



EXPANDING THE CIRCLE

**MONITORING THE HUMAN RIGHTS OF INDIGENOUS, FIRST NATIONS, ABORIGINAL,
INUIT AND MÉTIS PEOPLE WITH DISABILITIES IN CANADA**

SYSTEMIC REPORT

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Table of Contents

Introduction: Framing the Context of the Systemic Review	3
1. Access to the physical environment, transportation, information and communications.....	9
2. Education.....	19
3. Health	29
4. Cultural life	48
Conclusion	54
Moving Forward	56
References.....	59

Introduction: Framing the Context of the Systemic Review

This report reviews laws and policies in Canada and Ontario that affect the rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities. It does so as part of the Expanding the Circle project that focuses on expanding the conversation on disability rights monitoring, and is guided by DRPI's *National Law and Policy Monitoring Template* (<http://drpi.research.yorku.ca/drpi-resources/drpi-national-law-and-policy-monitoring-template/>). The *Template* is based on the United Nations *Convention on the Rights of Persons with Disabilities*. Its purpose is “to monitor human rights for people with disabilities at the systemic level, that is, at the level of existing laws, policies, and programs”, and to “identify and draw attention to the most critical gaps and deficiencies in the legislative and policy framework”. DRPI's *National Law and Policy Monitoring Template* was first used to conduct systemic monitoring on the rights of people with disabilities in Canada in 2012 (Mykitiuk & Peters, 2012; Peters & Mykitiuk, 2015). The systemic monitoring conducted in this report differs in that it focuses on laws and policies in Canada and Ontario that affect the rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities. The report focuses on four categories of rights: 1) *Access to the physical environment, transportation, information and communications*; 2) *Education*; 3) *Health*, and 4) *Cultural Life* and five key human rights principles: *dignity; autonomy, participation, inclusion & accessibility; non-discrimination & equality, and respect for difference*.

In the report, the term people with disabilities is used to demonstrate that the person comes before the disability. The terms Indigenous, First Nations, Aboriginal, Inuit and Métis people is used to acknowledge the diversity among groups. However, when legislation refers to a specific group, the term used by the legislation or report is used. For instance, the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), 2007, uses the term indigenous, so when referring to this piece of legislation the term indigenous is exclusively used.

Colonization

The *United Nations Convention on the Rights of Persons with Disabilities (CRPD)*, 2008, outlines the human rights of people with disabilities. In order to consider if the specific human rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities are being met in Ontario, it is necessary to consider the historical and continued effects of colonization on Indigenous, First Nations, Aboriginal, Inuit and Métis people and communities. People living on and off reserves have access to different rights and funding as bands receive funding , for things such as education, from the Federal Government rather than the Provincial Government. For instance, the Federal Government has jurisdiction over "Indians and Land reserved for the Indians," under section 91 (24) of the *Constitution Act, 1867*. Jurisdiction over First Nations and Inuit people means the Federal Government has exclusive authority to enact legislation over First Nations and Inuit people which is mainly applied to those living on reserves. Some nations govern their own affairs. Indigenous and Northern Affairs Canada (INAC), has varying levels of involvement in self-governance. Indigenous, First Nations, Aboriginal, Inuit and Métis people are still experiencing the effects of past and present government policies which have had a general socioeconomic impact on their wellbeing. This overall lower socioeconomic status shapes access to resources and experiences of disability.

In 1867, Canada was formally established with the creation of the *British North American Act* (Waldram, 2006). *The Act* gave the government full power and control “over the Indian and lands reserved for the Indians” (Waldram, 2006). From 1871 until 1921, a number of treaties were signed between the Crown and the indigenous people of Canada (Waldram, 2006). The signing of the treaties gave the Crown the rights to use Indigenous, First Nations, Aboriginal, Inuit and Métis land for settlement, agriculture and resource development (Stephens, 2014). Indigenous people signed the treaties in part because of the promises they were made for goods such as reserve land and farming supplies (Waldram, 2006).

Colonization has a significant impact on both past and present colonial activities, through attempting to assimilate Indigenous, First Nations, Aboriginal, Inuit and Métis people and ridding them of their cultural identity and land (Lavallee and Poole, 2010). In 1857, the *Gradual Citizenship Act* and *Indian Act*, (1874 and amended in 1985) was created which controlled and continues to regulate who is deemed a “status Indian” as well as directing education, health, and the land of Indigenous, First Nations, Aboriginal, Inuit and Métis people (Lavallee and Poole, 2010). Through historic Canadian legislation, indigenous people were banned from participating in their spiritual ceremonies. They faced physical consequences for speaking their languages in Indian Residential Schools (IRS), and today, Indigenous, First Nations, Aboriginal, Inuit and Métis children are apprehended by child services at a rate that is significantly higher than other people in Canada (Lavallee and Poole, 2010).

Understanding the colonial history is important when considering the way in which the human rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities are being met. Bryant, Raphael, & Rioux (2010), explains that human rights often depend on the realization of other rights. The “[l]inks between one right and another can impact the realization of both rights” (2010, p. 101). For instance, when thinking about the right to health, it is important to acknowledge other rights, and how those rights are implemented to understand how the right to health is experienced.

International human rights law differentiates between health and health care, acknowledging that health is a broader concept that includes both health care and social conditions which shape health (Yamin, 2005). For instance, when asking if people with disabilities have equal access to health, it is important to contextualize this answer by acknowledging that many reserve communities do not have access to safe drinking water (Shining Turtle, 2015). In 1995, Canada placed a 2% cap on reserve funding for education, health and social services. However, the Indigenous, First Nations, Aboriginal, Inuit and Métis population continues to grow at around 5 % per year. In contrast, provincially funded programming increases at anywhere between 2% and 6% per year.

Systemic Monitoring

This systemic report focuses on the four categories of rights: 1) Access to the physical environment, transportation, information and communications; 2) Education; 3) Health, and 4) Cultural Life. The systemic monitoring project follows the guidelines in the CRPD, and asks questions about whether the rights in the CRPD are accessible to Indigenous, First Nations, Aboriginal, Inuit and Métis people in Ontario. This report examines the gaps between rights granted in theory by international, national, and provincial legislation, and what actual access to rights looks like. This project examines rights, asks if and how they are being met, and why they are not being met in some areas and suggests how these gaps can be addressed.

Just as Indigenous, First Nations, Aboriginal, Inuit and Métis people are not a homogenous group, disability related needs also differ. For example, the question of whether something is accessible for an individual with a neurological impairment may have a different answer than asking if the same thing is available to a person with a hearing impairment.

International human rights legislation not only focuses on specific rights, such as the right to accessibility, but also highlights five general human rights principles. These five principles will be used to consider how laws and policies and their enactment are meeting the human rights principles for each of the four areas considered in this report. The five key human rights principles considered include: *dignity; autonomy, participation, inclusion & accessibility; non-discrimination & equality, and respect for difference.*

Dignity refers to the inherent worth of all people. Human rights are about protecting and promoting the self-respect of all people. All people should feel respected in their community, in society and in daily life. *Autonomy* means that every person is in the center of any decision that affects them. *Participation, inclusion & accessibility:* Participation is including all people in decision making processes. This can be at a local level, like at a church and in the community, or at a larger level such as political participation.

Inclusion and accessibility is the idea that all people can participate in society. This occurs when society is set up without physical or social barriers and is accessible to all people. Accessibility is about the physical and social environment being adapted to accommodate diverse needs. *Non-discrimination and equality* means that rights are guaranteed to everyone. Discrimination happens when certain groups are shown favoritism which can happen through law, and policies that favour one group of people over another. Equality does not mean that all people will be treated the same, but rather that adjustments be made in relation to needs so that they can access their rights equally and have an equal outcome. *Respect for difference* means honoring difference as part of human diversity. Difference is not a reason to deny rights. The community and society is responsible to adapt in accommodating difference (Disability Rights Promotion International, 2014).

Demographic

Part of the complex nature of this discussion is around definitions related to identity. For clarity, in this report, all Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities are addressed as one, while acknowledging differences in experiences. For example, the 2011 Statistics Canada census found that the number of Indigenous, First Nations, Aboriginal, Inuit and Métis people vary depending on what definition is used. Greater numbers of people reported having Aboriginal ancestry in comparison to people who identified as having an Aboriginal identity (Statistics Canada, 2011, Aboriginal peoples in Canada). According to the census, there are 301,403 Indigenous, First Nations, Aboriginal, Inuit and Métis people in Ontario. Most have a single First Nations identity, 201,100, and of them 141,165 have registered Indian status. The numbers also account for people with one First Nation identity who do not have status, single Métis identity, single Inuit identity, multiple Aboriginal identities, and identities not included elsewhere (p.6).

The Indigenous, First Nations, Aboriginal, Inuit and Métis population in Ontario is younger than the non-Indigenous population. The median age for Indigenous, First Nations, Aboriginal, Inuit and Métis

people is 31; the median age for all other people in Ontario is 40 (Statistics Canada, 2011, p. 20). This age difference suggests a potential need for different services between the two populations. For instance Indigenous, First Nations, Aboriginal, Inuit and Métis communities may have a greater need to focus on education because of its younger cohort. Statistics on employment, health and education change in relation to type of Aboriginal identity (Aboriginal Statistics at a Glance: Second Edition, 2015). For instance, Métis people are more likely to have a post-secondary degree, diploma, or certificate, followed by First Nations and then Inuit (Statistics Canada, 2015, p.18). Approximately 22% of Indigenous adults in Ontario have changed communities (Ontario Aboriginal Health Access Centres, 2015, p. 6). Ontario has the highest level of off-reserve migration in Canada. Ontario's Indigenous, First Nations, Aboriginal, Inuit and Métis population has increased by 24% between 2006 and 2011 (Ontario Aboriginal Health Access Centres, 2015, p. 6).

In 2011, 48% of all Indigenous, First Nations, Aboriginal, Inuit and Métis people in Canada between the age of 25 and 64 years reported having a post-secondary education, whereas 65% of non-Indigenous, First Nations, Aboriginal, Inuit and Métis people in the same category reported having a post-secondary education. Subsequently, the median income after tax was lower for Indigenous, First Nations, Aboriginal, Inuit and Métis people who earned approximately \$20,000 after taxes compared to non-Indigenous Canadians who earned \$27,600. Indigenous, First Nations, Aboriginal, Inuit and Métis people of working age are also less likely to be employed in comparison to non-Indigenous Canadians. According to the 2011 National Household Survey, 62.5% of Indigenous, First Nations, Aboriginal, Inuit and Métis people who are working age are employed, compared to 75.8% of non-Indigenous people.

Around 31% of Indigenous, First Nations, Aboriginal, Inuit and Métis people have a disability. Female elders have one of the highest rates of disability in Canada (Pierre, 2007, p. 9). Government policies and the social determinants of health shape Indigenous, First Nations, Aboriginal, Inuit and Métis experiences of health and increased rates of disability. In contrast, according to the Employment

and Social Development Canada (2012), around 15% of people in Ontario have a disability. The top three types of disabilities reported by Statistics Canada for all Canadians were in relation to pain, flexibility and mobility. The type of disabilities documented change in relation to age group. Young people between the ages of 15 to 24 were most likely to report learning and psychological disabilities; people between 45 and 64 years were most likely to experience disability in relation to flexibility, mobility and pain.

