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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (0845)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning, ladies and gentlemen. Welcome to the health committee.

Today we have a very important bill before our health committee. It's Bill C-300, An Act respecting a Federal Framework for Suicide Prevention. It is my honour and privilege to introduce the sponsor of this bill, MP Harold Albrecht, who has worked extensively on this particular issue.

Mr. Albrecht will be presenting first, and then we have, from the Mental Health Commission, Dr. David Goldbloom and Ms. Mary Bartram. I understand, Dr. Goldbloom, you'll be doing the presentation. We have Ms. Tana Nash from the Waterloo Region Suicide Prevention Council. Thank you so much for joining us, Ms. Nash.

We will begin with my friend and colleague Mr. Albrecht.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Thank you very much, Madam Chair.

I need to say at the outset that this is my first time appearing at a committee on this side of the table, so I thank you for your warm welcome and your understanding.

A lot of misconceptions exist regarding suicide. A stigma surrounding suicide exists that prevents an honest conversation. There are a lot of questions to which we simply don't have answers. Studies say that 96% of Canadians believe that discussing suicide openly will reduce the number of suicides. We don't know how many Canadians are comfortable engaging in that conversation.

A stigma definitely exists. Since raising this issue in Parliament, many constituents, friends, and members of the media have asked me who it was I knew whose death by suicide had motivated me to table this legislation. I'd like to briefly share my journey with you.

In March 2008 a young woman from Brampton, named Nadia, was suffering from postpartum mood disorder and insomnia. A student here in Ottawa, she felt isolated, and sought help online. Instead of help, Nadia found a predator. Instead of comfort, she was encouraged to hang herself in front of a webcam. Instead of finding a friend who would encourage her to find help, she found a predator who entered into a suicide pact with her, a pact she completed four years ago this month.

It turned out that the young woman with whom Nadia thought she was communicating was, in reality, a middle-aged man—a middle-aged male nurse from Minnesota who posed under an online pseudonym, and was linked to numerous other suicides in several countries.

It seemed that the digital cross-border nature of the crime was impeding prosecution. When I met Nadia's family, I quickly understood their pain, how their pain was extended each day, and how they were denied closure.

At the time, I was a grandfather to eight beautiful grandchildren—now nine—growing up in a world where wired communication is the wild west. That led me to introduce Motion 388, which called on the government to address in the Criminal Code the barriers that law enforcement agencies faced in Nadia's case. That motion passed unanimously in the House of Commons in November of 2008.

Through discussions on Motion 388, I met many people working on the front lines, such as Tana Nash, who tried their best to educate me on these issues. I met many Canadians affected by suicide who shared their pain with me, and I started to pay attention in a different way. Obituaries for young Canadians that didn't list a cause of death stood out to me like never before. Then one day I looked at my BlackBerry to find an email from Tana with news that both brought a chill to my bones and turned my stomach. In the space of just one week, three students from Waterloo region schools had died by suicide in unrelated incidents.

If there were a single thing, one single accident, to which I would attribute my reason to introduce Bill C-300, it would be that conversation.

The need for Bill C-300 is obvious, and I thank Parliament for recognizing this by such a strong vote in favour of it. I shared many statistics during the debate on Bill C-300, but today I would like to take the opposite approach, and share the things we don't know.

It's estimated that on average 10 Canadians die by suicide each day. That number in and of itself is terrifying, but we don't know how accurate it is. We know that the stigma surrounding suicide causes under-reporting, but we don't know how severely.

We know that suicide is a public health issue, but we have developed no best practices to treat it as such. Teachers in a position to recognize suicidal behaviours are rarely trained to do so, and it's uncommon even for medical doctors and nurses to receive specific training in this area. We know that there exists, in our society, groups more vulnerable to the threat of suicide than the general population —veterans and aboriginal Canadians are notable—but we struggle to develop a suitable evidence-based response.

We know that suicide is most often preventable, as I stated in Bill C-300's preamble, by knowledge, care, and compassion, but we do a poor job of sharing the knowledge regarding suicide prevention, which we have accumulated with those whose care and compassion compel them to work to save lives.

Finally, we know that addressing this challenge will require collaboration across jurisdictional, geographical, and sectoral lines, and increased lines of communication between agencies. But we also know that, between 1993 and the most recent election, only one piece of legislation relating to suicide prevention was introduced, and that private member's bill never reached second reading.

That's not to say we haven't made progress.

● (0850)

I understand you will be hearing today from the Mental Health Commission of Canada. I've been briefed on some of the projects they have been working on, and I would say that the MHCC has built a solid foundation on which the goals of Bill C-300 can be achieved. I'm happy to respond to your questions, but I would remind you that I am not an expert on preventing suicide. I would ask you to refer the more technical questions to the expert witnesses who will be here today, and whom you will be calling in the future.

I'm not superstitious, but I notice patterns. The number of my bill is C-300. Three members of Parliament voted against it. This committee is devoting three days of study to it. I will close by noting that coincidence and thanking this committee for ensuring that Bill C-300 is ready for third reading. Somewhere along the way, I started referring to Bill C-300 as a message of hope. I thank you for sharing in that message.

Thank you, Madam Chair.

The Chair: Thank you, Mr. Albrecht.

We'll now go to Dr. David Goldbloom.

Dr. David Goldbloom (Vice-Chair, Board of Directors, Mental Health Commission of Canada): Thank you and good morning. It's a great pleasure to be in front of this committee this morning.

[*Translation*]

My name is David Goldbloom. I am a psychiatrist. What a pleasure it is to be here today to discuss a topic that is of the utmost importance to me, both professionally and personally.

[*English*]

I'm here in my capacity as vice-chair of the Mental Health Commission of Canada, but I'm also here as a psychiatrist who has worked in the field of mental health for the last 30 years, dealing with individuals who are suicidal, and dealing with the aftermath of suicide for those families so profoundly and irrevocably affected by suicide. I'm also speaking to you as someone who's known suicide at a very personal level. Two physicians in my own family died by suicide. In my experience, everybody, in the course of their growing up, their personal lives, and their professional lives, knows someone who's been affected by this tragic outcome. I'm grateful for the opportunity that this hearing provides.

To provide you with a bit of background about the Mental Health Commission of Canada, I understand this is our first appearance in front of this committee as an organization. Just to remind you by way of brief history, the Mental Health Commission emerged from the Senate report on mental health and mental illness “Out of the Shadows at Last”, which came out in 2006, and among its 118 recommendations was the creation of a national mental health commission, enacted by the Government of Canada in 2007.

As a leading national mental health organization, the commission is working with a vast network of people, from mental health professionals like me to policy analysts, researchers, and scientists, but also and importantly, with people with lived experience with mental illness at every level in our organization, from the board to our front-line operations, as well as family members, because we believe that people with lived experience in their families are essential to driving change in mental health.

We have a 10-year mandate. We're now at the five-year point of the Mental Health Commission. It's an action-based organization, charged with collaborating with stakeholders and partners to transform the mental health landscape in Canada.

In our first five years of operation, the Mental Health Commission has focused its effort on several initiatives that were part of our initial mandate from the federal government.

The first is creating and implementing Canada's first-ever national mental health strategy. That mental health strategy is coming out in several months. I'm delighted that Mary Bartram, the director of our national mental health strategy, is seated to my left and has worked tirelessly in this regard.

The second is creating a knowledge exchange centre, whose mandate is to facilitate the development and mobilization of evidence-informed knowledge in the mental health community and in the community at large. Currently, we live in the world of web 2.0, where there's no filter for quality in terms of the information that people derive. This will be one-stop shopping on the web for all Canadians.

Third, our anti-stigma initiative, Opening Minds, is focusing on how to best fight the stigma associated with mental illness. Because until we achieve that kind of fundamental attitudinal and behavioural change in terms of discrimination, we're not going to be able to move the needle on advancing the experience of people with mental illness and their families.

More recently, our homelessness research demonstration project, At Home/Chez Soi, which you may know is the largest project in the world on intervening in the lives of people who are homeless and mentally ill, occurs in five Canadian cities: Vancouver, Winnipeg, Toronto, Montreal, and Moncton. That project concludes in 2013, having enrolled over 2,000 mentally ill Canadians, who found themselves homeless, in a really extraordinary intervention.

The commission, through its eight advisory committees, has also undertaken very specific projects in a variety of areas including: children and youth mental health; first nations, Inuit, and Métis mental health; workplace mental health; reforming our service system in mental health; looking at research in mental health; mental health and the law—given that our prisons now constitute the largest asylums in Canada housing people with mental illness; seniors' mental health; as well as issues that families and caregivers face when dealing with a loved one's mental health problems.

