COMMISSION OF INQUIRY INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF PHOENIX SINCLAIR

The Honourable Edward (Ted) Hughes, Q.C.,
Commissioner

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Transcript of Proceedings
Public Inquiry Hearing,
held at the Winnipeg Convention Centre,
375 York Avenue, Winnipeg, Manitoba

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JUNE 6, 2013

APPEARANCES

MS. S. WALSH, Commission Counsel
MR. D. OLSON, Senior Associate Counsel
MR. R. MASCARENHAS, Associate Commission Counsel
MS. K. DYCK, Associate Commission Counsel

MR. G. MCKINNON, for Department of Family Services and Labour

MS. L. HARRIS, for General Child and Family Services Authority

MR. H. COCHRANE, for First Nations of Northern Manitoba Child and Family Services Authority, First Nations of Southern Manitoba Child and Family Services Authority, and Child and Family All Nation Coordinated Response Network

MR. J. BENSON, for Intertribal Child and Family Services

MR. J. GINDIN and **MR. D. IRELAND**, for Mr. Nelson Draper Steve Sinclair, Ms. Kimberly-Ann Edwards

MR. J. FUNKE, for Assembly of Manitoba Chiefs and Southern Chiefs Organization Inc.

MR. W. HAIGHT, for Manitoba Métis Federation and Métis Child and Family Services Authority Inc.

MS. C. DUNN, for Ka Ni Kanichihk Inc.

MR. G. TRAMLEY, for Aboriginal Council of Winnipeg Inc.

MR. G. MCFETRIDGE, for Witness, Jan Sanderson

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JUNE 6, 2013

PROCEEDINGS CONTINUED FROM JUNE 5, 2013

THE COMMISSIONER: Good morning.

MS. WALSH: Good morning, Mr. Commissioner. My apologies for the late delay or the late start, we had a technical problem, missing a microphone, but we're ready.

THE COMMISSIONER: You got, you got it solved.

MS. WALSH: We did.

THE COMMISSIONER: All right.

MS. WALSH: If we could have the witnesses sworn or affirmed, please.

THE COMMISSIONER: Yes.

THE CLERK: Could you please state your full name for the record.

THE WITNESS: Jan Sanderson.

THE CLERK: And can you spell it please.

THE WITNESS: J-A-N. S-A-N-D-E-R-S-O-N.

THE CLERK: Do you wish to swear on the Bible or affirm to tell the truth?

THE WITNESS: Affirm, please.

JAN SANDERSON, affirmed, testified as follows:

THE CLERK: Can you please state and spell your full name for the record.

THE WITNESS: Robert Guzman Santos. R-O-B-E-R-T, G-U-Z-M-A-N, S-A-N-T-O-S.

THE CLERK: Would you like to swear on the Bible or affirm?

THE WITNESS: Affirm, please.

ROBERT GUZMAN SANTOS, affirmed,
testified as follows:

MS. WALSH: We'll start by entering into evidence the exhibits that relate to these witnesses. Just give the clerk a minute, we've had a changing of the guard with the clerk.

THE COMMISSIONER: Yes.

MS. WALSH: Okay. So the first document is entitled Early Childhood Development and the Healthy Child Manitoba Strategy and this is the Powerpoint presentation prepared by Deputy Minister Sanderson and Dr. Rob Santos and that would be Exhibit 151.

THE COMMISSIONER: 151.

THE CLERK: Exhibit 151.

EXHIBIT 151: EARLY CHILDHOOD

DEVELOPMENT AND THE HEALTHY CHILD MANITOBA STRATEGY POWERPOINT PRESENTATION

MS. WALSH: Then we have the Healthy Child Manitoba 2012 Report on Manitoba's Children and Youth.

THE CLERK: Exhibit 152.

EXHIBIT 152: HEALTHY CHILD MANITOBA 2012 REPORT ON MANITOBA'S CHILDREN AND YOUTH

MS. WALSH: Then you'll see in the documents handed to you, Mr. Commissioner, is Commission disclosure 1397, which we don't need to mark as an exhibit because it's part of our disclosure but it has not been entered into the record until now so you will get a hard copy of that when you receive the other exhibits but it has not been given an exhibit number --

THE COMMISSIONER: And, and --

MS. WALSH: -- consistent with our practice.

THE COMMISSIONER: -- how do you identify it?

MS. WALSH: It's Commission disclosure 1397. And it's called --

THE COMMISSIONER: Are there page numbers?

MS. WALSH: Yes.

THE COMMISSIONER: That's the way I've been --

MS. WALSH: Page -- it starts at page 26402.

THE COMMISSIONER: It's 26402.

MS. WALSH: And goes to page 26421.

THE COMMISSIONER: Thank you.

MS. WALSH: And it's entitled The Challenge of Integrated Children's Services in Manitoba.

THE COMMISSIONER: All right.

MS. WALSH: The next document to be marked as an exhibit is the FASD Progress (sic) and Initiatives Government-Wide by Strategy Goal.

THE CLERK: Exhibit 152.

MS. WALSH: No, that should be 153.

THE COMMISSIONER: That will be 153.

THE CLERK: I'm sorry, 153.

EXHIBIT 153: FASD PROGRAMS AND INITIATIVES GOVERNMENT-WIDE BY STRATEGY GOAL

MS. WALSH: Okay. And then the Department of Children and Youth Opportunities Annual Report for the fiscal year 2011-2012.

THE CLERK: Exhibit 154.

EXHIBIT 154: ANNUAL REPORT FOR THE DEPARTMENT OF CHILDREN AND YOUTH OPPORTUNITIES 2011-2012

THE COMMISSIONER: Exhibit 154.

MS. WALSH: And then the -- Manitoba's Healthy Child Manitoba Office Annual Report for 2011-2012.

THE COMMISSIONER: This is another annual report of the department?

MS. WALSH: This is an annual report of the Healthy Child Manitoba office.

THE COMMISSIONER: Right.

THE CLERK: Exhibit 155.

THE COMMISSIONER: Exhibit 155.

EXHIBIT 155: HEALTHY CHILD MANITOBA ANNUAL REPORT 2011-2012

MS. WALSH: And then the last document is actually a USB stick containing three videos that will be shown in conjunction with the Powerpoint presentation, Exhibit 151. So you won't get a copy of that USB stick --

THE COMMISSIONER: Right.

MS. WALSH: -- Mr. Commissioner, but that will be Exhibit 156.

THE COMMISSIONER: It will be marked as such.

MS. WALSH: Yes.

THE CLERK: Exhibit 156.

EXHIBIT 156: HEALTHY CHILD MANITOBA ANNUAL REPORT 2011-2012 FLASH DRIVE FOR POWERPOINT PRESENTATION

THE CLERK: Exhibits 151 through 155.

THE COMMISSIONER: Yes. Thank you. All right, Ms. Walsh.

MS. WALSH: Thank you, Mr. Commissioner.

DIRECT EXAMINATION BY MS. WALSH:

MS. WALSH: Starting with some background of each of our witnesses, starting with the Deputy Minister, Sanderson, you were appointed deputy minister of Children and Youth Opportunities in January of 2012?

MS. SANDERSON: Yes.

MS. WALSH: Now, is your microphone on?

MS. SANDERSON: Can you hear me?

MS. WALSH: Yes, good.

MS. SANDERSON: Okay.

MS. WALSH: Thank you. And you're going to

describe what that apartment is and does in the course of, of the Powerpoint presentation?

MS. SANDERSON: That's correct.

MS. WALSH: You have been the chief executive officer of Healthy Child Manitoba since 2001?

MS. SANDERSON: Yes.

MS. WALSH: You are currently secretary to the Healthy Child Committee of cabinet?

MS. SANDERSON: Correct.

MS. WALSH: And before your current position as deputy minister, you were appointed as -- of Children and Youth Opportunities you were the deputy minister of Healthy Living, Youth and Seniors?

MS. SANDERSON: Yes.

MS. WALSH: You have a masters degree in public affairs, through a joint program with the University of Winnipeg and the University of Manitoba?

MS. SANDERSON: Yes.

MS. WALSH: You have also worked as director of the Canada Service Bureau for the federal government?

MS. SANDERSON: Yes.

MS. WALSH: Regional director for the National Youth Program Katimavik?

MS. SANDERSON: Correct.

MS. WALSH: And you also worked with the

Government of Saskatchewan, with the Public Service Commission?

MS. SANDERSON: Yes.

MS. WALSH: And you were director of communications for the Department of Education, in Saskatchewan?

MS. SANDERSON: Yes.

MS. WALSH: And you were also director of human resources with the Department of Health and Family Services in Manitoba?

MS. SANDERSON: Yes.

MS. WALSH: And you have worked with the Civil Service Commissioner in Manitoba, holding senior positions in executive development and employment services and labour relations?

MS. SANDERSON: Correct.

MS. WALSH: Okay. Dr. Santos, you are associate secretary to Manitoba's Healthy Child Committee of cabinet?

MR. SANTOS: Yes.

MS. WALSH: You are also the executive director of Science and Policy at the Healthy Child Manitoba office?

MR. SANTOS: Yeah.

MS. WALSH: And in conjunction with these positions you have represented Manitoba on several federal, provincial, territorial committees?

MR. SANTOS: Yes.

MS. WALSH: Ranging from topics relating to early childhood development to programs for youth?

MR. SANTOS: That's right.

MS. WALSH: You have also served as an advisor for the Canadian Institutes of Health Research, the Institute of Human Development and Child and Youth Health?

MR. SANTOS: Yes.

MS. WALSH: And as an advisor to the Centre of Excellence for Early Childhood Development.

MR. SANTOS: Yes.

MS. WALSH: You've been an advisory to Statistic Canada's Aboriginal Children's Survey and National Longitudinal Survey of Children and Youth?

MR. SANTOS: Yes.

MS. WALSH: And an advisory to the Strategic Knowledge Cluster on Early Childhood Development?

MR. SANTOS: Yes.

MS. WALSH: And you have PhD in clinical psychology, specializing in community psychology, child development, population health and prevention science and policy.

MR. SANTOS: Yes.

MS. WALSH: And you are cross-appointed as a research scientist at the Manitoba Center for Health

Policy?

MR. SANTOS: Yes.

MS. WALSH: And you're an assistant professor in the Department of Community Health Sciences at the Faculty of Medicine at the U of M?

MR. SANTOS: That's correct.

MS. WALSH: In preparation for your testimony, the two of you have prepared a Powerpoint presentation which we've marked as Exhibit 151 and so I'm going to actually sit down and let you go through it. If you see me pop up, it signals that, that I have a question that I want to pose right then and there before you move on. The Commissioner may also pose a question, otherwise I'll reserve further questions until you have completed your presentation.

MS. SANDERSON: Thank you. Okay to begin?

THE COMMISSIONER: Please.

MS. SANDERSON: Okay. And please feel free to pause us and ask us to slow down because sometimes we get caught up in what we're talking about --

THE COMMISSIONER: Okay.

MS. SANDERSON: -- so ...

So, first of all, the, the key messages of the presentation that we hope to leave you with, which is the, the second slide, is the concept that prevention is

paramount in everything that you have been considering for the last several months, and you have heard a lot about the last couple of weeks. And, in fact, prevention is, in fact, the first step on a continuum of protection.

THE COMMISSIONER: Now, is this, is this in written form in front of us.

MS. SANDERSON: It should be, I believe.

THE COMMISSIONER: Is, is that 150 --

MS. WALSH: 151 looks like this, Mr. Commissioner.

THE COMMISSIONER: 151. Oh, here is it.

MS. SANDERSON: Right, there you go.

THE COMMISSIONER: Here is it. Yeah, okay.

MS. SANDERSON: Yes, okay?

THE COMMISSIONER: Carry on. Yeah, yeah.

MS. SANDERSON: I think you might have -- yeah, we need to go back one page.

THE COMMISSIONER: Yes.

MS. SANDERSON: Correct. Okay.

So prevention is paramount.

THE COMMISSIONER: Yeah.

MS. SANDERSON: We can either pay now or pay much later, if we, if we don't pay attention to the prevention end of the continuum and that there is plenty of evidence about cost effective investments that we can make. And

we're going to share some of that evidence with you this morning.

Each of us, all of us, have a role in this, it's a shared responsibility. We're here speaking to you as government employees about public policy but there's a strong belief in -- across systems that government can't be, of course, the parents of children in society, that there is a role for families, there's a role for community institutions, such as the ones that have spoken here over the last couple of weeks, and there's a role for public policy through government and that needs to be collaborative. And we'll talk about that as we unroll this, as well.

All of our futures are at stake, there is a public imperative. I think you have heard from many of the witnesses that the current way that things are going is not sustainable, it's not sustainable in our, in our child welfare system, in our justice system, in our health system and the exciting news, I think, about what we're going to share this morning is that some of these investments, early on, actually will make a difference in all of those systems, not only the child welfare system and go to some of the roots of the problems that you have heard so much about.

So those are the key messages and we'll use those

sort of as a -- as touchstones, as we talk over the course of the morning and sort of visit back to remind ourselves of where we're trying to get to here.

The presentation overview, just to give you an idea of how this is going to unfold, I'll speak very briefly about some context for a couple of moments, about the structure of our department and the Healthy Child office. So, Manitoba Children and Youth Opportunities, briefly. I'll talk to you about the Healthy Child Manitoba Act and then I'm going to turn it over to Rob and he's going to walk you through some of the science and the emerging evidence that is driving the decisions we're making around investments with public dollars.

Then we'll revisit what some of those specific investments are and we'll visit, sorry, what some of those specific investments are in Manitoba. So what we tend to call the Healthy Child Manitoba investment portfolio. So actual programs on the ground. And we'll close by talking about some of the challenges and opportunities that we see on the road ahead.

So, first of all, just to give you the current situation, you'll see a slide there that speaks about Manitoba Children and Youth Opportunities and as Ms. Walsh indicated in her opening, that's the department Rob and I currently report through. So it can be a little confusing,

there's both the Department of Children and Youth Opportunities and then there also is a Healthy Child Manitoba office and they're separate and distinct but they are related.

THE COMMISSIONER: And the first is the department of government and it's called what?

MS. SANDERSON: Children and Youth Opportunities.

THE COMMISSIONER: Children and Youth Opportunities.

MS. SANDERSON: It was only recently established in January of 2012.

THE COMMISSIONER: As a department of government.

MS. SANDERSON: Exactly.

THE COMMISSONER: Yeah. And then there is also?

MS. SANDERSON: Right. Then there is the Healthy Child Committee of Cabinet, which is currently chaired by the Minister of Children and Youth Opportunities.

THE COMMISSIONER: That's your minister?

MS. SANDERSON: Yes. And Rob and I have dual roles. So I'm, I'm the deputy to the Department of CYO, Children and Youth Opportunities.

THE COMMISSIONER: Yes.

MS. SANDERSON: But I am also the CEO of the Healthy Child Manitoba office.

THE COMMISSIONER: Yes.

MS. SANDERSON: Actually, I guess, three roles because I'm also the secretary to the Healthy Child Committee of Cabinet.

THE COMMISSIONER: You're, you're deputy to, to the department.

MS. SANDERSON: Yes.

THE COMMISSIONER: And you're CEO of Healthy Child Committee of, of Cabinet.

MS. SANDERSON: Healthy Child Manitoba office. CEO of the office.

THE COMMISSIONER: Oh, oh, CEO of?

MS. SANDERSON: Of the Healthy Child office which is a small office of about 35 staff as opposed to a department.

THE COMMISSIONER: All right, so you -- Healthy Child office, which is an office within the department?

MS. SANDERSON: No, we file a separate annual report, as you noticed, you said we've got two annual reports here.

THE COMMISSION: Yes.

MS. SANDERSON: So we file a separate annual report but we report up through the Department of Children and Youth Opportunities because that minister is chair right now of the Healthy Child Committee.

THE COMMISSIONER: So the -- you're CEO of the

Healthy Child office which is a standalone office?

MS. SANDERSON: Yes.

THE COMMISSIONER: But reports to, to the minister?

MS. SANDERSON: That's correct.

THE COMMISSIONER: As chair --

MS. SANDERSON: As the chair of the Healthy Child Committee of Cabinet.

BY MS. WALSH:

MS. WALSH: Just for clarification, as, as I think the presentation is going to indicate, there is an act, the Healthy Child Manitoba Act, that -- and it's under that --

MS. SANDERSON: Spells this --

MS. WALSH: -- the authority of that act that sets up the office.

MS. SANDERSON: Right.

MS. WALSH: Would that be fair?

MS. SANDERSON: And the CEO role and --

MS. WALSH: Right.

MS. SANDERSON: Yes.

THE COMMISSIONER: Oh, oh, all right, so -- well, does that, does that act also set up the department or is --

MS. SANDERSON: No.

THE COMMISSIONER: No. That's just under an OIC or something?

MS. SANDERSON: Exactly, yeah.

THE COMMISSIONER: All right. So -- and then you said you have a third responsibility?

MS. SANDERSON: And that's to be the secretary to the Healthy Child Committee of Cabinet.

THE COMMISSIONER: Healthy Child Committee of Cabinet?

MS. SANDERSON: Right. And I'll -- in one moment I'll give you more further -- a further explanation about that.

THE COMMISSIONER: All right. And, and Dr. Santos, your, your roles are?

MR. SANTOS: Associate secretary to the Healthy Child Committee of Cabinet.

THE COMMISSIONER: Associate secretary of the committee to cabinet?

MR. SANTOS: Yeah.

THE COMMISSIONER: Yes.

MR. SANTOS: And then I guess there's a dual role, as well, on science and policy for both the department, for CYO, as well as for the office, which is cross-departmental.

THE COMMISSIONER: Director of policy or?

MR. SANTOS: Executive director of science and policy.

THE COMMISSIONER: To, to --

MR. SANTOS: To both the department and to the committee which is 10 departments.

THE COMMISSIONER: The committee is comprised of 10 departments?

MS. SANDERSON: Yes.

MR. SANTOS: Yes.

THE COMMISSIONER: Right. Okay, I think I've got that.

MS. SANDERSON: Great. Thank you.

And a little later on we will get into the, the makeup of the committee and so on, but right now I'll just give you a bit of brief history. Prior to this current administration, the previous government in the mid-90s, late 90s, began to take an active interest in the work being done by people such as Dr. Fraser Mustard, who Rob will reference in a moment, and the idea that we needed a holistic approach to children and that there were, there were gaps and crevices that kids could fall through. And they established an office called the Children and Youth Secretariat which became sort of a precursor to what we have now. And the idea there was that this would be an

office, a very small sort of secretariat, that would work on cross-departmental issues for kids.

So, they introduced a concept that we still continue on with now, of developing protocols to bridge the gaps between services. So, for example, there is a protocol in existence around how the education system and the child welfare system will work together when kids in care are moving from one school to another. So, outlines what everyone's responsibilities are and so on, and has streamlined some of that work.

So that's the kind of work that the Child and Youth Secretariat was doing at the time that the government changed and the, the current administration sort of embraced that concept and went a step further by establishing the Healthy Child Committee of Cabinet, which is a cabinet committee dedicated to best possible outcomes for Manitoba's children, is the vision statement, with the idea being that at a very, very at the most senior level, they would be paying attention to children as a priority policy area.

In a few moments we'll explain a little bit more about what that means but for the moment I think it's interesting to note that the original chair of the Healthy Child Committee of Cabinet was the minister of Family Services at the time, a man named Tim Sale, who was also

the minister responsible at the time of devolution and so Mr. Sale was chairing a cross-departmental committee while also trying to make improvements to the child welfare system and had the vehicle of the Healthy Child Committee to draw on, as well.

THE COMMISSIONER: That's S-A-L-E, is his name?

MS. SANDERSON: Yes, that's correct.

The committee operated for a number of years and then in 2007 the Healthy Child Manitoba Act was introduced and there's reference to that in the, in the presentation in front of you, as well.

Essentially, the act was brought into place to entrench what was believed, at that time, to be a system that was working well, so entrenched the structures of the Healthy Child Committee, a corresponding deputy ministers' committee. So for every minister sitting around the Healthy Child table there is a corresponding deputy ministers' table and a number of community structures, all of which I am going to explain to you a little bit earlier, so this was -- a little bit later, so this was just to give you some brief background and then we'll, we'll go into more detail.

What we thought what we, we would do now is to kind of set a foundation of this conversation is have Rob walk us through the emerging science on the importance of

the early years and why this prevention piece has become so critical and why, in our view, and I think the view of a lot of stakeholders that we work with, it's a direction that we need more public support for, more public understanding of, in order to be able to advance this through public policy.

THE COMMISSIONER: Right.

MS. SANDERSON: So I'll turn it over to Rob.