Different experiences of what it means to have a disability, and the different living conditions between Indigenous, First Nations, Aboriginal, Inuit and Métis groups is significant when trying to document attempts to access rights. Accommodation related needs change in relation to the type of disability; thus what needs to be done to ensure the implementation of human rights is not the same for all types of disabilities. As was acknowledged at the *Expanding the Circle Annual General Meeting* (2016), the experience of each person accesses their rights differently; it is important to acknowledge the systemic framework, but also not to discredit the reality of individual experience.

1. Access to the physical environment, transportation, information and communications

The CRPD, 2008 art 9 (1), 9 (2) (a-e), addresses the general topic of accessibility. It holds that states should take “appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas.” Due to the fact that article 9 is a wide-ranging accessibility standard, other laws may not address all of its factors when considering the rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities in Ontario. The *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), 2007 art. 16, addresses the rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people to establish their own media and to have

access to non-Indigenous media. Article 30 of the CRPD specifies the right to participation in cultural life, recreation, leisure and sport.

In Canada, the *Canadian Charter of Rights and Freedoms*, 1982, addresses the subject of equality rights and states 15(1), “[e]very individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour...mental or physical disability.” This ensures that Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities have equal access to the law and equal access to the protection of their rights under the law as other Canadians.

The *Constitution Act*, 1982, s 36 (1) (a, c), addresses equalization and regional disparities. This section states that without changing the rights of the authority of Parliament, or the rights of any of the provincial legislatures, Parliament, legislatures and the Government of Canada are committed to (1) a, “promoting equal opportunities for the well-being of Canadians.” Section 36 (1) (c), addresses commitment to, “providing essential public services of reasonable quality to all Canadians.” Providing services for all Canadians includes promoting accessible public services including for people who are Indigenous, First Nations, Aboriginal, Inuit and Métis.

The *Canadian Human Rights Act*, 1985, applies to federally regulated services and also outlines accessibility standards. Accessibility standards are addressed in s 24 (1): “[t]he Governor in Council may, for the benefit of persons having any disability, make regulations prescribing standards of accessibility to services, facilities or premises.” This section addresses the potential for the creation of regulations to create accessibility standards for the built environment, and transportation.

Ontario has specific legislation that addresses the general right to accessibility. The *Human Rights Code*, 1990, s1 states that “every person has the right to equal treatment with respect to services, goods and facilities without discrimination because of race, ancestry...disability.” Section 34 states that if a person believes their rights were violated under Part 1 they may apply for a tribunal under s 45 (2).

The *Accessibility for Ontarians with Disabilities Act, 2005*, further protects accessibility rights. The *Integrated Accessibility Standards, 2011*, s 3 (2) provides that people with disabilities have equal opportunities to use and benefit from goods and services. This includes access to the built environment, and transportation. The *Accessibility Standard for Customer Service, 2007*, an Ontario Regulation, outlines relevant regulations in relation to the access of goods and services. It also addresses access to information and communication pertaining to goods and services. Section 3 (4) states, that when providing goods and services, the provider should communicate in a way that “takes into account the person’s disability.” Section 9 (1) states that if a goods or service provider is required to give a document to a person with a disability, the provider shall produce a document that takes into consideration the person’s disability. Also included is a section on mandatory training of staff who interact with the public regarding how to provide goods and services to people with disabilities (s 9 6(1)). The *Ontarians with Disabilities Act, 2001*, S.O. 2001, s 14 has guidelines for accessibility and public transportation.

Despite the legislation protecting human rights in Ontario, there are few cases relating specifically to accessibility of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities. There are cases relating to non-Indigenous people with disabilities that have upheld their accessibility rights. A potential reason for this dearth of cases may be the lack of awareness of human rights legislation as well as a lack of resources to address violations.

In *Wesley v. 2252466 Ontario Inc.* (2014), a gay Aboriginal man who was also deaf was hired by the respondent company to do landscaping work. He attended the interview for the position with an ASL interpreter and it was decided that he would communicate in the workplace using a notepad (para 15). He brought an interpreter with him to training, but they were sent home (para 16). His coworkers got tired of communicating with him via note-pad (para 40). After six weeks he was laid off. The Human Rights Tribunal of Ontario (HRTO) ruled that there was not enough evidence to prove that he was laid off because he was Aboriginal. However, his hearing disability was the main reason he was laid off (para

47). The company was found liable, because they did not meet his disability related needs (para 46). This case is an example of the HRTO upholding communication rights in the workplace.

Lisa Buck (who is Aboriginal) and Bradley Bondar, both filed human rights complaints of discrimination on the grounds of access to goods and services under s. 34 of the Ontario Human Rights Code, 1990. They settled a joint human rights complaint with the Ontario Northland Transportation Commission (ONTC), regarding lack of accessibility pertaining to public transit options. As part of the settlement, three motor coaches will be made wheelchair accessible, and efforts will be made to have these coaches accessible to passengers upon request (NewsWire, 2014). Northland drivers will also complete human rights training (NewsWire, 2014). While ancestry was not an issue in this case, significant populations of Indigenous, First Nations, Aboriginal, Inuit and Métis people live in northern Ontario. Indigenous, First Nations, Aboriginal, Inuit and Métis people are the fastest growing population in northern Ontario (Spotton, n.d., p. 15). This settlement has significant implications for people trying to gain access to the physical environment, and this decision has resulted in making public transit more accessible for all people with disabilities using this transportation service.

It is also worth noting that restrictions around Indigenous, First Nations, Aboriginal, Inuit and Métis people filing human rights complaints have been removed relatively recently. Since 2011, Indigenous, First Nations, Aboriginal, Inuit and Métis people can now file human rights complaints against First Nations governments as well as federally-run Aboriginal organizations if decisions made under the federal *Indian Act* are found to be discriminatory (Disability Rights Promotion International, 2014, p 20).

Analysis

Indigenous, First Nations, Aboriginal, Inuit and Métis people in Ontario with disabilities are not a homogenous group. Quality of life and access to resources and the built environment change based on a

number of things including whether people are living on reserves or elsewhere in Ontario, and if they reside in northern or southern Ontario.

The *Indian Act*, 1985, c I-5 gives the Federal Government responsibility for reserves and is implemented by Indigenous and Northern Affairs Canada (INAC). People living on reserves have the right to housing and education through the *Indian Act*. However, if Indigenous, First Nations, Aboriginal, Inuit and Métis people move from the reserve some of their rights may be restricted, as they will fall under the jurisdiction of the Provincial Governments (Disability Rights Promotion International, 2014, p.22). INAC may transfer money for housing and education to band councils; however, there are restrictions around the use of funds. This struggle over power and ability to use funds in a way deemed best at the local level contributes to subpar living conditions for all people on reserves. Furthermore, the disproportionate funding cap on reserves shapes how much access to funding bands have in comparison to provincially funded resources (Shining Turtle, 2015).

Any consideration of housing needs to recognize that in Ontario 2.4 % of Indigenous, First Nations, Aboriginal, Inuit and Métis children live with foster parents, compared to 0.2 percent of non-Indigenous children (2011 p.22, *Aboriginal peoples in Canada*). The fact that Indigenous, First Nations, Aboriginal, Inuit and Métis children are more likely to live in foster care continues a conversation about Indigenous, First Nations, Aboriginal, Inuit and Métis children being separated from their families. Unfortunately, the statistics do not include the number of children with disabilities in care. However, lack of access to resources to care for people with disabilities may result in disproportionate numbers of children with disabilities being placed in care.

Housing, more particularly access to the built environment, in relation to housing and infrastructure on reserves is a significant issue for accessibility. The general state of poverty on reserves impacts all residents. There are many social conditions that negatively impact health on reserves. The Assembly of First Nations identifies challenges including: “overcrowding, mould contamination, lack of

basic amenities” (2011, *Fact Sheet*). Lack of, or poor infrastructure including roads, water and hydro are also listed as problems. The Assembly of First Nations suggest that it is a challenge to access housing programs, and there is poor program delivery by both the Canadian and First Nations governments (Assembly of First Nations, 2011, *Fact Sheet*). The state of health is shaped by living in subpar housing. The Assembly of First Nations, explains that, “43.5% of adults with asthma and 52% of those with chronic bronchitis are living with mold in their homes.” Approximately 23% of people on reserves live in overcrowded housing units; overcrowding is linked to health problems (Assembly of First Nations, 2011, *Fact Sheet*).

This problem is often related to lack of band funding or misuse of funds and poor correlation of resources between the Federal Government, and band councils. For instance, the recent Attawapiskat housing crisis resulted in a question about how the band funds were used. People were forced to find long-term shelter in temporary housing units that were overcrowded. Shisheesh, a former band councillor elaborated, “[t]here are families in the two emergency trailers who have been living in single rooms, sharing kitchens and washrooms, for the past three years” (Aulakh, 2012). The unemployment rate is 70% on this reserve (Aulakh, 2012). While no specific mention of people with disabilities is made in relation to Attawapiskat, it is likely that the built environment, and limited transit options are not accessible, when the entire community lives in a state of poverty.

Issues around the safety of housing and other infrastructure on reserves is also a problem of jurisdiction, neither federal nor provincial building codes can be enforced on reserves so the building inspectors have no authority (Enforcing building, 2014). The quality of housing and infrastructure is directly related to the ease of access of to the physical environment.

There are also limited supports for individuals with disabilities living on reserves. For instance, there is an Assisted Living Program, which is an income dependent program that provides non-medical supports for people with disabilities and seniors. There are three aspects of this program: in-home care, adult foster care and

institutional care. The objective of the assisted living programs is to provide programming that helps individuals maintain their independence, while enhancing their quality of life. Health professionals identify individuals that need supports, but that do not have the financial ability to obtain the supports themselves (Indigenous and Northern Affairs Canada, 2013).

There remains a lack of accessible housing for Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities off reserves. There are allocated funds for creating publically funded housing for Indigenous, First Nations, Aboriginal, Inuit and Métis people in the community such as the Off-Reserve Aboriginal Housing Trust Fund (*The Ontario Off-Reserve Aboriginal Housing Trust Report, 2008*). This fund is to provide temporary supports for housing needs of Indigenous, First Nations, Aboriginal, Inuit and Métis people in Ontario to supplement government funds. *The Ontario Off-Reserve Aboriginal Housing Trust Report, 2008* identified barriers to accessible housing, some of which are related to lack of consideration of Indigenous, First Nations, Aboriginal, Inuit and Métis family structures and size. Furthermore, some people lived with a dependent who is not a child, so they were excluded from a number of available housing options (*The Ontario Off-Reserve Aboriginal Housing Trust Report, 2008, p. 35*).

Under the Ontario Affordable Housing Program, there are “modesty requirements” pertaining to both unit size and amenities. The prices are set based on maximum income levels which does not consider the “design or density of the housing, consequently inhibiting the development of affordable housing for segments of the Aboriginal population with specific needs, such as people with disabilities or large, extended families” (*The Ontario Off-Reserve Aboriginal Housing Trust Report, 2008, p. 48*). There is a call for Indigenous, First Nations, Aboriginal, Inuit and Métis involvement in the design process. There is a general lack of accessible housing options. One individual reported,

There are only two units that are wheelchair accessible in our town. Both are rented. When I leave home I have to leave town as there is nowhere for me to live other than my parent’s

[home]. I'm going to go to school and I've already been told there might be a two or three year waiting list for the next town I want to go to school in... you need to make sure more wheelchair units are available (*The Ontario Off-Reserve Aboriginal Housing Trust Report, 2008, p. 48*).

Cost was identified as the main barrier to developing sustainable housing and 40% of housing providers stated that their units are not accessible (p. 34). Affordable, accessible off reserve housing is especially important because people may need to live off reserve to access disability related services.