In all this work the commission is really fortunate, through its staff, its board, and advisory committee members, to have the input of Canada's leading experts in mental health and mental illness.

● (0855)

By drawing on the intellectual capital that represents, and by collaborating closely with the federal, provincial, and territorial governments, the commission is able to spark change in mental health from coast to coast to coast.

Now with respect to the bill that's being examined today by the committee, the commission clearly and obviously recognizes that suicide is a tragedy with a devastating impact on families and communities. Suicide and mental illness share many common risk factors. Over 90% of Canadians who die by suicide—and that's close to 4,000 Canadians a year—are experiencing mental health problems and illnesses. Worldwide, mental illness is the single most common determinant of suicide. That's why the Mental Health Commission is working now, through several initiatives, in partnership with the federal, provincial, and territorial governments, as well as leading individuals and organizations in the fields of mental health, public health, and health care in general, to catalyze reform and to improve systems in the area of suicide prevention.

We have active partnerships with the Canadian Institutes of Health Research, the Canadian Association for Suicide Prevention, and the Canadian Centre on Substance Abuse—substance abuse being one of the other big drivers of suicidal behaviour.

In addition, over 50,000 Canadians, coast to coast to coast, have been trained through our mental health first aid program. This program teaches people how to recognize the signs and symptoms of mental health problems and to guide a person to help. All mental health first aid courses include teaching on suicidal ideation. Mental health first aid is an evidence-based approach that we think is going to take off like a brush fire across the country.

So we welcome the focus and attention on suicide prevention, all the way from the local level in the Kitchener-Waterloo area right up to the national level, and we also believe there's an opportunity to address it as part of our national mental health strategy for all Canadians. This report that will be coming out within a couple of months is really unprecedented in scope and unprecedented in input. It's our first ever national mental health strategy, setting out a clear vision and priority for improving the mental health of all Canadians. We used the best available evidence and received the input of thousands of Canadians over the past four years, including many organizations working in suicide prevention. We've also drawn on the Canadian Association for Suicide Prevention's blueprint for a national suicide prevention strategy as well as other evidence-informed references in the field of suicide prevention.

We believe that this strategy, when implemented, will significantly advance suicide prevention in Canada, and we have very specific recommendations on raising awareness, education and training, promoting mental health in schools and workplaces, accessing help early when problems first emerge, improving access to treatments and supports, paying attention to the needs of high-risk groups, and strengthening our data collection.

The federal framework that's under consideration today will definitely advance the strategy's recommendations to mobilize leadership, to strengthen collaboration, and to strengthen the infrastructure that's required to improve mental health outcomes in Canada with a particular focus on suicide prevention. The commission is very encouraged by the dialogue happening here in our federal Parliament. We've had the opportunity to meet with some of you personally, and we look forward to working with you, and working indeed with all Canadians, as is our mandate, to catalyze change and to improve mental health outcomes all across this country.

Thank you.

● (0900)

The Chair: Thank you very much, Dr. Goldbloom.

Now we'll go to Ms. Tana Nash, please.

Ms. Tana Nash (Coordinator, Waterloo Region Suicide Prevention Council): Thank you. It's an honour to be here this morning.

I am here before you today as an advocate for suicide prevention and awareness, as the coordinator of the Waterloo Region Suicide Prevention Council but also as someone who has been bereaved by suicide.

During my first year of university, I lost my grandmother to suicide, and more recently I lost my only sister and sibling, Erin, to suicide.

Like so many advocates and grassroots organizations across Canada, I channeled that grief into something helpful, something hopeful and positive, so that others might not need to endure that same loss, that same needless and unnecessary loss.

In Waterloo Region there are many partners and volunteers breaking down stigma, raising awareness, providing education, and offering prevention and intervention solutions to reduce suicidal behaviours. And we are not alone.

Across Canada these efforts are fuelled by passion and a commitment to change, but are often disjointed, insufficient, and underfunded. So today is an important hour in Canada's history. As a government we are moving toward establishing a federal framework for suicide prevention, and by moving on this bill so quickly you are embracing Canada's need for quick action.

I am going to keep my remarks brief and make six key points, on why, in my judgment, Bill C-300 is so important for Canadians.

First, stating information about suicide prevention from a national, provincial, and a regional level is paramount. One new vision is using the workplace as a tool to do this, an area that has not been tapped into as strongly as we need to.

Bill Wilkerson and the Honourable Michael Wilson, released their final report for The Global Business and Economic Roundtable for Addiction and Mental Health this past December. The title is “Brain Health + Brain Skills = Brain Capital”. In it they talk extensively about the new workplace—the new neuroeconomic workplace—as a venue for suicide prevention.

The report says that the “NEW or NeuroEconomic Workplace is the workplace of the future. This NEW Workplace – as a venue for research, prevention and education – must be designed, managed and sustained to promote and protect the mental health of working populations as a straightforward duty of asset management”.

The report goes on to talk about how 85% of all new jobs now demand cerebral—not manual—skills, and what the report refers to as the advent of a brain-based economy wherein brain-based disorders are the leading source of disability.

I was asked to write for this report. I, too, call on Canada's business community to take a leadership role by offering prevention and intervention training in the workplace. Imagine mandating mental health first aid and gatekeeper suicide-prevention training such as ASIST or safeTALK, just as we have done with first aid and CPR, and providing employees with modules on what stress looks like, what depression looks like, what resiliency tools look like, and what the warning signs for suicide are. If we educate the workplace, we are also educating parents, just as we did with first aid and CPR.

I will add that both the Honourable Michael Wilson and Bill Wilkerson have expressed their support for Bill C-300 on behalf of the business community and asked me to bring that here today.

We can take this same model for disseminating information for suicide prevention in the workplace and apply it to other areas that affect thousands of Canadians, such as our national coaching certification. Our national coaches require first aid and CPR, but wouldn't it be great it they also were required to have mental health first aid and suicide-prevention training skills? And what about our future teachers and our education system? Currently they do not receive mental health or suicide-prevention training, although they are struggling with this every day.

The second point is promoting collaboration and knowledge exchange across regions. I can tell you from a grassroots organization that this is essential. We are all operating on shoestring and non-existent budgets, but we imagine a hub where all of us working across Canada can access tools, brochures, and ideas, and where we can simply add our own local crisis information, instead of reinventing the wheel.

● (0905)

For example, our region just completed a brochure entitled, “How Do I Write an Obituary When My loved One Died by Suicide?” I'm currently making presentations to all funeral homes in our region about the important role that funeral directors can play in breaking down stigma, as one of the first points of contact with family members; and what kinds of crisis or counselling services are available at the funeral service, because we know there will be other folks in the room who are skating on thin ice. I've also taken this presentation to the AGM of the Ontario Funeral Service Association, but we need to roll this out to all funeral homes across Canada.

My third point is on promoting the use of research and evidence-based practices. Implementing practical practices that work is essential to reducing the numbers of suicides. One example from the Waterloo region is the Skills for Safer Living group. This is a 20-week psychosocial, psycho-educational support group, but it's specifically for folks who have had suicide attempts and are still wrestling with wanting to die. This group was developed at St. Michael's Hospital with much evidence behind it that proves its success. It teaches things like emotional and coping skills, and how to gauge your own behaviour on a sliding scale, so that you know when you're escalating and how to reach out for help.

We are fortunate that this now runs in the Waterloo region, but when I talked to the Suicide Prevention Community Council of Hamilton last week, they hadn't heard about this great program. They are hungry to have such practical training in their region as well. It's another proven practice that can be rolled out across Canada.

My fourth point is on research as an essential part of Bill C-300. As the Wilson and Wilkerson report states, finding a cure for depression will stimulate the prevention of suicide on a large scale. It is estimated that as high as 90% of all those who take their own lives suffer depression at the time. Serving this purpose means saving the lives of kids.

The fifth point is on increasing public awareness. The stigma that still surrounds suicide prevails when it comes to advertising campaigns and awareness-raising. But as the Bell Let's Talk Day has proven, people want to talk about this issue. I can tell you that inevitably, time and time again, when I reach out to the community and start a dialogue, people want to talk about suicide. They simply need a leader to lead. They simply need the door to become open, because once it's open people want to talk.

I remember the first time I was at a local talk radio show and the producer was skeptical about having me on the program. She said she hoped I had lots of information to share, because nobody was going to call in. Well, 10 minutes into the 30-minute program, the phone lines were lit up. She popped her head in the door and asked if I could stay for an hour, because they couldn't believe the response. People want to have this dialogue.

