannot, of course, take away the need for financial accountability, and that is true across the health care system. Hospital boards everywhere in Canada have accountability to their local community and, at the same time, must report to whomever supplies the funds. But the two are distinct, and I think they can be distinct.

I wouldn't be surprised if in our everyday behaviour, in our vocabulary, we haven't made the changes necessary to reflect that change. It is just a reflection of the imperfection of our instruments as well as the fact that it takes people a while to adjust to new ways of dealing with one another. It is certainly the intent of transfer to change the accountability without cutting off the financial accountability which you can never get rid of as long as there is a third party paying.

DAVID NEWHOUSE: My understanding is that that is what the EPF, Established Programs Financing -- the federal government transfers enormous amounts of resources to the provinces without any financial accountability whatsoever. So there is certainly is a precedent for relieving the horrendous amount of financial accountability that does exist. Those are tremendous amounts, and no one asks the provinces to spend them on health. They can spend them any way they want.

MARIE FORTIER: But there are strings attached to EPF.

DAVID NEWHOUSE: There may be strings attached, but no one is holding them accountable.

MARIE FORTIER: What I am saying, David, is that financial accountability at different levels -- a hospital board in any province cannot operate without having some degree of financial accountability. You are raising the level of discussion to one of government-to-government transfer of funds, which is another forum, but in which there is accountability also.

Ask my provincial colleagues. I was DG of Health Insurance until a week ago, and they will remember that there were times when they saw that accountability as quite burdensome.

ALWYN MORRIS: Thank you.

I have Richard Jock here who is ready to jump in with both feet, so I will let him do that.

RICHARD JOCK: I think one of the important distinctions that we need to make right away is that we are not going to talk about how we can work with the status quo or how we should work with it or how we need to adjust or be flexible within the limitations that exist.

To me, one of the hopes I have is that there will be some fundamental changes. I think that is really what we need to focus on.

One of the reasons that I say that is that one example of that is the fact that, if you ask why First Nations organizations are funded through a process called Contribution Agreements, the legal answer that you are given is: Because First Nations don't legally exist. That is why Contribution Agreements are used.

When you have that kind of relationship, a government with somebody that doesn't exist according to them, that is not a relationship at all. For that reason, I there must be really a fundamental change in that relationship.

One of the illustrations of that is the continued denial of existence of treaty rights. We are being asked to defer that: "We can't talk about it; let's move on with programming." But the end is that, in defining a fundamental relationship with at least a certain group of people it will not meet all the needs certainly, and there are a lot of legal variations, et cetera, as Ron has certainly pointed out.

In terms of changing that, the treaty relationship must be affirmed and recognized and

implemented.

I think this is not only just a political kind of statement. I think it relates to everything that we have talked about over the last couple of days in terms of empowerment. Everything you read in international literature relates to individual empowerment, relates to community empowerment. Really, treaty rights and recognition is that kind of empowerment.

I recognize that it is important to move ahead and deal with people's human needs and some of the problems we have heard about, and I think we need to do that now and not wait for the Royal Commission. That's agreed. Their job is to redefine that relationship. I think, at the same time, we can't let the federal government off from that responsibility.

That is why I feel very strongly that that needs to be examined.

We have a good example south of the border in the U.S. where they have dealt with recognition of treaty rights to health care. They have many treaties with different provisions, et cetera, but they have been able to deal with it in a way that has not resulted in some sort of uncontrolled cost. It is really a philosophical thing.

We need to change our health system from a system by policy, a system oriented toward a welfare approach, to a rights approach. That will fundamentally change that relationship.

As well, if you look at some of the problems that exist with health services -- and some of those were referred to quite powerfully by Dr. Cox -- some of these are related to the different, complex, over-weaving jurisdictional problems that exist and the different agencies that have a say in funding, that have a say in policies. Part of defining some new relationship has to be cutting through that, because it needs to make sense.

It doesn't work right now; it's plain to see. I think one important aspect of that really clearly is the economics of it as well. We heard today a very short and punchy and excellent presentation about where the economics of the health system are going. I will tell you, we are going to get caught in that shift of economics because our needs aren't dealt with now. What are the prospects for being dealt with in the future in shifting priorities?

I think determining of costs in a market share, if that is the way you want to use it, or a true

attribution of costs that go to First Nations and making it possible for First Nations and other Aboriginal groups to manage those directly is where it is at. That is a change in the relationship.

ALWYN MORRIS: Can I just throw this in at this point in time?

A few people here talked about jurisdiction and cutting through the red tape because of how Aboriginal people fall through the jurisdictional problems. You ask a question: How do you get through it?