Racism and discrimination was also identified as barriers to accessible housing as local approval is needed for accessible housing projects. Racism may result in communal housing projects being located in less central areas of a community (*Ontario Off-Reserve Aboriginal Housing Trust Report, 2008, p. 60*). Housing barriers are particularly detrimental to people with disabilities who likely already facing barriers in accessing the physical environment, and public goods and services.

A study of the health needs of First Nations people in Hamilton found that poverty impacted where people live. Approximately 78% of First Nations people in Hamilton earn less than \$20,000 per year. Furthermore, 70% of the First Nations population lives in the lowest income areas, compared to 25% of the rest of the population (*Our Health Counts, 2011, p. 10*). Additionally, 63% of those surveyed stated that they did without essentials including food, in order to afford shelter (*Our Health Counts, 2011, p. 10*). Several suggestions came from this report including that governments and services that provide housing supports for low income individuals collaborate with urban Aboriginal agencies to understand the needs of the community (p.12). They also suggest that governments collaborate with communities to understand the social determinants of health and organize to address these inequalities (p.12-13). They suggest that there is a need for self-determination in health care: "that municipal, provincial and federal governments recognize and validate the Aboriginal cultural world-views and that self-determination is fundamental" (p.13). Lack of health care options and poor health care for all First Nations people in a community disproportionately affect the care that people with disabilities receive.

The right to accessibility is linked to the enactment of other rights, such as the right to health care and adequate housing.

There is legislation that ensures people with disabilities have access to public transit. However, an initial search for transit on reserves in Ontario showed few public transportation options. People with physical disabilities on reserves may have significant difficulties travelling both in their community and off the reserve on a regular basis.

Culture, education, poverty and lack of transportation shape the ability of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities to access information. While English and French are the official languages of Canada, some Indigenous, First Nations, Aboriginal, Inuit and Métis people speak Aboriginal languages. According to Statistics Canada, 2011, less than 1% of people identified an Aboriginal language as their mother tongue. It appears that communication and information for many public and private services are not readily available in Aboriginal languages. Health Canada identifies language barriers as a problem for people accessing health services (Language barriers, 2001). The *Canada Health Act*, 1985, includes “access to health services without financial or other barriers” and outlines what this entails (p. 16). Interpreters for health services have not been considered medically necessary and thus have not been covered by the government (Language barriers, 2001 p. 17). There are however, specific health care centres for Indigenous, First Nations, Aboriginal, Inuit and Métis people both on and off reserve, including the Ontario Aboriginal Health Access Centres (Association of Ontario Health Centres, n.d. , *Health Access Centres*). Access to resources such as health care in Aboriginal languages still may not be available to all Indigenous, First Nations, Aboriginal, Inuit and Métis people, and there are further questions of how accessible these services are to people with disabilities.

Information and communication may be hindered by lack of digital advancement on reserves. Lack of access to funds potentially creates a technology divide. Technologies like voice to text software

that make internet use accessible for people with specific disabilities are expensive; people living in poverty are less likely to have the means to afford accessible technologies. A cultural consideration is whether traditional focus on oral means of communication is developed in an accessible way. Given lower education rates, the focus on accessible formats such as sign language and Braille may be less relevant for some populations of people with disabilities in Ontario.

Compliance and the Right to Accessibility

Significant accessibility improvements need to be made for Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities to be fully included in society. Different impairments result in different accessibility needs. For instance, the physical environment may be accessible for an individual with a mental health history, but not a person using a wheelchair. Human rights are often situated as being granted on an equal basis for all, as outcome measures. For example, the *Integrated Accessibility Standards, 2011, s 3(2)* explains that people with disabilities must have equal opportunities to use and benefit from goods and services. This includes access to the built environment, and transportation; in reality, however, an individual needing accessible transit may only be able to access transit in urban locations when public transit systems are available.

Dignity is challenged when people do not have equal access to access the resources in the community. For instance, dignity is impacted by access to accessible housing. Without accessible housing and without access to the built environment Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities get the message that their vital needs are not significant. The focus on funding and jurisdiction conflicts challenges both *dignity* and *autonomy*.

For Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities, *autonomy* is limited by the relative lack of services to which they have access restricting choice and control. The relative poverty of Indigenous, First Nations, Aboriginal, Inuit and Métis people, compared to others living in Ontario further restricts access to resources. For example, people may have to be living on

reserve to quality for some services; however, they may not have access to transportation on the reserve if there is no public transportation system. Funding limitations both on and off reserve suggest that individuals with disabilities may have fewer options when trying to get accessible housing as previously noted (*The Ontario Off-Reserve Aboriginal Housing Trust Report, 2008*).

The lack of accessible communications, built environment, and transit may result in a more general *lack of inclusion*. For example, what does it mean if the space limitations for the Ontario Affordable Housing Program disregard the physical needs of people with disabilities wishing to live with their extended families? It appears that Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities may not have consistent access to communication tools, at the same level as other people in Ontario. Lower incomes, both on and off reserve may hinder the ability to use accessible technology. Limited housing options and ability to choose what community to live in results in very specific inability to exercise rights of *dignity, autonomy and equality* (*The Ontario Off-Reserve Aboriginal Housing Trust Report, 2008*, p. 48). Indigenous, First Nations, Aboriginal, Inuit and Métis people are disproportionately affected by jurisdiction disputes which results in less disability related funding than for other people in Ontario, and in turn less accessibility.

2. Education

The CRPD art. 24 recognizes the rights of people with disabilities to get an education. States are obligated to create an equal system for education that is inclusive of lifelong learning. The UNDRIP also addresses the right to education. Article 14.1 establishes that Indigenous, First Nations, Aboriginal, Inuit and Métis people have the right to create their own education systems. Article 14.2 declares that Indigenous, First Nations, Aboriginal, Inuit and Métis people, especially children, have the right to access all levels of education. Finally, art 14.3 explains that Indigenous, First Nations, Aboriginal, Inuit and Métis people especially children have the right to access an education when possible in their own culture.

The *Constitution Act of Canada, 1982*, s 36 (1) (a, c) addresses “equalization and regional disparities.” Section 36 (1) (c) addresses commitment to “providing essential public services of reasonable quality to all Canadians.” Education can be considered an essential public service to which people need equal access independent of geographic location. Section 93 grants the provinces the right to make education related laws.

Canada has specific legislation protecting the educational rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people. *The Indian Act, 1985*, s 116 states that every child over the age of seven must attend school until the age of 16 years, (Section 116 (1) (b)) unless they are sick, (s 117 a) or they have appropriate instruction elsewhere 117 (b). Education on reserves is federal jurisdiction and funding is provided by the Federal Government.

The *Education Act, 1990*, c E. 2 governs education in Ontario, but not on reserves. The *Act* includes important definitions for disability and education. Under the *Act*, an exceptional pupil is a student whose “behavioural, communicational, intellectual, physical or multiple exceptionalities are such that he or she is considered to need placement in a special education program by a committee, established under subparagraph iii of paragraph 5 of subsection 11 (1), of the board.” Special education programs are defined as programs that are modified for exceptional pupils as the result of assessments and evaluations. Special education service refers to resources and facilities that are necessary for the creation and implementation of special programs. Section 8 (3) states:

The Minister shall ensure that all exceptional children in Ontario have available to them... appropriate special education programs and special education services without payment of fees by parents or guardians resident in Ontario, and shall provide for the parents or guardians to appeal the appropriateness of the special education placement.

Section 8 (3a) requires boards to use procedures for early and continued intervention of learning abilities and needs. The reserves are federally funded, and reserves do not receive as much funding as

the Provincially Funded schools. INAC spent approximately \$14, 471 per student living on reserves in Ontario in the 2012-2013 school year. INAC developed an agreement with each of the 134 Nations as a basis for transferring funds to each band (Ontario Ministry of Education, 2007). The reserves incorporate culturally specific programming and the Ontario curriculum in their education systems. Education is then managed locally on each reserve with these funds. In Ontario, INAC directly manages seven schools with reserve funds. If there is no school on the reserve, First Nations purchase spaces in the local provincially funded school (INAC, *Federal Funding*, 2015. Section 188 (1) of the *Education Act, 1990*) mandates that a board can enter into an agreement to provide education for Indian pupils for a specific period of time. This includes the payment of fees for additional classroom accommodations (s 188 (3)). In Ontario, 82% of Indigenous, First Nations, Aboriginal, Inuit and Métis students attend provincially funded schools (People for Education, 2015, p. 9).

Funding-needs change based on the location of the school, as northern schools are more costly (INAC, 2015, *Federal Funding*). Disability related funding for students (indigenous or non-indigenous) often relies on disability classification and labelling. INAC supports indigenous student's special education needs on reserves through two programs. The Elementary and Secondary Education Program, funds education on reserves for students who have mild to moderate learning disabilities (INAC, 2015, *High-Cost Special*). Secondly, the High-Cost Special Education Program gives funding to band operated schools for students with moderate to profound learning disabilities. The funding allocations directly correspond to the individual needs of students. Bands councils, federal schools and provincial ministries are eligible for this funding. In order for students to qualify for High-Cost Special Education Program funding, students must have an Individual Education Plan (Ontario Ministry of Education, 2004) completed by the school. The IEP determines short-term and long-term goals for the student. It also specifies the learning needs and the cost of the needs. INAC has argued the need to have the IEP completed prior to applying for the funding, and the focus of both specialized funding categories on

learning disabilities may deter students from being able to access funds if their needs are outside of these categories (INAC, *High-Cost Special*, 2015).

Accessibility for Ontarians with Disabilities Act, 2005, c 11 provides accessibility guides for education. *Integrated Accessibility Standards, 2011*, s 15(1) specifies that training and educational institutions will provide material in an accessible format if requested. Section 16 (4), states that educators need disability awareness training.

A report by the Ontario Human Rights Commission (OHRC) about elementary and secondary schools found that the *Building Code Act, 1992*, c 23 is not up to par with the *Human Rights Code* regarding the rights of people with disabilities to the built environment. However, the *Human Rights Code, 1990*, is more significant than the *Building Code, 1992* and complaints about discrimination based on disability can still be filed if the *Building Code, 1992* is followed (OHRC, n.d., *Elementary and Secondary*).

Jurisdictional disputes may influence the quality of education that Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities receive. An important case was with twins, Sloan and Marvin Miller both who have Down Syndrome and live in the Mississaugas of New Credit First Nation (Hogg, 2015). The band would need an extra \$80,000 per year for education supports for the twins to attend school. INAC denied the reserve the funding request and suggested that the Nation take the funds from their already insufficient education budget of \$165,000 per year. In 2009, the Mississaugas of New Credit First Nation filed a human rights complaint with the Canadian Human Rights Commission for the twins. This complaint has yet to be resolved (Hogg, 2015).

Access

With respect to the rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities to education, it is important to recognize the context in which those rights exist, including colonization which shaped and continues to shape the education system and the acknowledged abuse

of IRS. Dr. Scott, the head of the Indian Affairs Department in 1920 explains the objective of the schools, “I want to get rid of the Indian problem... Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question and no Indian Department” (quoted in Truth and Reconciliation, 2012, p. 12). The goal of IRS was to “kill the Indian in the child” (Truth and Reconciliation, 2012, p. 12). In 1867, the Government of Canada approved the residential school model of education. The last residential school finally closed in 1996.