Across Canada there have been all sorts of great public awareness events, such as the public service announcements that ran in Saskatchewan as a result of MP David Batters' death, and bus banners in Vancouver. Across Canada there are posters, information, and literature, but let's pull these all together so that we can roll out these models of success from coast to coast, so that all Canadians can have access to them. We can also look to other countries for their successes, such as the television commercials that were aired in Scotland aimed at middle-aged males, which is still the number-one mortality demographic for suicide—and that is true here in Canada.

Finally, let's be bold. It is not good enough to simply say we will do the above points, such as education and sharing of information. We need to actually take a stand as a concerned body and say the goal of the campaign is to cut the annual death toll in half, or to reduce suicides by 20% within the specific timeframe, as Scotland's Choose Life program has done. Consider this: if we aimed at reducing suicides in Canada by two-thirds over the next 10 years, we would save more than 30,000 lives and prevent some 200,000 self-inflicted injuries.

Without sufficient funding none of these initiatives will materialize. However, with a well-funded coordinating body, a national game plan to save the lives of fellow Canadians is more than possible, it is doable. Better yet, let's not just follow the initiatives of other countries, let's lead the world. It might have taken us longer than other countries to get to this point of implementing a federal framework for suicide prevention, but now that we're here, let's surge forward and be a leader. Canada has the resources, and Bill C-300 provides the vessel for this to be possible.

Thank you.

● (0910)

The Chair: I thank you very much. The committee and I give our condolences to you on the loss in your families. Thank you for all your work on this very important initiative.

We'll now go into our Q and A for seven minutes, and we'll begin with Ms. Davies.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Chairperson.

First of all, thank you to the witnesses for coming here today.

Thank you, Mr. Albrecht, for coming to our committee and presenting your bill. I know you've done a lot of work on this. We appreciate you being here today. Obviously, the witnesses have a wealth of information, but your interest in the issue and your dedication is very much appreciated.

I have a couple of questions.

Because we have the Mental Health Commission here, welcome to the committee for your first appearance.

I'm interested to see how either you, Mr. Albrecht, or the commission see your bill in relation to the work that the commission's already doing. You've told us today that in a few months you are going to be rolling out your mental health strategy, which I assume will be a national strategy because you're a national organization. In fact, we've been hearing about it for quite a few months. I know there's significant interest in the work that you're doing. I'm curious to know what the differentiation is between the bill and what you're suggesting, Mr. Albrecht, and what work the commission is already undertaking. That's one question.

The second question is concerning a strategy as it relates to reform of health care delivery. We've had a lot of discussion at this committee about the need to reform health care delivery and the need to focus on integrated primary care, health promotion, and disease prevention. So in terms of developing a suicide prevention strategy, how do you see that being delivered? Is it important to have stand-alone services—and maybe Ms. Nash will be able to answer this? Or do you see it more important to integrate with other community-based health promotion services, so that it's a one-stop shop, and there's a comprehensiveness? Or do you think it's better to have more stand-alone services?

So it's those two questions.

● (0915)

Mr. Harold Albrecht: Madam Chair, I'll begin just briefly.

The Chair: Mr. Albrecht.

Mr. Harold Albrecht: First of all, as it relates to the coordination with the Mental Health Commission, I've been in dialogue with them at various points along the journey. Certainly all of us around this table applaud the work they're doing. There's no sense of competition or of one getting ahead of the other. This is simply my effort as a parliamentarian to draw specific attention to the area of suicide prevention.

Dr. Goldbloom mentioned that 90% of suicides, generally speaking, are related to issues of mental health. But we all know that there is a small percentage of people who end their lives by suicide, where there does not appear to have been any history of mental health issues.

I'm very specific on the public health aspect as well. We need, as has been mentioned, front-line training for those who are on the front line. My initiative is simply to boost and share my passion for suicide prevention in the context of the overall Mental Health Commission's report. In my dialogue with them I'm very satisfied that they are in fact doing that. I met with them probably a month or two ago, and they went over some of their initiatives. It's quite encouraging to see their specific emphasis on suicide prevention.

As it relates to the access by groups to the information that may be available, my idea is not to have a top-down, mandated, “this is the way you have to do it” suicide prevention. My idea is to have a central repository of information, research, statistics, and best practices that communities such as Waterloo or Iqaluit, or you name the community in Canada, can contextualize the general principles that apply to their specific area. But obviously, they need to contextualize it in their own area and access the resources that are there.

But I defer to my experts.

Dr. David Goldbloom: Let me echo what Harold has said. I believe there is a huge degree of overlap. If you start to parse out the various elements of our soon to be released national strategy, you'll see the extent to which suicide prevention is effectively embedded in many of the initiatives.

If we look around the world at what the evidence tells us about suicide prevention. Whether it's the education of primary care physicians in the detection and treatment of depression as a common psychiatric forerunner to suicide; working with media around responsible reporting of suicide, which again is an evidence-based intervention; or training gatekeepers, who might be school teachers, co-workers, or family and friends, in the recognition of problems and encouragement of people with mental illness to seek help; these are all very much encompassed under the umbrella of the ongoing work of the Mental Health Commission.

I want to say something else about suicide prevention, which relates to thinking upstream. It ties in to your second comment. The ultimate reduction of suicide prevention—the narrowest thinking about suicide prevention—is the barrier on the bridge that prevents the person from jumping off that bridge. There actually is good evidence that putting up those barriers, whether they're on the bridges or in the subways, makes a difference. But it doesn't change one iota what brought that citizen to that point in his or her life when he or she goes to that bridge or subway.

We need to be thinking more broadly about upstream interventions. That's where talking about mental health promotion and prevention are really integral components to mental health reform, and they're integral components within the mental health strategy.

It's not simply making more services available. It's how you put into place those initiatives in mental health promotion at an early level, for children and youth. Take the issue of suicide, for instance, which is now the number two cause of death in Canada for people aged 15 to 24. If you're in that age group, the number one cause of death is a motor vehicle accident, and number two is suicide. That's an extraordinary and appalling statistic.

While it is true that men over the age of 55 are the highest risk group for suicide, they're also falling vulnerable to other illnesses that will end their lives. Young people aged 15 to 24 are generally a physically healthy group.

● (0920)

The Chair: Thank you, Dr. Goldbloom.

We'll now go to Mr. Lizon.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much, Madam Chair.

Thank you, witnesses, for coming here this morning.

Harold, I would like to congratulate you and thank you for your initiative.

With regard to how serious the issue of suicide is, I don't think there's anybody in this room who doesn't know someone who has committed suicide. I don't have any statistics on it, but even in my experience—I don't have anybody in my immediate family, but I had cousins who committed suicide. I had a school friend who fell victim to mental illness, and before he reached the age of 30 he committed suicide. The signs were there. He was watched by the family, and eventually he found a way to end his life.

We have a lot of people around the table who have a lot of knowledge and experience in the medical field. My professional background is in engineering, but I have a lifetime of experience. Harold mentioned that 90% of suicide cases are related to mental health. Well in my view, probably 100% of the cases are related to mental state, or the state of mind at the moment a person decides to take that action and end his or her life. Whether some cases are preventable or detectable is a question we can ask. In some cases there are no signs, and therefore preventing people from committing suicide in such cases is very difficult.

My first question is to Harold.

In your comments, Harold, you acknowledge the journey to introduce Bill C-300. I notice in the first point of the preamble that you take note of the spiritual aspect of suicide prevention. You didn't touch on this in your comments. I'm curious. Can you tell us more about what you meant?

Mr. Harold Albrecht: Well, thank you for noting that.

Those of you who were in Parliament the day I gave my first speech, in the first hour of debate, will recall that I acknowledged spiritual factors.

Obviously, there are biological, psychological, and physiological factors that experts here will know a lot more about than I, but one of my concerns is that we often, to our peril, ignore the spiritual aspect of our physical makeup, in terms of our attitudes towards ourselves and our self-worth.

Often it's the spiritual community that surrounds people in their hour of need. I can say, from my personal experience over this last year, having lost my wife, that the spiritual community was my first line of defence, if I can use that analogy. Actually, I had a personal conversation with Dr. Goldbloom a few months back, and he acknowledged the participation in a religious group as being one of what he refers to as the "upstream factors" in prevention.