If we are going to figure a way out of it, there must be some recommendations or some ideas as to how we get through that jurisdictional red tape. Is it really only going to be through constitutional, or is there some way to do it through the process that we are involved in now?

I will invite Judy and then Mike.

RICHARD JOCK: Could I just make a brief comment as to one other aspect before you move on.

One of the things I also want to stress before I conclude is that I think we, at times, also make the mistake of getting sucked into sectoral approaches ourselves. In fact, if you look at our agenda, it is health

and social, but it has been basically health -- and I am most comfortable with that. Really related to that should be health, the environment, our education systems -- how do those things move together?

In addition to being holistic, we have to really make sure that we don't set up the same sort of bureaucratic boundaries, the same sort of limitations, the same sort of line agencies that we criticize the federal government and other people for.

I think we have to be consistent in what we do and work to do that rationalization of our systems as well.

I will stop for now.

ALWYN MORRIS: Thank you. I would like to get that jurisdictional question. When I said those words, Judy just jumped out of her seat. Go right ahead.

JUDY MOSES: I think one of the most important things that is going to make change is for governments to really understand what "holistic" means and to begin practising it.

The jurisdiction has been used as an excuse for inaction. There was a 1991 report, a royal commission report on health care here in British Columbia, and it devoted a whole chapter to the issue of Aboriginal

health. It was very, very critical of both the federal and the provincial governments for their inaction and for using jurisdiction as an excuse for not responding to the health care needs of Aboriginal communities.

Just in the past year, in the Ministry of Health, there has been a lot of activity happening to devolve and regionalize decision-making from a central place in Victoria out to regional health boards. The Ministry is very, very strong right now in terms of moving forward with regionalization.

In B.C. we have an NDP government. I look at that as a window of opportunity. We have four years within that window to make some significant policy changes. Those policy changes need to come from strong advocates working within the system. You can't put Aboriginal people in senior government positions unless they are going to be accountable and committed to their own people and also who are competent in policy development and program management, who are going to be working very hard to make those changes.

Working in the Alcohol and Drug Programs, which is only a $57 million program in a $6 billion ministry, we have made some changes in the past year to get out of the business of delivery services to

Aboriginal people. We have worked hard to transfer $5 million for addictions, mental health and family violence programs out of the bureaucracy over to Aboriginal control.

We have done that through an infrastructure of regional health boards who are all Aboriginal people, health care professionals sitting on those health boards. There are six committees; there are 40 people sitting on those committees. They all employ their own regional co-ordinators and they all have their own administering agency within that structure.

They have funded over 200 projects in the past year, and I expect that we will be working further within that structure.

That structure isn't perfect. It is not a nation-to-nation arrangement. Those kinds of arrangement will be responsibility under the B.C. Treaty Commission, self-government arrangements.

It is limited -- and that is an issue. Government is saying, "Here is $5 million, but we want you to spend it on addictions, mental health and family violence." That isn't holistic. There have to be some changes.

Working within government as an

advocate, we will work hard to make those changes to accommodate the needs out there.

What we have done in the past year is very, very significant and it serves as a model for other ministries. That $5 million represents .05 per cent of the provincial government's health budget. There is a lot of room to move further.

There are significant amounts of funding in other ministries and also within the Ministry of Health that are dedicated to Aboriginal programs, but are not controlled by Aboriginal people. There needs to be a lot more thinking and response from the bureaucracy to deliver programs holistically and Aboriginal people delivering those programs.

Those are some policy changes that I think need to happen and need to happen now.

ALWYN MORRIS: Thank you, Judy.

Mike, I will let you jump in here.

MICHAEL SIMS: I don't know whether I shall jump in the place that you want me to jump in. I would like to begin by expressing to Richard that whoever told him that story about why contribution arrangements exist doesn't know what they are talking about. It is just another little piece.

One of the gratifying things that I got out of these last two days is that, had I organized the same discussion within my own group, I think I would have got the same definition of what "holistic health" is. It would have included housing, economic development, education and community government as part of the holistic definition.

I think the problem is that we understand what holistic is, but we don't know how to practise it. Western society does not have a precedent nor a model for what First Nations are attempting to do. We are all focusing on individuals. Individualism is paramount and survival of the fittest is what counts. If rural communities that aren't Native disappear, they disappear. It's unfortunate, but that's the way life is from a western point of view.

So we don't have any precedents and we don't have any lessons to give you. We are groping, like you are, to find solutions. We are trying to grope by changing funding arrangements. When we talk about accountability mechanisms, had the alternative funding approach that DIAND is presently trying to use been put forward 10 years ago, everybody would have died of fright. The central agencies would have said, "You can't do that."