There is a difference in education level for Indigenous, First Nations, Aboriginal, Inuit and Métis people compared to other Canadians. Nearly two thirds of Indigenous, First Nations, Aboriginal, Inuit and Métis people in Canada between the ages of 25 to 64 have a high school education compared to 85% of other Canadians (Statistics Canada, 2011, p.26, *Aboriginal peoples in Canada*). These statistics do not include the completion rates of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities compared to other people with disabilities. Both people with disabilities and Indigenous, First Nations, Aboriginal, Inuit and Métis people when considered as separate populations do not have adequate access to education.

There is an identified knowledge gap about the special education needs of students with disabilities in Canada, particularly in Indigenous, First Nations, Aboriginal, Inuit and Métis communities. “Overall, knowledge and research on special education needs in First Nation communities remain limited and inconclusive in terms of the cultural aspects of special needs” (INAC, 2007, *Formative Evaluation*, p. 14). INAC reporting does not always address the level or specific types of disabilities that children have, making a general understanding of special education needs challenging. Available research however suggests that disability, and special needs are higher on reserves (2007, p.14).

It is difficult to compare the quality of education on reserves and off reserves, because of the partly de-centralized nature of the funding and governance structures that school systems both on and off-reserve use. Furthermore, the quality of accessible education in each individual school board and

school likely differs because of de-centralization. The provincial Ministry of Education is responsible for providing regulations and policy for the school boards. The Ontario *Education Act*, 1990 establishes school boards as corporations governed by trustees. School boards are mandated to establish Special Education Advisory Committees (Ontario Ministry of Education, 2014, *Introduction-Special Education*).

Provincially funded schools are in the process of changing their funding structure, so the effectiveness of the new structure and how it compares to the services that are available on reserves is not yet clear (Ministry of Education, 2015, p. 30). The new grant programs are based on identifying local needs, and the needs of First Nations, Métis, and Inuit students are identified as part of this focus (p. 30).

A 2001-2002 report by the Ontario Human Rights Commission (OHRC,) outlines some of the challenges that students with disabilities face when trying to access the public education system (OHRC, n.d., *Elementary and Secondary*). While this report is dated, it draws attention to problems that are ongoing. It is significant to acknowledge that students with disabilities attending provincially funded schools often face significant barriers to accessing education. For instance, stakeholders continue to express concerns about the equality of educational services available for students with disabilities. Stakeholders report that access to special education, and procedures at the local school level are not consistent with the Ministry of Education's guidelines, and that the inconsistencies may result in human rights violations (OHRC, n.d., *Elementary and Secondary*). The OHRC learned that parental advocacy is a huge part of the special education system. The Provincial Auditor's 2001 Annual Report also concluded that:

...it is up to parents to advocate for their child when they feel their child is not getting the assistance that he or she requires. However, the ability of parents to advocate for their child is variable depending on how well informed they are about available services and supports (OHRC, n.d., *Elementary and Secondary*).

If parents do not fully understand the education system and do not have the socioeconomic resources to act as advocates when their child's needs are not being met, their child may be disadvantaged in comparison to other students with disabilities. Furthermore, parents are encouraged to assume that professionals have a better understanding of the needs of their child and that education professionals know best and have the best interest of their child in mind. Parents explain that despite legislation and policy that promotes inclusion, parents often struggle to have their child's IEP followed (OHRC, n.d., *Elementary and Secondary*).

Students are also faced with negative attitudes and stereotypes regarding disability, and generalized assumptions about the effects of a specific disability on an individual. ARCH Disability Law Centre noted that disability related bullying is a significant problem and may prevent students from attending school (OHRC, n.d., *Elementary and Secondary*).

In the OHRC report about education, participants expressed concerns about the disability funding process which relies on pre-set categories of disability, rather than considering the specific needs of students. The disability related reports of needs were often based on stereotypes and exaggeration in order to qualify for funding. "The Ontario Coalition for Inclusive Education remarked: 'It pays to devalue students. Money is lost if strengths are documented. So where is the motivation to provide accommodations that promote learning?'" (OHRC, n.d., *Elementary and Secondary*). It is too early to understand if the new funding guidelines will be implemented in ways that respect the right to education of students with disabilities. There is also tension over the cost of implementing accommodations. Even though the Ministry of Education is responsible for funding, it is the school board that is often held responsible when students do not receive accommodations (OHRC, n.d., *Elementary and Secondary*).

The Ontario Government has an implementation plan for addressing the achievement gap between Indigenous, First Nations, Aboriginal, Inuit and Métis students and other students (People for

Education, 2015, p. 14). This plan seeks to increase the number of students who achieve the provincial standard on the Education Quality and Accountability Office literacy and numeracy tests, as well as increasing graduation rates. The plan includes increasing collaboration between Indigenous, First Nations, Aboriginal, Inuit and Métis communities and provincial school boards. The plan also proposes increasing connections between students, educators and the wider circle of families and communities (People for Education, 2015, p. 14). The plan also includes proposes increasing the number of Indigenous, First Nations, Aboriginal, Inuit and Métis teaching and non-teaching staff (p. 14).

Post-secondary Education

The *Accessibility for Ontarians with Disabilities Act (AODA), 2005* and the *Ontarians with Disabilities Act (ODA), 2001*, c. 32 outline the rights of people with disabilities to have equal access to post-secondary education. Ogilvie and Eggleton, in a report about barriers to post-secondary education faced by various demographics in Canada explains that Indigenous, First Nations, Aboriginal, Inuit and Métis people have lower secondary and in turn post-secondary graduation rates (2011, p.43). The 2006 census shows that 8% of Indigenous, First Nations, Aboriginal, Inuit and Métis people have a post-secondary education compared to 23% of other Canadians (Ogilvie and Eggleton, 2011, p. 43). However, while there are studies explaining barriers to post-secondary education for Indigenous, First Nations, Aboriginal, Inuit and Métis high school graduates, the barriers listed do not include disability (Statistics Canada, 2015, p. 20). People with disabilities and Indigenous, First Nations, Aboriginal, Inuit and Métis people are discussed separately and a combined discussion of the two groups and their unique experiences are not addressed

Many post-secondary students with disabilities depend on the Ontario Student Assistance Program (OSAP), in order to receive disability related grants for accommodation needs such as tutors and computer software. The Ontario Government clarifies that if you are eligible to apply for band funding, the band is the first-payer. If the band does not cover all costs, a student can still apply to OSAP,

although, there may be funding gaps for Indigenous, First Nations, Aboriginal, Inuit and Métis students with disabilities who need specialized grants for supports. INAC has funding programs and bursaries for eligible “Status Indian” and Inuit students for post-secondary education, and to help cover the cost of travel and living expenses (INAC, 2015, *Education*, 2015).

Access to higher education is linked to access to work and increasing the socio-economic status of Indigenous, First Nations, Aboriginal, Inuit and Métis people (Ogilvie and Eggleton, 2011, p. 43).

Ability to access education is directly related to future employment rates (2011, p. 33). Income also rises in relation to education level (2011, p. 36). This in turn shapes the ability to access adequate shelter, food and other things that impact quality of health. Thus the ability to access the right to education will likely shape quality of life, and access to other rights and needs.

Compliance and the Right to Education

Significant improvement is needed in order to work towards ensuring the right to accessible education for Indigenous, First Nations, Aboriginal, Inuit and Métis children. Laws often address Indigenous, First Nations, Aboriginal, Inuit and Métis right to education but the specific needs of those with disabilities are not addressed. Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities are not a homogenous group, and access to education depends on location and cost associated with a particular disability.

Many students are not able to make choices – they are therefore unable to have their autonomy respected. The complicated bureaucratic processes related to accommodation, funding, and the specific needs and desires of the student with a disability, are mostly disregarded in the accommodation process. The OHRC report explains that emphasis is given to the opinion of experts, who are assumed to know best. This process may be particularly challenging for Indigenous, First Nations, Aboriginal, Inuit and Métis communities because the individual is compartmentalized and community knowledge about disability and health may be disregarded.

All students with disabilities struggle for full participation and inclusion in the education system. Education may not be attainable as a result of many conditions - from buildings that are not accessible to staff that do not fully understand a specific disability (People for Education, 2015). There is also a lack of knowledge among elementary and secondary staff about Indigenous, First Nations, Aboriginal, Inuit and Métis culture (People for Education, 2015, p.9). Often, there are debates around what accommodations are best for individual students, and also about what inclusive education means. In addition, students have been forced to wait as schools debate funding for accommodations (OHRC, n.d.). Professional assessments are needed for education supports and there are often long lines for assessments. Delayed supports for accessible education violate the right to education for students. Parents are expected to play an advocacy role in their child's education. While favouritism is not outwardly shown, guardians who have a higher income and education have a better chance of helping their child overcome barriers in the education system.

Differences in funding and jurisdiction mean that different, and often fewer services are available on reserves for special education, resulting in discrimination against Indigenous, First Nations, Aboriginal, Inuit and Métis students with disabilities. Therefore, the realization of right to education is experienced differently based on students' location. On July 5, 2016, the Federal Health Minister Jane Philpott and Indigenous Affairs Minister Carolyn Bennett announced up to \$382 million will go toward the equal treatment of on-reserve children with a disability or a short-term condition in Canada, "The Canadian Human Rights Tribunal ruled in January that the Canadian government was racially discriminating against 163,000 First Nations children and that to change this, Ottawa should implement Jordan's Principle." Cindy Blackstock of the First Nations Child and Family Caring Society of Canada "questions how Ottawa will define Jordan's Principle and if they will apply it to all services for children including education" (Talaga, 2016). Funding for children with disabilities on reserves could help the realization of the right to equal education.

There appears to be little room in the current legislation to consider the intersectional needs of students, including students with multiple disabilities. It appears that funding results in emphasizing negative qualities. There may be little room to address the needs of a student as a whole and their cultural knowledge and understanding of disability. Often in the mainstream education system there is inadequate understanding of and *respect for difference*. Disability is framed as a limitation from which students must continually play catch-up from, but there are not adequate accommodations to make this a reality.

3. Health

The right to health includes both health care and other factors that shape health (Yamin, 2005). There is an international framework that protects the right to the highest attainable standard of health. Article 12 of the *International Covenant on Economic, Social and Cultural Rights*, (ICESCR) 1976, guarantees that everyone has the right to the highest attainable level of both physical and mental health. In 2000, CESCR created a General Comment about the meaning of the right to health. Significantly, the General Comment acknowledged the link between the right to health to other rights such as the right to food and housing (Bryant et al., 2010, p. 97; *General Comment No.14. The Right to the Highest Attainable Standard of Health*, 2000). The General Comment acknowledges that the right to health does not exist in isolation, but relies on other rights. This is significant for contextualizing what the right to health means for indigenous people with disabilities in Canada. The Committee understands health as timely and appropriate care, and including other determinants of health such as clean drinking water, safe food and access to health information (Bryant et al., 2010, p. 98-9; *General Comment No.14. The Right to the Highest Attainable Standard of Health*, 2000).

The right to health includes both freedoms and entitlements. For instance, freedom includes the ability to determine what happens to one's body (*General Comment No.14. The Right to the Highest Attainable Standard of Health*, 2000). Entitlement is about having the right to access a health system

and attain the highest possible standard of health (Bryant et al., 2010, p. 99; *General Comment No.14. The Right to the Highest Attainable Standard of Health*, 2000). Lastly, all services must be accessible, available and of good quality (Bryant et al., 2010, p. 100). The right to the “highest attainable standard of health” is significant for people with disabilities; because it clarifies that they are entitled to the same standard of health, and cannot be discriminated against because of disability (Bryant et al., 2010, p. 107).