I think it's important that we don't simply have that barrier. We use the analogy sometimes of people who have an ambulance stationed at the bottom of a cliff to take people to the hospital. Well, the next step is to put the barrier up above so that there is no need for ambulances at the bottom, but the best step is to go beyond that and hope that they won't get to that barrier.

For me, the spiritual aspect is important, and it is important that we acknowledge it. The leaders of many churches and religious groups, in our small towns especially, are equipped to have the compassion and the outreach mentality to help those who are struggling with self-worth.

All I'm asking is that we don't miss this key component. I'm not saying that it's the be-all and end-all. It's a key component of the prevention aspect, and of going as far upstream as we can and not simply putting a barrier up at the bridge.

● (0925)

Mr. Wladyslaw Lizon: Thank you very much.

The second question I have is for Dr. Goldbloom, or maybe Tana.

What is your organization doing to reduce suicide or self-injury, and have you found a particular strategy or combination of strategies to be particularly effective?

Maybe you can also touch on what I mentioned about that group of people who show no signs of problems—silent sufferers, who don't show their emotions to anybody—who all of a sudden end by ending their life.

Dr. David Goldbloom: I think the suffering in silence that you're talking about is a very common experience, even in people in whom the signs of mental illness may be obvious to other people but where the stigma prevents open discussion about this common human experience, which affects six million Canadians every year. Every year six million Canadians experience some form of mental illness. It's in our workplaces, in our schools, in our homes, in our communities, in our faith organizations—wherever you want to look.

Again, some of the upstream efforts are to change the culture and climate, to change the dialogue around mental illness, to better train people in the community—non-professionals—to recognize of the signs of mental illness, and to encourage people to get help. Will there always be a group who are caught unawares by people who will end their lives by suicide whom nobody picked up on, nobody recognized? Yes, there will be, in the same way that there will be people who have heart attacks with no outward symptoms of cardiac disease before they die of a heart attack. This doesn't change the fact that there is a much larger group of people with whom we can intervene earlier.

The mental health strategies initiatives, if they're implemented by the governments that have the power and the authority to do so—because the Mental Health Commission does not run mental health services in any jurisdiction, but works collaboratively with the people who control the resources to do so—there is the potential to improve the detection, the recognition, the intervention, and the acknowledgement.

The Chair: Thank you, Dr. Goldbloom, for those insightful comments.

We'll now go to Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you, Madam Chair.

I want to thank everyone for coming today to share your information with us.

I wanted to also thank Harold very much for bringing forward this bill. As you well know, we have supported it from the beginning.

This was first flagged in the House of Commons by the Liberal Party when Mr. Rae mentioned that he himself had faced a certain amount of depression at a certain point in his life. The stigma, as we well know, is a big part of suicide prevention. I was shocked this very weekend to have a very dear friend of mine tell me that she had been battling with depression for quite a long time and that she was so ashamed to tell anyone about it. To meet her, you would think she was the life of the party; she was always full of fun. But it was interesting that she finally admitted it, and I think she did so because she was probably reaching a particular point in her life at which it was becoming too much for her to cope with alone.

I think that everything that you have said is very important, but I want to touch on a couple of parts that weren't discussed here today and that I'm sure are going to be discussed as we move on, later on. One of them, of course, is the high rate of aboriginal and Inuit suicide in this country. We know that we can compare ourselves to countries such as New Zealand and Australia in terms of looking at this issue. I wonder whether Dr. Goldbloom or anyone else, maybe Mary, can talk a little about what we can do to deal with that particular...because it's not as simple or as generic as if we were looking at other solutions for preventing suicides. I would like to hear somebody talk a little bit about the effective things one can do. There is a federal government program—we know that—and the question is whether it is working. If it isn't working, why is it not working? What are the specific initiatives we need to undertake to deal with this?

The other issue I want to talk a lot about, which no one speaks to, or which is only now beginning to come to the surface, is post-traumatic stress disorder, especially amongst our veterans. This is an issue I would really like us to touch on to consider how we can prevent it from happening. In many ways, if you want to prevent post-traumatic stress disorder in our veterans, the point is not to send them to a theatre of war, which is where they meet all those things. We know that isn't really a very practical solution.

What are the things that we can do, in those two groups, to address this particular issue and the specific problems that they face?

● (0930)

The Chair: Who would like to take that question?

Mr. Harold Albrecht: Could I just make a quick comment on it?

This is simply to point out that I intentionally did not include specific, identifiable groups within the bill, because the minute you do that, there's a potential that you've left out another group. If I identified the veterans, if I identified our police who are on the front lines, if I identified men over 55, inevitably there would be some group omitted.

In fact, my previous profession of dentistry has the dubious distinction of having the highest suicide rate among Canadians. We specifically didn't include that.

My idea is that as a framework is developed, as people such as the Mental Health Commission work on it, they will drill down deeper and get at the specifics.

But thank you for raising this. I did acknowledge it in my opening comments.

Hon. Hedy Fry: Yes, I actually am not commenting on whether you put it in or not, but am asking about those two specific—

Mr. Harold Albrecht: Right. I just wanted to point out that some have asked why it isn't there.

I defer.

Dr. David Goldbloom: Thank you.

As I mentioned earlier, one of the eight advisory committees to the Mental Health Commission is its first nation and Métis advisory committee. This issue has been very much front and centre both at the advisory committee level and also on our board, in which Manitok Thompson from Nunavut and Madeleine Dion Stout from Vancouver provide very significant first nations and Inuit voices at the commission.

I mentioned earlier mental health first aid. We are in the process of completing an adaptation of this that is specific to indigenous populations because of the elevated risk for suicide, recognizing that there are many social determinants of health and illness that play out in particular for our first nations, Inuit, and Métis people.

With regard to the military, we have had tremendous input from Lieutenant-Colonel Stéphane Grenier in the area of post-traumatic stress disorder and peer support, which has been a very powerful force within the Canadian armed forces. We have been developing, for the civilian population, a peer support initiative to help people that draws very heavily on the military experience, much as they have in the United States. The United States Air Force suicide prevention program is one of the finest in the world and draws heavily on the peer support element.

If I may, I'd like to ask Mary Bartram to comment specifically on the mental strategy with respect to these two issues.

Ms. Mary Bartram (Director, Mental Health Strategy, Mental Health Commission of Canada): Specifically on first nations, Inuit, and Métis suicide prevention, the mental health strategy will include a significant focus on the mental health issues of that population. The focus is on contextualizing that in the context of residential schools and the impact of colonization. The Truth and Reconciliation Commission, which is under way right now, is an important point of reference for this committee as well.

There's improving access to a full continuum of services for mental health problems that integrates the best of mainstream and traditional and customary knowledge from first nations, Inuit, and Métis traditions. Also, there's the importance of governance issues. There's been research undertaken around the importance of communities having governance over their own services and so on. The most clear findings from the research community around the importance of supporting communities to have governance over their own services and institutions is another critical part that will be brought forward in the mental health strategy.

We'll certainly be making those recommendations for uptake, and recognizing the ways in which a national mental health strategy in this country has to include a strong focus both on the contributions and the needs of that population group.

The Chair: Thank you so much.

Mr. Strahl.

Hon. Hedy Fry: How am I doing for time? Have I finished my seven minutes?

The Chair: You're out of time, Dr. Fry, but thank you for those good questions.

Mr. Strahl.

● (0935)

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you very much, Madam Chair, and Harold, and to the witnesses. This is certainly, as my colleague said, something that touches us all, and something I'm sure we could talk about for quite some time.

I'm going to focus on a couple of things, and make some comments, maybe. I think one of the keys, as we talk about mental health, is reaching out to people who perhaps are falling through the cracks. As much as we look inward here, people aren't likely to be following House of Commons debates, or going to read the report that comes out of the standing committee, or even the Mental Health Commission's report.

That's why I was so encouraged—again, as popular as Libby and Hedy may be in Vancouver—to see the Vancouver Canucks, and specifically one of the big rugged defencemen, Kevin Bieksa, promoting mindcheck.ca, which is a kind of tribute that the organization has launched as a result of the death of Rick Rypien. As a professional hockey player, you'd think he had everything going for him, but he took his own life after many years of struggling to overcome depression.

I just wanted to salute them and encourage people to check that out. It's pretty powerful to see them. You think of these professionals as being tough and having everything going for them. They lay it out there for Canadians and say, it doesn't mean you're weak. It doesn't mean you're not trying. Anyway, anyone who's seen that message will be very touched by it.

We talked about gatekeepers a little bit.