Times change. The law of the land hasn't changed and accountability of Parliament hasn't changed; yet, these mechanisms have evolved because that is what was necessary.

In my particular contribution apart from that, I think one of the things we have to consider in dealing with how holistic strategies can become in place is to seek to answer the question that Allan Blakeney asked this morning. He asked: How can you teach what you have learned to others?

I listened this morning to Carolyn Pettifer and Richard and Louis and the other contributors, and many of the things they told the audience I knew. Where I sit, I know those things, and I know about many others. But I am sure Richard didn't know necessarily what Louis was doing or what Carolyn was doing.

I think one of the solutions to making holistic health and learning occur is the sharing of information and finding ways in which First Nations can systematically share their experiences with one another. It is not enough to have people standing up for 10 minutes and giving a little piece of wisdom and a little piece of experience. There has to be a way, I think, to systematically allow that sharing to occur so that

everybody is learning from one another.

I think some of the things that Bill Mussell said, very wise things, we have to integrate and start to practise in the way we organize. It is not changing programs; it is not changing the rules of the game. That's another part of it. But if we don't learn from each other, if you don't learn from each other and if you don't teach others and share with others, then I don't think there will ever be a movement forward into dealing with this thing at practical levels.

ALWYN MORRIS: Could I ask a question before other people jump in here; I would just like to make a comment.

If we are in a process of trying to educate both internally and externally, aren't the bureaucrats at all levels, both federally and provincially, still within the confines of the legislative framework they have to operate in. If you are still caught within that legislative framework, even if you have learned the tasks and the understanding of a holistic model given by the Aboriginal community, how can you implement that philosophy under the current legislative framework?

I will let you respond, and then I want to bring Sheila in after that.

MICHAEL SIMS: We have an Indian Act to work with in Indian Affairs that none of our programs are legislated. They are all policy. The policy provides a framework. Ministers approve a framework and a set of objectives for a policy, and then provide some money.

Bureaucrats then start to lay some rules around it and some accountability frameworks. Although they are produced by people and they can be changed, without changing law, the only thing that is sitting there is a general framework of the accountability of ministers to Parliament and the way the money is voted.

You would be surprised that empowerment and control is there for the taking. The examples that were interesting this morning were that most of those people have taken it, because they have been determined to take it and have had a vision of what they want. They have gained the control. They just have to get people convinced that that is the way to go, and then the rules are changed. It is not legislation.

ALWYN MORRIS: Thank you. Sheila, please.

SHEILA GENAILLE: Thank you, Alwyn.

You asked about jurisdiction, so I am going to address that as well as my comments to the previous

speaker.

Not all Aboriginal people in this country come under the Department of Indian Affairs.

If you want to know about jurisdiction and how it affects the Métis, section 91(24) of the Constitution of Canada provides that federal government has a responsibility for Indians and lands reserved for Indians. Under this section the federal government has acknowledged responsibility for Indian and Inuit nations, but the federal government does not accept its jurisdictional responsibility for the Métis people of this country.

What we have to do, as Métis people, is to approach our provincial governments or territorial governments, wherever we live. We ask them if they have some obligation for our people, and their answer is: You are Aboriginal; you must deal with the federal government.

Ron had alluded earlier to a political football. That's what the history and the present reality of the Métis people of this country is. There is no jurisdiction; we are a political football.

The health and the social quandary of the Métis people of Canada is amplified in my community. The jurisdictional dilemma is the basis of this

amplification of the social and health reality. The "Aboriginal" label used by politicians, professionals, statisticians and even presenters here at this meeting effectively masks the desperate state of affairs of our communities.

I am sure that, if Métis-specific data, rather than Aboriginal data, was ever gathered, the status quo situation of the Inuit and Indian people would pale by comparison with the socio-economic situation of the Métis Nation.

I notice from reading some of the discussion papers that many have used the terms "Aboriginal" and "indigenous." I also notice that what is really meant is Indian and Inuit people. These papers start from the premise that there is a relationship with the federal government and that there are resources available. When you use the term "Aboriginal" without clarification in your papers, you disguise and perpetuate the tragedy and status quo of my people, the Métis.

The Métis Nation again asks that you not generate status-blind data, papers, presentations and recommendations. If you mean Inuit or if you mean First Nations, say so.

The Métis Nation's social, political and

legal reality requires that you treat our issues separately. If you don't, you will continue to perpetuate a Canadian tragedy.

I would like to offer some of the recommendations that the questions ask.