Article 25 of the CRPD outlines the right to health, specifically in the context of persons with disabilities. People with disabilities, like all people, have the right to the “highest attainable standard of health without discrimination on the basis of disability.” Article 25 acknowledges providing services as close as possible to people’s communities. The article does not address culture. The UNDRIP art. 21.1 states that indigenous people have the right to the improvement of their economic and social conditions, including health. Article 25 also mandates that states “shall” take “effective measures” and when necessary special measures to ensure the continued improvement of economic and social conditions paying special attention to indigenous Elders and persons with disabilities. Article 24.1 states that indigenous people have the right to their traditions and medicines and to practice their traditional approach to health, having equal access to social and health services. Like the CRPD and the CESCR, Article 24.2 of the UNDRIP mandates that indigenous people have the right to the highest attainable standard of health. The UN Special Rapporteur for Health argues, “Lessons should be learned from past and present experiences, which demonstrate that any hierarchy among human rights, a prioritizing of one right or one group of rights over another, leads to detrimental outcomes and systemic violations of human rights” (Un Human Rights Council, 2015).

Access to health care services for Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities is complex and like other services for this population, jurisdiction debates arise and thus essential services are not always available (NCCA, 2011, *Aboriginal Health: A Patchwork of Policies and*

Legislation) . The laws governing health care for people living on reserves and off reserves differ. *The British North American Act, 1867* defines health services as a provincial responsibility. The *Indian Act, 1867* includes health in s. 73: (g) to provide medical treatment and health services for Indians; (h) to provide compulsory hospitalization and treatment for infectious diseases among Indians; however, the language is not specific.

The Federal Government's Indian Health Policy in 1979 makes clear the government's role in the provision of health care (Health Canada, 2014, *Indian Health*). The policy lays out the integrated nature of health care with the responsibility for care shared between Federal, Provincial, and Municipal governments, Indian bands and the private sector (Health Canada, 2014, *Indian Health*).

The Government of Canada notes that there are different understandings of who is responsible for health care (Parliament of Canada, 2010).

The *Indian Health Policy* comes from recognition of the commitment of the government to treaties and to assist in the preservation of culture (Health Canada, 2014, *Indian Health*). It acknowledges the conditions of community decline and poverty which affect many Indigenous, First Nations, Aboriginal, Inuit and Métis people and seeks to create a framework to change these conditions which affect health. The policy addresses three central areas: community development, strengthening the relationship with the Federal Government, and the Canadian health system. The Federal Government describes its role as:

[being] committed to maintaining an active role in the Canadian health system as it affects Indians. It is committed to encouraging provinces to maintain their role and to filling gaps in necessary diagnostic, treatment and rehabilitative services. It is committed to promoting the capacity of Indian communities to play an active, more positive role in the health system and in decisions affecting their health (Health Canada, 2014, *Indian Health*).

The language of encouragement and filling gaps, suggests that there is space for this piecemeal style of policy to be ineffective, with each level of government left with space to interpret their role and responsibility.

Services to “status Indians” are provided through the First Nations and Inuit Health Branch (FNIHB) (National Collaborating Centre for Aboriginal Health, 2011, *Setting the Context*). Health Canada, which is federally mandated, works with other federal and provincial partners to support healthy Indigenous, First Nations, Aboriginal, Inuit and Métis families and communities. They support the greater control of health systems by Indigenous, First Nations, Aboriginal, Inuit and Métis people. FNIHB either funds or directly delivers community-based health programs and disease prevention, home and community care services, non-insured health benefits and communal disease and environmental health prevention. Métis people are not eligible for non-insured health benefits (Health Canada, 2015, *First Nations and Inuit Health*).

The health policy in Canada is complex, and does not address the needs of Indigenous, First Nations, Aboriginal, Inuit and Métis people not residing on reserves. Jurisdiction debates about who should pay for health services have resulted in gaps in the delivery of health care. Jordan River Anderson was a child from Manitoba’s Norway House Cree Nation (National Collaborating Centre for Aboriginal Health, 2011, *The Aboriginal health legislation and policy framework in Canada*). He had neuromuscular disorder that involved the use of multiple service providers. He spent his entire life in a hospital because of a jurisdiction dispute between the Federal and Provincial Governments about who would pay for his home care. A private member’s motion was introduced in the Federal House of Commons, referred to as Jordan’s Principle, that mandate that where there is a jurisdiction dispute surrounding the care of an Indigenous, First Nations, Aboriginal, Inuit or Métis child, the government of initial contact will provide services, and issues of funding will be addressed later (National Collaborating Centre for Aboriginal Health, 2011, *The Aboriginal health legislation and policy framework in Canada*). Despite the passing of

Jordan's Principle, there is still a struggle with the coordination of the responsibilities of the three levels of government. For instance, in 2013 there were 50 cases of Indigenous, First Nations, Aboriginal, Inuit and Métis children trying to access funding through Jordan's Principle in Manitoba (Peters, 2013). The Federal Government has denied that there are jurisdictional disputes.

Maurina Beadle lives on the Pictou Landing reserve in Nova Scotia with her son Jeremy Meawasige. The cost of his care and treatment for disability related needs is \$6,000 per month. Beadle lives on a reserve, so the cost of Meawasige's care is the responsibility of the Federal Government but the Federal Government wanted to cap the payments at \$2,000 per month. Beadle fought for the same level of funding for care that they would receive if they lived off the reserve. During the case, Pictou Landing First Nation was subsidizing his care costs. The Federal Court of Canada ruled that in the case of Pictou Landing Band Council & Marina Beadle v. Attorney General of Canada, the Federal Government must cover the entire cost of his care in keeping with Jordan's Principle (CBC News, 2014). This funding debate appears to disproportionately affect people with severe disabilities as the Federal Government does not adopt its role as first-payer. The Federal Government appealed the favorable federal court ruling (Pictou Landing Band Council and Maurina Beadle v. the Attorney General of Canada [PLBC v. Canada], 2013); however, it dropped the appeal, meaning that the favorable precedent remains (First Nations Child & Family Caring Society of Canada, 2015).

Jordan's Principle is significant for child welfare and health in Canada. The First Nations Child and Family Caring Society (Caring Society), and the Assembly of First Nations filed a complaint in 2007 regarding the Federal Government's service provision for First Nations children and family services, as well as for failing to implement Jordan's Principle. The Caring Society held that failure to implement Jordan's Principle is discriminatory under the *Canadian Human Rights Act* (First Nations Child, 2015, *Role of Jordan's Principle*, para 392). The case argues that children are denied access to services simply because they are Indigenous, First Nations, Aboriginal, Inuit or Metis. The lack of clarity in the way

funding is provided means that children may be removed from their homes in order to access resources (para 408). The Caring Society argued that Canada's standard of "complex medical issue" is "ambiguous, doesn't provide a faster mechanism for urgent cases and has no clear rationale behind it" (para 446). The Caring Society has asked for an order saying that that approach to Jordan's Principle is discriminatory and the Principle needs to be properly implemented (para 483; First Nations Child, 2015, *Role of Jordan's Principle*). The debate around the proper implementation of Jordan's Principle illustrates issues arising from jurisdiction disputes. "The Canadian Human Rights Tribunal ruled in January that the Canadian government was racially discriminating against 163,000 First Nations children and that to change this, Ottawa should implement Jordan's Principle" (Talaga, 2016). Following the ruling, the Federal Health Minister Jane Philpott and Indigenous Affairs Minister Carolyn Bennett announcement for up to \$382 million to go toward on-reserve children with a disability or a short-term condition in Canada. The funding should be used to prevent complex jurisdiction debates and to ensure people's access to health. "Health Canada said that it will work with First Nations and a regional service co-ordinator to help assess children's needs and come up with care plans, according to a government backgrounder" (Talaga, 2016). It is significant to note that Jordan's Principle particularly applies to children with disabilities. It does not address issues related to lack of access to services for adults on reserves unresolved

The *Constitution Act, 1876* does not directly include health as solely or clearly a Federal or Provincial jurisdiction. The Supreme Court holds that health is not included in the *Constitution Act, 1867*, but is to be addressed in Parliament (s. 91) and Provincial (s. 92) legislation in relation to the question of specific circumstances. The Federal Government has limited responsibility for the delivery of health care services, and the provinces are responsible for most health care related services (Parliament of Canada, 2010).

The *Canada Health Act*, 1985, c C.-6 governs how the Federal Government and the provinces share the costs of health care. Section 3 of the act outlines the objective of Canadian health care policy which is to “protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.” This demonstrates the inclusive nature of Canadian health policy which highlights the removal of barriers to access.

The report, *Health Care Models in Canada a Provincial Perspective* (2013), explains that there are around 300, 000 Indigenous, First Nations, Aboriginal, Inuit and Métis people in Ontario. One in five Indigenous, First Nations, Aboriginal, Inuit and Métis people in Canada reside in Ontario (p.22). Furthermore, 80% of Indigenous, First Nations, Aboriginal, Inuit and Métis people reside off reserve, and 62% reside in urban areas. Thus, looking at the provincially run health care system in Ontario is significant when considering if the health care needs of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities are being met (The Institute of Public Administration of Canada, IPAC, 2013).

In Ontario, the Ministry of Health and Long-Term Care (MOHLTC), provides direction and planning for the health care system and its efficiency in accordance with the *Ministry of Health and Long-Term Care Act*, 1990, c M26. There are 14 Local Health Integration Networks (LHINs). LHINs are responsible for planning, implementing and integrating the health services that are provided by hospitals, Community Care Access Centres and Community Health Centres (IPAC, 2013). “They are also responsible for planning, funding and integrating the home care, long-term care, and mental health and addiction sectors” (p. 23). Under the MOHLTC are the 14 LHINs, the Ontario Health and Insurance Plan, and Public Health. Other services, such as community health centres, and mental health and addictions services are the responsibility of individual LHINS (p. 24). The decentralized nature of the health care

system in Ontario, and the number of relevant acts creates potential space for the service needs of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities to be neglected (NCCAH).

The *Home Care and Community Services Act, 1994*, c 26 outlines home care service guidelines in Ontario. According to s. 9(1) the Minister may enter into an agreement with First Nations people to provide community services for a particular community or communities.

Ontario created an Aboriginal Health and Wellness Strategy in 1990, and put in place an Aboriginal Health Policy in 1994. The Aboriginal Health Policy serves as a governing policy and supports the Ministry of Health in accessing inequities for Indigenous, First Nations, Aboriginal, Inuit and Métis health programming, responds to Aboriginal needs at a community level, and improves the coordination between ministry branches to support a holistic understanding of health (NCCAH, 2011, p. 7, *Looking For Aboriginal Health in Legislation and Policies*). It is also worth noting that the *Indian Welfare Service Act, 1990* mandates that Indigenous, First Nations, Aboriginal, Inuit and Métis people in Ontario are eligible for the same benefits as other people under the Ontario Disability Support Program (NCCAH, 2011, p. 55). Over the last 50 years significant efforts have been made to address legislative gaps; however, there are still limits to who can register under the *Indian Act*, and jurisdiction disputes occur (NCCAH, 2011, *Looking For Aboriginal Health in Legislation and Policies*). The Health Canada Advisory Panel on health care innovation notes that the delivery of health care services in Canada for First Nations and Inuit people is fragmented (p. 32). Further explaining, “the result is that the endemic lack of coordination in Canada’s health care systems is exacerbated by jurisdictional ambiguity and inconsistencies” (p. 75).