MR. SANTOS: Thank you. So I want to just begin by crediting and honouring the late Dr. Fraser Mustard, who Ms. McCuaig referred to in her testimony last, last week. He, probably single handily, led the revolution on early childhood development across Canada and internationally in many countries. He was the co-author, with the Honourable Margaret McCain, of the three earlier reports, studies, that Ms. McCuaig referred to last, last week, the third version having come out about a year and a half ago. And then there's a picture there on the slide of him receiving the Order of the Buffalo Hunt from the Premier from his contributions to Manitoba in this area. And so he's not well known I think to the -- to many of the general public but to those working in terms of children's outcomes he's, he's well known as probably the leading champion and he passed away in November of 2011.

And so a lot of the work here comes from his

championing this agenda along with other prominent experts in Canada with the current government, the previous administration, governments across the country and across the world in terms of how important it is for all of society to focus on the early years.

THE COMMISSIONER: And he worked out of McMaster, I think?

MR. SANTOS: That's right.

THE COMMISSIONER: Yeah.

MR. SANTOS: He was formerly the head of the faculty there.

THE COMMISSIONER: Yeah. I have followed him over the years.

MR. SANTOS: Yeah. That's great.

And so we're just going to touch on some of the things that were -- have already been referred to by Ms. McCuaig, by Dr. Brownell yesterday, and others throughout the inquiry.

Back in 2000 a landmark report was published in the US by the national research council and the institute medicine called from Neurons to Neighbourhoods, the Science of Early Childhood Development and that, at the time, summarized the state of the art and the science on, on ECD on early childhood development and the key quote from there, which is important for this inquiry and for all of

us to understand, as well, those early years matter enormously by no means are -- do they set the destiny of children, they set a foundation, sturdy or fragile, for what comes later.

And so while we want -- while we don't want to understate how important those years are, we also want to emphasize that of course we make a difference for children at any time in their lives but the biggest opportunity is really in those early years from before children are born, while they're in their mom's womb, up until they start school and kindergarten.

You've heard already from other witnesses about the importance of early childhood development so this slide sort of summarizes 40 years of -- plus of evidence on, on the lifelong benefits, not just to children but to all of society, in terms of lifelong health, lifelong educational attainment, investment in children is, is fundamental to developing communities. It happens to be the most effective approach to crime prevention in the literature. It's the foundations of economic productivity and prosperity because of the nature of, of the modern economy depends heavily on the knowledge and skills of, of people, of human beings and so human capital development is the economic angel to early childhood development.

And then as Dr. Brownell, I think, mentioned

yesterday, you can -- the return on the investment is up to 17 fold return, depending on the time (inaudible) and the nature of the, the intervention for children.

In other words, this is one of those social (inaudible) health and social policies that pays itself in many fold. There's also a perspective from many that it's unique among policies and that it bridges different sides of the political spectrum left and right of the centre. So on the one hand it promotes equity, full participation, social justice for all of the members of society, starting from before they were born. It's also the most efficient policy, the best use of limited public dollars, and so whatever your political stripe, I think part of the appeal, certainly in Manitoba and nationally and internationally, in early childhood, is it speaks to the full range of political perspectives in terms of what the priorities are for the public which makes it, hopefully, easier to implement in terms of public support.

So this slide tries to summarize several decades of what we know about early brain development and I'll show you a few more slides in a second to illustrate.

The quote there is an intentional pun, "A Womb with a View." Many neonatologists talk about the first three months after a child is born as the fourth trimester. The reason for that is humans are unique on the planet as a

species in our brains not being fully formed at the time of childbirth. That's revolutionary reasons, the human brain is so large that if, if, if our -- biologically we waited until children's brains were fully formed every woman would die during childbirth because of the size of the birth canal.

And so evolution, mother nature has, has developed this approach where children are born with their brains not fully developed, entirely dependent on the environment, especially the social environment, to develop and that has implications for not just this inquiry but for all of, all of policy that affects the population.

So, when you measure activity in, in the, in the human brain what surprises many is the most active time of brain development at any time in the life course, from before we are born, to our elderly years, is in the early years, so by age three, if you do PET scans, for example, of children's brains, they're twice as active as any, any adults, their parents, their pediatrician, and so on.

That's important because that rapid pace of development is both an opportunity and a period of vulnerability in terms of what experiences and environments we make available to young children in the early years.

And here, if I may, I'll just, I'll just click on this video to illustrate. The -- there are three core

concepts that we wanted to submit to the inquiry on early child development. These videos were produced at Harvard University by the Centre for the Developing Child. This is a centre established after the Neurons to Neighborhoods report because it was seen to be hugely important to continue assembling the evidence and sharing it widely, especially to the public and to policy makers, to influence public decisions about our children.

And so the first core concept is how experience builds the architecture of the brain, and I think we have that transition of the clerk so I'll just click it up here.

(AUDIO/VISUAL RECORDING PLAYED)

MR. SANTOS: Thank you.

So this, this idea of experiences building the architecture of the brain is important because not everybody is fully aware, including many parents, about how important that, that environment is for the child and this actually is true when the child is still in -- during the pregnancy period.

So it's a -- to build on what was in the video, what we have on the slide here are pictures of the density, the thickness of, of synapses of nerve cells in the brain, from left to right at birth, at age six, and then at age

14. And you can see the density of nerve cells and the developing brain are very dense, much more dense than those early years. And as mentioned in the video, experience sculpts the developing brain. Areas of the brain that aren't stimulated or aren't attuned to that experience die away, and so there's this, there's this millions of years in the making developmental process in the brain of the brain preparing itself, based on the signals, the experiences that it's receiving from its environment, the, the world that the child is born into, to prepare that child for that world, for better, for worse. And so this overproduction of neurons in the brain is then shaved and sculpted by experience.

And so what this slide shows is how brains are built, as mentioned in the video, from the bottom up. And so in the bottom of the chart is the age of the child, the first nine months of conception or in utero. The early months of the first year of life in the square area and then the first 18 years of life, through childhood.

And you can see that the basics are built first, of seeing, hearing, vision and hearing, the sensory pathways are among the first areas of the brain to develop. Language develops very early, most people know that it's easy to learn a second language or a third language when you're younger, and then not shortly after, in pre-school

period but not completed until the early adult period, teenage years are the higher cognitive functions, reasoning, planning for the future, and, and so on, which Ms. McCuaig I believe mentioned last week.

So skills beget skills, brains build from the bottom up. So what some of the recent discoveries in the neuroscience, the brain research over the last several years, is how long it takes for the brain to fully develop and mature to its relatively complete state. So over the first two decades of life, through childhood up until children enter young adulthood, the grey matter of the brain is replaced over time by white matter, which are the, the fatty covered, the myleonated sheets of the brain that enable rapid thinking, processing, intelligence, the higher cognitive functions.

So the pictures here, at age five, age eight, 12, 16 and 20 of the brain, as they become more purple, shows that that's happening. So it's -- the brain is kind of being remodeled from the back to the front, with the higher functions being at the front of the brain in the prefrontal cortex.

So this remodeling, this brain under construction, happens through the third decade of life. So there's evidence now that the brains are, are still developing up until the mid-20s. And so as, as many people

were discovering this has lots of implications for what we do also for teenagers, for young people, and as Ms. McCuaig mentioned last week, for young people who become parents of children, themselves, and what we need to think about and do to support their, their optimal development and their children's.

This slide shows the same time at the bottom from the time children are born until their, their adult years and it just shows the contrast between the amount of physiological effort required to change the brain and so the -- as the brain is so malleable, so developing so rapidly in the early years of life, malleability is very high, which then over time tapers off. Can still change our ways later on but they become more set as we become adults.

The physiological effort to change the brain, how it's organized, how it thinks and feels, how it responds to the environment, how it deals with stress, how it plans for the future, becomes much harder into the adult years and this is represented in the, in the later slide that we'll show in terms of the enormous costs associated with after the fact intervention as, as Dr. Brownell mentioned yesterday, it's much harder, more intensive, more expensive, often less effective to intervene after a

problem has already occurred. Partly because of the physiological effort required to change the human brain.

So the second -- the first core concept from the, the centre was around how experience shapes the -- builds the architecture of the brain. The second is this particular kind of environmental experience or interaction that shapes the circuitry of the brain. If you just click on the picture -- you need to click on the picture of the baby with the tennis racket. And it's -- that researchers have called serve and return, very much like a racket sport, as you will see.

(AUDIO/VISUAL RECORDING PLAYED)

MR. SANTOS: Thank you. So the serve and return interaction is the fundamental environmental experience that shapes early brain development. Every brain in this room, every brain in the province, every human brain since we became homosapiens, those brains were built that way, through this developed process over, over time of the human brain, as a baby, being dependent on the actions and interactions of caring wise adults that surround that child, that developing child.

The connections developed from these, what appear to be very simple interactions, produce thousands of

connections in the brain every second as, as that rapid brain development is occurring.

One of the breakthroughs over the last decade has been something that Ms. McCuaig referenced last week, as well, that's called epigenetics and so if we think back 20 years to the 1990s, the whole world was preoccupied, in the scientific community, with mapping the human genome of the -- the human blueprint they were calling it, that once we understood the components of human DNA we would have all the answers. It turns out that that's only a fraction of the story of what makes us human and how, and how we develop. It turns out, as mentioned, that our DNA, our genes, are dependent on the environment for their expression for better or for worse, which is the field of epigenetics. And so there is an increasingly understood process of signals from the environment, for better or for worse, caring and nurturing, threat, danger, maltreatment for example, violence, that sends cues electrochemically to the developing brain and to the genes in the human, human body that sets in motion a process of turning on or off those genes and many of those genes regulate some of the things that, that matter most to us throughout our lives, our emotions, how we cope with stress, as well as physiologically in terms of our, our health and, and illness.

And so if you think about the environment as kind of the -- being able to turn on and off the light switches in our genes, that's, that's a, that's a simple way of understanding what's happening here.

The implication of this is, is quite far reaching for the inquiry in terms of understanding the nature of the challenges, of the problems, of the travesties, as well as some of the potential solutions.

So epigenetics, in more technical terms, refers to changes in gene expression that don't change the actual genes or their sequence, themselves, so it's merely about their expression, whether they are turned on or off.

What's striking about the -- this breakthrough science is that these effects can occur intergenerationally and so if you think about in the picture there, the developing fetus, the baby in their -- his or her mom's womb, there are three generational effects operating there already, epigenetically. There is the parent's own DNA and their epigenetics, there's the baby's own DNA and there's the reproductive cells of that, that baby when they become an adult and so the messages, the signals sent by the environments of all those generations have the potential, for better, for worse, for carrying forward over time, sometimes skipping a generation. And so there's, there's amazing research now showing that, for example, the

nutritional environments of grandmother's will affect the obesity status of their grandchildren because of epigenetic mechanisms resulting from those environmental experiences, going from famine to, to different settings, for example.

Epigenetics has now been tied to a whole host of things that plague human life, cancer, prenatal changes to the fetus, brain disorders including mental illness and mental health disorders, as well as chronic disease, metabolic problems, as well as autoimmune diseases, like lupus and other -- diabetes, for example.

Part of what science is coming to understand from multiple disciplines, from anthropology, from neuroscience, from psychology, from medicine, in other areas, is that what might be like a strong explanation for some of the, the biggest challenges facing the public in terms of health and wellbeing for, for people in modern society, is what's known as developmental mismatch. And so we have, evolutionarily speaking, very ancient bodies but living in modern circumstances. So a good example is the human body has been evolved over millions of years to walk a minimum of a least 20 miles a day. Most of us don't get a fraction of that in modern life because of how we've organized modern society.

And so on the slide here are pictures of covers of many books published just in the -- in recent years,

piecing together those multiple strands of evidence from different disciplines that show how that mismatch is likely one of the leading ways of understanding why we have the diseases that we have today, why we have the mental health issues that we have today, and so on.

So understanding our origins, our ancestral history within this evolutionary perspective becomes important and it also provides an unusually positive bridge to what I think the inquiry has heard in terms of ancestral and traditional wisdoms certainly from indigenous cultures.

Many of the things that were shown to be hugely important for human development in our ancestral environments, things like breast feeding, co-sleeping with parents and their children, something that's called alloparenting, which one of the books is called Mothers and Others, so extended family but also non -- can non-biologically related adults in the community all taking shared responsibility for the parenting of the next generation.

The extended family I mentioned. Intergenerational peers turns out to be very important for child and youth development, being exposed and being able to interact with children and adults of multiple ages at the same time which contrasts how we organize much of modern day life, for example, by grades and schools of

children the same age, and spending most of their time with other children of the same age.

Play has become identified as a huge and important driver of human development, not just cognitive language and literacy and numeracy development but also social and emotional development. Play kind of gets short shrift in modern society as frivolous but it turns out that play is actually the work of child development, of brain development and, and our modern day life has often crowded that out.

The importance of the land, of nature, of oral history of the transmission of knowledge and wisdom, orally, verbally through generations and then, of course the centrality of language and culture, all intertwined in, in our ancestral communities, our ancestral members in terms of raising children.

So the implications here are to try to recapture what, what some are calling more of a back to basics approach of these fundamentals that our, our brains need to develop successfully, for us to adapt successfully to modern life to, you know, the requirements of living in the 21st century world.

So building on experiences, building the architecture of the brain, that serve and return interaction shaping the circuitry of the brain. The third

core concept which is probably the most important of the three, for the Commission, the inquiry, is this idea of toxic stress derailing healthy development and so if you could click.

(AUDIO/VIDEO RECORDING PLAYED)

MR. SANTOS: Thank you. Just cancel it, please. Thanks.

So, with those three core concepts there are sort of two big implications not just for the inquiry but for what we do for all of our children, you know, today and for future generations.

The first big implication is the importance of nurturing environments for all human development, right from the beginning, from the prenatal period. That serve and return interaction being particularly powerful and important. Also showing, as I will show you in a slide in a second, why neglect, as one of the most pernicious and invisible forms of child maltreatment is so damaging because of the absence of that serve and return interaction, the developing brain simply doesn't have the opportunities to develop in the ways that it, it needs to in order to be healthy and successful in life.

The second big implication is the importance for

all of us, and I want to speak beyond programs and services, but all of our actions in our lives that affect young children, in particular, is the importance of either reducing or buffering toxic stress. It's very clear now from this evidence that there is, there is physical damage, visible damage, as I will show you, to the developing brain as a function of, of things like crime and poverty, addictions, violence, chronic uncontrollable stressors that literally have a toxic effect on the developing brain.

So here we have photos of -- microscopic photos of, of neurons, of brain cells. On the top is a normally developing brain, you can see there's lots of connections when you look at the, the actual nerve cell. On the bottom is a, is a microphoto of a, of a brain in the environment of toxic stressors, you can see actual physical damage on the neuron, fewer connections, and it's the connections that matter most in the developing brain, the density and the connections that shape the -- you know, the, the future of that child.

And so leading authorities, the Canadian Medical Association, for example, the Canadian Pediatric Society, the parallel organizations in the U.S., just in the past few weeks, in the mass media, have talked about the need for physicians, as one group, to treat poverty, toxic stressors, as they would other, other causal agents for

disease because of the enormous negative effect they have on human health and illness, which is a different realm of action if you think about people trying to be medical doctors, how do you, how do you do that, and, and it implies what is a big foundational principle of the prevention approach that we have been working within, working across systems and sectors in a, in a very integrated collaborative way. Because no one area can possibly do, on their own, what's needed in order to effect the kind of change required.

Many physicians are now saying that they can have a bigger impact on human illness, not by -- not, not simply by treating diseases after the fact or through medication but by actually tackling with what other witnesses have referred to as the social determinance of health, simply because of the huge imprint that they leave on the human body.

And so this is another framework from the Harvard Centre, the basis gist here is that that environment is constantly shaping that interplay between our genes and our environment, those accumulate over time.

The late Clyde Hertzman, from B.C., called this biological embedding. And so over the last 20 years as people began to understand the effects of poverty, of education, of other social forces on health, on human

health, the question then got, got posed, well, how do these -- how does the social environment get under the skin, how does what we're -- the environments that we're living in actually come into, into play and affect our developing biology and, and human health.

And this all centers on that epigenetic process that the brain is constantly adapting right before birth to the environment that it's being reared in, for better or for worse, adapting as best it can, and many of the problems that we see over the life course, problems with education, problems with health, physical and mental health, as well as health related behaviours, substance use, smoking, drinking, drug use, physical activity, are all efforts of the human organism to adapt to those environments, sometimes, sometimes effectively, sometimes less so. And so the -- again this tying back the story of how all those foundations start very early in life.

There are studies now, these are studies from a massive study of tens of thousands of, of adults at Kaiser Permanente in the, in the States, where they looked at toxic stressors or what they call adverse childhood experiences, so very similar things, chronic poverty, child maltreatment in childhood, addictions and, and severe violence in the family, in the community.

What this chart shows on the bottom is with

increasing numbers of toxic stressors or adverse childhood experiences, here from zero to eight, you have anywhere from a doubling to nearly a quadrupling of the odds of those children having cardiac disease as adults, decades later.

There is similar data showing that children growing up in poverty only in their early years, they may enter better socio-economic status in later years, still predicts their obesity status as adults, their body/mass index. And there is a mass of literature, this is just one example showing how the social environment, how social deprivation, social disadvantage, gets under the skin to shape human health.

This also appears in mental health and addictions, as well. The same pattern shows with increasing numbers of toxic stressors in childhood, especially in early childhood. You have a quadrupling or a quintupling of the prevalence of things like alcoholism, substance use. There are similar charts for suicide attempts. Pretty much every outcome that matters to use in our health is, is -- can be related back to these adverse childhood experiences.

The implication, of course, for the physicians treating these diseases and these mental health illnesses and disorders in a, in a health management organization is

that the most effective treatment would have been prevention much earlier to prevent or reduce these, these adverse experiences when these, these adults were children.

And then just to link this back to our indigenous knowledge, our indigenous communities and indigenous peoples, there are indigenous researchers, Amy Bombay is a psychologist, specializing in neuroscience, she did her PhD at Carlton University, she's doing a post-doctoral fellowship now at the University of Ottawa. She has published two papers that illustrate this growing bridge between this epigenetic research and history and the trauma of indigenous peoples in Canada, and particularly Indian Residential Schools.

She's written a great review paper about intergenerational trauma and, and ties in the available evidence around epigenetics as a likely mechanism of why the, the negative effects of trauma, in some cases several generations ago, in some cases several -- almost over a hundred years ago, can persist today.

She's also looked at studies of, of children of, of, of adults who were children in the residential schools and this is just an illustrative study that just shows how that experience of their parents moderates their children's own development, in this case of whether they're going to develop clinical depression and how they deal with things

like traumas, as adults, themselves, or how they deal with racism and perceived discrimination, in their own lives. And so this ties back to the biological understanding we have of trauma which is that it's affecting the developing child's stress regulation system, how does that child deal with stress, small or large, how capable is that child of dealing with challenges in their life over time.

As well as the capabilities of their own parents who, themselves, many of them were reared in, in similar environments that limits their own capabilities and capacities for that kind of nurturing, that kind of serve and return interaction that their own children require.

And so this is helpful because many in the general public, and we know this from public opinion polls and just from anecdotal data, is that many in the general public still struggle to understand why it is that the effects of the Residential Schools still persist into modern day, why can't they just get over it, is a common refrain.

Many of those people may understand better with unfortunately grounding it in science as opposed to history, as if that weren't enough but there is a growing scientific understanding of why the particular traumas and experiences in the Residential Schools, the cultural dislocation, dispossession, the eradication of their

language as well as the child maltreatment experienced by many of the Residential School survivors could translate epigenetically into their own challenges as adults and transfer those intergenerationally, epigenetically, to their own children and why it's imperative for us to also act, for all of those but also the, the children as yet unborn. And there is a direct scientific tie-in here to the, the philosophy of many indigenous communities about thinking about the seventh generation yet to come in terms of, of children.

There's also work, Lawrence Kirmayer from McGill University, he is a well respected psychiatrist in the area of indigenous work. There's perspectives that tie back to the same story about understanding resilience, how do we overcome the odds, how do we overcome trauma and, and, and toxic stressors in our lives. And again, grounded in the ancestral wisdom, this idea of the collective of being grounded in language, culture, the land, all the things that we've heard from our indigenous colleagues at this inquiry as well as other things like the Truth and Reconciliation Commission.

And they have implications for understanding the challenges that we face, the problems and, and, and issues that we have to address as well as potential solutions.

Another bridge between traditional knowledge and

brain science is the growing understanding about the emotional systems of the brain. And so Jaak Panksepp is a well respected neuroscientist, he's just published a book, with Lucy Biven, called the Archeology of Mind, which delves deeply into the oldest structures of the human brain, many of which are built over the last million or billion years, over time.

They have identified the seven fundamental emotional systems in the brain, which are seeking, anger, fear, lust, care, panic and play. Those are important because those, for most of our existence as a species on, on earth, were our tools for living effectively, of, of, of exploring new areas, of, of building relationships with one another, of dealing with challenges, of procreation, of the passing of, of wisdom and so on there.