One of the things, as I alluded to and I keep referring to, is the consistent lumping together of all Aboriginal people in this country. This must end. The Métis Nation has been fighting this policy and will continue to fight this policy. I suggest that the majority of Aboriginal people in this country do not live on a land base or do not live on reserves.

Collectively, yes, we as Aboriginal people share the same problems and share the same issues. But, when we start to address solutions, that is where the distinctness arises. There are three Aboriginal groups in this country, and we are distinct and unique from one another.

Politicians and bureaucrats must change their attitude and stop thinking that they are the big brothers to the Métis people of this country and that they are the only ones capable of developing policies and programs. The Métis people are more than capable of developing programs, policy and also implementing what

they develop. We want to work and be treated as equal partners in this process.

As Carolyn stated this morning, funding must be made more equitable to the Métis Nation. We cannot make substantial progress on a project-by-project basis when we are always continuing to wonder when the next dollar is coming to continue this process. We must have more access to the funds so that we may achieve a healthy Métis Nation.

I have heard several references over the last two days to traditional healing. Again, I must caution. Whose tradition? The Mohawk tradition, the Métis tradition, the Inuit tradition? We must be very careful when we generalize using these terms.

Another thing I heard talk about is the spirituality. Again, that is an individual thing. David is over there; he was talking about education. He was giving numbers of his people raising over the years.

The Métis people aren't so lucky. We don't have the Department of Indian Affairs to go to to get dollars to send our children to school. Education is very important to our people. It promotes a healthy community. It promotes self-worth. Knowing our own history and being proud of who we are promotes self-pride.

In closing -- and I know we are running out of time. Before you generalize on Aboriginal people and indigenous people, take a look at who they are. Take a look at the people Ron George represents. They don't live on reserves; they are First Nations people. Take a look at the people I represent. We are Métis people; we don't live on reserves; we don't have a land base.

Also, in closing, I would urge the Commission to increase the participation of Métis people in future rounds. I also thank them for inviting me here today.

Thank you very much.

ALWYN MORRIS: Thank you, Sheila. I would like to go to Professor Stephen Chase and, depending on how long he is, we will decide whether we can afford to keep going here.

STEPHEN CHASE: Thank you, Mr. Chairman.

First of all, I appreciate the designation "Professor," but I wish to assure everyone that I am not a professor -- sometimes not absent-minded, but not a professor.

First of all, I would like to thank the Royal Commission and staff for inviting me here. It is

a particular honour to sit at the table as a participant. I am representing my Minister, the Honourable Russ King, from New Brunswick, and he deeply regrets not being able to be here, because he is very supportive of facilitative and co-operative arrangements with the Native community, and has demonstrated that.

I am not going to make any political statements. I would, however, like to direct a few remarks toward the questions.

To respond to your comment earlier, I think we can match the objectives. I think there is probably a lot more common thinking here than we may realize. Maybe we will come to realize it afterward. I am really encouraged by what I have heard.

For me, the sheer scope and complexity of the problem is intimidating. It is probably not much wonder that in the past there has been difficulty coming to grips with it and hiding behind jurisdictional lines and those sorts of things. I think through this process we have begun to recognize that there are ways to approach the problem and to deal with it on a piece-by-piece basis. There are successes out there. We have heard some important successes today.

I also think that it is possible within

the existing framework, however long it takes to have that framework changed. We have examples of success, and I think there is a preparedness there to work toward successes.

What can the provinces offer? There are not many provincial representatives here, I don't think. There are a few.

I believe that provinces have a broad-based experience in public health, mental health, social services, substance abuse, ranging through to prevention and training programs, education. I think that kind of experience would be critically important to be brought to bear in assisting Native communities to work toward self-sufficiency and, as Bill Mussell said, self-management.

I think the three parties need to get together and work toward defining the problem and the goals. Yesterday someone said that goals are important, that for an individual to be able to pull himself up by his boot straps, he needs to have a goal. I think communities can have goals equally with individuals and, until those goals are established, it is going to be very hard to surmount the problems.

I think that there has been some tendency

here to look at things in terms of health and, to a lesser extent, holistic social approaches. I really believe that what is needed is a holistic socio-economic approach to deal with the underlying problems, not simply with the treatment of symptoms of deeper underlying problems.

An economic strategy is every bit as much a part of solutions as are whatever health strategies and social service strategies we may choose to develop.

I think the overall objective needs to be the promotion of community and individual self-sufficiency and well-being, together with the assumption of responsibility and accountability that are associated with self-sufficiency.

I think the provinces are well-positioned to work with the Native communities and help them take charge in improving their ability to plan, to set goals, to design programs, to administer and deliver programs. The provinces can be facilitative in assisting the establishment of linkages to mainstream programs. In short, there is a wealth of experience and capability that we may have lost sight of.