Harold, you and I share the same faith background. I say this with some trepidation, but I know one of the concerns I've had, as someone who is of the Christian faith, is that there are times when our leaders take away the physiological aspect of this, and where people I know have gone to their church leaders, and it's been, you're a little bit weak spiritually. The term that I've heard, even in non-religious circles, is about battling demons. I react very strongly to that. This is a medical condition, and often folks in every walk of life see it as something other than that.

I guess that brings me to my question. Another concern I have is that people who have a mental illness, at least the ones I've been close to, are constantly doing everything they can to get away from the medication. They've been diagnosed. They've been given treatment options. But as opposed to something like diabetes or high blood pressure, where you just say, I'm going to have to be medicated for that, I think there's this stigma where people are running away from the treatment options they've been given.

Perhaps someone could address this. Is that a problem? Is that widespread? Is that just something I've heard anecdotally? What is being done to educate people that you work as hard as you can, but for some folks, they just need to accept the fact that they're going to have to accept the help that's been given to them?

I'm sorry about that rambling intervention.

Ms. Tana Nash: Thank you for that. I was just going to make a couple of comments.

I really think it goes back, first, to the stigma. Using the medical example, diabetes or any other physical illness that requires us to take medication seems to be easier to swallow. We still need to continue to educate in our communities across Canada and get that message out there that it's okay, that this is an illness.

You're right. I think because of the stigma, people don't want to take medication. Sometimes it's because they don't want to admit that they have a mental health issue, because we kind of put it that way as Canadians. We need to say that it's okay. It's okay to have depression. You didn't ask to have depression, anxiety, or bipolar disorder, just as you didn't ask to have cancer or any other physical illness. We need to keep that message coming forward.

Just as a tie-in, because you were talking about that stigma, I'll give you an example. A high school in our region recently did a whole campaign in support of this bill. They decided to have a suicide prevention day and sign a petition for this bill, and just talk about it. The peer advisor that led this came to me and said that because of that day, four students came forward who said that they had been struggling with suicidal thoughts and that because we had made it open and possible for them to talk about it, they had now reached out to counselling and support and were getting the help they needed. There were four individuals, because we had that day of breaking down those stigmas.

I really think that's the first step.

● (0940)

Mr. Harold Albrecht: Could I just make a comment about your notice about the public people who are being upfront about their struggle? You mentioned a player from Vancouver. I'll betray my age and say that Ron Ellis, a former teammate of Paul Henderson, also is very public about his struggle.

Back to your point about the issue of just over-spiritualizing, if I can use that word, I totally agree with you. I was very careful in the crafting of this bill to have it be one of the key components, which acknowledges the complexity of it. You and I know, and everyone around this table knows, that many theologians we look up to have been open about their struggles with depression. They did not over-spiritualize it in the sense that, yes, it is biological and psychological and physiological. Thank you for pointing that out.

The Chair: Thank you so much.

Thank you, Mr. Strahl.

We're now going to have to go on to the second round. We're going to have time, actually, for just one question in the second round, so that we can bring in all those other witnesses who are waiting so patiently to testify.

I will begin with Ms. Quach.

[*Translation*]

Ms. Anne Minh-Thu Quach (Beauharnois—Salaberry, NDP): Thank you, Madam Chair.

I appreciate the opportunity we have been given to delve deeper into the issue of suicide with the help of our witnesses.

I have a number of questions. I will start with Mr. Goldbloom and Mr. Albrecht.

In your strategy and your vision for the policy framework—

Dr. David Goldbloom: Forgive me, but I cannot hear you very well. Just a moment, please.

Okay, that's better.

Ms. Anne Minh-Thu Quach: First of all, did you look at the possibility of working on social determinants of health as a way to reach to society's most disadvantaged and vulnerable populations? I am talking about isolation, poverty, housing difficulties and any other factors that might exacerbate depression or distress?

Second, did you look at the possibility of building on and promoting the efforts being made by streetworkers, those working at the ground level and who are very likely to come into direct contact with individuals experiencing problems that stem from social determinants of health?

Dr. David Goldbloom: I hope you won't mind if I answer in English.

Ms. Anne Minh-Thu Quach: Not at all.

Dr. David Goldbloom: Okay, thank you.

[*English*]

I think if you look at the At Home/Chez Soi project, it started with a group of Canadians who face the most extreme social deprivation. They are people who are living under bridges and are experiencing mental illness, substance abuse, extraordinary poverty, and profound social isolation. Our first major initiative in that regard, the $110 million the federal government gave us to fund the At Home/Chez Soi initiative, was a good example of how we can provide an innovative approach through housing to improve mental and physical health, and other manifestations of quality of life for people who have severe mental illness.

That project is now being replicated in France and is being studied around the world. I think there is also going to be learning from that for other Canadians, beyond the five cities. When we talk about mental health promotion and prevention, certainly within the context of the national strategy, the social determinants of health receive significant attention.

Mr. Harold Albrecht: I would just like to respond.

The very essence of Bill C-300 is to utilize the good work that's already occurring on the front lines, whether it's the Waterloo Region Suicide Prevention Council, Canadian Association for Suicide Prevention, or myriad groups across the country that are already doing good work. The real heart of what Bill C-300 is doing is trying to bring these groups together, provide resources for them, and have them share what they're already doing so that the best practices can be shared. I think you've hit at the very heart of what my bill tries to do.

● (0945)

Dr. David Goldbloom: If I can add one comment, it is that most adult Canadians with mental illness are in the Canadian workplace, and that's why one of our foci has been the Canadian workplace.

We're about to release the standards for psychological safety in the Canadian workplace. This is unprecedented internationally. We're very good at providing people with helmets and steel-toed boots for physical safety in the workplace, but the reality is that, in our postmodern economy, it's our above-the-neck capacity that contributes to our productivity, and it's mental illness that creates profound disability and cost to the Canadian workplace and economy. So these psychological standards are going to be quite revolutionary when they come out very shortly.

[*Translation*]

Ms. Anne Minh-Thu Quach: Thank you.

I am going to hand the floor over to my colleague Dany Morin, who has a question for Mr. Goldbloom.

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Mr. Goldbloom, members of the GLBT community are known to have a higher risk of suicide than the general population.

Could you tell us about any strategies that you have put in place at the Mental Health Commission of Canada to target this specific population?

[*English*]

Dr. David Goldbloom: Thank you.

This is actually an identified subpopulation within the mental health strategy, precisely because of what you have identified, that this is a population we recognize to be at higher risk at certain vulnerable periods in their lives to depression, and to suicide.

Mary, I don't know if you want to comment at all about the acknowledgement of the LGBT community within the mental health strategy.

The Chair: I'm sorry, but we're out of time. Perhaps Dr. Morin could pick up on that question with our next group. We've gone a little bit over time, actually, so I think we'd better just hold it there.

I want to especially thank MP Harold Albrecht, who has brought this very important bill forward. It's an honour to have you on this committee. Thank you.

Thank you to all the people here. It is really heartening to hear about all the great work you're doing on this very important issue.

I'm going to suspend for one minute. For those of you in the audience, we have a very big panel coming next. I would ask two things of the committee, please. Any conversations you might want with the people who are sitting here, please do them outside the door. We're short of time. We have a very big panel coming on, and we want to make sure this bill is addressed properly.

I'm going to suspend for one minute and ask the new witnesses to come forward so that we can begin the testimony right away.

Mr. Harold Albrecht: Can I just say thanks, Madam Chair, to the committee for giving this three full days of study? I really appreciate that. I'll say at the same time that it's going to move quickly into the next stages.

The Chair: Thank you.

The meeting is suspended.

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——————— (Pause) ———————

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• (0950)

The Chair: I would like to resume the committee meeting, so we have sufficient time to hear all our very important testimony from our witnesses.

I want to welcome the witnesses here today to speak on Bill C-300. We're very much looking forward to your very insightful wisdom.

From Health Canada, we have Ms. Kathy Langlois. Thank you. We have from the Public Health Agency of Canada, Ms. Marla Israel. Welcome. Via video, we have Ms. Janice Burke. Ms. Burke, can you hear me clearly?

Ms. Janice Burke (Senior Director, Strategic Policy Integration, Department of Veterans Affairs): Yes, I can. Thank you.

The Chair: Great. Thank you.

I must tell you this, as we're doing a video conference. You will be giving your presentation, but during the questions and answers, if you want to make a comment, please just raise your hand so I don't miss you, because we want to make sure we get all your input as well.

Ms. Janice Burke is with Veterans Affairs from Prince Edward Island, coming via video conference, of course. She's the senior director of strategic policy integration.