There is now work showing how these can tie directly to very longstanding traditional teachings by indigenous peoples, that seven sacred teachings, for example, as actually being anchored in these differing areas of the brain, so there are bridges and one of the messages that we, we really want to encourage people to think about is the compatibility of these different perspectives on knowledge. Scientific knowledge is just one of the seats at the table, it's relatively new to public policy, we need to look at experience, we need to

look at clinical and individual wisdom, we need to look at tradition and things, so that the challenge really is to assemble all these things together to help us find better and better solutions and the exciting part of this is that it turns up much of this because we're all ultimately connected back, is quite compatible.

A good example of that comes from two reports that I think have been mentioned, or have been submitted by the previous witnesses, so the, the Truth and Reconciliation Commission of Canada, with Justice Murray Sinclair as the Commissioner, some months ago released its interim report. One of its -- its eighth recommendation, in terms of action to follow the Residential Schools, is that all levels of government develop culturally appropriate early childhood and parenting programs to assist young parents and families affected by the impact of residential schools, and historic policies of cultural oppression and the development of parental understanding and skills.

And so the other report that I believe Dr. Trocmé offered two weeks ago is the Royal Society of Canada's report on Early Childhood development. So they were asked by -- they convened an expert panel, chaired by Professor Michel Boivin from Laval University and the now late Dr. Clyde Hertzman, from UBC to, to co-chair.

They talk about how the overrepresentation of indigenous children in the child and family services system is indivisible from the Residential Schools history of our country and that addressing that the reconciliation steps required to redress those traumas and injustices have everything to do with addressing, today and into the future, the adverse childhood experiences still encountered by too many young children, particularly in their early years.

So to take this more closer to home, we have data in Manitoba and in some cases some of it is unique to the province, on exactly these mechanisms, and so one could ask the question, well, what is the prevalence of toxic stressors for children being born in Manitoba. And so what we have here, the finding which is -- that's startling to many, is that one in four babies born every year in Manitoba is born into toxic stress, defined as three or more risk factors that are operating at the time of the child's birth in the province. This is based on universal data collected by public health nurses, through each regional health authority, called the Families First Screen which is really a quick screen of about three dozen risk factors, biological, social, environmental, that enable us to look at what are children experiencing right from the beginning, and these are indicative, not just at the time

of childbirth but, of course, they are likely operating during the time of pregnancy.

And, as mentioned, the prenatal period and, and as Dr. Brownell mentioned yesterday, the preconception period become important areas of attention, if we are to prevent, on a larger scale, on a more effective scale, child maltreatment in the future. And these, these results are similar to other babies born in other jurisdictions across the country.

This says something, I think, about society and what we accept as what one, one expert has called an intolerable equilibrium, that we've sort of settled as a society into. These data are quite consistent, year over year because of the, the structural factors here. This is a -- some of these toxic stressors include things like poverty that we talked about already.

The picture is, is even more contrasting when we look at indigenous babies born in our province where we find that provincially, and this is off-reserve births, two out of every three aboriginal babies in Manitoba are born into toxic stress. That's about 2,000 every year. And when you break that down by our two most populace indigenous groups, the First Nations is about three and four babies and for Metis and Inuit it's one and two babies.

THE COMMISSIONER: Both off and on reserve?

MR. SANTOS: This is off reserve data. What we know from a parallel screen that is just being implemented now, in many First Nations is that these prevalence figures are higher in many reserve communities because of the conditions in those communities.

So an implication here, of course, given what we know about early brain development, is that we really need to do all that we can, across system sectors, and beyond programs and services to people in the everyday lives of young children and pregnant moms and their families to buffer the effects of these toxic stressors or better yet, to reduce or eliminate them if we can, right from the start.

Just to give you a picture of what these look like, they do look different for our aboriginal newborns versus our non-aboriginal newborns. The toxic stressors faced by our aboriginal newborns are largely socio-economic. The top one is poverty, financial difficulties and then things associated with that like mom not completing high school.

There is some equal opportunity toxic stressors in -- equal opportunity in that they affect all segments of the population. For example, teratogens or toxic stressors like smoking during pregnancy, drinking alcohol during

pregnancy, as well as the histories of the families, for example, of whether there is a child abuse history of the mother.

Mental health of the mom is a huge toxic stressor, for example, significant depression or anxiety. For two reasons, one, it affects the neurodevelopment of the child hypogenetically. It also affects the care giving ability of that parent.

THE COMMISSIONER: What are those percentages, the percentage of babies that fall into that category?

MR. SANTOS: That's right. That's right.

And then just for illustrative purposes, the arrows going down, up or horizontal show whether there has been a change over the last -- over that period, 2003 to '09 in that toxic stressor.

So you can see on the left, the non-aboriginal, while that's -- when we look at that group it's only about one in six -- well, I shouldn't say only, that -- any level is probably unacceptable but the, the contrast is quite high, two out of every three babies, who are aboriginal, versus about one in six non-aboriginal newborns every year.

And so there is, there is already a list here of things, of clues, of potential areas of focus where there is already significant work, of course, and across the province to tackle all of these things, in utero and before

children are even conceived in terms of preparing the next generation of parents, both in terms of how they care for themselves, nutrition, not smoking or drinking while, while pregnant but the larger issues that almost every witness has made reference to, in terms of the structure of society, of the, the level of inequality in the society of available socio-economic resources, of available housing, et cetera, and social support, become hugely important for brain development.

The second check point that we can look at after the child is born which was also created under the Healthy Child Strategy over the last decade, in conjunction with almost every jurisdiction across the country and in many countries in the world now, as Ms. McCuaig mentioned last week is something called the Early Development Instrument, the EDI.

THE COMMISSIONER: This is the second checkpoint?

MR. SANTOS: This is the second checkpoint at age five, in kindergarten. And so back in 2002/03 school year, the province invited all the public school divisions to voluntarily phase in the EDI in kindergartens, as a kind of census. In other words, it's collected for all children by all kindergarten teachers in all public school divisions.

Within a couple of years all the school divisions who ready become fully aware and active partners and the

importance of the, the years before children start school had already voluntarily phased in the EDI as a, as a routine measure of how children are doing when they started school, in kindergarten, in most divisions.

Since that time period we've had an active open invitation to our, our indigenous colleagues and partners and in the last couple of cycles there has been a phase in now on reserve and it would -- through the Manitoba First Nations Educational Resource Centre as our partner, about 50 percent of the First Nations Band School kindergarten classrooms are now collecting this, as well. So we have -- we'll have a growing picture of, of early development on our -- on reserve communities, as well.

And as mentioned, Ms. McCuaig mentioned, and as Dr. Brownell mentioned yesterday, for the EDI report, just as a refresher, the EDI looks at the five classic areas of child development, physical, social, emotional, cognitive, which is literacy and numeracy, and then communication and general knowledge skills. Sort of the fundamentals of school successes and success in life over time.

And as mentioned, the importance not just of the cognitive academic skills but what some call the soft skills or the non-cognitive skills which turn out to be as or more important in terms of social and emotional skills and development.

So what does that picture look like for Manitoba? So what we find that same one in four statistic for the whole population in Manitoba, every time -- we collect the EDI bi-annually, so about 29 percent, about one in four, of all kindergarten children in the public school divisions are vulnerable, as measured by the EDI, vulnerable denoting being low, very low in at least one of those five areas, physical, social, emotional, cognitive or communication.

Again, there's a contrast with our indigenous children, almost double that prevalence rate, about 45 percent or about two in four aboriginal children, kindergarteners, are vulnerable when they start school. And so this is -- there's lots of research, these, these results for both indigenous and non-indigenous children are similar in other jurisdictions.

If you look at B.C., Alberta, Saskatchewan, for example, it's very similar. And again that equilibrium is apparent that the, the -- all the causal factors and mechanisms that lead to how children are doing are not doing so well, appear to be operating in almost every community.

And then again there's a clue here because we know that these data are also a good forecast of what happens to children later, both in terms of school and in life. And so it gives us an early indicator, an early

warning system, if you would like, like the birth screen, to know how we're doing in the early years but also areas that we need to shore up and, and improve on over time.

Ms. Spillett yesterday reminded us, as I think other witnesses did, about the importance of not just looking at the deficits, at the misery, at the weakness, but at the strength and the resilience and the resource in all peoples, particularly indigenous peoples in communities.

So we just added this slide to show that while 45 percent of aboriginal children every year starting kindergarten are vulnerable, an equal proportion, 45 percent, are doing very well on the EDI as measured by the EDI, they're in the top 10 percentile, above 90 percent across the board.

So there's clues here and we have started to try to understand this better with the data, is to -- what is happening that we have such distinct classes of children, at age five, in the indigenous -- in our indigenous communities doing so differently. Effectively, no middle class. There's children doing very well, and then there's children not doing very well at all. And you can see the contrast there between two-thirds of, of the provincial and this is true for non-aboriginal children, in general, doing very well. So while we don't want to ignore or overlook

the strengths also apparent for -- that are operating in the lives of young aboriginal children, there's still an inequity there very young, very early, as Dr. Brownell discussed yesterday.

The relationship between early development and socio-economic status is the same as, as other witnesses have already testified, is that there is a gradient such that there is a disproportional amount of things we don't want, of misery outcomes in the -- as you move down the socio-economic ladder.

Some years ago we did a survey of parents whose children were in kindergarten and we collected not just what we have available publicly in terms of the income of the area or community that they live in, we actually got information about their own families from the parents about their education and their own household income as a measure of SES, of socio-economic status, and we find again the same story that in these days about 40 percent of children and the, the bottom 25 percent of socio-economic status, were vulnerable compared to about 15 percent than the more well off groups.

The implication here is Ms. McCuaig, Dr. Brownell and others have testified is that while targeting this is very important, we need to do more as much as we can for those with greater need, proportional universality.

We also -- if we only target interventions we miss, in this case, about two-thirds of children who are measurably vulnerable, just -- who happen to be in the middle class. And so this is something that is operating across income groups, it's just that the concentration of factors and causal mechanisms that lead to poor outcomes are much more concentrated in the poor, as, as you already know, the toxic stressors are much more prevalent in our low SES communities and, and peoples.

So some of the hopeful part of the data, especially when we look over time, with longitudinal data, is that children move in and out of vulnerability as they grow up, for better and for worse. It's not permanent, there's no time in life, with few exceptions, where this cannot change, at least some for the better.

So when we want to look at this is to look at vulnerability at birth as -- with the data I mentioned a second ago, that families first, and we find about one in four, as mentioned, are vulnerable at birth and then if we look five years later we see that same statistic, about one in four kids are vulnerable at kindergarten, and it kind of feels like there has been no change.

It turns out that when you look between any two points of time children follow one of four pathways. Children stay on a good positive developmental track or, or

trajectory, in this case about 60 percent of children who are doing okay at birth are doing okay when they're age five.

And then there's a group of kids who are doing okay at one point, not vulnerable, who enter a period of vulnerability at that next check point, in this case about 17 percent are vulnerable at age five.

Interestingly, when we look at this, about a similar proportion, escape vulnerability, they overcome the odds, they're resilient, that's the green trajectory. And then there's that bottom group on the chart, the red group, long term vulnerable where they are vulnerable at each check point and that's about -- it's typically 10 percent of the population of children.

And so this has implications for understanding what drives healthy development and prevents vulnerability or reduces it and gives clues about what the policy next needs to look like for our children.

If the goals are to level the playing field, to ensure that we have equitable outcomes so that whether a child is rich or poor, aboriginal, non-aboriginal, they have the opportunity to have the same good outcomes as other children, flattening that and leveling the playing field. And if our second goal is to improve the children's Development over time, their trajectories, then you need a

mix as people have already testified at this inquiry.

We want to keep children on that positive pathway so universal supports are typically the first port of call there, so things like universal healthcare, universal public education.

What we lack is a universal early childhood system. Many children, as I have shown you, need more supports, building on a universal foundation to build resilience, to overcome toxic stressors, or to overcome the odds, or to prevent them from entering vulnerability later on. Those are typically targeted interventions on top of universal.

And then lastly there is a smaller group of children that need additional supports to universal and targeted, those are typically treatment, clinical services, and these parallel Dr. Brownell's upstream, midstream, and downstream discussion yesterday.

The challenge here is it's hard to do this unilaterally for any province because the mix of toxic stressors and protective factors in any community varies community to community and so what we need to do is understand local context, local capacity and strengths as well as challenges and do the best we can to tailor the mix for what the children need in each community as opposed to a one size fits all provincially.

These are data that I think Dr. Brownell referenced or is in one of the previous exhibits, the How are Manitoba's Children Doing report that was released last November.

This just shows, on the bottom, the number of vulnerabilities on the EDI from one to five and the prevalence of basically failing reading or numerous "E" tests in Grade 3.

The troubling part of this picture is that the EDI is a good predictor of how children are doing three years later despite the excellence of schools, despite all the resources available to children in Grade 1, 2 and 3.

It shows how much of a foundation is set before children ever come to school and it's the largest single biggest reason why the school community trustees, superintendents, educators have come on full side to working with, with everybody on the early years agenda.

And so an adage in the prevention field is that if you can predict something you can prevent it, and what we're showing here is one example of how we are able to predict these things earlier on which gives us prospects for prevention down the road.

So that's the bad news story. The good news story is that children from age five to Grade 3 follow the same four pathways, vulnerability is not permanent at age

five either, and so you have these similar pathways. Dr. Brownell has referenced them a little bit differently.

So at the top one, where kids stay on track, is the positive trajectory, the kids that escape vulnerability are called positive deflection, they kind of bump back onto track. Negative deflection are kids that are okay in kindergarten but are doing poorly at Grade 3, and then the negative trajectory are those long term vulnerable kids, again that are doing poorly at both check points.

So if you -- I'll just scroll back and forth. The colours of the pie charts here show the proportion of children in each of the groups. So for reading and for math, left and right. So the good news is in both cases the majority of children going from kindergarten to Grade 3 are on a positive track. Another good news story is that there is a much larger proportion in both reading and math of kids getting positively deflected, of kids that needed help in kindergarten getting the help they needed to do well, at least by these outcome initiatives three years later. But there's still some work to be done, of course, for the kids who are on -- enduring vulnerability pathways.

When we look at the influence of socio-economic status which this shows you reading in the bottom SES quintile the bottom fifth of SES for reading and on the

left and then the bottom -- the top fifth or quintile for the -- on the right.

So you can see the inequity there, that in the bottom the lowest socio-economic communities in Winnipeg and Brandon, in this case, about -- only about half of the children are on that positive trajectory, the poor -- only about half of poor children, compared to about three-quarters of the children in the highest income group.

The good news, I guess, if there is some here, is that if you look at the lowest income group of children there is a much larger group who are being positively deflected and so all that targeted effort that schools have been actively working on, is working such that they're having more success in deflecting kids, getting kids back on track in low SES than they are even in the high SES groups, partly because of attention, partly because some of those challenges in more -- children from wealthier families are often less visible to some.

So there's good news and bad news here in terms of our predictive ability but a real goal that is kind of a funny thing for a scientist to say is actually we don't want to be able to predict, we want to be able to do things so that these early forecasts don't, you know, bear the storm clouds later.

As Dr. Brownell mentioned yesterday, there's a

whole host of factors from before children are born, leading them to age five and, and Grade 3 that contribute to those outcomes but SES dominates them all. It's not that these other factors about how children are developing at birth biologically, all the resources and experiences in their environments, it's just that SES is related to every one of them, they're all driven or graded socially, economically, in, in their operation. And so this has implications for how we organize and collaborate and set up prevention and intervention to make a difference.

Dr. Brownell mentioned this yesterday, as well, this is the data from the EDI report that just shows the overlap of those three adverse groups, children born to moms who are teenagers at the first child birth, teen moms; children on income assistance and families on IA; and then children in CFS and the overlap and the, the striking figure that, in Winnipeg, for children born in the years 2000 and 2001, one in three Winnipeg children are in one or more of those groups. A figure that's largely unchanged from another cohort that she studied, that were born in 1984 and '85, a decade and a half earlier.

So, again, the structural features of socio-economic status being very hard to change in the immediate term but have a long lasting reach in terms of their effects on child development and the factors that can

prevent child maltreatment in communities.

THE COMMISSIONER: Now, at some point we need to take a mid-morning break, that -- you tell me when it's a convenient time, if you want to finish a slide or two before you break, it's entirely up to you when it's an appropriate time.

MR. SANTOS: I think there's an actual break after --

MS. SANDERSON: Six more slides.

MR. SANTOS: Yeah. Thank you.

So what this chart shows is the membership of children in one or more of those three adverse groups. So the orange colour are children not in any of those groups, the red are children born to teen moms, the green are children in CFS and the blue are children and families on income assistance.

The height of the bar shows the prevalence of vulnerability at age five in those groups. So if you look from left to right, the zero group, they're not in any of the three groups, but one in four of them are vulnerable, which is what the provincial statistic is.

If you are in one of those groups as a, as a five year old, the prevalence of, of, of vulnerability at age five, in kindergarten goes up to about one in three, up to 40 percent.

If you're a child in two, two of those groups, combinations, it goes up from 40 to about 50 and it's over 50 percent if you're one of the children who are in all three, and as Ms. Walsh and others mentioned yesterday, that is a description of, of, of the family of Phoenix Sinclair.

So the implication here is that already, by age five, using information that we have readily available about the, the status of children, the membership in one of these groups, we can identify not only how they are doing but these are also forecasts of what is to come.

Now, I would just add that none of these are -- as mentioned earlier, are set in stone, there are children and every one of these at risk groups that overcome those odds and do well but as a group, on average, across studies, the odds of them doing well are much lessened compared to children who are in those, in those groups.

And just to contrast this with the data that Dr. Brownell presented yesterday, which was about a different group that were followed into high school, we've combined those on the next slide, which is a bit of a -- just shows the difference, so these, these are the same groups, it's a different cohort of kids, but this is whether they fail to graduation high school within seven years of Grade 9, so you have a couple more years to complete Grade 12.

I'm just going to flip back and forth because you can see how the bars just kind of ramp up dramatically, you know, about 12 years later, because of the cumulative nature of toxic stressors that they build up over time and they multiple their negative effects and so the argument for early intervention becomes clear because we can, we can tackle some of this much earlier before those problems affect many, many more children. So by the time the children, who are in all three groups, 84 percent of them do not complete high school.

And then this chart, which is a bit more busy, just shows those outcomes and the academic and social paper that Dr. Brownell presented yesterday, including the EDI data from the other group, just showing their odds of those poor outcomes over time. The higher bar means higher odds of that, that outcome and then the colours are rated from left to right, kind of follow children growing up.

So the blue, left to right, is EDI, the vulnerability at age five, the next one is at Grade 9, whether they completed all the credits. The green one is whether they completed high school, the purple is whether that child goes on to become -- or that girl goes on to become a teenage mother, herself. And then the orange is whether that child, as an adult, received income

assistance, the intergenerational cycle of social assistance.

And you can see almost without exception in all the combinations of the three adverse groups, the odds of the negative outcome just goes up exponentially as children grow up over time and so the implication again here is that if we're trying to improve the odds for children we want to make the investments when we have the best chances of good odds of, of success and it's -- it should be evident that it -- you've got better chances when you've only, only, so called only two or three times the odds of a poor outcome versus 13, to 14, to 15 fold the odds of a poor outcome as an adult.

And it's not to say that we can't do things over the life course but with limited resources the evidence is very clear that we will have the biggest potential for impact if we do this much earlier, as well as over time.

This is illustrated in this chart here, it's similar to the one earlier, the gold bar show the relative malleability of the brain from the early years of life into the elderly years. So those of us in the room that are over the age of five, there's still gold there for us, our brains still have hope but it's much less than when we were babies.

The green bar show the relative investment, in

every jurisdiction and this is characteristic, in Manitoba and every country, really in the world, on health, education and social services. And you can see the mismatch between when we can make the biggest impact in terms of human development and brain development and when we spend most public dollars. And this is understandable, we are very much a reactive or even a second chance society, we, we often decided to act after a problem has already occurred because the problem has become apparent. But with the knowledge in hand now part of the challenge is balancing what Jan called a portfolio. Because it's not simply about moving existing resources over, as somebody with elderly parents, I want to make sure they're cared for, but we also need to attend to our youngest generation.

The economics of this are very strong, Jim Heckman was referenced by previous witnesses, he won the Noble Prize in economics in 2000. He's become an unlikely champion for early childhood. He started out by looking for when does the sweet spot occur for investment in education.

Job training, he had to go back further into schooling. He didn't find a cost benefit return of investment until the pre-school period. This is for two reasons. One is because the, the brain, itself, is like an RRSP or a -- like a bank account, it's a compound interest

model of development. If you start early and let that investment multiple over time, you get a better return.

Secondly, it's because of what was shown on the video is in that the brain is built from the bottom up, it's cumulative, skill begets skill and so the foundations become hugely important, very challenging to -- for adult education when the foundations weren't, weren't as solid in their earlier years.

The challenge of public health and, and tackling things after the problem has already occurred has already been discussed by other witnesses. This is other data reinforcing that. These are data from CIHI, the Canadian Institute for Health Information, they're a national agency that counts health statistics.