To be specific, what do I think needs to be done? If we are working toward the goal of self-sufficiency, we need to have, first, a political will

to do that. We need to develop effective partnerships and provide for community involvement, amongst all the players, both the levels of government as well as within and among communities. We need a holistic socio-economic strategy. We need to establish plans and priorities. I could well say that the Native communities need to establish plans and priorities.

Above all, I think it has come out very clearly that we need well co-ordinated, multi-disciplinary approaches in delivering services. I think, if we had that, we would go a long way toward resolving the issue we are here to deal with.

Thank you very much.

ALWYN MORRIS: Thank you.

In closing -- my Chairman over there is looking at me. He is my next-door neighbour, and I don't want him to come and knock on my door in the middle of the night or wake me up.

DR. LOUIS T. MONTOUR: Vice versa, Alwyn.

ALWYN MORRIS: What I would like to do is close off with a few comments.

There are a few people who didn't speak, and I would urge them to eventually get into the discussion

in the Plenary which is going to happen next on all subject matters.

The other issue is that there seem to be some fundamental problems, both in the political sphere and in our own communities. We are a minority people with a large demand on services, and we are a minority because of what happened historically. We are going to need to somehow influence that structuring and those political decisions that make legislation. We need to try to influence those things.

In addition to that, until we are able to do that, we are going to have to work under the current regime, which is not necessarily very successful. But until we do get that change, that seems to be almost our only approach. Certainly, we are going to have to rely on individuals who are in the Aboriginal milieu, that being the Inuit, the Indian and the Métis, to listen to us carefully.

With that, thank you very much for participating. I will hand it over to Louis T.

DR. LOUIS T. MONTOUR: Thank you very much, Alwyn, and congratulations on a difficult job well done.

I would like to thank Judy Moses, Stephen

Chase, David Newhouse, Richard Jock, Lou Demerais, Ron George, Patrick Johnston, Mike Sims, Marie Fortier, Jane Gottfriedson, Dr. Catherine Cook, Dr. Marlyn Cox, Huguette Sauvageau and Sheila Genaille for their participation.

We will now proceed directly to the closing Plenary. You are free to ask questions on any and all subjects for today, including this last panel.

Je voudrais vous offrir, Madame Sauvageau, l'opportunité d'être la première à parler, si vous voulez. Vous pouvez parler en français; les traducteurs sont toujours là.

HUGUETTE SAUVAGEAU: J'aurais voulu faire quelques commentaires sur l'organisation des services de santé et des services sociaux pour les signataires de la Convention de la Baie-James, les Cris et les Inuit, dans la province de Québec.

Il faut remarquer que ces deux populations-là ont des conseils régionaux, comme toutes les autres régions de la province de Québec. Ils ont leurs propres conseils d'administration et ils peuvent adresser leurs problèmes de santé avec une approche selon leurs besoins et leurs priorités. Ils reçoivent des budgets d'année en année, et ils ont des augmentations de budgets selon les programmes qui sont mis en place.

C'est tout.

DR LOUIS T. MONTOUR: Merci beaucoup pour vos commentaires.

I would now like to open the floor to general questions. We will proceed until six o'clock, and I will then call on Elder Glen Douglas to do the closing.

I would like to remind everyone here that questions at the mike are limited to those people who have white participant badges.

I believe Microphone No. 3 is first.

CARRIE HAWYARD: Carrie Hayward from the Ministry of Health in Ontario.

I would like to share with you an initiative which has been under way for two years and has probably two years to go. It has been an initiative where we have tried to bring together the objectives of the Aboriginal communities and the Government of Ontario, and so far seems to be succeeding.

I want to give you a little bit of very short history of this initiative and then talk about some of the challenges that are faced in this initiative as well as where we have achieved some success.

DR. LOUIS T. MONTOUR: I would to reinforce "very short", please.

CARRIE HAYWARD: Absolutely.

In 1985 Ontario made a statement that it could no longer deny services to people living on-reserve. In 1991 the Ontario government signed a statement of political relationship with First Nations which recognized the inherent right to self-government and recognized a nation-to-nation relationship.

Two years ago we started an Aboriginal family violence initiative, "Aboriginal" meaning the Ontario Native Women's Association, the Ontario Métis-Aboriginal Association, the Ontario Federation of Indian Friendship Centres and the five organizations which represent First Nation political interests. This is a joint initiative between the Aboriginal organizations and the Government of Ontario.

What do I mean by "joint"? We had joint development of the terms of reference: What would this initiative even try to do and how would it try to do it?