Analysis

Mikkonen and Raphael (2010), in their discussion of Canadian health care, argue that the main factors which determine the health of Canadians is not what health care services are available to individuals, but how health is impacted by living conditions (p. 7). The social determinants of health

include income and wealth distribution; clean water, employment and working conditions, education, food, and housing. Mikkonen and Raphael (2010), argue that “in most cases these living conditions are – for better or worse – imposed upon us by the quality of the communities, housing situations, our work settings, health and social service agencies, and educational institutions with which we interact” (p. 7). They argue that the social determinants of health can be used to understand the health disparities that exist among Canadians (p. 7).

Location impacts these social determinants. For instance, across Inuit Nunangat it costs from \$360 to \$450 per week to feed a family of four. In contrast, across the rest of Canada it costs between \$200 to \$250 for the same amount and quality of food (Statistics Canada, 2015, p. 30).

The social determinants of health are impacted by the ability to attain other rights, such as self-determination. Bryant et al., explains, “[t]his connection between health status and the exercise of rights has significant implications for people with disabilities” (2010, p. 105). The World Health Organization (WHO) incorporates both medical and social conditions of health into definitions of health (Bryant, et al., 2010, p. 352). Their definition recognizes that, an ‘individuals’ health relies also on social well-being, which cannot be guaranteed when systemic discrimination and policies of inequity persist” (p. 352). This provides a framework for understanding the social challenges that both Indigenous, First Nations, Aboriginal, Inuit and Métis people and people with disabilities experience in addressing health as it is inked to social conditions.

The median income is lower for Indigenous, First Nations, Aboriginal, Inuit and Métis people in Canada and this shapes the experience of access resources and stability of health (Statistics Canada, 2011, *Aboriginal Peoples in Canada*, p. 37). On many reserves the water is not clean, housing is substandard and general hygiene is compromised. In a self-reported study in 2012, 52% of First Nations, people rated their health as excellent or very good. These numbers were below the self-ratings of the

62% of non-Aboriginal identify populations who rated their health as excellent or very good (Statistics Canada, 2015, p. 28).

The social determinants of health, as well as Indigenous, First Nations, Aboriginal, Inuit and Métis understandings of health and wellness need to be considered when questioning if there are adequate health services for people with disabilities. For instance, mental health and substance use impact mental wellness in communities (Health Canada, 2014, *First Nations Mental Wellness*, p.5). While acknowledging that specific mental health issues may be faced by individuals, and specific communities, wellness is the “broader term that can be defined as a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, and is able to make a contribution to her or his own community” (p.5). Mental wellness is influenced by “culture, language, Elders, families, and creation, and is necessary for healthy individual, community and family life” (p. 5). Cultural values, language, sacred practices and traditions of Indigenous, First Nations, Aboriginal, Inuit and Métis people shape the health of individuals, families and communities. Culture is understood as the root of health and a “good life” (p.5).

In order to consider if Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities can attain the highest standard of health, it is important to look at the inaccessibility of the health care system for Indigenous, First Nations, Aboriginal, Inuit and Métis people in general. Health Canada acknowledges there is a significant gap between the health status of First Nations and Inuit, compared with other Canadians and this is being addressed through funded programming” (Health Canada, 2015, *First Nations and Inuit*). Health Canada is working to “improve health outcomes, provide access to quality health services and support greater control of the health system by First Nations and Inuit” (Health Canada, 2015, *First Nations and Inuit*). The summary report on First Nations Mental Wellness Continuum Framework (2014), also acknowledges that services are not always delivered in a “culturally safe” manner (p.5).

Indigenous, First Nations, Aboriginal, Inuit and Métis people have higher rates of specific disabilities and thus have needs in relation to these specific conditions. For instance, there has been a rapid increase of diabetes and cardiovascular disease among First Nations people. The Public Health Agency of Canada reported (2011), “After adjusting for difference in age structure, the prevalence of diabetes was 17.2% among First Nations individuals living on-reserve, 10.3% among First Nations individuals living off-reserve, and 7.3% among Métis” (p.6), while the prevalence of diabetes for non-First Nations individuals is 5.0%. This is linked to the rapid social, dietary and lifestyle changes experienced by some Indigenous, First Nations, Aboriginal, Inuit and Métis people. Statistics Canada explains that these “health inequalities are explained, in part, by the fact that Aboriginal people have lower socio-economic status than other Canadians, a characteristic that is widely known to be associated with poorer health” (Tjepkem, 2002; Bryant et al., 2010). A study of Aboriginal people living off reserve shows that as income increases self-reported improvements in health also increase (Tjepkema, 2002, p. 3).

Colonial history and the social status of Indigenous, First Nations, Aboriginal, Inuit and Métis people are linked to poorer health outcomes, which are directly linked to disability. The Truth and Reconciliation (TRC), report which reported on the legacy of Indian Residential Schools explains that the infant mortality rate is between 1.7 and 4 times higher for First Nations and Inuit children. Furthermore, TRC reports,

First Nations people were six times more likely than the general population to suffer alcohol-related deaths, and more than three times more likely to suffer drug-induced deaths. The overall suicide rate among First Nation communities is about twice that of the total Canadian population. For Inuit, the rate is still higher: six to eleven times the rate for the general population. Aboriginal youth between the ages of ten and twenty-nine who are living on reserves are five to six times more likely to die by suicide

than non-Aboriginal youth. (TRC, 2015 p. 161)

Self-inflicted injuries and suicide are among the leading cause of death for First Nations people under the age of 44 (Health Canada, 2015, *Mental Health and Wellness*).

The TRC Report reports the lasting mental health effects of the residential schools. Sexual and physical abuse, as well as forced separation from families, communities and being taught that their culture was inferior resulted in challenges to the mental wellness of students. This trauma was sometimes passed between generations (TRC, 2015 p. 158). The report calls upon Federal and Provincial Governments to recognize that the current state of Aboriginal health is a direct result of abusive government policies, such as residential schools, and to implement the health care rights of Aboriginal people (p. 160). The TRC Report found that it is difficult to measure progress because much of the information about the health of Aboriginal people is out dated. The TRC Report reports that the “lack of accessible data on comparable health indicators means that these issues receive less public, media, and political attention” (p. 161). Discussions of disability are related to health disparities in Aboriginal communities.

After signing the *Indian Residential School Settlement Agreement*, 2006, and the residential school apology, the Federal Government ended funding for Aboriginal health organizations such as the Aboriginal Healing Foundation and National Aboriginal Health Organization (TRC, 2015, p. 162). Those organizations were committed to doing research and treatment initiatives that were community defined and controlled. Their termination further limited the ability to understand health issues faced by Aboriginal people, and created gaps in service provision. There are still limited healing resources available for those experiencing the health effects of IRS such as the Indian Residential School Health Support Program that provides health resources for eligible survivors, and their families. Eligibility is limited to the schools included in the 2006 Indian Residential School Settlement Agreement (Health Canada, 2015, *Indian Residential Schools*).

The Federal Government has also cut funding for primary health programs like Fetal Alcohol Spectrum Disorder (TRC, 2015 p. 162). Health services and services for disability related needs exist, but are not consistently available, and may be subject to government cutbacks. This is detrimental for people with disabilities who rely on a specific service. The TRC Report explains that best practice for Aboriginal wellness is having a range of services available including mainstream health, traditional practices and medicines which are under community control and leadership (p. 163). There is a need for more Aboriginal health service providers (p. 163).

A health care professional told the Advisory Panel on Healthcare Innovation,

I had a First Nations patient from up North who needed drainage of cancer-related fluid around the lungs. The patient was required to fly down weekly to my urban hospital to have the fluid drained despite the fact that this could be done at home with a catheter and the use of sealed bottles. I was told this was because there was no funding to pay for the bottles, but that in a different budget envelope there was funding for his medical transport. This meant that in his last six weeks of life, he had to be flown down once a week for care, rather than being looked after at home. On top of the impact that this had on his quality of care, the system should consider the cost. One of his six return trips alone would have more than paid for all of the bottles needed for caring for him at home. (Health Canada, 2015, *Unleashing Innovation*, p. 65)

This example demonstrates that the same quality of health care is not available for Indigenous, First Nations, Aboriginal, Inuit and Métis people in urban versus rural areas. There are continual recommendations as to how to bridge the gaps in health care such as the TRC Report, the Report on the Advisory Panel on Healthcare Innovation, and the First Nations Wellness Continuum Framework described below.

First Nations communities have identified their challenges in accessing the Canadian health care system as well as provincial health care systems and how to improve health and wellness. The themes

include: culture as a foundation; community development, ownership and capacity building; quality health care systems and competent service delivery, and collaboration with partners (Health Canada, 2014, *First Nations Mental Wellness*). This First Nations Wellness Continuum Framework outlined above, and implementation plan was created through collaboration between First Nations partners and FNIB.

As previously mentioned, there is a patchwork of off reserve health supports for Indigenous, First Nations, Aboriginal, Inuit and Métis people. The Friendship Centre Movement (FCM) is Canada's largest off reserve service delivery body (Ontario Federation of Indigenous Friendship Centres (OFIFC), 2013, *About ONECA*). It is a not-for-profit organization that serves the needs of urban Indigenous people. Each friendship centre is managed independently and responds to the needs of specific communities within its geographical area. Health outreach programs that address the health needs of individual communities using a holistic framework are available at 11 friendship centres in Ontario in communities that do not have access to Aboriginal Health Access Centres. Health care plans are developed by working one on one with individuals. However, due to the diversity of disability related needs, it is unclear if such programs are accessible for people with disabilities. There are also 16 addictions and mental health workers available in Friendship Centres, and individuals can access traditional approaches to mental health, one on one support, and other programs (OFIFC, 2013, *Healing*).

The Association for Ontario Health Centres (AOHC), a community governed health care provider, has several branches, including Aboriginal Health Access Centres. They are Aboriginal led community primary health care providers. They provide traditional cultural programming, as well as health promotion and community development (Association of Ontario Health Centres, n.d., *Aboriginal Health*). The AOHC has an extensive accessibility policy, yet it is not clear if they have the resources to provide specific health care services for people with disabilities.

It is also worth noting that it is unclear if the demand on these specialized health services is so great that Aboriginal people wishing to access these services would need to wait longer than acquiring services elsewhere (Association of Ontario Health Centres, n.d., *Accessibility*). The needs of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities are diverse. There are Indigenous counselling services that may be beneficial to some individuals with disabilities. There is also an Ontario Native Education Counselling Association that recognizes the specific development of counselling practices in keeping with the needs of native communities (ONECA, 2012). While services like counselling are available, there is no guarantee regarding availability in individual communities. Indigenous, First Nations, Aboriginal, Inuit and Métis communities have taken specific steps towards reclaiming their health care. Community driven and culturally safe resources can still be understood as creating potential for meeting disability related needs, especially when disability is framed in the larger context of health and wellness.

Indigenous, First Nations, Aboriginal, Inuit and Métis communities are engaging in health research. While there is still a lack of understanding of disability related needs, there are also efforts to recognize and address this need. There is a call for more community based health research (FIRE Network, 2015). For example, the FIRE Network, which stands for “Indigenous implementation research and evaluation,” is a forum that includes different Indigenous groups and health groups. They have national and regional Indigenous governing bodies and organizations.

There is a need to connect with communities and primary care providers when doing research. Considering cultural safety also means including the IRS experience in health research, which will eventually lead to greater understanding and collaboration between indigenous communities and health care providers (FIRE Network, 2015). Addressing the recommendations of the TRC report, particularly health, is a step in moving towards reconciliation. There is also an indigenous physicians association of Canada and partnerships for developing an indigenous curriculum for medical schools. The research, and

capacity development is approached with the objective of improving health and wellness and developing research capacity.