These are data counting the number of health professionals in Manitoba per hundred thousand population. So there's about a million people in Manitoba, give or take, so if you multiple all these numbers by 10 that's about how many of these practitioners we have in the health field as of 2010.

So for every hundred thousand Manitobans there are 20 psychologists, 68 social workers, 76 registered psychiatric nurses, RPNs, about 186 physicians and these, and we have the most resource we have are our nurses, our Registered nurses, about 935 nurses per hundred thousand

Manitobans.

We've used this data with other data showing because of the high prevalence of need, of vulnerability for our children, even if somebody decided to deploy every single one of these healthcare professionals, out of ERs, out of personal care homes, out of non-child services, to children who needed health services, we could never treat our way out of the problem. This public health paradox or prevention paradox has been known for several decades and history has shown, time and again, that no major public health threat, and many agree that child maltreatment, child abuse and neglect is itself a massive public health threat, has ever been reversed by treating people, one and one, after the fact. It's only reversed, historically, by prevention at a population level. Hence our key message about prevention being paramount. So this applies to child maltreatment, mental illness, physical health, et cetera.

The big challenge, as we showed you on the previous slide is as a society, as reflected in our governments, we have organized ourselves as an after the fact society, largely. There's been massive effort over the last many decades on the prevention side but it's -- but relatively speaking it had -- it, it, it pales in comparison to the investment on the tertiary side.

So this is probably a good transition point for a

break, Mr. Commissioner. We just want to reiterate the same messages in that fundamental, again, to the prevention as paramount are those two areas of action, increasing nurturing environments for all children, especially the most vulnerable, and doing everything we can to decrease or buffer toxic stressors right from the beginning, from prenatally, at least until they are starting school, if we are going to have the biggest impact.

THE COMMISSIONER: Right. I think that is a good point to take our break so we will adjourn for 15 minutes.

MR. SANTOS: Thank you.

MS. SANDERSON: Excellent.

(BRIEF RECESS)

THE COMMISSIONER: All right, please.

MS. SANDERSON: Thank you. So I'm going to pick up in just a moment and talk about the Manitoba experience and how a lot of the science that Rob was speaking about has influenced us and how we hope we're putting it, imbedding it in the public policy that we're developing.

Before I do that, there was just one example that I asked Rob is he would just use, to illustrate for a minute some of the science he's been talking about and what

it means, or the implications for kids. So I'm going to ask him to explain this --

THE COMMISSIONER: Right.

MS. SANDERSON: -- particular research study.

THE COMMISSIONER: Right.

MR. SANTOS: Sure.

So if you look at any child who has been unfortunate to experience toxic stressors in the early development and their brains have been shaped accordingly, two things. One is that if you think about the brain as adapting to the environment that it's being reared in and being raised in, it makes sense. So many of the toxic stressors represent signals for disadvantage, not enough food, not enough money, threat, danger, unpredictability, chaos, all the things that we don't want for ourselves or our children. But the brain becomes shaped in order to live in that kind of an environment.

The difficulty then becomes when a child, whose brain has become adapted to a threatening predatory environment also has to live and interact in other settings where those threats are not, not as operative. For example, in the schools.

So many researchers, developmental researchers, have studied this with clever ways, such as having young children look at pictures of human faces expressing

different expressions, and asking them to describe what it is that they see. And as you might predict, children that have had their brain shaped to prepare for dangerous environments interpret human faces and human emotions differently than children that haven't been reared in those environments.

So you have children who have difficulty or different ways of processing in their brains social information and so what looks to most of us like somebody just looking at you right now, is looked at as disrespect or as danger, or as aggression which, you can imagine, leads to all kinds of difficulties for that child when, in fact, those emotional expressions, those cues in the environment, actually do not represent any threats or danger.

Often those children become rejected by their peers, they get involved in aggressive acts towards others, have difficulties regulating their own emotion and so on. So that there's this, sort of, real life -- I think Jan asked for that story because I think it helps picture what it means for an individual child whose brain has been shaped in this way, for understandable reasons, but when those -- it's very much that mismatch concept, like the brain is not -- that child's brain is no longer matched well and, and the supports that we need to provide to that

child, and that developing youth, teenager, that carries forward. So those same children who have difficulties interpreting or have, have different ways of attributing people's intentions, their actions, their emotions, also become, as in the case of the inquiry, future parents and with their own challenges difficulties in raising children.

A very common thing and a big target of many prevention programs, where they have children to prevent child maltreatment is to help parents reinterpret, reattribute what their children are doing. You often hear parents who are in an abusive situation say that my baby meant to make me mad, or my baby is testing my patience and at that age it's simply developmentally impossible. And so it's helping individuals who have this way of processing social information in a different way so that they can better interact in a more positive way. And so it has implications not just for helping children but helping parents with their own children.

MS. SANDERSON: And I guess I would just add, too, that there is physiological implications to all this, so if you are a child who has been raised in adverse circumstances, who interprets the world as a risky place, generally speaking, and is always on hyper alert, then you've got adrenalin and other toxic hormones surging through your system at a different rate than other kids do.

It may manifest itself as you being labeled as the bully, you may be labeled as having ADHD, and a whole other chain of events can unfold from there that all really have a physiological starting place.

So, what do we do with all this, I guess. And we've, we've sort of bombarded you with a lot of information so apologies for that but now we are going to talk about the practical side of what this looks like in Manitoba, without trying to suggest for one moment that we've got it all figured out because clearly we haven't. You've heard a lot about that for the last number of weeks and months. But that hopefully we're on a positive path and that there is hope in all of this, around what can be done in the systems.

So, first of all, let's revisit the Healthy Child Manitoba Act, you have it on the slide in front of you. It is enabling legislation that recognized that we had developed this sort of long term, cross-departmental prevention approach and that the government wanted to make sure that it was imbedded in legislation so that it would be protected as time moves forward because we all understand that this isn't something that is going to be fixed in a brief period of time.

The purpose of the, of the legislation and the healthy child approach is to achieve the best possible

outcomes for Manitoba's children, with a policy emphasis on early childhood development, for all the reasons that you just heard from Rob.

It legislates several cross-sectoral government structures, such as the cabinet committee which crosses multiple departments. It also legislates community structures and I'll talk about those in just a moment.

Very importantly, it gives us the authority to collect and link data across the sectors. So a lot of the research that Rob is referring to within Manitoba is us linking education data with health data, with social services data, which families are on EIA and so on.

Being able to collect and link that data is really the only way we are going to know if we're making a difference or not by the investments we're making.

And it also contains a requirement for regular public reporting on progress in child and youth development. So you have as one of the exhibits the five year report so at least every five years we're required to do a report to the public on how are kids doing in this province. And the first of those reports, since the passage of the act, was just released in April and is one of the exhibits.

MR. SANTOS: 152.

MS. SANDERSON: One -- Exhibit 152.

THE COMMISSIONER: Yes.

MS. SANDERSON: So just we're going to work our way through what does this Healthy Child Manitoba portfolio look like, what's the work of the cabinet committee who works together, and so on. So, first of all, the Healthy Child Manitoba vision, which I have mentioned a few times, is the best possible outcomes for Manitoba's children. What does that really mean and sometimes the fact that we --

THE COMMISSIONER: Just a minute, before you get to that.

MS. SANDERSON: Sure. Sorry.

THE COMMISSIONER: The slide preceding that --

MS. SANDERSON: Right.

THE COMMISSIONER: -- Healthy Manitoba is number three.

MS. SANDERSON: Yes.

THE COMMISSIONER: What's two -- I -- a number of --

MS. SANDERSON: These -- those were the major sections of the presentation. So number one was sort of the background of the department.

THE COMMISSIONER: Number one is Manitoba Children and Youth Opportunities.

MS. SANDERSON: Right.

THE COMMISSIONER: Number two, the Healthy Child --

MS. SANDERSON: Manitoba Act.

THE COMMISSIONER: -- Manitoba Act?

MS. SANDERSON: Right.

THE COMMISSIONER: Oh, okay. Well, should that be number two up on top of that preceding slide?

MS. SANDERSON: It could be. The Healthy Child Manitoba Act was referenced right at the beginning --

THE COMMISSIONER: Oh, right at the beginning, okay.

MS. SANDERSON: -- too, so it's --

THE COMMISSIONER: This -- okay.

MS. SANDERSON: -- a little confusing, sorry.

THE COMMISSIONER: Right, I'm -- I understand now.

MS. SANDERSON: So number three is just sort of the outline for the, the following pieces of the presentation.

THE COMMISSIONER: Right.

MS. SANDERSON: So the vision -- and I just want to point out that when we talk about healthy, we're talking about a very broad definition of health, it's not physical health, entirely, it's listed there that:

> To their fullest potentials kids will be physically and emotionally healthy, safe and secure, successful at learning and socially engaged and responsible.

And those outcomes are actually agreed to nationally, many jurisdictions measure against those outcomes so we actually have some cross-jurisdictional data in that regard, as well.

Our mission statement which is really more about how we intend to achieve that vision is that:

> Healthy Child Manitoba will work across departments and sectors to facilitate community development.

So many of the speakers that you've had, virtually all of the presenters you have had as witnesses for the last week are people that we work with in the community and often that we're giving some level of funding to. We believe in a community development model, we realize that Civil Servants are not the best ones to be out there servicing at, at grassroots level so about 80 percent of our funding goes out the door as grants to other

organizations that are very close to families to deliver services and again, I can give you some examples as we go forward.

So facilitate community development for the wellbeing of Manitoba's children, youth, families and communities, again with a priority focus on the early years. Our mandate is prenatal, to age 18, but we put a particular policy imperative on the early years because of the importance of that investment and also because there has never really been a public policy structure around the early years, the way there is for public education, for example, when you hit age five.

So until Fraser Mustard and others started shining a light on the early years, it was a bit of a vacuum as to what happened to kids between birth and showing up at school. We know that they got inoculated, that was one of the few check points, but other than that, kind of every man for himself out there, in terms of families and young kids. And we're trying to build more of a system for the early years.

There's a number of guiding principles listed. First of all, that we will be community based and I referenced that a moment ago, in terms of utilizing those systems that are closest to families and most respected and trusted as our delivery agents.

That would be inclusive so that obviously the doors are open to all families from all walks of life but recognizing that we have to make a special effort to reach out to families who are typically disengaged by services -- from services, and so making particular targeted efforts.

That those services will be comprehensive so it will be a spectrum that follows kids as they grow up and we don't have these crevices where they may not have access to services.

That they will be integrated. In other words, the systems are talking to one another, including sharing information about how kids are doing. Part of that we achieve through the protocols that I mentioned earlier.

Services will be accessible. So in places where families will naturally go to find them, and believe me that can be a challenge, as you can imagine, with the geography of the province and even, even within the inner city there are streets that people will not cross. So you might think you only need one healthy baby site in Point Douglas but, in fact, you need several. So we'll come back to that.

Quality assurance. We're very committed to, first of all, bringing to the province best practice, best practice programs that have a good solid evidence base. That's our, our first choice. We are, however, also

developing programs locally in Manitoba but where we develop then we put an even greater emphasis on rolling them out in a manner that they can be rigorously evaluated and reporting back on the results of those evaluations.

And public accountability which speaks both to that five year report I talked about earlier, but as I outlined, some of the programs that we're investing in you'll see that in a number of cases we've done or had done third party evaluations of the programs and those reports are released to the public as well as the lessons learned from them and our intentions of addressing the gaps that have been identified through evaluation so ...

The physical structures begin, first of all, with our leadership structure, which is the Healthy Child Committee of Cabinet, and I've -- haven't yet listed for you the departments that are involved on that committee. When it started in 2000 it was eight ministries, it's now 10, and you'll see, first of all, is Mr. Kevin Chief, the Minister of Children and Youth Opportunities. I won't name all the ministers but I will go through all the departments.

So, Aboriginal and Northern Affairs, Culture, Heritage and Tourism, Minister of Education, Family Services and Labour, who is also the minister responsible for the Status of Women. The Minister of Health, the

Minister of Healthy Living, Seniors and Consumer Affairs. The Minister of Housing and Community Development, the Minister of Immigration and Multiculturalism, and the Minister of Justice and Attorney General all sit on the Health Child Committee of Cabinet.

The chair is appointed by the Premiere and over the years the Minister of Family Services has been the chair, the Minister of Healthy Living and later the Minister of Healthy Living, Youth and Seniors and now, currently, the Minister of Child and Youth Opportunities.

And -- well, in a moment I'll explain the corresponding deputy minister committee but not quite yet.

Some current areas of focus of the cabinet committee and they -- we tend to do strategic planning sessions with them, approximately every 12 months, and they select areas of focus. Early childhood has continued to be an area of focus right from the onset. Mental health and emotional wellbeing is now very much on the minds of the ministers.

Crime prevention but through a social development approach also very much at the forefront. And this whole concept of integrated services and systems which really serves all of the, the previously listed areas of focus.

We oversee some cross-departmental strategies such as the fetal alcohol spectrum disorder

cross-departmental strategy, and then we actively participate on other strategies, such as All Aboard, which you heard about from Lisa Donner, earlier.

I should just mention that the other strategies listed at the bottom of that current areas of focus include Neighbourhoods Alive, which is a community development strategy. Reclaiming Hope, which is youth suicide prevention. And Rising to the Challenge, which is the mental health strategy for the province. And Healthy Child not -- is not only involved in all those but, in fact, the Healthy Child Committee of Cabinet has been used as the oversight body for a great number of them because the right ministers are on the -- in the room at a regular -- on a regular basis.

THE COMMISSIONER: How often do they meet as a committee?

MS. SANDERSON: They meet at least every two months and in the off-month the corresponding deputy minister's community meets.

On a really practical level, to give you an idea of how this all works, the agendas for the ministers are formed by the deputy ministers committee but there are also very much influenced by community structures. We haven't quite got to those yet but they're coming up.

So, we have, around the province, 26 parent/child

coalitions that we give modest funding to, to do local investments in early childhood. So, let's just pick a region, the central region, sort of Portage la Prairie all the way down to the, the border to the States. We ask the major sectors to come together around a table to plan for and consider the well being of kids. So the Regional Health Authority is there, the school division is there, aboriginal organizations and leadership, CFS. In some cases the faith community, parents, recreation. We give them in the area of -- central region in the area of about $80,000 a year that they can make some local investments on. And more often than not they spend that on hiring -- a small piece of that on hiring a coordinator who then will provide services through family resources centre, like a mom and tot program, lending libraries, a whole range of things are responsive to what that particular region might need. Which is very powerful at a local level and it gets those sectors talking to each other.

What has turned out to be equally powerful and I have to admit unanticipated, is that those parent/child coalitions are the eyes and ears of what's happening in our province. They feed back to us, you know, that new program you just introduced, the uptake has been amazing or, you know, that new program you just introduced, we can't seem to get the parent to buy into it, we need to talk about it.

At least once -- well, several times a year we pull representatives of parent/child coalitions together to share information both directions and one major event a year, often which Rob is a keynote speaker, where we share the most recent emerging research and ask them, given what you just heard, what do you think we should be doing in Manitoba; what would it mean in your region; you know, what does it mean in your sector, as a public health nurse, as a champion in your school division. So those parent/child coalitions also help us build the agenda that we will take back to ministers.

I mentioned earlier that we do strategic planning at least once a year, roughly, and that usually means taking longer than the usual two hour meeting which is what it typically is, two hours every two months. And I don't think I'm breaching cabinet committee secrets because I've heard our own ministers talk about this publicly, one of the very first meetings we did, when we were all trying to figure out what is this new structure and how do we use it, we simply asked the ministers to come to the table and answer the question when you think about children in the province, from your portfolio, what keeps you awake at night?

And, of course, we went around the room and for the Justice minister it was the rise of violence, violent

incidents that they were seeing among young people. For Education, it was the mental health issues that they were seeing in classrooms that they hadn't seen before. For Health, it was obesity. And so on and so forth. And it was the old facilitator's trick of write it all down and then step back and ask those people to tell you what -- how to interpret it and they basically all looked at it and said well, first of all, the problem I am dealing with, my department doesn't actually have the solutions, your department has the solutions. And it was that sort of spider web conversation around the room that made us sort of have that ah-ha moment about yeah, if we're not working together, we're not -- this isn't going to work at all.

So, that's been sort of the driving impetus for how we operate the, the committee.

I will also mention that both the Premier and the cabinet committee members have an open door policy in terms of members of the legislative assembly attending the meetings. So, back benchers are also welcome and often have later become members of the Healthy Child Committee, so there's been a lot of continuity in the membership.

THE COMMISSIONER: Well, and certainly engagement on the part of, of -- it's unusual, I think, to have that many ministers forming a committee on --

MS. SANDERSON: Yes.

THE COMMISSIONER: -- on a particular subject, I think it's --

MS. SANDERSON: Yes.

THE COMMISSIONER: -- very commendable.

MS. SANDERSON: Some of those ministers also sit on Treasury Board, where the money decisions are made --

THE COMMISSIONER: Yeah.

MS. SANDERSON: -- and some sit on the Priorities and Planning Committee where priorities are being set, so that helps us, we think.

I have to mention the third community structure so on the slide out there right now we've got the, the government structures on the left-hand side, and on the right-hand side, we're listing sort of how we get our community input. And I've mentioned the makeup of the coalitions.

We also have a provincial Healthy Child Advisory Committee that's about 30 stakeholders who either are serving youth, children and youth, so it -- big -- Boys and Girls Clubs, for example, is there because they chair the Youth Serving Alliance of Manitoba. The Manitoba Child Care Association is represented. The Pediatric Society is represented. The CEOs of the child welfare authorities are invited and/or -- either attend or send representatives.

And that provincial Healthy Child Advisory

Committee meets quarterly, it's now chaired by Jamie Wilson, who is the Treaty Commissioner in Manitoba and he's just recently assumed that role. It was previously chaired by a retired school superintendent from the north, who agreed to do it for a year and stayed for 12.

So, it's, it's a group that also has had a huge degree of commitment and also helps us inform the, the cabinet committee. Those structures, the parent/child coalitions, and the advisory committee, are also entrenched in the legislation.

The next couple of slides are to give you sort of a precursor to the investment portfolio and the kinds of programs we're, we're putting public dollars into.

So the first slide here, which shows you the little tykes, kind of running across the surface there and growing up as they go, is an illustration of these important developmental opportunities for investment as kids grow, so across the top you've got pregnancy, birth and infancy, early child care -- childhood care and learning and we've talked a lot about that.

We do also make investments in middle childhood and in adolescent development. I won't be speaking about those so much today because we're focusing on the early childhood piece.

The outcomes that we're targeting, I mentioned

earlier and they're captured there on top of this platform. And then the platform, itself, refers to both financial supports that are being provided, that I'll elaborate on, including a prenatal benefit and some federal financial benefits, as well, that go to low income families. And then the community based family supports that we invest in, and those are the core programs that Healthy Child Manitoba strategy has either introduced or is working cross-departmentally with.

The next slide is again a bit of a synopsis slide but it's taking more of a developmental metaphor, if you wish, in which you kind of see the child nested in the environments that he or she will grow up in and the major influences on the outcomes for that child. So, family being one of the very first influences, and then pre-school and school, and then community.

And the outcomes are also stretched out across that, that trajectory because, at the very heart of things the, the first consideration is the physical and emotional health of the child and, as time goes by, safety and security, of course, become very important, their success as learners, and what we really want is, as they, they leave the school environment that they will be socially engaged and responsible. And there's investments that we're making at every phrase, to try to encourage that.

Down the left-hand side are the key areas of investment that the Healthy Child office is responsible for. I need to say that there are many other investments across government being made for kids so, for example, child care. We're not going to talk about that so much today but it falls under the Healthy Child banner, as well.

So, working our way up, Healthy Baby is a program that's focused prenatally and in the first year of birth. Families First, our FASD strategy, Triple P Roots and so on. So rather than read them all now, I'll get into actually helping you understand what they all are.

We, we try to include this quote by the former and now late Minister of Aboriginal and Northern Affairs, Oscar Lathlin, who was a member of the Healthy Child Committee of Cabinet for a number of years and who had said that "Manitoba cannot prosper if aboriginal people do not prosper." And what we've taken that to mean and sort of extrapolated from over the years is that we absolutely need to be paying attention, first of all because it's the right thing to do, but secondly, because it's the practical thing to do. Our fastest growing population is our aboriginal population, it's our youngest population, it's got tremendous potential.

At the recent Business Council of Manitoba leadership celebration of 15 years, the anniversary of the

Business Council, a number of key business leaders in the province spoke, and virtually every single one of them, without realizing that they were all going to do it, spoke about the importance of engaging aboriginal youth and, and helping them on a trajectory to enter the, the work world.

We are here to argue that while that is very important, if we don't start earlier, as you heard, that's an uphill battle, working with youth. So it's the right thing to do, it's also the smart thing to do.