Aboriginal organizations engaged in consultation processes of their own determination throughout last year and over 6,000 people in Ontario from Aboriginal communities were involved. Each organization produced its own report and then, jointly, those organizations and government sat down and wrote a

background paper that talked about the principles and directions of Aboriginal communities. Ninety-five per cent of that document became a Cabinet submission, and Ontario recently received approval.

Now we are into the phase of strategic development which I think will take some time as well.

I want to talk about three challenges. One is something that Bill Mussell spoke about this afternoon, and that is the dialogue between the government and Aboriginal organizations. It takes time to develop a common language and common understanding of the concepts. When the Aboriginal community uses the word "consultation," I have learned quickly in my short time in government that that is not necessarily what government understands it to be.

Second, it has taken time to address mutual distrust. It has taken time to build mutual respect. It has taken time to educate civil servants about the aspirations of Aboriginal communities. It has taken time to relieve some threats to the power structure of government.

The second challenge has been co-ordination. I mentioned the eight Aboriginal organizations involved. Yes, the Government of Ontario

is involved; that constitutes 11 separate, different ministries with their own mandates.

Two federal departments sit ex officio: Health and Welfare Canada and Indian and Northern Affairs. There could be many, many others that would be part of this table to present a complete picture to address Aboriginal family violence.

In terms of that challenge, there are two parts. One is that we have established a working relationship, but the second and greater challenge will be how to implement in a holistic way or how do we implement those recommendations that will be very, very holistic and that come from the Aboriginal community? How will be mobilize those 11 different ministries to act?

The third challenge I want to talk about is resources. Some of the Aboriginal communities hypothetically talk about the need for $100 million to address what has become the Aboriginal family healing strategy.

Bob Evans talked at lunch today about the crisis in the health economic system. That is true in Ontario as well. I think the challenge is harnessing and directing resources. How do we move those dollars from the illness system, as he described it, to a

community-based system? How do we remove dollars from those non-Aboriginal communities and agencies that are now serving Aboriginal people ineffectively?

Just in the Ministry of Health alone, in terms of First Nation people primarily, we have been able to estimate, at minimum, that we spend $100 million on health -- that is the minimum. What is also spent by all of those other ministries who provide services or support to First Nation and other Aboriginal people? How do we harness and collect those resources and direct them? I think that will be the even greater challenge because there is still considerable ill health. How will we move those dollars into community-based systems, not only move them but in a holistic way?

DR. LOUIS T. MONTOUR: Thank you very much. Microphone No. 2, please.

JEAN AQUASH: I am Jean Aquash. I was invited here as an Anishnawbe Elder, and I thought I would share with you a couple of comments I wanted to make on what I heard around the Round Table.

In the last couple of days, as I have been listening, I have really gotten confused as to how you use that word "holistic." In my teachings, as I listen to the old people, the things they handed down, "holistic"

means mind, body, spirit and the emotions. With that you have to practise kindness, unconditional love, truth and honesty and to share these as you practise them in your life with the people around you. It doesn't matter what colour of man you share it with.

The way it is used flippantly in the last couple of days, I don't see the connection of those words to be used in the programs that it is used under. To use that holistic word in giving out funding from the government to the people with kindness, with unconditional love, with understanding, with truth and respect, and all of those good words, to me that is the word that is handed down to me by the teachings of the old people.

Another thing I wanted to share, in the teachings and the understanding of the old people, is how the first Indian came about to agree with the white people through the treaties. That doesn't mean that the land was given away or sold. So the money that is applied for health for our people is through the federal government.

The Indian Act came about to assimilate our people to act like new Indians and not to act like the old way any more. That is where the Indian Act came in, according to the teachings of the old people.

I really respect Richard Jock for

bringing out the conversation about the treaty in the Round Table. I really consider myself as an Anishnawbe person. All these words that are given to us in different forms, whether it is "indigenous" or "Aboriginal" or "First Nations", I don't really prefer to use the word "First Nations", and I am just going to say that for myself, to own it. To me, that is just an adopted word to be able to fit in the system of what we know today, and it is only a borrowed system. Our system truly comes from the Creator. We never really made any man-made laws. The word "First Nation" or the word "Nation" comes from people who make man-made laws, and they make their own money.

Anishnawbe people don't do that. The Anishnawbe people still hold their laws by the law of the Creator, and they have law lodges to carry those things out.

As an Elder, I thought I would share that with you and the teachings that have been given to me.

Thank you.

DR. LOUIS T. MONTOUR: Thank you very much, Jean.

I believe it is Microphone No. 1, and then No. 3.

LOU DEMERAIS: I just want to make a

brief announcement as well as a brief presentation.