From the Correctional Service of Canada we have Ms. Jennifer Wheatley. Where's Ms. Wheatley? There you go. I can barely see your name over all these TVs. Welcome, Ms. Wheatley. You're the director general of mental health.

From the Department of National Defence, we have Colonel Rakesh Jetly, the mental health advisor. Welcome. We have Lieutenant-Colonel Suzanne Bailey, the national practice leader for social work and mental health training. Welcome, as well.

Colonel, will you be the one who is going to be giving the presentation?

Col Rakesh Jetly (Mental Health Advisor, Directorate of Mental Health, Department of National Defence): I'm giving the opening remarks.

The Chair: Thank you.

I understand that the speakers have all gotten together and have a certain order they want to speak in. Is there a reason for this?

Ms. Marla Israel (Acting Director General, Centre for Health Promotion, Public Health Agency of Canada): No, not at all. With respect, it's just because the Public Health Agency has been involved in a lot of upstream promotion efforts, so there was a sense of having the Public Health Agency start. That's all.

The Chair: Okay. Well, I've just been informed of this. It's fine with me. It's kind of nice to know a little ahead of time so we can get started.

We'll start with PHAC, the Public Health Agency.

Ms. Israel, go ahead.

Ms. Marla Israel: Thank you very much.

Thank you so much, Madam Chair and honourable members, for the opportunity to discuss the important topic of suicide prevention.

[*Translation*]

In my remarks today, I will provide a brief overview of suicide prevention and the actions taken by the Public Health Agency of Canada to address suicide and mental health promotion. I will also highlight the work currently being done by Health Canada on suicide prevention in First Nations and Inuit communities, as well as the research efforts of the Canadian Institutes of Health Research in mental health promotion and suicide prevention.

I am pleased to be here with Ms. Langlois, who will answer questions later.

[*English*]

Of course, my federal colleagues are here as well, and we'll be happy to speak to their issues.

Suicide, suicidal thoughts, and suicidal behaviours have devastating impacts on families and communities across the country. Probably the hardest issue to confront after a child, a friend, or a parent has taken his or her own life is the feeling of disbelief that a person could feel so terribly alone with their pain and suffering that the only way out is ending their life.

Through this bill and the efforts of the Mental Health Commission of Canada, media, stakeholders, parliamentarians, etc., the issue of suicide and the importance of positive mental health at earlier ages and stages is being confronted head-on. All of us—families, caregivers, levels of government, and community leaders—have a role to play in preventing suicide and in reaching out to individuals, families, friends, and communities who are struggling with this issue.

● (0955)

[*Translation*]

The statistics are telling. Canada has a suicide rate of about 11 people per 100,000. Approximately 3,700 individuals take their lives each year. In general, boys and men commit suicide at a rate 3 to 4 times greater than girls and women. In addition, suicide is not just a problem for the young. Older men, for instance, have particularly troubling rates of suicide.

Further, for certain populations within Canada, rates of suicide are disproportionately high. This includes Canada's aboriginal population. While some communities, thankfully, have little experience with suicide, others struggle on a daily basis. Suicide accounts for 22% of all deaths among First Nations youth 10 to 19 years of age, and 16% among First Nations adults aged 20 to 44 years. The suicide rate in regions of Canada with a high proportion of Inuit residents is approximately 11.5%, which is 6 times higher than for the rest of Canada.

[*English*]

From a public health perspective, suicide prevention begins with a solid foundation of positive mental health—resilience, solid relationships, sound parents, positive self-esteem, confidence in oneself, and good supports. Initiatives that begin early in life and encompass a person's whole environment will reap solid rewards later in life, when stress is high and when anxiety and depression take shape.

I would like to take a brief moment to highlight the efforts under way in the health portfolio to address suicide prevention. Activities at the Public Health Agency employ a population health perspective to promote healthy living and to understand the issues that can lead to poor mental health, including suicide.

Our work promotes public health prevention and promotion. We work with provinces and territories and with Statistics Canada to provide surveillance information and reports such as “A Report on Mental Illnesses in Canada”. We provide grants and contributions to researchers, academics, and community organizations to better understand interventions that may serve to prevent suicide at later stages. We deliver children's programs that are heavily focused on creating a better start and being better able to confront the transition to the school setting.

Approximately $114 million is spent on the Canadian prenatal nutrition program, the community action program for children, and the aboriginal head start program in urban and northern communities. As well, $27 million goes towards the innovation strategy, which contributes to the development of protective factors for improving the health of children, youth, and families.

In an effort to promote mental health and prevent suicide among seniors, the agency funded the development of the first evidence-based national guidelines on seniors' mental health, which are used to address a number of mental health issues, including depression and suicide prevention. Also, of course, we collaborate with provinces and territories.

[*Translation*]

The First Nations and Inuit Health Branch of Health Canada works closely with its partners to support First Nations and Inuit communities, investing $245 million per year in community-based programs and services associated with the mental wellness of First Nations and Inuit. Culturally based, community-driven programming is a significant contributor to positive health outcomes among First Nations and Inuit communities, families and individuals.

[*English*]

In specific response to the challenge of youth suicide amongst Canada's aboriginal peoples, in 2005 the aboriginal youth suicide prevention strategy was launched with an investment of $65 million over five years.

The strategy was renewed in 2010 with an investment of $75 million over an additional five years. The strategy supports first nations and Inuit families in over 150 communities to prevent and respond to youth suicide. The national anti-drug strategy is contributing to protect youth and families against the harmful effects of illicit drug use, with $9.1 million annually to improve access to quality addiction services for first nations and Inuit.

The Canadian Institutes of Health Research is increasing our understanding of suicide, helping to build the knowledge base as well as the capacity to respond more effectively by providing resources, treatment, and supports. With over $315 million since 2006, of which $25 million has been specific to suicide prevention research, it has allowed a significant contribution to scientific knowledge.

The work of the health portfolio is not, however, the only work of the federal government in this domain. Next you will hear from colleagues at the Canadian Forces, Veterans Affairs, and Correctional Services, about the work they are doing to advance the promotion of positive mental health and to prevent suicide for the populations they serve.

Bill C-300 serves as a useful instrument to promote dialogue, education, and awareness among federal partners. The potential development of a federal framework on suicide prevention will also carve the way for greater federal integration of initiatives, programs, and services, and will assist in greater collaboration among partners.

To conclude, the health portfolio is committed to contributing its expertise and knowledge toward the prevention of the loss of life to suicide and to help those impacted by it. Our efforts continue through partnerships and in collaboration with others to make a difference in the mental health of Canadians.

We look forward to the outcomes of this parliamentary process.

● (1000)

The Chair: Thank you very much.

Ms. Israel, I understand that you had amalgamated with Health Canada, so I want everyone to know that Ms. Kathy Langlois is an expert in first nations and Inuit health. So during question period, at least, they can zero in on her.

Thank you so much for this direction and for your insightful comments.

Now we'll go via video to Ms. Janice Burke, Veterans Affairs. She can begin now.

Thank you.

Ms. Janice Burke: Thank you, Madam Chair and honourable members. I thank you as well for inviting me to discuss the very important subject of suicide prevention. In my remarks today, I will provide an overview on the issue of suicide in our veteran population and address suicide prevention efforts under way at Veterans Affairs Canada.

Canada's veterans and their families are not immune to the problem of suicide. With the increased tempo of military operations in the 1990s and onward, Canadian military personnel veterans have been deployed to hot spots around the globe and have been increasingly exposed to operational stress, which has led to mental health problems on the part of some.

Of the approximately 700,000 veterans in Canada, more than 200,000 are Veterans Affairs clients. Most telling is that since the year 2000, the number of individuals who have received a disability benefit for a mental health condition has increased from 2,000 to approximately 15,000. Of those, 71% are receiving benefits related to post-traumatic stress disorder, and 17% have served in Afghanistan.

Determining accurate suicide rates in the Canadian veteran population is difficult. Because of the stigma, it is under-reported. But I think we can all agree that one suicide is too many, and research indicates that veterans are vulnerable. Suicide prevention is a challenge for all involved in mental health treatment and prevention.

In an effort to be more informed on the issue of suicide in the military and veteran population, Veterans Affairs Canada and National Defence recently requested that veterans, as well as Canadian Forces members, be highlighted in the cancer and mortality study conducted by Statistics Canada. Released on May 31, 2011, this study analyzed mortality data for CF members and veterans who enrolled in the Canadian Forces between 1972 and 2006.