The puzzle piece is just a way in which we frame how the different pieces come together to support early childhood development and many of those puzzle pieces I'll be talking to you about. And then down the left-hand side we've got the -- sort of the shape of the keystone province and showing that we do, in fact, have parent/child centre coalitions spread across the whole province who are helping with the delivery of these various pieces.

So, into programs, themselves. We have, in Manitoba, the Health Baby Program, which is a two-part program that begins prenatally and continues until age one of the child. The first component is a prenatal benefit and it is intended for low income, women living in low income situations who are pregnant.

It does a number of things. First of all, if your net annual family income is below $32,000 then you are

eligible for the benefit. It's on a sliding scale and the maximum payout is about $81 a month.

In order to receive that benefit we require proof of pregnancy and that's obviously sort of an accountability piece but it also means that early on in the pregnancy there is an incentive for women to connect with the health system. Whether that's a doctor, a nurse in a northern nursing station or a mid-wife, it's all acceptable, we just need confirmation. Very simple application process and you will start receiving the, the benefit in your fourth month of your pregnancy.

And I should make note that that benefit is available to women in First Nation communities, as well, which at the time when the Premier announced he, rather famously said because it was the headline, that in Manitoba a baby, is a baby, is a baby and we're not going to pay attention to the jurisdictional differences.

In addition to connecting women to health services in order to confirm the pregnancy, we also have made a very conscious decision, we could have set up bank accounts and, you know, just done direct transfer on a monthly basis. We don't do that. We send a cheque out monthly and we include a friendly little insert that will talk about anything from non-alcohol drinks you might enjoy during the Christmas season to here's a recipe for a

healthy low cost meal that would be good for you during your pregnancy, to encouraging you to take prenatal vitamins, so just little friendly messages that basically say your pregnancy is an important time, we value it, we want to support you.

THE COMMISSIONER: And that's $80 a month?

MS. SANDERSON: $80 a month is the maximum.

THE COMMISSIONER: Yes. And, and what are the qualifications to, to be -- to participate?

MS. SANDERSON: If you're, if you're pregnant --

THE COMMISSIONER: Yes.

MS. SANDERSON: -- and your family income, your net family income is less than $32,000 --

THE COMMISSIONER: Yes.

MS. SANDERSON: -- a year, annually.

THE COMMISSIONER: Yeah.

MS. SANDERSON: And those are basically the requirements.

THE COMMISSIONER: Yeah. Thank you.

MS. SANDERSON: We had lengthy debate, some of it involving lawyers, with all due respect, for a great period of time, about being able to put a simple permission on the application form so that we could ask women, is it all right with you if we share the fact that you're pregnant with either the public health system in your area or the

local Healthy Baby program. And trying to get that wording right took quite some time but we now have such a simple statement on the application, the vast majority of women complete it and say yes, it is fine with me, which has made a huge difference because now we can quickly channel out to the public health system that women -- these women in your region have registered this month, they're pregnant and they're automatically have one of the risk factors, they're living in poverty.

THE COMMISSIONER: And you identified their location?

MS. SANDERSON: Right, yeah. And they get contact information and the public health nurse can use that to make the friendly first contact. And when I talk about Families First home visiting, we can even begin home visiting before the baby is born, if the need is there, so we'll come back to that.

Just a few quick stats. In 11/12 we had almost 4,000 women on the benefit and virtually 50 percent of them are in Winnipeg, 50 percent were outside of Winnipeg, and 28 percent were from First Nation communities.

And by the way, we make those referrals to the federal programs, too, so the northern nursing station, for example, will get referral from us if we have the permission of the woman.

THE COMMISSIONER: Half, half Winnipeg, half --

MS. SANDERSON: Outside, so rural and northern.

THE COMMISSIONER: -- rural, yeah, and other. And the breakdown with respect to aboriginal?

MS. SANDERSON: Twenty-eight percent living on First Nation communities.

THE COMMISSIONER: Oh, 28 percent living in First Nation communities?

MS. SANDERSON: Right.

So that's the first component, that's the prenatal benefit. We also have Healthy Baby community programs that are operating in church basements and family resource centres so, for example, Sharon Taylor was one of your panelists from the four community programs, from Wolseley Family Place.

THE COMMISSIONER: Yes.

MS. SANDERSON: They have a Healthy Baby site at Wolseley Family Place. They're scattered throughout the city and they're scattered throughout the province in more than a hundred community sites.

For those who may have participated in a typical prenatal program, where you're basically -- I participated in one a long time ago, basically taught what to expect from the health system during your pregnancy and so on. That is not what a Healthy Baby program looks like.

The Healthy Baby program is a very casual environment where women are encouraged to come while they're pregnant and up until the time that their baby is one years old, so when you walk into the Knox United Church, in the inner-city here, there will be women of multi-cultural backgrounds. There will be small babies, there will be women who have just discovered they're pregnant. There will be a public health nurse there, a nutritionist and then a group facilitator who is going to lead a discussion on some topic. There is a curriculum that backs all this up.

The women participating wouldn't necessarily know that there is a binder of curriculum materials but the importance of breast feeding is going to be discussed at some point, prenatal vitamins. A healthy snack will be served. Often a healthy meal is made by the participants so if there is a kitchen facility they'll make a meal and often be sent home with a bag with the ingredients so they could make that meal when they get home, as well.

We use milk incentives to also bring them into, into the program. The biggest incentive is the social inclusion aspect, I'm pretty convinced of that. And I'll pause for just a second and, and share an anecdote because these are the things that stick with me.

I had the opportunity to go to a Healthy Baby

program in a school attached to a housing project, in Winnipeg, so very, very low income group being served out of this family resource centre. The Healthy Baby program was just starting and I'm telling you, it was a miserable nasty February day, with high winds, snow, the whole kit and caboodle, and these women were arriving with their small babies, or they were pregnant and they were brushing off the snow and about 15 of them were probably there. The public health nurse was doing -- quietly weighing babies in the corner and giving advice and so on and someone said: Where's Mary? And someone else said: I don't know she usually comes but she didn't come last week either. And someone else said: I don't think she has been feeling very well, I haven't seen her out much. And two of the moms stood up and said: If somebody will just keep an eye on the baby we're going to go and get her.

And they left the program and they came back 15 minutes later and they had Mary, who was pregnant and, in fact, very despondent, and hadn't left her apartment in over a week, didn't have much on hand to eat and before the session was over the public health nurse had spent some time with her, she was going home with a bag of food from the family resource program but more important than anything, she was talking and laughing with the women from her community.

So it's that -- it's the practical side of things but it's also the social inclusion aspect.

THE COMMISSIONER: Is that a province-wide program?

MS. SANDERSON: It is, yes. It's -- in rural Manitoba it's sort of a mobile program.

THE COMMISSIONER: Yeah.

MS. SANDERSON: In lots of cases and it's more monthly than it is weekly --

THE COMMISSIONER: Yes.

MS. SANDERSON: -- but it's out there.

THE COMMISSIONER: It's there.

MS. SANDERSON: So -- yes.

And, again, we use community agencies to deliver it. We're the funder, we're the quality control piece of it, we provide the training, the curriculum but we use local agencies such as Healthy Start for Mom and Me to deliver it, or Regional Health Authorities in the rural areas.

We have had a third party evaluation of the Healthy Baby program, and that was done by the Manitoba Centre for Health Policy. Dr. Brownell was here yesterday from the centre. And what we learned about both the prenatal benefit and the community support programs is that it does increase connection to prenatal care. It has

prevented low birth weight or reduced low birth weight and pre-term births and it has increased breast feeding.

What we also found though is that we weren't reaching all of the most vulnerable population that would have benefited from the program and of course we can't get the results if we don't have the people in the room so we have become extremely proactive about improving our relationships and our communication, for example, with social workers who work with families on social assistance. So we give them an orientation to Healthy Baby.

And recently a cluster of academics, health professionals and Healthy Child submitted for a research grant and received a grant to initiate a program called, called Partners in Inner-City Integrated Prenatal Care, PIIPC, a lot easier to say, PIIPC.

And what that program is doing is reaching out to probably the most vulnerable populations, so there is -- the Winnipeg Regional Health Authority has a street program, a van, that goes out and does needle exchange, for example, and provides contraceptives and so on to women who are in many cases homeless.

They are now, as a result of the, the funding that we got for the program, they are now offering to do pregnancy tests immediately. If the test is positive they have the resources to provide -- first of all, pick up a

phone and make an appointment for a women -- a woman immediately, if she's willing to go to a clinic at the Health Sciences Centre, to have the pregnancy confirmed there and an overall health check and so on.

They can provide her with bus tickets to do that. On occasion they have called taxis to enable that.

We now have a relationship with that clinic at the Health Sciences Centre so if a woman that's been referred through this program is there, they immediately check in with the women, casually ask if they can get them a sandwich while they're waiting for their appointment. The decks are cleared so they, in fact, get an appointment that day and then they are referred to one of these Healthy Programs that I just described.

Several of the inner-city Healthy Baby programs, again with this funding from the, the research grant now have mid-wives available on the site. So for these women, if it is easier for them to connect and get their prenatal care from a mid-wife than it is to make the trek to the Health Sciences Centre then that's an option that's now available to them. And, of course, all of this is being evaluated to see what kind of impact it has on reaching the hardest to reach and potentially the most vulnerable population.

The FASD strategy, this is here for a number of

reasons. First of all, because it is very actively an issue in our province, as it is elsewhere, but very much so in Manitoba. It's only in the last probably 10 years that we have really begun to understand and openly talk about the impact of FASD on our population.

So in the past, I'll go back probably approximately 10 years, we had several departments who had bits and pieces of what would be helpful in terms of an overall FASD strategy. So, for example, the Health Department had some diagnostic capacity but not very much, and only if you lived in Winnipeg and only if you knew how to get it, and only if your doctor knew that it was there, and only if your doctor happened to be paying attention and knew what to look for when looking at a child to determine whether developmentally there might be some FASD effect at play. So, a lot of potential gaps there.

We had the education system doing some prevention efforts in the sense that FASD is now in the health curriculum. I find it really encouraging that 15 years ago, when my kid did her, her science fair project she was the only child who did one on FASD, now when you go to a science fair there's numerable presentations on FASD. So it's become part of the imbedded health curriculum, that's a little piece of prevention, but it was all very sporadic like, like this.

So one of the first priorities of the Healthy Child Committee of Cabinet was to say how do we build a provincial strategy on this particular issue and what can we learn as we go from it.

So we now have such a strategy and it contains the components that are listed on the slide there, which involved numerous departments. So from a prevention point of view we still have health doing -- sorry, education doing what they were doing in the curriculum and we enrich that regularly.

We have increasing public awareness campaigns. We've got the Manitoba Liquor Control Commission, for example, that does their With Child Without Alcohol campaign on an ongoing basis and they now pay for that, so that frees up dollars that we can put into other forms of prevention.

But what we've really found is there comes a point where just knowing what FASD is isn't the solution. Prevention also means how do you help those folks who have a lot of the adverse circumstances in their background that Rob was talking about this morning and therefore enter their pregnancy or their child bearing years already with mental health issues, addictions issues and so on.

So we also have a program called Insight, which is a peer mentoring program where we hire and train --

well, sorry, we give a grant, again, to external agencies such as the Aboriginal Health and Wellness Centre, who in turn hires mentors that will work with women who are at high risk of a pregnancy that's affected by alcohol.

More often than not, unfortunately we know they're at a high risk because they've already had at least one child and in many cases three, four or five children, who have been affected by alcohol during pregnancy and many times have been apprehended.

In an ironic way this creates a window of opportunity to work with these women because they've had so much loss they want to make a change in their life and they're looking for a way to do that. And that's the moment where the, the peer mentorship partnership can be extremely effective. So we match them up with individuals who, themselves, have experienced some hard knocks in life, they get what these women are living with, but they've also had very intensive training and they maintain an ongoing relationship with the, the mothers or the, the women who aspire to be mothers in the future and they connect them with addiction services and so on and either help them to get on the road to having an alcohol and drug free pregnancy or help them connect with reliable birth control and so on so that they can delay pregnancy until they are ready and that's the goals of the, of the Insight program.

That's an example of the sort of targeted prevention investments.

We also have interventions and supports for families who are already living with the challenges of FASD. We have funding that goes into certain classrooms in the province that are piloting really very creative approaches to working with kids and proving that these kids have tremendously more capacity to learn, grow, change than we ever anticipated with the right environment and the right sort of relationship between teacher and student, small class sizes, toned down stimulants, a whole range of things which -- it's extremely exciting, actually, could talk about forever but we won't.

We have a research and evaluation component, we've -- we are funding an FASD research scientist at the, the Health Sciences Centre. All of the investments I have talked about we have -- we are actively evaluating and we are part of a northwest partnership that spans the territories and the western part of the country where we are investing in research together and where we also partner on major knowledge events like conferences and so on and try to spread all what we're understanding.

That strategy that I just described involves the Health Department, Education, Justice, Family Services and Labour, Healthy Child, Healthy Living. Those are probably

the, the major -- Aboriginal and Northern Affairs, the major departments, and all working together now as opposed to the earlier more fractured system, so ...

Families First, I think you heard referenced several times, Wanda Phillips Beck mentioned it when she was talking about their home visiting program that they -- the federal government does in First Nation communities. So we, too, have a home visiting program modelled after a best practice in the States.

The sort of gold standard of home visiting programs is -- actually involves nurses doing the home visiting, that's a very, very expensive model and Manitoba decided, a number of years ago, when they were introducing the home visiting model, that we would try a model where public health nurses supervise but the home visitors are peers and the training they get is quite phenomenal and they get, obviously, good supervision from the public health system.

So, again, we provide the funding out to the regional health authorities and we provide the oversight. We do the quality control, we deliver the training, we do regular check-ups on how the program is rolling out and so on.

We have approximately 150 home visitors across the province, serving approximately 1500 families in any

given year. And that's out of approximately 15,000 births a year.

Some of the data that Rob was drawing on earlier comes from the Family First screen so at birth we have -- the public health system does a screen of all births in the province, virtually all births in the province, and, and that initial screen then sends up red flags, and if there are enough red flags that there are certain vulnerabilities or risk factors in a family, than a more in-depth family screen is done through a home visit and again, if significant factors appear then the family is offered a home visitor and that home visitor can stay with them until the child is age five.

THE COMMISSIONER: And the -- are those 150 home visitors, they're full-time employees?

MS. SANDERSON: Yeah, those are -- that's a full-time equivalent, there's actually a lot of part-time home visitors --

THE COMMISSIONER: Yeah, I see.

MS. SANDERSON: -- but that's the full-time equivalent.

THE COMMISSIONER: And, and what triggers the, the availability, are -- the intervention of the service or the use of the service?

MS. SANDERSON: The, the results of a second

screen by a public health nurse. So -- and Rob can speak more about what the questions on the screen are but basically it is uncovering whether or not women feel that they have got a social network they can rely on. Do they literally have the financial resources they need. Are they in a supportive relationship. Are they subject to stress, violence and so on. And all of those it's, it's weighed and measured --

THE COMMISSIONER: And this is subsequent to birth?

MS. SANDERSON: Right, yes. I -- that's a really good question, actually. We would like to connect before birth and whenever we can, we will, and that's why when I mentioned that the Healthy Baby program now informs the health system earlier about the pregnancy, that is enabling us to start, there's, there's actually lots to be gained from a Family First home visitor making a few visits before the baby is born.

The home visitor's primary role is to build the parent/child attachment at -- as early as possible and again I'll just share because early on I had the experience, when I first started in the job, I wanted to know more about the programs, obviously, but I wasn't about to tag along on a home visit because that just feels really intrusive but because we do this training for the home

visitors I went to one of the training sessions and by luck it was a day when one of the trainee home visitors was going to be given a practical situation, a real life situation by virtue of a mom visiting with a baby and the home visitor was going to interact and try to practice some of her new skills in front of a small group of people who would then assess her and, and then they added me to the mix. So the poor home visitor, was I'm sure extremely stressed but as it transpired the woman who had agreed to come had just recently signed on to Families First because she had a newborn baby and she would have met the screening criteria. I don't know what her story was but when she arrived she didn't, in fact, bring the newborn baby because the baby hadn't been feeling very well so she brought her toddler and had -- have to respect this woman, she wanted to keep her commitment. She had to find a babysitter for the baby, she had to take a bus with the toddler and get to this hall, like (inaudible) where we were doing the training, and then basically it was set up so there was an array of toys on the floor with a blanket, and some pillows, and a chair for mom and the home visitor, where they were trying to re-enact what a living-room situation would look like.

And it was such an eye opener for me and so consistent with what some of -- what Rob was talking about

this morning because this little toddler wasn't really very verbal yet but he was fascinated, obviously, by all the toys and he was picking them up and he was trying to give them to his mom and, of course, she was nervous on top of everything else, but she was not engaging and she was sort of looking away from him and within a matter of moments he moved onto the next adult, who happened to be the home visitor.

And her job, at that point, is not to become buddies with the child but to start the transfer of the connection between the child, except it's not a newborn, it's a toddler who is already kind of set in his ways and, and so on. She did an amazing job because what she did and what they're trained to do is help the mom understand that they're an expert in their child, that they have the skills they need to be a good parent, they know more.

So as this child was bringing her the toys, she turned to the mom and said I wonder why he picked that toy out of all these toys and the mom immediately said well, because his favourite colour is blue, he'll always pick the blue things. That's amazing, how do you know that? And they started having this conversation.

And then she said to the little boy, show your mom, she wants to see the blue toy. The little boy came

over, mom started to engage. And it was just sort of this eureka moment, for me.

And a few minutes later the little guy picked up a book and he brought it over to his mom and the, the home visitor said, you know, why don't you show him the book, you don't even have to read the words, you know, just point to the pictures. And the mom opened the book and the little boy stood at a distance and she started showing him the pictures, and it just struck me that, you know, in all these pictures we show the natural thing is you pull a child onto your lap when you look at a book. But, of course, it's not the natural thing if it wasn't the natural thing in your world. And just the, the history and the adverse circumstances that we need to help folks bridge through these programs was just so self-evident in that four minutes that it became so much easier for me to talk about these programs, so --

THE COMMISSIONER: How does the availability of the program become known?

MS. SANDERSON: Through -- because we have the universal public health check, at birth, virtually universal, I never want to guarantee anything, but every family has -- is screened at birth, so that's the first check point.

THE COMMISSIONER: I see.

MS. SANDERSON: It is voluntary and there -- so families sometimes will decline. There is nothing that says we won't take referrals later on so if a family resource centre or a child welfare identifies that they think Family First would be helpful, they can make a referral and the connection will be made.

So we've had an evaluation of the Family First program, as well, and the results are shown here, that it's shown an increase in positive parenting approaches, an increase in the parent's wellbeing. So their sense and confidence in their ability to parent.

An increase in their social support. So the home visitor doesn't want to build a dependency, they want to build connections. So they'll start, once they get sort of a relationship going, they'll start going to the library for tiny tot time with mom and child and start getting them connected to various social programs.

We also -- it's mentioned here so I'll mention it -- we proclaimed a home visitor day on an annual basis to celebrate the work the home visitors do.

But the evaluation also discovered gaps. One of those is that we weren't having a significant impact on mom's mental health and we know that that's a key contributor and, and input in terms of outcomes for kids so we really wanted to make a difference in that.

Once again, we banned together between the academic world, the health world and healthy child to apply for funding, which we got from the Public Health Agency of Canada, so federal funding, to develop something we called Towards Flourishing, flourishing meaning flourishing health, mental health. And we're piloting within certain communities sort of enriched services and, and that takes the form of a mental health facilitator that works with the home visitors and the public health nurses, gives them ideas, suggestions of ways in which they can promote positive mental health with the mothers and some of those -- it's not -- it rarely requires a referral to a clinical service, it's more about helping moms refrain their, their circumstances and so it can be as simple as a little notepad where every day you write down one positive thing that happened today or, or one moment you had with the baby that made you smile, or made you laugh, or whatever. And when the home visitor is checking in she's asking you about those things. She's not being Pollyanna about it, she's also asking you all the practical questions about how things are going and other pieces of your life that are complicated, but she's also reminding you that there are these positive pieces.

We're evaluating that, as well, so we'll know how much of an impact it makes.

In both cases, Towards Flourishing and the, the Healthy Baby, the inner-city prenatal incentives that I talked about, those are dependent on the, on the external funding we have, so once we do the evaluation then we'll have to figure out if they're effective where do we go from there in terms of ongoing funding.

I'll mention the Francophone ECD hubs because early childhood development hubs are a model that we're very, very interested in and that are talked about a lot in the early years reports by Dr. Fraser Mustard and his colleagues and I believe Kerry McCuaig also made reference to.

Our Francophone community has really bought into the idea of early childhood hubs and they were driven to it, even before we were starting to think about it, or talk about it, because they're really interested in language and preserving language and, as you remember from Rob's slides, that language capacity peaks pretty early so they, they don't want to wait till school starts.