I have with me some copies of an 18-minute video that was produced in the Kootenays by the Tribal Council up there. It is entitled "Silent Love". It's a video on the emotional side of AIDS. What it does is show a young man who suffers from AIDS, and he is very near the end of his life. He is being looked after by his family and his community. There is quite a powerful message of love in there. I have about eight copies available here, but I could also give out my business card. If you want a copy, see me afterward.

There is no charge for it except if you are government, and then it is $50,000 a copy. There is no charge to anybody. I just have very limited copies, and I can get more copies made.

I want to give the first copy to the Co-Chairman Georges Erasmus.

Thank you very much.

DR. LOUIS T. MONTOUR: George, will you write that cheque?

Microphone 3, please.

DR. CATHERINE COOK: Good afternoon.

I just have a few comments. I think most of the individuals at the Round Table this afternoon

addressed the issues that I would like to have discussed, so I will be brief, Louis.

DR. LOUIS T. MONTOUR: I am sorry, I wasn't aware you hadn't presented initially. My apologies.

DR. CATHERINE COOK: One of the things that has been confusing me since the start of the Royal Commission is that I have been unclear on exactly what it was that was expected of us in terms of coming up with answers or plans or policies toward better health and social development. I think probably the reason for that is because it has not been clearly defined who and what it is that we are attempting to address.

Perhaps that is one of the things that we could really look at -- an accurate definition of who we are attempting to improve and provide service for.

Many of the members at the Round Table today touched on education as an important issue. To me, health and education go hand in hand. There really is no separation of the two. As we improve our education, I think the health and well-being of our people will improve and, as the health and well-being of our people improve, so shall the education.

Services to the people in the area where

I am from I can look at in two ways. I am a Métis. My community is relatively isolated and, as such, exists with zero services in terms of home care, social services, personal care homes, assistance to the elderly, medical care. We drive 75 miles to see a medical doctor. Ambulance is non-existent.

On the reserves where I work the health care is administered by the Medical Services -- we are working on that. I think things have improved a bit over the last few years, but we have a long way to go.

Some of the concerns I have are with the transfer process. I think we have to continually re-evaluate the transfer process. As Kim Scott alluded to in her paper, there are many things that have been left out. Flexibility for planning and funding for community development is a very big issue. When we see the escalating costs of chronic and lifestyle diseases in our communities every day, it is fairly clear that we need some good long-term planning.

Non-insured health benefits is a great mystery to me. I think we have to be very careful in how that continues to be implemented. The move to have Blue Cross take over the prescription drug disbursal is probably something that could be reviewed. I think it is possible

that less of an outcry would have been made had the Native people been addressed and asked to help in reviewing the contract prior to actually -- actually, I am not sure if it has been finalized at this point. Possibly the Native people could form an institute that would take are of those sorts of issues.

At the present time, as I see it, the non-insured health benefits -- and this may be inaccurate, but the figure that I have is in excess of $450 million -- are probably at the present time going largely to service providers and benefiting the Native people overall in a very minimal way.

I think we have a lot of work to do and we have to continue to work together.

Thank you.

DR. LOUIS T. MONTOUR: Thank you very much. We have time for two more comments.

DR. MICHAEL MONTOUR: My name is Michael Montour. I am a Mohawk from Six Nations Grand River Territory.

I would like to discuss some ideas regarding policy. Some of these were touched on to a certain extent by other speakers.

Part of the discussion has skirted

around the idea of defining exactly what the problem is, who we are trying to address in terms of Aboriginals. The subject was raised about the Métis people being different from the Indians and being different from the Inuit. I guess the Métis have a little bit of an advantage in that they have only recently started to get recognized; whereas, the Indians were all lumped together back over 120 years ago under the Indian Act. The Mohawks are as different from the Cree as the Métis are from the Mohawks.

I think it would help if we could try to recognize that there are not only differences but similarities among and within the groups. From that foundation, different policies could come forward that would be common for all the groups. It would also allow for development of an equal means of treating different issues.

One of the other concepts deals with whether our rights should be limited by geography. There are some rights that are guaranteed under the Constitution, as was mentioned earlier. There are rights that are unique to Indian people that are recognized under the Indian Act. Again, those rights are only allowed if you are residing on the reserve. I think there should be some policy development along the line to make sure that this paradox

is eliminated from the legislation, that the rights that are guaranteed under the Constitution are compatible with rights that are available under the Indian Act. If you are allowed to be tax-exempt or allowed to have access to certain health care provisions because you are residing on the reserve, then in keeping with the Charter of Rights and Freedoms those provisions should be available to people that are living off-reserve.