Fallon Andy and Krysta Williams (Native Youth Sexual Health Network, 2016), who are engaged with media, arts, advocacy and reproductive justice for indigenous youth argue that we need to move away from a one size fits all approach to health. There are sub-movements for better health research and practice within the larger indigenous community. For instance, indigenous youth are organizing around health care, health research and self-determination. There is a need to cultivate intergenerational conversations to develop better understandings of health that respects the knowledge of diverse community members with a focus on youth and the coming generations.

The Well-Living House is an example of an action research center (FIRE Network, 2015). It has a focus on indigenous governance of Indigenous knowledge and capacity building. It addresses family wellbeing and health and asks how to “work in a good way” in sharing knowledge. The long-term goal is to have indigenous children born into communities that promote health and wellness. The Well-Living House is a community network that seeks to document and share positive things that are already happening in the community.

Health movements in a more general way are having conversations about health, wellness and wellbeing that contribute to larger conversations about health and disability. There are youth focused health projects that address the particular needs of youth and consider health from an indigenous youth perspective (Native Youth Sexual Health Network, 2016). The Native Youth Sexual Health Network works to address structural and systemic violence that impacts the sexual health of indigenous youth. This network exists in Canada, the United States and Australia, drawing attention to the somewhat arbitrary nature of land and borders created by the state, and on which that legislation relies. Key areas of focus for the network include what we do with our bodies, and ensuring that choices belong to individuals. This network allows for a greater understanding of health in relation to history. For

example, young Indigenous people are not “risky,” as a group; rather the risk needs to be named and contextualized as racism. Therefore reducing risk is about naming and understanding the harms of colonization in the current health care delivery context.

The Native Youth Sexual Health Network suggests more holistic way of addressing health care. They call for a focus on sovereignty and acknowledging ancestral strength, and recognizing that people already have the strength to challenge and reduce the effects of colonization and the industrial health complex. Some western models of health focus on deficit, and the language of risk is used which often serves to stigmatize youth and describe individuals as a problem. For example, research may say that Indigenous, First Nations, Aboriginal, Inuit and Métis youth in a certain community have a high risk of suicide. However, this risk needs to be contextualized and we need to recognize that this risk is grounded in “colonialism, racism, patriarchy and misogyny” (Native Youth Sexual Health Network, 2016). They address the need for supporting individuals and meeting people where they are at, rather than stigmatizing and shaming. This network and indigenous youth activism is part of a call for a “health and cultural safety” model of addressing Indigenous health needs. This should be the baseline for care, and individuals need to be able to decide if they feel safe in accessing care, rather than being told by others if they should experience a service as culturally safe.

Knowledge needs to be based on lived experience, and there is a need to honour individual stories and experiences, but not generalize and suggest that experiences are universal. There needs to be an understanding of the differences between Indigenous communities across Canada, and that different communities have varying health needs and can understand and express those needs themselves (Native Youth Sexual Health Network, 2016).

The Native Youth Sexual Health Network (2016) argue that the four pillars of treatment in western harm reduction approaches blame the individual. This approach to harm reduction has a punishing and shaming element. Harm reduction can look like policing and prisons rather than

community intervention. Using this model, treatment may force people into certain forms of care that are not fitting. For example, evidence has shown that people may be sent to treatment centers where they have to be sober to access services. Such an approach ignores the frameworks of colonialism and racism that contribute to experiences of health. Drawing from the work of indigenous people living with HIV and AIDs, there is a four fire model of Indigenous harm reduction. The four pillars are: cultural safety, reclamation, sovereignty, and self-determination (Native Youth Sexual Health Network, 2016). Cultural safe care means listening to what people need in health care. Reclamation acknowledges the colonial influence on health care. Sovereignty explores the idea of how to give people options in health care and respect their choices. This discussion of harm-reduction highlights the question what does choice look like in accessing health care? Indigenous people have unique approaches to health and health research, which need to be incorporated into health care in an accessible way in order for the health care needs of indigenous people with disabilities to be addressed.

Part of the problem experienced by Indigenous, First Nations, Aboriginal, Inuit and Métis people trying to access health care is a research gap identified by an urban health report focusing on the City of Hamilton (Our Health Counts, 2011, p. 8). This gap in research results in lagging health policy and service implementation and delivery. For instance, 40% of Aboriginal people in Hamilton rate their level of access to health care as poor. Barriers to health care include wait lists, lack of transit, direct costs, and lack of trust in health care providers (p.12). The lack of primary care results in greater numbers of Aboriginal people accessing emergency services (p. 12). Research with individual communities is significant because each has unique barriers to health care.

While mental health, Fetal Alcohol Spectrum Disorder, and other particular health issues impacting Indigenous, First Nations, Aboriginal, Inuit and Métis communities are being addressed, there is an overall lack of discussion of accessibility for Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities in the health care system. Indigenous, First Nations, Aboriginal, Inuit and Métis

people with disabilities face multiple barriers when accessing health services, being disabled, being indigenous, and potentially living in poverty. While health care rights are legally protected, fighting for human rights and access to health is a timely and tiring process, thus process of advocating for healthcare rights may not be accessible to everyone.

Compliance and the Right to Health

As the figures and reports indicate, Indigenous, First Nations, Aboriginal, Inuit and Métis people and thus Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities do not have equal access to health or the health care system as other people in Ontario. Significant improvements need to be made to have culturally appropriate services available that are inclusive of all disabilities. Efforts are being made to increase accessibility to the system and to understand the needs of Indigenous, First Nations, Aboriginal, Inuit and Métis people. Efforts are also being made to close the gaps to health and health care for people with disabilities. The key is to understand those two different issues together as a system of support and care within a human rights framework – ensuring both the highest attainable standard of health and dignity, autonomy, equality, community participation and respect for difference.

The human rights treaties guarantee people with disabilities and indigenous people the highest attainable standard of health and health care. The jurisdiction battles and patchwork of services means that Indigenous, First Nations, Aboriginal, Inuit and Métis people in general often do not have their health care needs adequately addressed. The principle of *non-discrimination and equality* is not being met if health needs are not properly being addressed because of culture and racism. People both living on reserve and off with complex health needs, particularly people with disabilities, have to struggle to receive the highest attainable standard of health.

Autonomy is an important right for all in health care but there was little evidence in this policy review that it is a central core of the way health care services are set up. Most of the health care decisions for Indigenous, First Nations, Aboriginal, Inuit and Métis people, particularly those with

disabilities appear to be shaped by the lack of resources. Rather than the individual being at the center of their care choices, decisions may be shaped by the government economic policy and restraint.

The right to *inclusion and participation* is similarly limited to what health care options are available. While there are Indigenous, First Nations, Aboriginal, Inuit and Métis specific health services, it is not clear if they are consistently available across Ontario. These culturally specific health services may also focus on providing services for specific disabilities. Friendship Centres, for example, offer programs for addictions and mental health, but not other disability related supports. Participation, inclusion and access to services often depend on the type of disability an individual has (OFIFC, 2013, *Addictions*).

4. Cultural life

Article 30 (1) of the CRPD ensures the cultural rights of people with disabilities. This includes things such as access to cultural materials, and being able to take-part in cultural activities. The UNDRIP focuses on the cultural rights of Indigenous people. For instance, Article 3 explains that Indigenous people have the right to self-determination and to freely pursue their cultural development. Article 9 of the UNDRIP explains that Indigenous people have the right to belong to their Indigenous nation, in accordance with the traditions of that community. Articles 9 through 11 of the UNDRIP outlines the right to practice one's own culture and have that culture protected and to engage with spiritual practices. Also included is the right to history, language, and ways of considering the world. Article 34 of the UNDRIP mandates that Indigenous people have the right to maintain their institutions and their "distinctive customs, spirituality, traditions, procedures, practices..." ICESCR 1976 also includes cultural rights. Article 15 (1a) of ICESCR states that parties to the Convention recognize the "right of everyone to take part in cultural life."

The *Constitution Act, 1982* s 35 both recognizes and affirms Aboriginal rights. While these rights were mandated prior to s 35; s 35 recognizes existing treaty rights. Indigenous and Northern Affairs

Canada has clarified that these rights refer to the “traditions and customs that distinguish the unique culture of each First Nation and were practiced prior to European contact” (Government of Canada, 2010).

The *Canadian Multiculturalism Act*, 1985, c 24 acknowledges the diversity of Canadians and promotes a multicultural future, while working to “achieve the equality of all Canadians in the economic, social, cultural and political life of Canada.” Section 3 (1) provides for a multicultural policy of Canada. Section 3 (1a) recognizes that multiculturalism reflects the cultural and racial diversity of Canadian society and the right to promote and enhance cultural knowledge. Section 3 (1d) affirms that people come from specific communities which share a common origin. Section 3 (1f) mandates that the institutions in Canada to be both inclusive and respectful of Canada’s diversity.

In Ontario, the *Child and Family Services Act*, 1990 recognizes Aboriginal history and the provision of child and family services in a way that acknowledges the culture and traditions of the family and extended families 1 (2.5). Section 37 (4) provides for the best interests of a child stating that if the child is Aboriginal this should be taken into consideration. The importance of their unique Indigenous heritage and “preserving the child’s cultural identity” is stressed.

The AODA, also addresses cultural rights for people with disabilities. Section 3 (2) of the *Accessibility Standard for Customer Service*, 2007 regulates the opportunity of people with disabilities to have equal opportunities to use and to benefit from goods and services, including cultural spaces such as movie theaters and libraries. Note that while there is international and national legislation around the right to have and express one’s culture, the CRPD is the only legally binding framework that addresses disability and culture.

The specific needs of people with disabilities are to be taken into consideration during conversations about accessing culture and heritage. For example, three youth with “high needs” were abruptly removed from their non-Aboriginal long-term foster home and placed in an Aboriginal foster

home in order to preserve their cultural heritage (Tikanye v. Anishinaabe Abinoojii Family Services, 2007). It was ruled that best interest includes considering and balancing the importance of Aboriginal heritage and preserving cultural identity. The children were removed from their long-term foster family and placed in a group home with a culturally appropriate setting. A psychological assessment accepted that it takes years of living within a culture to develop an identity. The lack of exposure the youth had to Aboriginal culture, combined with their disability specific learning and adjustment needs suggests that it is not likely that they would adopt a native identity in the few years before they reached their 18th birthdays (para. 16). The court concluded that the three youth should be returned to their original foster home. While heritage and cultural identity are important, this case demonstrates that the cultural needs have to be carefully balanced and take into account accessibility. This case draws attention to the diversity of disability and disability related needs in accessing culture in a holistic and meaningful way, especially for those with intellectual disabilities.

Analysis

Questions of access to culture and ability to participate in cultural life are complex. Accessibility includes physical access to cultural events. Access also includes presenting material in accessible formats, ranging from sign-language to plain text documents. Accessibility includes acceptance of people with differences in mental and emotional states. When considering whether Indigenous, First Nations, Aboriginal, Inuit and Métis people have access to culture there are three factors to take into account.

The first question is whether Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities have access to mainstream culture on an equal basis as others in Ontario. Despite the AODA and the *Accessibility Standard for Customer Service, 2007* culture is not accessible for many people in Ontario with disabilities. Businesses are slow to implement changes in service delivery and to adequately modify the built and sensory environment. Also, if there is no public transportation service,

people may not be able to physically get to cultural events and spaces. Furthermore, there are no agreed upon standards for what counts as accessible. Since Indigenous, First Nations, Aboriginal, Inuit and Métis people, particularly Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities have relatively lower incomes, the cost of cultural events and materials may make them inaccessible.