So they have, using funding that we provide and the federal government matches, the Francophone school division began investing in the early years and they're -- they've created these hubs most often attached to Francophone schools where we will fund Healthy Baby programs but they will also find other services.

So, for example, developmental screens so that they can get hearing, visual and language, speech and language screening, as well, very early on so they know if their kids have any of those challenges they can start to get services very early, as well.

They will do early literacy programs with parents and kids. They will lend out Francophone books and so on. So they've taken a really holistic approach, partially driven by the desire to preserve the language but also really embedded in the science that Rob talked about earlier, and we're learning a lot from their experience.

Another program that we're rolling out is the Triple P, Positive Parenting Program that is actually now internationally recognized as a best practice in parenting. I'm going to let Rob explain the evaluation background to it but I'm just going to touch briefly on the fact that this is a really good example of that sort of proportionate universality that Dr. Brownell talked about, about how all families benefit from some things and we can't only invest public dollars in reaching those with the greatest needs because we have a broader responsibility to the public and all parents benefit from some support.

One of the things that we really liked about Triple P when we did the research into potential parenting programs is the fact that it has this universal overlay

which is really a public education marketing approach to tips on parenting, seminars that can be offered on a Tuesday night in your local school for two years, every parent is welcome to come, and then it drills down as you find the parents have deeper and deeper needs, the level of service can go deeper as their needs require. And Rob can talk about that a little bit, as well.

I should also mention that the, the reason for the -- our investment in Triple P or the driver behind looking for a parenting program came from one of those strategic planning sessions with the ministers because we looked at our current investment portfolio, we looked at all the things that impact on kids, and the glaring gap was we really didn't have a consistent provincial approach to supporting parents.

So Rob was charged with doing the research and finding the best practice out there and this is what we recommended to government. So I'll turn over to you for that.

MR. SANTOS: Sure.

THE COMMISSIONER: Well, now, just let me ask.

MS.SANDERSON: Sure.

THE COMMISSIONER: Is this a good time to break for lunch or, or, or -- I assume we're going to be here awhile or?

MS. WALSH: I'm not sure. I mean, it's, it's really up to, to the witnesses. After they finish their presentation I probably have 20 minutes, half an hour of material to review --

THE COMMISSIONER: Yeah.

MS. WALSH: -- with them and then there may be other questions, as well.

THE COMMISSIONER: Well, we'll certainly be here this afternoon then. I --

MS. SANDERSON: I think so.

MS. WALSH: I would think so because we certainly don't want to rush this.

THE COMMISSIONER: Well, and we have the time.

MS. WALSH: Yes, absolutely.

MR. SANTOS: Yeah.

THE COMMISSIONER: Well, is -- in that you're going into this area --

MR. SANTOS: Yeah.

THE COMMISSIONER: -- with Dr. Santos speaking, it's probably a good time to break.

MS. SANDERSON: Yeah.

THE COMMISSIONER: Shall we break till 1:45, would that give people enough time?

MS. WALSH: I don't think we need any more than that, so -- yeah.

THE COMMISSIONER: It's 12:30 now, if we break to -- were you suggesting less time than an hour and a quarter?

MS. WALSH: Could we -- I think so. I think the witnesses are nodding, I mean people just -- maybe just need a quick break and we can come back.

MS. SANDERSON: An hour.

MS. WALSH: Yeah.

THE COMMISSIONER: One hour? All right.

MS. SANDERSON: One hour would be good.

THE COMMISSIONER: We'll adjourn till 1:30 then.

MS. WALSH: Okay.

MS. SANDERSON: Great, thank you.

THE COMMISSIONER: All right. Fine, thank you.

(LUNCHEON RECESS)

THE COMMISSIONER: All right, witnesses.

MS. SANDERSON: Thank you. So I think we were going to resume with Rob giving a bit of the background on the selection of the Triple P Positive Parenting Program.

THE COMMISSIONER: Yes.

MR. SANTOS: Thank you. This is probably a good point to mention something that I am not sure has come up too much but one of the challenges in programs and services

regarding reaching those in the greatest need is also managing the stigma that's often attached with targeting programs to those with the greatest needs. So one of the advantages to programs like Triple P and others, that have multiple levels of, of resources and entry, is that it allows parents to access as much as they are comfortable at a given point in time.

And so while one might assume that many of the parents in the adverse circumstances that we have discussed would immediately go to the most intensive support and practice, many of them are often more comfortable or often prefer to enter at more universal levels, along with every other parent and, and use as much as they see fit or as they need. Almost as a, as a way of trying it out, as well, before making the -- you know, the personal and the time commitment in order to, to participate in a more intensive program.

And so as again, another benefit of a multi-level approach with both universal and targeted components, is that it empowers parents and, and people around them to tailor their needs to the resources available as opposed to presupposing them, for example, based on their circumstances and really empowering those parents, sort of consistent with what Ms. Spillett talked about yesterday.

So Triple P, I'll talk about it in a second, the

research basis, but in terms of what the program's system looks like is there are these five levels that Jan described, ranging from a broad multi-media universal component that not only offers parenting tips to all parents but conveys very strongly with well designed messages about how important parents are, not just to their children but to, you know, the futures of communities, as we have been talking about, all the way to differing levels of intensity.

The, the major advantage to reaching many parents with such an approach is that it upscales the existing workforce in different sectors and so all the people out there, right now, who have some contact with parents, it could be public health nurses, early childhood educators, classroom teachers, community members, all the different people that parents already have some relationship with, part of the strategy is to provide those practitioners with the resources, evidence based materials or full blown programs to offer to the parents that they see already, day to day, rather than solely focusing it all in one area, one agency, one sector. It's intended to be a population level approach to reach as many parents as possible.

So in terms of the background there has been many reviews about this issue and some general principles that are worth considering in the inquiry in terms of the public

health approach that Dr. Brownell talked about yesterday which is really a prevention approach before problems occur.

One is that you want parenting programs -- and this is speaking very broadly not just Triple P specifically, but better available that have some evidence that they work, that they are beneficial, the parents like them, value them, and when they use those strategies they are beneficial to their relationships with their children and to the development of their children.

Cost effectiveness is obviously important because of limited resources. There are many programs that are effective but cost more than the benefits that they generate and it's often better to, if choices are available, to have some of the interventions that have been discussed already that yield returns, that give back, that not only pay for themselves but pay dividends.

Number three is, and a big focus appropriately so for the inquiry on cultural relevance and acceptability. There's -- part of the evidence base that we now expect from any program for families is well, what do the parents, themselves, and those families think of those programs, particularly from a cultural perspective.

I've already mentioned stigma and that strategies, there is evidence based strategies to reduce

the shame and stigma of any parent who needs support and part of the public message in -- at the most universal level of Triple P is exactly that message, is that at some point everybody could use a helping hand or, or advice from all walks of life.

As the parent of two very young children, I can attest to that, despite all this knowledge I could also relate to the -- you know, the discomfort that some parents might feel if they were to seek out support for parenting, there's an assumption that still persists that we should all know how to do that, that we come with in-built knowledge or that, you know, babies are born with an instruction manual, which is obviously not the case.

Engaging participants, consumers, participants in the development of those programs is hugely important so Triple P has that history of, of constant feedback and input from parents and practitioners, themselves.

Achieving targets for participation. There's very clear evidence, from a public health standpoint, that in order to change things at a population level, for example, smoking or increasing exercise or other things, that you have to engage at least 25 percent of the whole population to shift shiftings for the better.

And then lastly, an evaluation plan basically to measure progress, to measure results, and to use that to

improve your efforts. And so be able to track outcomes at a population level becomes important, as well.

So back in 2005 when this was announced part of what led into this cross-departmental support for, for Triple P among all the other available parenting support programs in the literature was quite an impressive evidence base as well as strong epidemiological evidence which is basically data on how common problems are in the community and given areas in this case children's mental health is one example.

So of all the available researched parenting support programs in the world, Triple P has the largest evidence base, it's been trialed with randomized trials with a gold standard evaluation approach over three decades, in 20 countries. It's now available in 17 languages, over 55,000 practitioners worldwide have been trained and six million children and their families have been reached. So the question as to whether this program works, is effective, has largely been addressed by -- including with indigenous populations in other countries and increasingly in Canada the real question for evaluation of this program, when implemented, is can you deliver it in the manner that reaches enough families, that engages enough parents to participate to make a difference.

The experiences locally, in terms of (inaudible)

from multiple sectors from the community, in fact one of the, the witnesses last Friday, in one of her former roles as the executive director of an aboriginal led community based agency, was part of a group of similar agencies that were independent of knowing that we were also contemplating this program, we're also preparing an application to bring Triple P to Manitoba, albeit with a different model of having dedicated practitioners and use staff resources to deliver it, which is one that has not happened yet.

And then lastly the potential of being able to change things not on a -- even a one-to-one basis because even the best sort of focused parenting programs can only reach particularly parent, one-on-one or even groups of parents, small numbers at a time. So the prospect of being able to change things for the better on a large scale are quite exciting.

So a number of independent expert reviews, a great report by Dr. Harriet MacMillan from McMaster, published in the Lancet some years ago, that reviewed the available evidence base for interventions to prevent child maltreatment is referenced in there. The study, that I'll talk about in a second, Dr. Brownell referenced yesterday, is the South Carolina Population Trial of Triple P that was published in 2009.

The Institute of Medicine released a

groundbreaking blueprint report with the major headline being that mental illness was actually now -- it was now within our hands to prevent not just treat including through approaches like this. As well as excellent institutions like the Washington State Institute for Public Policy which -- whose forte it is, is to review the cost effectiveness of interventions, and they can put a dollar value on, you know, how much public return there is for every dollar invested in these kinds of programs.

So I'll just share you briefly the three major findings of the South Carolina Population Trial of Triple P. So what they did, back in the mid-2000s, funded by the CDC, the U.S. Centres for Disease Control and Prevention, as a violence prevention initiative, was to implement, on a state-wide basis, a province-wide basis, in South Carolina, a randomized trial of all five levels of Triple P universal to target and to clinical, and the data that they used to evaluate was existing administrative data such as those used in Manitoba and elsewhere as indicators of child maltreatment. And what they found -- I would have wished it to be front page news because it was the first in the world to show that you could actually prevent child maltreatment, child abuse and neglect, at a population level within a couple of years.

So here's what they found. They randomized half

of the counties in South Carolina to receive all five levels of Triple P, trained up many practitioners to offer it to all parents and then the other counties had services as usual.

The first big finding was that there was a 28 percent prevention of substantiated child abuse and neglect, so this is based on official child protection records.

The second major outcome was a 35 percent reduction in child abuse injury hospitalizations, so these are kids getting admitted to hospital for child abuse and neglect and a 44 percent prevention effect in kids getting taken into care, or a child out of home placements.

What's striking about this is that the design of the evaluation is strong, it's, it's a gold standard randomized design so you can attribute these effects to the intervention, despite the complexity of all the other things affecting these outcomes.

The size of the state of South Carolina is similar to medium sized provinces, such as Manitoba, they've trained about as many folks as other jurisdictions have, and these outcomes are apparent, not 10, 20, 30 years later, as in some of the other studies but within about two years of implementation. And so this obviously has to be replicated, every study is compelling but you need the

weight of evidence so what this has shown is that it's possible, at a population level, with an intervention like this but others possibly could have the same effect, within a relatively short time period.

Part of the potential reasons for this are, for those reasons outlined earlier, is that a non-stigmatizing approach that welcomes all families at different levels of entry, that offers evidence based approaches for them to have practical strategies for parenting, including dealing with difficult behavior and some of the triggers that often precede child abuse or neglect. As well as strengthening existing capacity in existing systems already serving parents in places that they already know and trust.

So I'll turn it back to Jan to talk about implementation.

MS. SANDERSON: Sure. So in terms of how have we rolled out Triple P in Manitoba, I think Rob referenced when we went to Treasury Board to sort of obtain the funding for it there was a number of various ways we could go, some more expensive than others and so on.

The, the resources that were dedicated to the program enabled us to take a model where we would provide training to people in the system who were already providing services to parents. So family resource centres, schools, child care centres. We would pay the cost of that

training, so we had the budget for that. We even had some budget to be able to help with travel costs, and so on, so people from around the province could come and, and attend the training.

What we didn't have and still don't have is any new resources to give to an agency so they could go hire another person to delivery Triple P. So we were working on the, the premise and the hope that they would be able to imbed the services into their agencies using their existing staff. And to some extent that has happened but we, pretty consistently, continue to hear back from agencies that if only they also had resourcing so they could dedicate a staff person to this role, that would improve their outreach.

We've also been able to add a 1-800 line that's available about 10 hours a day so that you can phone for Triple P advice over the phone and, of course, the practitioners we have trained are trained in the various levels. So we have some folks who are trained, and certified and comfortable in delivering sessions at a seminar level to a group of parents for two hours in an evening and then we have others that have more in-depth training that are able to do more of almost a group intervention with a group of six to eight parents who are going to attend for eight weeks to 10 weeks, so almost more

like a group session.

So that's what it looks like in the province right now. We have had both uptake and resistance from aboriginal organizations, so it's a little -- it's hard to get a bit of a handle on it, but I think it's only fair to say that there's both, so there -- we've got some headlines here for you on the way in which Triple P is being adopted in some northern community, communities, including a recent article in the Opasquia Times up in The Pas.

Norway House is a First Nations community that has adopted the program quite in-depth and is imbedding it within their school system and so on. At the same time we do hear back from some aboriginal organizations that they would prefer a model that was more culturally appropriate.

There is an indigenous approach to Triple P that we have introduced and we are now working with an advisory group to sort of bring it -- a more Manitoba feel to it.

We are convinced, because the literature is convincing, that the techniques are appropriate across cultures, it's more of the communication style and the approach that probably needs to be modified.

The next program we're just going to talk briefly about, and we are getting near the end of the list of programs, is the Roots of Empathy program. It was developed in Canada by a woman named Mary Gordon, who now

works out of the Roots of Empathy organization and heads up that organization in Toronto. And Mary's background was that she was originally an elementary school teacher in the inner-city of Toronto, she eventually moved out of the classroom to start family resource programs in these inner-city schools because she was very convinced that pre-school and early years was the way to go to connect families to schools.

She became even more convinced that empathy was something that was lacking in the culture and in young children but also in the classrooms and that she came up with the concept that babies are sort of a universal symbol of caring and she built a whole program around that concept that has been subsequently been evaluated, both in Manitoba, by ourselves, but also in other settings, as well. And the basic premise is that a classroom adopts a family, including a newborn baby, at the beginning of a school year and that baby grows up, over the course of the year, attending the, the school regularly, monthly. The parent, could be mom, dad, grandparent, auntie, attends with the baby and talks to the kids about the development that the baby is going through right now, the kids ask questions, they learn a little bit about child development. The teacher incorporates things about the baby into the class curriculum so if they are studying early math and so

on then they'll add up how much Billy weighed last time we met him, and how much he weighs now, and what do you think he's going to weigh next month when we see him. But the real key is that the kids learn to talk in a language about feelings and they learn that by trying to translate for the baby, who is unable to speak for him or herself, and the kids have to give words.

So, if you're watching the baby and he's fussy, what do you think he's thinking about right now, what do you think he would like from us, how can we help? And then later they have the conversation about, you know, when you're not feeling very good how do you express that and what do you want people to do?

What we've discovered from the, the research that we've done is we've followed these kids -- I should say that there's a -- it can start as early as kindergarten, there's curriculum for kindergarten, middle school and junior high and we have classrooms all over the province at all of those levels that are incorporating this.

It's also been endorsed by the Assembly of First Nations as being consistent with their beliefs and teachings and culture and we are partnering with First Nation Education Resource Centre to roll it out into First Nations Schools, as well.

So our own evaluation has shown that it has

prevented aggression, and promoted pro-social behavior and we have been able to follow kids for up to three years to determine if that is still in effect. We would like to do more longitudinal work on that and there is an abundance of information on roots of empathy and its new baby sister project, Seeds of Empathy, which is for child care programs, so even preschool, same principles apply.

It's been adopted in schools around the world, as both an anti-bullying kind of approach, but we think that it's much more broad than that, that it actually builds kids' abilities to be self-reflective and to manage their own behaviours, elements of self-control and so on.

So the next three slides are just really about a couple of emerging pieces we just wanted to bring to your attention. We've got sort of a slide that encompasses a number of pieces around mental health and I referenced earlier that that's a current issue in front of the Healthy Child Committee of Cabinet. The education stakeholders asked for time with the ministers a number of months ago, and that would be people from school trustees, school superintendents, people who provide student services within schools, all came to the, the Healthy Child table to say that they were alarmed, concerned, and overwhelmed by the range and depth of mental health issues they were now seeing in schools and at a progressively earlier age.

Everything from sort of the dramatic end of the continuum, very concerning end of the continuum where they were concerned about kids doing self-harm, might be cutting, might be suicidal attempts and so on, all the way back to kids with mild behaviour problems that they see starting to explode into more complicated situations. And they essentially said to the ministers, we know this is not an issue that only educational can solve, that's why we're here. This is an issue that involves many ministries and we would like to know that you are going to, sort of, take an active interest in it, which we have done and at the direction of the ministries we've struck up and oversight committee to look into mental health concerns within the education system which will be linked with the other studies that are shown here.

So we already have a provincial mental health strategy and we have a youth suicide prevention strategy. Rob is a lead, basically, or one of the co-leads on virtually all of those, so he is kind of the common link between the work of these various bodies with the hope that we can respond to a paper that's been tabled by the, the education stakeholders and that's part of what you see on the copy of the, the front of the reports there.

And then we had just sort of put a little advertisement, coming soon, for our own five year report,

which is now out and available and, in fact, has been tabled as an exhibit.

THE COMMISSIONER: Which exhibit? Yes.

MS. SANDERSON: 152.

THE COMMISSIONER: 152, yes.

MS. SANDERSON: And I think Dr. Brownell mentioned, yesterday, that the Manitoba Centre for Health Policy had done the precursor report, which is on the left of the screen there, How are Manitoba's Children Doing?

THE COMMISSIONER: Yes.

MS. SANDERSON: So they took, took a lot of the data that they exclusively have access to, that they can blend and so on and churned out a lot of the, the facts and figures that we then relied on to be able to put out the Healthy Child Manitoba report.

The report does not contain recommendations, it was a snapshot of how are kids doing on a number of domains, directly related back to those outcomes we talked about earlier, the physical and emotionally healthy, safe and secure, socially responsibly engaged, so we've measured ourselves against how are we doing on all of those. The implications will be that subsequent reports will show the progress against those same measurements.

So as we sort of wind down here, just wanted to talk about both challenges and opportunities in sort of

broad terms. Public understanding and support and money for prevention as protection. So we've said that one of the key messages throughout all this is that prevention is paramount. Finding support for prevention is always a struggle and it's that way for some very realistic, pragmatic reasons.

I can tell you that there is no shortage of conversation amongst the ministers and the deputy ministers about this or a shortage of commitment to doing more in the area of prevention but many investments in prevention take a long time to pay back.

So, for example, the Minister of Justice, no question he would rather be doing prevention than building more jails but you don't get to close the jail cells the minute you start the prevention investment. So, in the meantime, he has to keep building the jails and so there's cost pressures like that that are just very practical in front of us, all the time.

One of the things we keep reminding people about, about the early years, is that it has actually a very quick payoff in that if we can do the right things pre-school, and more kids arrive fully ready to learn on that EDI instrument that we mentioned earlier, the paybacks happen by age five, because you're already reducing the pressure on the special education investments, such as teacher's

assistants, and reading recovery programs and things of that nature.

Along with that becomes a reduction in some of the behavioural classroom disruption kinds of issues, as well. So, in fact, you get a better learning environment not only for the kids who are at risk but the, the entire classroom environment. So there's immediate paybacks in that sense and then, of course, there's the long term paybacks that those same investments have in terms of school completion, reduction in teen pregnancy some of them, reduction in addictions, and reduction in criminal involvement. So you get both short and long term.

There is cross-sectoral complexity in all of these things because we need multiple partners on side. First of all, we need our own departments on side and the reality is that sometimes we've got the bus moving all in one direction and then at the last moment one of the wheels kinds of comes waddling off because we're going into budgets and every department was going to dedicate this much to, let's say the FASD strategy but all of a sudden they get their budget target and there just isn't enough room. So their piece can't happen so we have to take a step back and figure out how do we modify all the pieces? Because you can't rush ahead with diagnosis and put all your money there if you have no support services on the

other side of diagnosing FASD. So, it always has to be that sort of locked step kind of approach and that's just between our own departments.

We're also trying to this work cross-sectorally with agencies on the front lines out there and I mean, Triple P would be a good example, we're convinced it's a worthwhile investment but it would be that much more rich if there was resources right on the street corners where families could drop in and have easy access to Triple P.

And then there is the whole question of disentangling protection and wellbeing and, and obviously safety is also paramount. So you've got two things that we are saying are paramount and when do you accept the fact that the prevention piece has to give way to the, the safety piece, and that is a call that the child welfare system has to make on a daily basis and I wouldn't presume to say the best way to do that.