Similarly, these rights should be extended as well to other people of Native ancestry, whether they are Métis or non-status. I realize that the limiting factor there really comes at a federal level in terms of the number of dollars that would be required to implement an idea of that nature.

I think the Aboriginal people or Native people, or whatever handle you want to use, would be supportive in concept for an approach along this line.

The comment that was made by the Elder regarding the difficulty in reconciling the term "holistic" with health issues was interesting. Once you realize what Native people mean by health, the use of "holistic" and "health" in the same sentence becomes redundant. They are really talking about two concepts that are the same.

The next item I would like to touch on is that policy development and furtherance need to be encouraged through the present political process, whether that is at a community level or groups that are off-reserve that are addressing the issues. There needs to be some sort of policy developed in order to allow these different groups to identify their goals and, through a co-operative and collaborative process with existing expertise, to identify policies that are appropriate to their needs, to their communities, to their specific areas.

I am not sure if that is clear. There are needs that are in common at a national level, but there are also needs that are very specific to certain areas.

I think this whole process can be furthered by developing policy to augment support for health groups, whether they are professional or para-professional or people who are skilled, Again, that can happen at a community, provincial or national level. The experience the Native physicians have had with their own group, often when we are participating in sessions where other health professionals are participating, we are often not recognized as being equals. Hopefully, that is something that will change with further education. That is not something that can be changed with policy,

I am sure.

One thing that can perhaps be helped by policy is to ensure that organizations that are in existence and groups that are in existence in the community are supported not only in financial terms but through their peers as well.

DR. LOUIS T. MONTOUR: I would like to ask you, Michael, to please make your final point.

DR. MICHAEL MONTOUR: That is my final point. Thank you.

DR. LOUIS T. MONTOUR: Microphone No. 2, and you have three minutes.

TUMA YOUNG: My name is Tuma, and it is really only one word. It is just like Cher; nobody knows her last name. The same thing with me. If you know me by Tuma, then you know who I am.

I am from the Micmac AIDS Task Force.

I was just thinking about the question that was asked at the Round Table, what process can we do. I was jotting down some things, and I was just thinking about how my work does it.

We just went out and did it. We just go out and do it -- and I am not necessarily addressing the Royal Commission here. I am addressing all of you.

Just go ahead and do it. Go ahead. Don't wait for anybody. Don't wait for the federal government to tell you it's okay to go ahead; don't wait for the province; don't wait for the funding. If you go ahead and do it, something is being done anyway.

I was just thinking about when we first started. If we had to wait for funding from Health and Welfare, we still wouldn't be doing the things we are doing.

To get rid of political interference, because health is an issue that takes more, it has to be risen above. I know where I come from there is a lot of interference. Chiefs want to get in on the action, and all this stuff. So what we did was we handpicked individuals who are really concerned, and they represented their organizations. They all came together.

We didn't know anything about AIDS, but we knew that this was an important issue for us to deal with. So we got out and we said, "This is what we're going to do. We're going to educate ourselves and we're going to put in AIDS education programs in our organizations, and then we're going to educate the Chiefs, the Councils and stuff like that." We did community workshops. They asked me to do them. I said, "Sure, if you pay for the gas and feed me when I get there, that will be all."

I think it was during Drug Awareness Week, and I did 12 workshops that week. I travelled all over Nova Scotia. Then the following year they asked me to include New Brunswick and P.E.I. So this year we are really expanding.

We got all the Atlantic Aboriginal communities to pass a resolution at the Atlantic Health Conference that they will develop policies and protocols related to AIDS and education in every aspect of their lives and in the communities. That is something they can do without funding, without relying on the federal government. This is something that people themselves can do. Then they can go back and go for funding.

That is my major point. Just do it.

I heard that multidisciplinary approach --

DR. LOUIS T. MONTOUR: I would like to stop you at this point and recommend to the rest of the audience that you have made an excellent point, and the motto -- and you have heard it from many other people -- is just do it.

TUMA YOUNG: There are other points here, too.

DR. LOUIS T. MONTOUR: I am sorry, we

are out of time. There will be more time tomorrow.

TUMA YOUNG: Is that a promise?

DR. LOUIS T. MONTOUR: If you get in line and you are recognized, you can speak.

I would like to close this session today. Before I do that, I would like to remind people that a summary of the first draft of notes from yesterday is available on the tables outside. Please feel free to collect them.

I would like to call on Elder Glen Douglas to please do the closing.

--- Closing Prayer

--- Whereupon the Hearing adjourned at 6:00 p.m. to resume on Friday, March 12, 1993 at 8:30 a.m.