The study reported that persons with a history of military service, who enrolled between those years, had the same overall risk of suicide as the general population. However, released male veterans had a 1.5 higher risk of suicide than men in the Canadian population. Released female veterans had the same overall risk of suicide as the general female population.

The problem of suicide is complex and multifactorial. We work closely with National Defence to ensure an effective transition from military service to civilian life, and intervene early with injured or ill releasing members. This early intervention is greatly aided by the recent co-location of Veterans Affairs and National Defence staff at integrated personnel support centres located on or near major CF bases.

Every releasing member participates in a transition interview, often with their family included, to help identify needs, both physical and mental health, related to their re-establishment in civilian life. We connect them to a range of programs and services available from Veterans Affairs Canada as well as from provincial governments and community organizations.

The new Veterans Charter was implemented in 2006 to help meet the transition needs of releasing Canadian Forces members and their families. It provides individualized programs and services designed to support their wellness, and physical and mental health, including suicide prevention. Its features include a focus on the achievement and maintenance of wellness for the veteran and his or her family; provision of comprehensive medical, psychosocial, and vocational rehabilitation; application of modern disability management principles; provision of disability benefits for service-related injuries; and a whole suite of programs and services supported by individual case management and mental health services.

Veterans Affairs Canada's mental health strategy focuses on promoting the mental health and recovery of veterans and their families. Its goals are to ensure access to a comprehensive continuum of programs and services to meet the mental health needs of veterans and their families, to build capacity across the country to provide specialized care to veterans with mental health conditions, and to strengthen the role of Veterans Affairs as a leader in the area of mental health.

It is based on determinants of health such as economic, social, personal, physical, and health services, and promotes positive veteran and family well-being. These include case management for clients with client needs. We have a specialized network between Veterans Affairs and National Defence, with 17 mental health clinics across the country. We have a crisis 24-7 assistance service to provide short-term, professional counselling. We have a specialized clinical care manager service, which makes a professional clinician —psychologist, nurse, or occupational therapist—available when and where needed for at-risk clients and clients with complex mental health needs.

In terms of VAC's initiatives in the area of suicide, we have been very active in suicide prevention among veteran clients.

● (1005)

Together with the Canadian Forces we share an integrated suicide prevention approach. The VAC suicide prevention framework that was implemented in 2010 is an evidence-based suicide pathway framework for suicide prevention at VAC, developed by both VAC and CF health services. It includes components such as knowledge exchange to raise awareness of VAC mental health services and supports, and how to access them, and improvements in screening, assessment, and crisis intervention. Front-line staff situated in 60 points of service across the country have been trained in suicide intervention using the applied suicide intervention skills training model.

Protocols consist of cues for referral and suicide screening questions. They're also in place for front-line staff to assist veterans and other clients who may be at risk of suicide.

The Chair: Ms. Burke, your time is just about up now.

Can you conclude, please?

Ms. Janice Burke: Sure.

Essentially, we also have a number of social supports in place. Our programs are also geared to overcoming barriers to care. This means we have a lot of collaboration with other government departments, non-government associations, and community agencies.

The Chair: Thank you very much, Ms. Burke.

That's very useful to know. If you can submit your paper to the clerk, we can get it translated and distributed to the members. I'd really appreciate that.

We will now go to the Department of National Defence with Colonel Jetly, please.

Col Rakesh Jetly: Thank you very much for this opportunity to speak on Bill C-300.

Lieutenant-Colonel Bailey and I represent the Canadian Forces, more specifically, Canadian Forces health services.

The CF has placed a particular emphasis on suicide prevention for many years. In the interest of time, we'll limit our discussion to current efforts.

As already discussed today, suicide is a public health problem and a major cause of death among young people in western societies. The Canadian Forces rate has remained consistently below the age-match rate within Canadian society; however, the CF position remains that even one life lost to suicide is one too many. We grieve the loss and, as an organization, ask out loud, “Could we have done more?”

In September 2009, the Canadian Forces hosted an international expert panel on suicide prevention in military populations. In addition to our own internal experts, we consulted experts from academia, and from allied military such as those of the U.K., U.S., Australia, and the Netherlands. We have brought copies of the expert panel report, in English and French, and could make PDF versions available if necessary.

The overarching recommendation of the panel was that effective suicide prevention must indeed focus upstream with the effective treatment of mental illness. The three cornerstones or pillars of an effective mental health suicide intervention program are excellence in mental health care; leadership; and an engaged and aware military population or any population that one is dealing with.

To expand on the above, we continue to strive toward a mental health treatment program that is second to none. This means timely access to multidisciplinary expert care, evidence-based treatments, no co-payments for medication, and no limits on interventions such as psychotherapy, provided they are clinically indicated.

We also continue to implement measures to enhance early identification and treatment in primary care settings of conditions that are known to contribute to suicide.

The unique role of leadership in the Canadian Forces context cannot be understated. For example, the leader-subordinate relationship in the CF is much more than employer-employee. As well, leadership is responsible for all aspects of a member's well-being, including provision of their health care.

Leaders ultimately create and fund health systems, but more importantly, they create a workplace climate conducive to judgment-free discussion about mental health issues, including suicide. Many of the barriers that may have discouraged care-seeking in the past can be overcome through effective leadership. This idea is best exemplified by the current CDS's “Be the Difference” campaign in which he has charged all CF leaders to be facilitators and partners in the mental health of soldiers. He essentially reminds us that mental health is everybody's business and responsibility.

The third cornerstone involves ensuring that the CF members themselves are provided with sufficient information to recognize when they or someone else may be struggling, and that they know when and where to seek help if required. We provide education and training throughout the career and deployment cycles, starting at the recruit level, for both Canadian Forces personnel and their families in order to give them the tangible knowledge and skills to help themselves, to seek care, and to help their peers.

Many other specific topics and recommendations are discussed in the reports including the fact that since April 2010 we have begun what we call a medical-professional-technical review of every suicide, for which we will send a senior mental health professional and a family physician to the site of the suicide, and on behalf of the Surgeon General, do a detailed review of the circumstances surrounding the event. Those include the mental health of the individual, any care that was provided, workplace circumstances, and other stressors.

This process provides us important lessons learned from every single suicide that occurs within our organization, and this new and valuable process will give us near-immediate feedback and identification of any trends that emerge.

There were 61 recommendations in the report. I'll highlight just two of them. We also have ongoing concerns regarding the responsible reporting of suicides in the media, and we take every opportunity to educate reporters and journalism students on the very real risks of contagion and imitation with regard to the reporting of suicides.

To conclude, the Canadian Forces is committed to contributing its expertise and knowledge towards the prevention of the loss of life to suicide, and to helping those impacted by it. Our efforts continue through partnerships and in collaboration with others to make a difference in the mental health of Canadians. We look forward to the outcomes of this parliamentary process.

Thank you.

● (1010)

The Chair: Thank you so much, sir, for your input.

We'll now go to Ms. Wheatley from the Correctional Service of Canada.

Ms. Wheatley, I notice that your presentation is very long. You're going to have to compress it a bit.

Mrs. Jennifer Wheatley (Director General, Mental Health, Correctional Service of Canada): Yes, we've cut it down.

The Chair: Thank you. Please, begin.

Mrs. Jennifer Wheatley: Good morning, Madam Chair and honourable members of the committee. I'm very pleased to have the opportunity to speak to you today about the ways in which the Correctional Service of Canada has undertaken a multifaceted approach to suicide prevention.

CSC employs over 19,000 employees across the country in 57 institutions, 16 community correctional centres, and 84 parole offices to keep our citizens safe. On an average day, we're responsible for over 13,000 federally incarcerated inmates and 8,700 offenders in the community.

In accordance with the Corrections and Conditional Release Act, CSC provides inmates with essential health care, including reasonable access to non-essential mental health care that will contribute to the rehabilitation and successful reintegration into the community.

Improving our capacities to address the mental health needs of offenders is a key priority for CSC. As part of our overall mental health strategy, which was approved in 2004, CSC's approach to suicide prevention includes staff training and education, suicide prevention information for inmates, screening, assessment, monitoring, treatment, and reviews. I'll just briefly expand on a few of these.

CSC front-line staff are provided with initial and ongoing suicide prevention training in order to help them recognize and intervene appropriately for offenders at risk for suicide. In addition, we provide suicide prevention information and reference materials to inmates, which includes access to the inmate suicide awareness and prevention workshop. This workshop assists inmates in recognizing the signs and symptoms of suicide and promotes the services and supports available to them.