And then the last piece is just moving science into practice and so Rob and others, there's actually a vast science around all this, across North America and around the world now, it's not a question of not knowing the right things to do, it's a question of being able to act on the right things to do. And I believe there's actually research into that which would say -- what is it, 25 years?

MR. SANTOS: Two decades now.

MS. SANDERSON: Approximately two decades for something that has been proven through science to be fully adopted and put into action, and regrettably two decades is a very long time for kids to wait. So if there's a way we can speed this up, that would be better.

In terms of opportunities for the future we, we want to just comment for a moment on a model that's been referred to by people a few times, I think Kerry McCuaig talked about it. And that is an integrated service centre for early childhood development, the idea that you would have a hub where families could come and their kids would be supported in what they need but so would parents.

We are hoping to move in that direction and we already have one pilot site at Lord Selkirk Park. In fact, I think there's a couple of pictures of it, yeah, we can flip to that, Rob. Where we are using the Abecedarian evidence based approach to early childhood development and that's a very big word that basically means we've added enrichments to what a typical government funded sponsored child care program would look like.

So it's located in a housing project, a social housing project that was already being refurbished, renovated, the investments were being made, so the department of housing agreed to build a physical facility

that was really geared to early childhood development. It's very attractive, it really gives the community a sense of pride and that their kids are being valued. The architect that designed it was amazing and he had a ton of fun with it.

And what we then did is to invite any families in the Lord Selkirk Park Housing Project, that had pre-school children and would like their children to attend this program to indicate that and essentially their, their names all went into a lottery.

We then pulled names out of that lottery and that's how we selected the 30 children that are attending the program within the doors of the childcare centre.

We also have an adjacent family resource centre and the other families and kids get lots of services from there. But we wanted to be able to -- we couldn't take all the kids anyway and we wanted to be able to distinguish and prove is it making a difference to have this enriched program.

The enrichments are a better ratio than you would typically find between staff and young children and this is all drawn from evidence of the Abecedarian approach in other settings.

There's a home visitor, which is a very important component and I believe you heard some reference to that

earlier. That home visitor or outreach worker is taking the learnings from the centre to the parents and one of the keys learnings is around something called the learning games, which are very simple little games that you might plan with a toddler, including you know, insy winsy (phonetic) spider and things like that. But when the home visitor goes back to the home and says Jane is loving this program, this little game that we play at school, you should try it and they sort of transfer to the parent the ability to do it, they also say to the parent, look at that, did you see how she made eye contact with you and laughed? That was brain development, that you just did right there, that's how she's learning at school, that's why she's thriving there, and so on and so forth. So it's that transfer of knowledge and empowering parents to understand that they are an important teacher to their kids.

There is also a hot meal program. Any -- and cultural components that are being imbedded as well. So Carolyn Young was here, the director of the, the daycare.

I think you asked her a little bit -- someone asked her the question was it a cultural program and she rightly said no, it's not, that's not its roots but, in fact, they do have an elder that visits regularly, they're doing drumming with the kids, and Carolyn is making every

effort to hire staff locally.

Red River College, which is the body that certifies early childhood educators in Winnipeg, is providing them with ongoing support and education and so on because Red River is very interested in this approach, as well, so it's sort of a joint learning for them. And then we have the evaluation in the background. So that's a little bit about Lord Selkirk.

The other -- let me back up for one second to -- the other opportunity we just wanted to mention was an integrated service delivery approach that we're hoping to pilot with the General CFS Authority in the Gimli area. And we've talking about this for a number of years with all the authorities. It was one of the earlier recommendations from one of the earlier reviews was a more integrated approach to delivering services to children and, from what I have said, you can see that we've been trying to do that on a broad province-wide basis but now we want to go deep in a geographic area and what we think we mean by that, if I can just describe it, would be that we would pull together the obvious leadership from that geographic area, so the school superintendent, the, the CEO of the Regional Health Authority, the CFS senior officials in that area, as well as agencies that families trust to deliver services and we would start working with them to say what's working

in this region and what's not, with a particular focus, from the outset, on kids either in care or kids at risk of coming into care.

So, that's our most vulnerable population, let's start there, let's find out if out there on the, the front lines, do we have policies that just don't make sense, that get in the way of doing the right things for kids.

We hear that that's the case, we also hear that there's amazing work happening out there but sometimes we hear that it's despite the policies and programs that are there, so we really need to uncover all of that, and we want to know that when it's working it's not working because of certain personalities. I mean, that's always going to be important but if Joe retires, we can't have the whole system fall apart so we want systemic approaches that are working for kids. So that's the integrated child service, children services approach that we plan to roll out this fall, in at least one region, and see how it goes.

Just in closing, I wanted to point, I said earlier that at least once a year we have a national child day event which is a large forum where we exchange the best information we can gain with all those people on the front lines, including our parent/child coalitions, home visitors and so on, and in return they tell us what the real world looks like and we try to make the two things come together.

The forum that was held in 2012 was focused on our aboriginal children and I have to say it was probably one of the most powerful forums we have had and was positively evaluated, as well, but was a tremendous opportunity for us, also, to hear from those agencies that deal, on a daily basis, and are supporting aboriginal families.

And the last slide is really just a snapshot and that happens to be a public consultation on crime prevention. There's probably some correlations we can draw to crime prevention but that's not why it's there. It's really there to remind us about the importance of public engagement in these conversations, particularly in a democracy.

We don't have as many people talking about prevention as we do about the tragedy of Phoenix Sinclair and it's very important that we're shining a light on the tragedy but the, the media coverage, the general interest in phase three, is important to consider because it's also what we have to work with all the time, and that is how do you build the same level of public interest and support on the prevention end of the continuum so we don't have to deal with the tragic end of the continuum. And our political leaders will say that, as well, is we live in a democracy, we respond to what we hear from the public. We

need the public putting more pressure, demand, emphasis on the importance of the early years and the kinds of things that, that Rob was talking about earlier.

So that's one of the, the pieces that we consider to be part of our mandate, is building public understanding and ironically, public pressure on the political system to respond and continue to invest in what we consider to be the very important area of prevention and particularly in the earliest years.

And we've restated the key messages there, I think we probably have said them frequently enough, about prevention is paramount. If we don't pay now we will pay much more later. We all have a role and all of our futures are at stake, there is definitely a public comparative at play here and we do believe we can do it.

And that completes the presentation.

THE COMMISSIONER: Well, thank you very much, it's quite apparent as to what is going on in Winnipeg, it's, it's a good opportunity to get that out and get that known.

MS. SANDERSON: Thank you.

THE COMMISSIONER: And I hope that will be of some benefit, being able to tell that story because it's, it's a real one and it hasn't solved all the problems but it's certainly on the road.

MS. SANDERSON: Thank you.

THE COMMISSIONER: All right, Ms. Walsh?

MS. WALSH: Thank you, Mr. Commissioner.

And yes, I want to reiterate the Commissioner's thanks, I don't think there are many large public inquiries where we hear a deputy minister make reference to insy winsy spider, so it was quite a unique presentation from every aspect and actually that speaks to the, to the level of dedication and involvement, I think.

And, and I do note that, that either or both of you was -- made efforts to be here for much of phase three, which was dedicated to understanding the community, its needs and responsibilities, and that was evident in your evidence today, that you made efforts to tie in much of the evidence that we've heard and bridge that with the evidence that you've brought to the table, including your scientific evidence and how it relates to policy. So I'm grateful for that.

MR. SANTOS: Thank you.

BY MS. WALSH:

MS. WALSH: Having heard all of this, there are some areas that, that I want to pursue a little.

MS. SANDERSON: Um-hum.

MS. WALSH: And just before that, bringing it

back as I did with, with Dr. Brownell, to the facts of this case, the evidence in phase one was that Samantha Kematch, for her fourth child, did become involved with the Healthy Baby program, both before and after the birth of that baby and in terms of your reference to isolation, she did reconnect with friends at that program, who were also pregnant, and the evidence was that those friends were concerned about Phoenix and made efforts to bring that to, to the attention of, of the authorities.

There was also evidence that Samantha met with the public health nurse and was involved with screening for Families First and was involved with -- initially with that program, as well.

So that was an interesting aspect --

MS. SANDERSON: Um-hum.

MS. WALSH: -- to note.

The Healthy Child Manitoba strategy is built on principles or on the principle that the wellbeing of children is a shared responsibility in society. Is that fair?

MS. SANDERSON: Definitely, yes.

MS. WALSH: And my understanding is that a key mechanism for the Healthy Child Manitoba strategy is partnerships, both across government departments and with community based organizations?

MS. SANDERSON: Yes.

MS. WALSH: Okay. And I think it's fair to say that this approach is consistent with what we heard in phase two about the approach in the new model of child welfare delivery, based on differential response?

MS. SANDERSON: Yes.

MS. WALSH: It also appears to be consistent with the document that you referred to, the September 2009 paper, which is our Commission disclosure 1397, at page 26402. If we could just pull that up. Which is a paper that discusses integration and we'll, we'll pull that up on the screen for you.

MS. SANDERSON: Okay, that would be so much easier.

MS. WALSH: If we can go to page -- there you go. So then the first, the title page, "The Challenge of Integrated (Challenge of Integrated) Children's Services in Manitoba." And I just want to explore this paper a little bit, especially in light of your having referenced it and, and explore with you for a bit the concept of collaboration and how that is actually being implemented at your department level or at the government level.

So this paper which you've referred to was prepared in, in 2009, it's a paper that you're obviously familiar with?

MS. SANDERSON: Yes.

MS. WALSH: And if we turn to the next page, 26403, the background of the paper is that following the death of Phoenix Sinclair and the discovery of her death, of course, a number of external reports were prepared and included a number of -- which included a number of recommendations, including requiring the involvement of intersectoral partners in order to effectively address the recommendations?

MS. SANDERSON: Yes.

MS. WALSH: And I won't go through the entire paper but the paper talks about why integration is important and I think it's fair to say that, that it recognizes the things that, that you have talked about as why collaboration and integration is important from a holistic perspective in dealing with families and children.

MS. SANDERSON: Yes.

MS. WALSH: And, and the paper acknowledges that it's particularly important in the delivery of child welfare services that a society that -- and I'm quoting from page 26405 here, mid-way down.

MS. SANDERSON: Um-hum.

MS. WALSH: First of all, it says:

"The arguments for full system

> integration for children are profound, not only in terms of human rights principles of fairness and equity, but also in the potential economic gain for society."

And we certainly heard your evidence about both of those things and the evidence of other witness.

And then lower down it says:

> "A society that envelopes its children in an integrated system that leaves no room for the most vulnerable to fall through the cracks will ensure a stronger and healthier society in the future."

And at the end of that paragraph talks about an ecological model which is what we heard from Dr. Alex Wright, as well, in terms of looking at dealing with families, both at, at the child, the family, the community and the society level and it says:

> "This ecological model is similar

to the holistic world view held by many Aboriginal cultures ... and illustrated through the image of the Medicine Wheel."

Then the paper goes on to identify the structures of Healthy Child Manitoba --

MS. SANDERSON: Um-hum.

MS. WALSH: -- which you outlined so carefully for us and it identifies that there are a number of excellent examples of cooperation and collaboration around specific issues relating to child and families. But it also says that more needs to be done, that, that full integration has not taken place.

Now, now this paper was written in 2009 but is that still true today?

MS. SANDERSON: Yes, I would say that we, we do not have full integration. We have other examples that have been added I would say but not the integration that we're striving for.

MS. WALSH: Okay. So -- and that's something that I want to pursue a little bit.

MS. SANDERSON: Sure.

MS. WALSH: In terms of implementing the collaboration that would be truly effective, what do we

need to do? For instance, we've heard about, about all the, the different departments that come to the meetings of -- and make up the Committee of Cabinet but is there any mandated framework that says what they should be doing and how, in terms of delivering policy and services for children?

MS. SANDERSON: There's various mandates associated with the system. So, for example, CFS definitely has a mandate, but there isn't an integration mandate that cuts across all of those systems.

I would say what we have right now, and I'm going to let Rob have an opportunity, too, but -- is at a very senior leadership level so at your ministerial level and the deputies, a very great commitment to the concept of integration and even integration of policy concepts. But then the systems filter out, you know, you get your ADMs, you get sort of the bureaucratic levels and the many times our delivery systems are outside of the government structure so school divisions, health authorities, CFS authorities. And the opportunity to diffuse just keeps happening.

So we haven't done the same level of work at the front lines in terms of what does that integration translate like. So policy concept is great, application needs work and that's why we're thinking that maybe a

regional approach rather than trying to tackle the whole province at the same time, but a regional approach might be the way to go and then we would learn more about both those things that are working -- we have great examples of cases where systems come together and the individuals work around the child and do rapid around services and it's, it's all great but it doesn't purvey through the entire system and that's what we need to learn about. Is that fair?

MS. WALSH: Yes. Dr. Santos, did you want to comment on that?

MR. SANTOS: Yeah, a couple of comments in terms of becoming more effective. Integration is obviously a valued goal in the vision. An important principle that's easier to say that do, as well, is that integration, on its own, isn't necessarily effective. In other words, if the components or the pieces of the puzzle, themselves, are not optimally effective, there is no reason to believe that integrating them will make things more effective, necessarily, and so part of the challenge and this -- we've heard this from our community partners and our own government departments is that most of what we do in terms of programs and services for our children, our best efforts with the information that we have, what we don't -- because of resources and other challenges, don't know how effective they are. Like, we've, we've given some examples of where

we've built that in, that say that, and although there has been great improvements across the systems over the last decade, we still have a ways to go. There's really a big question mark as to how effective are we overall?

And I guess the worry that I have, that is based on evidence of efforts of integration that didn't produce better outcomes is because often the components that you're bringing together themselves aren't optimized and so I think we need to work on both improvement of each of the pieces as well as this even larger effort of bringing people together.

The second thing that's come up is around well, how do systems truly work together. So if you take the analogy of the human body and all the different systems in the body working together, I think there's instructive lessons there. So communication is a big deal on the body. Like I talked about the, the brain development connecting to the hormonal system and stress response, there's all kinds of places along those pathways where things can go awry. The same is true in systems of services and so you know, having more time, effort and energy spent on looking at those modifiable barriers that Jan mentioned, certainly at the front line but also in the mid and higher policy levels, the society that we have, the departments and services that we have, Leslie and others talked about this,

and previous witnesses, are ones that we have created.

In many ways, we are stuck with them because it is hard to reboot the system, we have to work often more slowly at refining and improving, which is important. But there are probably things that are -- have been around for a long time or haven't been reviewed in awhile in terms of communication. One of the focuses of this inquiry was around tracking and identification numbers and ways of not losing children in different cracks in the system.

There is something that's been called PHIAnoia which is referring to the Personal Health Information Act, PHIA and paranoia around PHIA, in terms of people's legitimate concerns about inappropriately violating the privacy of individuals for the sake of sharing information for services.

If you talk to legal counsel with expertise, who drafted that legislation, they'll say there's, there's enough within those acts to enable things in the public interest, or in the best interest of the child and yet there is a communication gap in many places about people, understandably worried, that they are going to do the wrong thing and so they err on the side of caution and don't share. And so there's probably merit in having the -- a look at all the legislation that affects all the partner departments of Healthy Child including but not limited to

family services and CFS because -- with a modern eye to it, with this idea in mind.

Because within the system people have told us, anecdotally that there are things that they have worked around but maybe there's ways we can scale that up, and so both on the effectiveness side as well as on the communications side, I think those are two areas that there's, there's models elsewhere for having tried that in different settings. There's also pitfalls we can avoid, from other experiences, for example, in efforts to integrate children's mental health services in other jurisdictions that are probably instructive because it's the same challenge of different people in different systems and silos doing their best despite those silos or despite acting in solo fashion. There's probably room for improvement.

MS. WALSH: Thank you. And over and above the specific programs that, that are delivered and that do or don't need integration, and I hear what you're saying about being careful what, what gets integrated, my question is, in terms of a legislative framework right now is there any legislative framework that requires all of the government departments to collaborate and to deliver services with the best interests of the child in mind?

MS. SANDERSON: I would say that the Healthy

Child Act enables, it doesn't require, and it was, it was designed in that way but it's probably the closest that we have to something that says that the systems must work together in the best interests of the children. It says that there are structures that enable that to happen.

MS. WALSH: And in terms of all of these various systems that deliver services to children and, and really, as we've heard, that's pretty broad, I mean, it's, it's child welfare, certainly, but it's also education and early childhood education and housing and social assistance.

One thing that you probably heard Kerry McCuaig say was we have all these government departments, we have all the community based organizations delivering wonderful programs, the government's funding wonderful programs, but who is in charge?

MS. SANDERSON: Um-hum.

MS. WALSH: And is that still a question that remains unanswered. If you can say.

MS. SANDERSON: Sure. I -- there's also strength in diversity, I guess. And I have a lot of respect for Ms. McCuaig and the work she has done and we have worked with her and so on, so -- but I believe that she was sort of at least pulling in the direction of a single department that would oversee all the key areas for children.

THE COMMISSIONER: I'm sorry, I missed, who are

you speaking of?

MS. SANDERSON: Kerry McCuaig.

THE COMMISSIONER: Oh, yes, um-hum.

MS. SANDERSON: (Inaudible.) We've resisted that in Manitoba because we have seen the experience elsewhere where that's been at least explored and I, I don't know of any experiment where they have put everything that you just listed related to children in one department because it would be the vast majority --

MS. WALSH: Yes.

MS. SANDERSON: -- of a government's budget.

But even where they have tried to put some of those key services for children together in one place it has not been sustained, the department ultimately gets separated again with social services going one direction, education going the other, for a variety of reasons. That's why the approach that was taken in Manitoba was taken in that if we can at least bring the people around the table, who have the leadership of each of those, then we're recognizing that there's different policy triggers in each of those department areas that need to be utilized but we're also recognizing that there is a commonality and it's through the commonality that we are trying to achieve change.

I, I am not in a position to say whether it would

be more effective if it was more directive in the legislation and I think that's something that can be explored in, in your deliberations. But we also don't have any evidence of a system like that. So we consider it to be somewhat cutting edge for the structures that we have in Manitoba and we're still evaluating to determine if they are more successful than traditional.

I, I know that Rob would say and he can reiterate it in a second, but if we try something different we need to do it in a way that we'll be able to measure or not -- whether or not it's effective because there's been so many experiments out there and -- then they're backed away from and we still don't know the answer about what worked and what didn't work so ...

BY MS. WALSH:

MS. WALSH: We saw, in the Atlantic provinces they are integrating into one department, education and early childhood education, and certain family supports that go with that.

MS. SANDERSON: And, and that actually is, is happening in a few jurisdictions. That wouldn't be the same, of course, as integrating housing and --

MS. WALSH: Right.

MS. SANDERSON: -- social assistance and all of

those other pieces.

MR. SANTOS: Health.

MS. SANDERSON: Health, yes. Right.

Prince Edward Island or the Maritime provinces are also smaller so it's generally felt that -- a little bit easier to do that and very interesting to find out how it works. I mean, the whole country will be watching to see how that works.

We have -- currently our early childhood programming, such as childcare, happens in the Department of Family Services and Labour and the education system is managed by the Department of Education. However, they sit on interdepartmental working group on the early years, they both sit at the Healthy Child table. There is -- I can attest to constant dialogue going on, on how we strengthen that system, and work together. I am not saying that it wouldn't be effective to merge the departments, I'm not sure, I'm not convinced that it's necessary in order to be effective.

MS. WALSH: So if I'm understanding you correctly, in response to the, the conclusions of the paper that we looked at, Commission disclosure 1397, your response is that that further integration that's recommended you're trying it out at a regional level in the pilot project in Gimli, is that ...

MS. SANDERSON: I think we're trying something perhaps a little more bold in the project in Gimli in that we're saying not only are we going to ask government departments to come together but we're going to ask the leadership of the sectors in the delivery system, so your school superintendents and so on, to come together and basically build a children's agenda for their region.

What it -- what would they say their strategic plan needs to be and what would they say is currently working and what's getting in the way of their success. And then they have access, in Manitoba, to something they would not have access to anywhere else in the, in the country and that is, first point of contact would be a deputy ministers' committee where they can come and talk to 10 deputy ministers that represent their various systems and say you know what, if you don't change the housing policy we're not going to be able to be effective in what we want to do in education because just as we get these kids sort of feeling comfortable in the school and so on, they're evicted from their house because of family violence or some such policy as that, we need a change in that regard. Okay, now we have something concrete that we can start working on. It's those sorts of pieces that we need from the front line to tell us what needs to change.

MS. WALSH: All right.

MS. SANDERSON: Does that ...

MS. WALSH: Yes.

MR. SANTOS: And with respect to the, the who's is in charge question, it's, it's a challenging one, especially in the Canadian context so it's a question that's posed at the national level, in a federation, who is in charge and on the provinces or the federal government.