The second thing to consider is whether Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities have access to their culture, and the traditions of their Nation, on an equal basis as other community members – this has to take into account both indigenous culture and disability culture. This can be considered in numerous ways, for instances are Pow Wows and sweat lodges physically accessible? Cultural events were not consistently accessible. Most Nations do not have an accessibility statement on their website. However, individual events may be marked as accessible. For example, the Odawa Pow Wow is described as accessible; however, it is mentioned that the outdoor nature of the event at a campground may result in mobility challenges (Odawa, 2016). Saugeen First Nation has event posters available online from their most recent Pow Wow; however, there is no mention of accessibility on the poster for the event or on advertisements for other cultural events on their website (Saugeen First Nation, 2016). How is disability culture being built into the indigenous culture in these events? People with disabilities also have a history of institutionalization similar to that of the Canadian indigenous people. This is an important piece of their history.

Aside from the CRPD, laws and legislation separately address accessibility and the right to practice culture and cultural traditions, leaving grey area as to the rights of people with disabilities to have equal access to events and ceremonies. The rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people to practice their culture is often discussed in a collective framework, and the rights of individual people to access their culture is not fully addressed. For instance, s 3 of the *Canadian*

Multiculturalism Act, 1985, addresses the right to promote and enhance cultural knowledge. However, the Act does not address whether cultural events and ceremonies need to be accessible.

Regardless of whether or not events are accessible, it is difficult for individuals when information on accessibility is not readily available and people need to continually ask whether or not they are able to attend. A future question when considering accessibility and culture is to consider the number of people with disabilities, and the types of disabilities who are involved in governance on reserves in Ontario. Political participation is an issue key to the implementation of rights (see CRPD, Article 29).

The third factor when considering accessibility is whether colonial frameworks of constructing disability are challenged. For instance, there is an effort to incorporate indigenous knowledge of disability, and challenge colonial understanding mental health. However, the legislative framework revolves around defining disability and addressing disability using definitions which may be contrary to cultural understandings of human diversity (Disability Rights Promotion International, 2014; Hickey, 2015). For instance, in order for schools to access supports for students with disabilities on reserves, they still need to follow a process that includes a medical diagnosis, similar to the process in the Ontario school boards (Government of Canada, 2015). The medical focus on diagnosing disability may prevent people from accessing services who need accommodations, but who do not necessarily view their difference through a medical model diagnostic framework. The summary of the final report of the Truth and Reconciliation Commission of Canada titled, *The TRC report (2015)*, acknowledges the colonial and historical framework for conditions that may be seen as disabilities, and the need for sensitivity in addressing those conditions. For instance, the report explores the connection between substance abuse experienced by residential school survivors, and the over-incarceration of Aboriginal people (TRC, 2015 p. 174).

While there are some healing resources and culturally specific counselling available as previously acknowledged, the government has also created a timeline for healing. For instance, the Aboriginal Healing Foundation which was created to address the impact of abuse from the IRS closed in 2014 because they had a limited mandate and their funding and timeline was complete (Aboriginal Healing Foundation, 2016).

Participation in cultural life can also mean a culturally sensitive justice system. The Truth and Reconciliation Report explains that cultural rights include the right to implement their own justice system supported by the state. The report notes that the justice system should be accessible for Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities; however, it does not mention the diversity of disability and related accessibility needs (TRC, 2015, p. 204).

There are also Indigenous, First Nations, Aboriginal, Inuit and Métis focused correctional services. Correction Services Canada outlines the services that are available in each province for Aboriginal offenders (Correctional Services Canada, 2015). Waseskun Healing Centre is an example of an Aboriginal specific healing program that is partnered with corrections. A report on the centre does not specifically mention disability; however, their approach to healing is holistic. It relies on the teachings of the medicine wheel and addressing the physical, emotional, mental and spiritual components of a person (Bell, 2008, p. 5).

Compliance and the Right the Culture

Significant improvements need to be made in order for culture to be fully accessible for Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities. Canada has a framework of rights that protects the cultural rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people as previously outlined. Disability specific frameworks in Ontario do not focus on access to cultural rights, aside from ensuring the rights of people with disabilities to have equal access to cultural venues and

events. There is a need for legislation that addresses the specific rights of indigenous people with disabilities to be able to access their disability culture and their indigenous culture. The decentralized, self-governing nature of reserves makes it hard to draw general conclusions about *accessibility and inclusion*.

Dignity is respected when there are culturally sensitive programs, such as correction facilities and healing programs that address the complex and sometimes historic causes of trauma. Nevertheless, while there appears to be resources for specific types of disabilities (such as mental health); people with other disabilities such as mobility related impairments may still face significant barriers. For instance, the accessibility of cultural ceremonies is unclear, and inconsistent. *Participation, inclusion, and accessibility* of cultural life is a complex issue. Cultural organizations may be underfunded, and accessibility becomes an afterthought. Also the culture of people with disabilities and who are Indigenous, First Nations, Aboriginal, Inuit and Métis is a story that needs to be told. It is a distinct and silenced story.

Central to teaching is the notion of respecting human diversity and difference. The holistic approaches for addressing intergeneration trauma and incorporating people into the community outlined in the TRC Report and the Waseskun Healing Centre's Report reflect respect for human *diversity and difference*. However, the potential lack of accessibility for cultural events, and the potential differing understandings of disability in each community may result in varying levels of the way in which *dignity* is experienced (Bell, 2008). In focusing on Indigenous, First Nations, Aboriginal, Inuit and Métis understandings of disability, a question remains whether there is room for individuals to understand their disability and disability related needs within this framework.

Conclusion

There are laws and policies that guarantee the rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people, and grant them access on an equal basis with others to accessibility, education,

health and culture. However, at times the laws fail to address the needs of indigenous people who also have disabilities. This is particularly true when entering a conversation about what accessing rights means for individuals. For instance, the rights of Indigenous, First Nations, Aboriginal, Inuit and Métis people to practice their culture is often discussed in a collective framework, and the rights and particular accessibility needs of individual people to access their culture is not fully addressed (Bryant, et al., 2010).

The five key human rights: dignity; autonomy; participation, inclusion & accessibility; non-discrimination & equality and, respect for difference are often not met in practice. They are challenged in a system that suggests that funding concerns take precedent over human rights. For instance, what does it mean to have accessible health care if dignity or autonomy is undermined? Furthermore, human rights do not exist in isolation, and the ability to access one right influences the ability to access other rights.

The ability to access rights changes in relation to geographic location – that is, the ability to access rights both on and off reserve or in Northern and Southern Ontario. For example, Indigenous, First Nations, Aboriginal, Inuit and Métis children with disabilities have in theory an equal right to education. If students have high-cost education needs and live on a reserve, a debate may arise about who is to pay for the cost, and ability to access appropriate education may be denied (Hogg, 2015).

Ability to access resources is shaped by funding gaps and lack of transparency by all levels of government. This leaves people knowing they have a right, but unsure how to access the right, when different levels of government deny responsibility for providing the support services and resources. Funding debates result in people receiving less than adequate care and a denial of their rights.

Often, the need for advocacy is a necessary condition for rights to be implemented. Reports suggest that the work of navigating the education system to access needed resources and supports for a child often falls to the parents and guardians. The guarantee of rights is contradicted by the needs to

advocate for what should be taken as a guarantee. If an individual with a disability is unable to advocate for themselves, and does not have a supporter who has the knowledge and time to advocate for them, they may be unable to access their rights.

There is also the question of whether services address the cross-cultural needs of people with disabilities. Accesses to culturally appropriate services are available depending on the community, yet services to support participation are not consistently available. This complicates the question of whether there are culturally appropriate services available for Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities, by asking what culturally appropriate services means and looks like. Understandings of Indigenous, First Nations, Aboriginal, Inuit and Métis health and disability need to be situated within history. For instance, Indigenous, First Nations, Aboriginal, Inuit and Métis people's health and higher rates of disability needs to be understood through a lens of colonization (FIRE Network, 2015).

Moving Forward

This report explored four categories of specific rights and the barriers people face in addressing these rights. However, more questions emerge that are beyond the framework of this report and are outlined below for future research. More work needs to be done to incorporate Indigenous, First Nations, Aboriginal, Inuit and Métis understandings of disability into a discussion of disability and human rights. How are the five key human rights principles interpreted from an indigenous point of view? Indigenous, First Nations, Aboriginal, Inuit and Métis people may understand disability differently. For instance, everyone may be viewed as having a role in a community, and disability is understood as a special gift from the creator (Disability Rights Promotion International, 2014). Indigenous, First Nations, Aboriginal, Inuit and Métis people often view the body and health from a more holistic framework than others.

Further research could consider whether indigenous knowledge is respected during the enactment of rights, and attainment of services, particularly surrounding education and health care. An important question to ask is whether Indigenous, First Nations, Aboriginal, Inuit and Métis knowledge is respected during the diagnostic and accommodation process? Are Indigenous, First Nations, Aboriginal, Inuit and Métis teachers, psychiatrists and doctors available during the diagnostic and accommodation process? Are human rights models of disability, rather than medical and charity models being respected in our indigenous communities. Are labelling and diagnosis and accommodations forced on students using a Eurocentric and abelist methodology? Do Indigenous, First Nations, Aboriginal, Inuit and Métis parents and Elders and those with disabilities feel connected to the education process? Does accessible education take cultural needs into consideration? Given the high number of Indigenous, First Nations, Aboriginal, Inuit and Métis children and people with disabilities removed from their homes, both historically and in the present, research is needed to examine the numbers and circumstances surrounding children being removed from their homes in order to attain educational and other disability related supports and if this constitutes a human rights violation. With the recent announcement by the Federal Health Minister Jane Philpott and Indigenous Affairs Minister Carolyn Bennett of funding for children with disabilities on reserves, how will Jordan's Principle create changes for children with disabilities in terms of accessing their rights to health and education?

A further question to consider is whether the health needs of Indigenous, First Nations, Aboriginal, Inuit and Métis people with disabilities are being met at all stages of life? Are there adequate resources for Indigenous, First Nations, Aboriginal, Inuit and Métis individuals wishing to reside in long-term care homes? Are there supports for Indigenous, First Nations, Aboriginal, Inuit and Métis women with disabilities during pregnancy and child rearing? There are gaps in health outcomes and health services, and there is a lack of understanding the many ways in which these gaps impact people with disabilities. Further research is needed to consider how gender and age impact the accessibility of

cultural programs for people with disabilities. Do women and youth have equal access to culturally sensitive corrections programs in Ontario that are disability sensitive?

Human rights monitoring and reporting needs to go beyond recommendations to the development and implementation of plans that ensure that rights on paper are implemented (Rioux, Pinto & Parekh, 2015). The existing recommendations and conversations need to be taken into consideration when addressing how to move forward towards ensuring human rights are met. For instance, the TRC report *Honouring the Truth, Reconciling for the Future* (2015), provides guidance for moving forward. There are also reports that address specific issues, such as the Report on the Advisory Panel on Healthcare Innovation (NCCAH, 2011, *Looking For Aboriginal Health in Legislation and Policies*, p. 132). Further research could consider the other rights guaranteed under the CRPD, and how they are experienced by Indigenous, First Nations, Aboriginal, Inuit and Métis people.

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