It's a question that Ms. Spillett raised yesterday, in terms of who is in charge at the local level and there are a host of, each in their own right, valid views about who should be in charge. From Leslie's perspective it was aboriginal led community based organizations, for others like Ms. McCuaig it was that well, really there's -- it can only come from the Premier, for example, and she gave the Ontario example.

I think I would like to link part of the answer back without -- with the shared responsibility of value in mind which is that -- Jan's reference earlier to the public. In other words, in a democracy, whether it's a provincial government, an aboriginal government, a federal government, whatever level of government, they're ultimately elected to the consent of the governed and so I think it comes back to each of us, which is part of the message we have tried to foster, is that while government has a clear role, if the only action that stems from change

is that government needs to do more things solely then we can't get there because of the limited reach of government, government itself operates in a devolved set of systems, the direct delivery is the Regional Health Authority, school division, CFS agencies, community agencies.

So by design and by necessity control and who is in charge is distributed across many areas. So the best evidence available is that you need to, just like the human body, there, there does have to be kind of something leading the way like your brain but on its own it can't do anything, you can't move your legs and arms without your muscles, it can't keep the heart beating without the circulatory system.

So there are models in nature and in science that we have -- can learn from because the reality is we've designed our public institutions as separate institutions. Our legislation, to answer your question earlier about legislative frameworks are very narrow and focused by design. The CFS Act pertains to CFS, the Regional Health Authority Acts pertains to the health system, and so if there's efforts in those areas a similar approach of coordinated integration, whether it's legislative policy, practice, evaluation also has to be coordinated and multi-level I think, to make an impact.

And the question about other examples where

that's happened have done that over long periods of time, probably for cultural reasons where, again, who is in charge is the citizen, the public -- other witnesses gave examples of other countries that have better indicators of how well children are doing than Canada. If you look at the histories of those nations, there is an in-built expectation, from day one, from every member of that society, that this is a right of the members of your society, including people that immigrate to that country. Finland was an example given.

And so until we get to that point the question as to who is in charge necessarily I think has to fall back to each of us in terms of what do we expect from our governments and our public institutions and our community agencies. And more importantly, what do we expect from ourselves in the roles that each of us have, day to day, in the lives of children. And once we are able to do those things, I think you'll see the kinds of outcomes that we all aspire to.

MS. WALSH: You're talking about public support for political action?

MR. SANTOS: Yeah. And as Jan mentioned, prevention in every jurisdiction across the world, even in those countries, has a hard time because of many reasons and until we get to the point where every person, literally

that -- at least those that vote because our children don't have that right yet --

MS. WALSH: Um-hum.

MR. SANTOS: -- we have to do that on their behalf and their best interests, has that understanding of how important this is, then -- governments can only go as far as their, their, their publics will allow them. And if you look at public, recent public debate about what people are concerned about or worrying about, we don't have enough of this which is why the coverage of this inquiry, the leadership of many reporters, locally and nationally, about this issue specifically and generally matters hugely because it does shift people's understanding and what they expect from their governments and their public institutions.

MS. WALSH: In terms of statements about prevention that we saw in some of the reports, in the paper that Dr. Brownell prepared for the Commission, and you heard her say it yesterday, she talked about the importance of prevention and she described it as the morally right thing to be doing. And she also said that it was economically the right thing to be doing, based on the evidence.

You're both nodding your heads.

MS. SANDERSON: Yes. I think that's, in some

ways, the, the magic of these prevention and early intervention investments is they do satisfy our, our need to do the right thing from a moral imperative. None of us wants to see children suffer, or families for that matter. No one wants to hear the Phoenix story again, ever. But, the same investments, the very same investments, also make excellent sense to the, the business leaders in this province because of the economic payback that they can achieve.

They also make tremendous sense to those who are concerned about social justice because early childhood development is the great equalizer. If we can have kids arriving at school ready to learn, that social disparity that Dr. Brownell and others talked about, will be significantly diminished in the next generation, potentially.

And they also -- it also has tremendous appeal to parents and grandparents. I mean, it's, it's -- has a universal sales pitch behind it, if you want, and yes, it does start from a moral imperative, I would agree.

MS. WALSH: Okay. You talked, this morning, about a need to make structural changes to the socio-economic situation and certainly in, in Exhibit 152, the Healthy Child Manitoba report, there is evidence, I mean, at the -- in the beginning of, of the document,

starting I think at page 4, you identify that a number of ongoing challenges exist for Manitoba so one of those is that families with young children under six have the highest prevalence of food insecurity in Manitoba.

Mr. Commissioner, are you looking for that document? I mean --

THE COMMISSIONER: Is that 152, isn't it?

MS. WALSH: It is, it is.

THE COMMISSIONER: Yes, I have it.

BY MS. WALSH:

MS. WALSH: The report identifies, at page 5, that:

> "At all stages, children from vulnerable populations, particularly Aboriginal children and children in low income families, are more likely to experience poor outcomes."

At page 19, the report notes that the depth of poverty is a major concern and that income and equality is increasing as the gap between lowest income and highest income group, groups expands.

And this is consistent with what you told us this morning. So in addition to, and we'll talk a little bit more about, about an early childhood education development strategy but as part of prevention, these socio-economic structural issues need to be addressed. Is that fair?

MR. SANTOS: Yes.

MS. SANDERSON: Um-hum.

MR. SANTOS: And partly because of those two big actions that are required to promote not only the early development but success for the whole society. Nurturing environments is one but buffering or reducing toxic stressors and the leading one, or the one that is the, the magnet for many of the other ones, is poverty. The accumulation of disadvantage that goes along with being poor is part of what's driving those poor outcomes which is why, again, to add to Jan's comments, the, the dilemma of how to organize either government or society is one that probably should not be the responsibility of any one person.

Like, for example, if you had a super ministry of every sector related to children's services, including health, education, income assistance, that's a lot to put on one person's shoulders and logistically it's not clear how that would happen. So, by definition, you have to have a coordinated approach with significant leadership such as

from a premier establishing a standing committee cabinet or other mechanisms, that then has the potential as a team to really move the levers that they have access and, and influence over in concert with others who also have a big role to play in that same piece.

And so if you look at the poverty reduction agenda, Ms. Donner testified, it's a multi (inaudible) kind of approach that includes but isn't limited to focus on children because -- some people even argue that the term child poverty is a misnomer because children live in families and communities, who themselves are poor. And so this is where the tie in comes back to the shared responsibility of, of every one of us because indirectly or directly we support or fail to, to challenge those ongoing structural inequalities in terms of what is expected for a good life, in terms of access to the basic human needs that Ms. Spillett talked about yesterday.

The same things that help kids overcome the odds when they live in conditions of disadvantage, indeed the same things that each one of us, who were lucky enough to not have to live through many of those circumstances used for -- to succeed ourselves, they're the same things. There's something magical about resilience, it's ordinary magic, it's just that some children, through circumstances not of their own choosing, don't -- do not have that same

equitable access to those opportunities and resources, and that's -- comes back to us in terms of how we have organized ourselves, our society, where our tax dollars go, what we fight for, what we don't.

MS. SANDERSON: Can I --

MS. WALSH: In terms of -- oh, yes.

MS. SANDERSON: Can I just add that we need to be doing two things at once, maybe, maybe more than two, but because resolving the poverty issue is complex and will take time, unfortunately, we have to continue to do whatever we can to mitigate the results of the poverty or the impact of poverty.

So a lot of the programs we described today don't put more money in the hands or the pockets of family but they are reducing the negative impact of living in poverty. It's one of those catch-22 things that some of the very dollars that might be going to alleviate poverty are now going to those programs but until we can do the former, we need to keep doing the latter, as well. So that's part of why we talk about this balanced portfolio of investments because we have to deal with the circumstances we're in today while striving for where we want to get to tomorrow, I guess is ...

MS. WALSH: Well, and as, as we heard, for instance, from Carolyn Young, who is running the

Abecedarian program, that program is a holistic program in the sense that although it's, it's early childhood education, it also has a visitor, a person who goes in to -- I think her evidence was that she saw every family every week and sometimes --

MS. SANDERSON: Right.

MS. WALSH: -- every day and was there to help them navigate through social assistance or getting back to education. So that is, I think it's fair to say, an example of an early childhood strategy that is inclusive of anti-poverty --

MS. SANDERSON: Yes.

MS. WALSH: -- strategies.

MS. SANDERSON: Yes. And I would have even said it in its broader context, in the sense that it's located in a social housing project. In an ideal world we won't have social housing projects anymore, but in the meantime we still do so if we're renovate them, as it was in that case, or if we're building one, let's make sure it's got the capacity to provide the -- that level of service for families so ...

MS. WALSH: In terms of -- I mean, certainly at the Healthy Child Committee Cabinet -- Cabinet Committee, you have ministers who are responsible for housing --

MS. SANDERSON: Um-hum.

MS. WALSH: -- for social assistance. Is there any requirement within the legislation for government to give priority to or to consider Healthy Child principles and strategies when it develops its budget?

MS. SANDERSON: There is no requirement for that. There, there is policy, we do have something called an ECD lens. So when departments are submitting budget submissions, they may be asked how it sits, how it sits through the ECD lens and that's something that we will then help them with, if they ask us for assistance in that.

Generally speaking, most proposals that are going to Treasury Board, that have to do with children, will also get reviewed by the Healthy Child Committee. Not all but most of them. And then, of course, we have the opportunity to apply that ECD lens. But it's by policy, it's not by legislation.

MS. WALSH: In terms of the anti-poverty reduction strategy, we heard Ms. Donner testify about how many regulated child care spaces there are available and if we could pull up Exhibit 97 which was the all -- data summary of the All Aboard Consultations from March of 2013. And you know what, this doesn't have page numbers so I'm not sure -- I don't know that there is actually any real need to pull it up. But if you want to see it, I can, I can show it to you after I've referred to it, it's Pillar

Three: "Percent age of Children ages 12 and under for whom there is a Regulated Child Care Space." And for 2011/2012 overall for ages 0-12, 16.6 percent. For pre-school it's a little bit better, age 0-5, 23.6 percent.

I gather that's something that you would like to see enhanced?

MS. SANDERSON: Yes. And I think in -- you have to unpackage the numbers a bit, too. For example, the Lord Selkirk Early Childhood Centre that we talked about, the families that are registered there may not even appear in those numbers because they probably never had their name on a child care list, waiting for services, and they won't show up in the numbers of working families that are in need of child care because they're not working families.

So, I may be making the problem sound even worse but in some ways it may be in the sense that the families that may need it the most are the families who aren't even contemplating their need for it, at the moment.

Until we built that centre the Lord Selkirk residents weren't clambering for an early childhood centre because they don't have time in their lives to clamber for those sorts of things, they're trying to figure out how to get through the day on limited resources, et cetera.

So, in addition to regulated child care for working families, families going to school, we also need

spaces for families in these situations so that they can begin to imagine going to school and working.

MS. WALSH: And so I do -- I did note that you said that we lack a universal early childhood system and is it fair to say, based on the extensive scientific presentation that you delivered, that that's essential for prevention?

MR. SANTOS: Yes.

MS. SANDERSON: Yes.

MS. WALSH: Finally, in the Early Development Instrument which was Exhibit 144, was filed with Dr. Brownell's testimony, the Early Development Instrument in Manitoba, published in May of 2012 and I think, Dr. Santos, you were the leader author --

MR. SANTOS: Yes.

MS. WALSH: -- on this. The very -- and you don't need to pull it up unless the witnesses need it -- but on the very last page, the last paragraphs says:

> "Nationally and internationally, Manitoba is recognized as being unique in its scientific and intersectoral policy potential ... to close the gap between what we know and what we do ... in the

everyday lives of children and families. This is the potential to 'give every child the best start in life' ... to address and redress inequalities in children's development opportunities, reduce any equities in their developmental outcomes and 'close the gap in a generation' ... Investments in the early years are empirically warranted and ultimately are investments in a democratic and just society. While Manitoba has made considerable progress in recent years ... considerable additional public support and political will are needed to significantly increase evidence-based action for Manitoba's youngest children."

And Dr. Santos, that statement is supported by all of the evidence that you showed us today?

MR. SANTOS: It is. There's two gaps to be closed that -- Jen referenced one earlier. One is the gap

in our ability to use evidence to close the gap. In the health field is what she was referring to, on average it takes two decades for a discovery, for example, in medicine to translate into everyday practice in medical care and there's massive efforts in learning how to scale up or reach out much more quickly.

The same is true for early child development. When I first started in government, as a student, back in the mid-90s under the previous government, the quote around the time was for every dollar you get seven dollars back. Why? Because of a 1993 paper of the Perry Preschool study following those children, to age 27. President Obama quoted that recently in a State of the Union address a couple of years ago. That, that paper on pre-preschool was published 20 years ago.

Now, a lot has happened since then, that statistic drove members -- ministers of the Fillman government to take action, Fraser Mustard came here and you saw lots of -- the beginnings of what we presented today.

I really feel that the evidence is very clear that we need to find a way to accelerate that knowledge translation into tangible every day action for children. And I mean that beyond programs and services.

Much of what we talked about today are things that any caring adult, in the life of a child, or pregnant

mom can do themselves. Granted there are things that we can do, through public institutions or programs and services to enable that, to empower people to do that, but there are examples around the world in much less wealthier countries where that happens much more often, partly because there's less inequity in those communities.

And so if we can find a way to do that together, I agree with all the witnesses who talk about this being a shared endeavour. There probably isn't one right solution to doing that because it's difficult to do that in any other area of, of life. But as Jan talked about, early childhood being the greater equalizer that's, that's very clear now. And there are examples in other jurisdictions outside of the country who have done those things in that order, the public support was so overwhelming that the political will followed.

Sometimes they have it in a different order but it's very clear that consensus is really the, the mechanism that's needed. There's great risk at, especially doing the things that have not a lot of evidence behind them and making broad commitments, as opposed to building that together and evaluating as you go. And one of the things that I think is very clear from the evidence is the compatibility of these different perspectives. There are examples locally and nationally and internationally of

people doing things together, even though they might have different views about the solutions and those typically lead to better outcomes because I guess like the blind man and the elephant, everybody has one part of the truth.

So that approach to doing things is very important, as well, in terms of closing the gap. Part of what was quoted in that closing paragraph is from Sir Michael Marmot's report for the Royal Health Organizations Commission on the Social Determinance of Health which is talking much more broader than early childhood but in every sector today, whether it's crime prevention, promoting health, education, the solutions all come back to the same period of life and so our job, I think, as people working in the area or as community members is to really harness that and pull together so that we don't wait another -- for another report showing the age 50 follow up of per- preschool showing even better results than we thought before because the investments has grown and magnified.

But it's a challenge, as we have noted, because of the complexity of the systems that we have, ourselves, created and our different views about what the right thing to do is. But if we can find those shared values, which is why the, the principles and the goals of -- and, and values of the Healthy Child strategy have remained unchanged over almost two decades, with many people involved, it's because

I think there's evidence, too, in Manitoba, that we share those values as Manitobans, and that we can put that evidence into practice. And we have some examples to, to give us hope that there are precedents that, you know, that can be done because somebody has done it and then to keep working hard to not lose sight of, of both the long term goal as well as the immediate benefits that people are already talking about in terms of supporting young children.

MS. WALSH: So we know what to do, public support and political will.

MR. SANTOS: Are two of the ingredients, I would say, in the larger recipe of transformative change.

MS. WALSH: And that would include a recipe that, that includes ingredients from, to keep the metaphor, government and communities --

MR. SANTOS: Absolutely.

MS. WALSH: -- which would necessarily require community capacity, as well.

MR. SANTOS: Yeah, and I would also add, if I could, the need to integrate not just services but perspectives as I think I've sort of indirectly talked about. There is huge value in bringing science together with traditional knowledge, with practitioner wisdom, with the values of parents. And, in fact, if you look at the

literature that's actually what constitutes evidence based practice is the bringing together, the integration of those different perspectives.

And then under other conventions, like the UN Convention, children's own perspectives and decisions that affect them, and so there are examples internationally including locally, of doing those things but typically this is one thing where you really need everybody at the circle and around the circle.

MS. WALSH: Thank you, those are my questions.

MS. SANDERSON: Thank you.

THE COMMISSIONER: Thank you, Ms. Walsh.

Will there be other questions? Ms. Dunn, do you have a question?

MS. DUNN: One question.

CROSS-EXAMINATION BY MS. DUNN:

MS. DUNN: Thank you, Mr. Commissioner. My name is Catherine Dunn and I am counsel for Ka Ni Kanichihk which is obviously a community based aboriginal organization. And Dr. Santos, you've quoted Ms. Spillett a number of times in your evidence this afternoon and, of course, then you are obviously aware that she feels, as do probably all of the aboriginal community based organizations in Winnipeg that cultural continuity is a

very important aspect for, for children, for families, for aboriginal populations in Manitoba; correct?

MR. SANTOS: Yes.

MS. DUNN: And I believe you heard Ms. Spillett say that, in a very strong way, that she felt, particularly at the local level, that community based organizations should be fully partnered with the government in giving service delivery and culturally based programming to, to people in Winnipeg and, and beyond Winnipeg.

And you may have been present for some of the other testimony from other people from community based organizations who were saying that they felt, for whatever reason, that they didn't feel fully partnered with the government in terms of service delivery.

I wonder if perhaps the assistant deputy minister could comment on that as -- from the government's perspective, if they feel that that is a wrong perception or if it a perception that you are aware of and intending to deal with.

MS. SANDERSON: I think we can say that it's a perception that we are aware of, that's held by some agencies and actually we've sort of opened up a dialogue around that, having heard of it. I think it's complicated in the sense that there are other aboriginal agencies that would say that we have longstanding positive partnerships,

as well, but I think what is not in dispute is that the closer the delivery system can be to the families that need it the better and so we are willing and do partner with a lot of agencies.

I am not sure that we would transfer the whole -- we can't transfer the whole responsibility for the public policy making but we can certainly do even more in terms of seeking input into that policy making and that is a principle that Healthy Child is, is founded on. So the involvement of community, not only in program delivery but in, in policy influence and input. So we remain committed to that.

MS. DUNN: And the, and the last question, I guess, was Ms. Spillett's observation that in her view she felt that there should be more aboriginals delivering community based services, not just community based services delivering to the public or including the aboriginal population but a much heavier number of aboriginals actually inputting those services to their people in, in, in Winnipeg. So I would like you to comment on that.

MS. SANDERSON: I think that's a sound principle, that we, we can work towards and are working towards. I think the devolution of the, the CFS system was, in fact, founded on that principle as well so it, it is something that government is cognitive of and working towards.

MS. DUNN: Okay. Thank you very much, those are my questions. Thank you, Mr. Commissioner.

THE COMMISSIONER: Thank you.

I take it there's no others? Ms. Walsh then any re-examination?

MS. WALSH: I do not. Mr. McFetridge?

THE COMMISSIONER: So pardon me, I ...

MS. WALSH: Hiding behind his monitor?

THE COMMISSIONER: Yes.

MS. WALSH: I have no further questions.

THE COMMISSIONER: All right. You're completed and I thank you very much for your contribution you've made and I know you were here most of the last 10 days, getting ready for today, to have the background of what had been said on this phase and that -- your contribution and time given to this is appreciated.

MS. SANDERSON: Thank you, we appreciate the opportunity.

MR. SANTOS: Thank you.

MS. SANDERSON: Thanks.

(WITNESSES EXCUSED)

THE COMMISSIONER: Well, we're finished.

MS. WALSH: Mr. Commissioner, subject to future

advice from counsel, I am pleased to say that after hearing from 126 witnesses over the course of 85 days of hearings, that completes the evidence of this inquiry.

THE COMMISSIONER: Mr. Funke, wants to correct you perhaps.

MS. WALSH: Oh, no.

MR. FUNKE: Not, not to correct, Ms. Walsh, Mr. Commissioner, earlier last week you asked me for some updated information from Mr. Whitford.

THE COMMISSIONER: Yes.

MR. FUNKE: Who testified on behalf of the Eagle Urban Transition Centre. He is attempting to get that information to me, I hoped to have it today so that it could be formally presented to you while the inquiry was still in session. He hasn't been successful in getting all of the information to me but we will be providing to it in due course. I will provide it to Ms. Walsh and forward it to counsel for all the other parties and intervenors and trust that it will still be provided to for your consideration.

THE COMMISSIONER: That will be, that will be satisfactory.

MS. WALSH: And --

MR. FUNKE: Thank you.

MS. WALSH: -- it's precisely for reasons like

that that, Mr. Commissioner, that I couched my comments in saying from the outset that subject to future advice from counsel there may be other matters that will have to be entered into evidence. We recognize that.

THE COMMISSIONER: Right. All right. We've got our -- assuming we don't have to come together for any other reason, we will be together mid-July for the closing summations. Thank you all --

MS. WALSH: Thank you.

THE COMMISSIONER: -- very much. We stand adjourned.

(PROCEEDINGS ADJOURNED TO JULY 22, 2013)