Moreover, CSC has a comprehensive screening process to identify inmates at risk for suicide. This includes, at intake, five separate screening processes to identify those who are at an elevated rate. It includes an initial screening while offenders are still in provincial custody, screening within 24 hours, a preliminary nursing assessment within 24 hours, a comprehensive mental health screening within 14 days, and a more comprehensive nursing screening within 14 days.

CSC is also embedded in policy based on best practices, such as the requirement to formally screen any time there's a significant change in the offender's status, such as transfer to a new institution or admission into segregation. Inmates identified at risk for suicide are referred to a mental health professional for a more indepth assessment. If a mental health professional is not immediately available, the inmate is monitored in person until a mental health professional can assess the level of risk and appropriate interventions.

Based on best practice literature, CSC has standardized monitoring in communication protocols, while still allowing for appropriate clinical judgment. This helps support an interdisciplinary approach to the management and intervention of inmates at risk for suicide.

Inmates identified at risk are provided with treatment appropriate to their level of need. This could include what's commonly referred to as outpatient treatment in the community, where they receive services and treatment from a mental health professional in their institution. Or it could include in-patient treatment at one of CSC's five treatment centres. The service has five treatment centres, which are all independently accredited health care facilities for the treatment of our most acutely ill inmates. We also have a partnership with Institut Philippe-Pinel, a psychiatric in-patient facility in Quebec.

Finally, CSC investigates the circumstances surrounding all inmate suicides in order to learn and help prevent further suicides in the future.

Recognizing that more needs to be done, in 2008 CSC joined with other provincial and territorial correctional jurisdictions to collaborate in the area of mental health. Mandated to develop a mental health strategy for corrections in Canada, one of the key areas of focus for this group includes reviews and best practice recommendations to prevent suicide and self-injury in correctional environments.

In closing, CSC recognizes that even one inmate suicide is too many. As an organization, we are continuously looking to enhance our prevention and intervention strategies to respond to the issue of inmate suicides through the integration of best practices, collaborative partnerships, evidence-based interventions, and investigations into all incidents.

Thank you very much.

● (1015)

The Chair: I have to congratulate you. You organized yourselves so well. This is a chairperson's nightmare, to get everybody's testimony in. I want to thank you for that pre-organizational method you used. I caught on really quickly as I got the pattern. Thank you very much for doing that because everything you did was very logical, and we have the maximum amount of information now that we can start with.

We're now going into our first Q and A. This a seven-minute round with both the Q and A encompassed in that.

Ms. Burke, again, if you want to say something, raise your hand, please, so I don't miss you. Thank you for helping me out.

Dr. Morin, you're first.

[*Translation*]

Mr. Dany Morin: Thank you very much for your presentations.

I have a number of questions. The first one is for Ms. Burke.

When I was first elected, a veteran and his wife paid me a visit at my office. The veteran was in his forties and had tried to commit suicide a few weeks prior. He came to see me because he was at the end of his rope. He had suffered a serious accident while on a mission abroad and was living with a disability. When he told me his story, he talked about the blatant lack of compassion from the officer handling his file, the trouble he had getting the department to reimburse him for numerous medical expenses and the debilitating disability that had pushed him into trying to end his own life.

My question is a general one. What tangible measures are you taking to ensure that veterans are not pushed to the breaking point and that Veterans Affairs does everything in its power to help them, instead of being uncompassionate as was the case with this veteran?

[*English*]

Ms. Janice Burke: Thank you for your question.

I'm actually very concerned with the case that you just described. I can assure you that at Veterans Affairs Canada our front-line staff and case managers are very knowledgeable and passionate staff, and are very aware of the many complex issues that our veterans experience, as well as the impact that has on families.

Essentially, what our strategy is in working with the veterans is to ensure that we have early intervention. We begin that at the point of their transition from military to civilian life. We ensure that we meet with every veteran who is transitioning. We include the family in that interview. We work with them to put case management plans in place to ensure that their benefits are in place when they release, so that there's a continuity of support and there are no gaps in their treatment.

We work very closely with them in terms of their care plans and in the rehabilitation program. We have a number of operational stress injury clinics across the country where our veterans get very quick access to psychologists, psychiatrists, and social workers. In addition, we have a peer support program. What we find is that sometimes, because of stigma, our veterans are not coming to programs that would benefit them.

We have a number of peer support coordinators, who have lived the experience of mental health conditions, working with veterans and getting them into our programs. When they are in their programs, care is provided for all of their health care needs, whether it's treatment for mental health or physical conditions. We certainly work closely with them. Across the country we have over 200 case managers who provide that dedicated service.

In conclusion, certainly the case you describe concerns me greatly. If cases like this arise, please to not hesitate to contact our district office immediately. We will definitely have our case managers look into that.

● (1020)

[*Translation*]

Mr. Dany Morin: Thank you very much. I appreciate your answer.

My next question is for the Health Canada and Public Health Agency of Canada officials.

When the previous group of witnesses appeared, I asked about the GLBT subpopulation, which has a higher risk of mental illness and suicide than the general population. Could you describe the specific actions being taken or the department's current approach to target this specific population?

Ms. Marla Israel: Thank you for your question. It is an extremely important concern. Right now, we are continuing to study the risks that exist within vulnerable populations. One of the biggest challenges when it comes to the gay and lesbian communities is the stigma that is often attached. I think we can help vulnerable populations, especially youth.

One of the Public Health Agency of Canada's projects targets students and focuses on the importance of preventing bullying. This has always been the case; the reality is that gays and lesbians often exist in silence. That is something that must be addressed in schools particularly.

The agency is also working with the Douglas institute in Montreal, which is developing a method that can be used to gain insight into vulnerable populations and to determine what distinguishes people who have the skills to cope from those who do not. Does the agency understand the challenges? We are continuing to study them so we can come up with projects and methods to help vulnerable populations like the gay and lesbian community.

Mr. Dany Morin: Thank you.

Ms. Quach has a brief question.

[*English*]

The Chair: I'm sorry. We're out of time now.

Thank you. And thank you for the question, Dr. Morin.

We have to go to Ms. Block.

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): Thank you very much, Madam Chair.

I would like to welcome all of you here today.

I also want to take the opportunity to acknowledge and congratulate our colleague Mr. Albrecht for introducing Bill C-300. He has been a relentless advocate on this issue. In fact he started with motion 388 in the last Parliament.

I'm not sure, but I don't think he mentioned today that he was also a founding member and co-chair of an all-party parliamentary committee on palliative and compassionate care. It studied four different areas, one of them being suicide prevention. Last fall that group managed to introduce their report called “Not To Be Forgotten”. I encourage you to take a look at it, and specifically at the chapter on the work you're doing.

Today when Mr. Albrecht was here, he mentioned he was intentional about not identifying any one particular group in his bill. As we can see here today, we have many different groups represented. So perhaps there's an understanding that strategies can transcend age and context, while recognizing the unique challenges you face within the different areas you are representing.

I am a member of a family that has survived suicide. It was many years ago—24 years ago, in fact. I lost my youngest brother. It was his third attempt. As family, obviously there was something we did not access or that was not available to us to try to work through what might have been creating this need in him, and certainly he did end up taking his own life.

Ms. Israel, I want to focus on something you mentioned earlier in terms of framing the issue. You said, “Suicide, suicidal thoughts, and suicidal behaviours have devastating impacts on families and communities across the country.” Then you stated, “All of us—families, caregivers, levels of government, and community leaders—have a role to play in preventing suicide and in reaching out to individuals, families, friends....”

I know you are actively working on strategies to help avoid the risk factors for suicide in children, and that you have developed national guidelines for seniors. I'd like to give you an opportunity to speak to both of those.

Also, if there's anything you are working on in terms of providing assistance to families who are survivors of suicide, would you speak about that as well?

● (1025)

Ms. Marla Israel: Thank you so much for the question, and thank you for sharing your story. I think it's important for us, as officials, to never lose sight of those stories. It's what guides our work.

Let me start with the second half of your question, which was about specific care for families when it comes to those surviving suicides. Unfortunately, we're not, to my knowledge, working on something specifically for families, per se.

One of the things you mentioned was the population spectrum. You are dealing with children and their needs, and seniors and their needs. It's interesting, because yesterday, the researcher at the Douglas Institute in Montreal, who is working with us on this study on the diagnostics, was telling me that in the course of his research he's come to find out that the most important thing to be looking at is how you parent and how you recognize those signs you were talking about. Many of us take it for granted that we would be able to recognize those signs. But even physicians in primary care, and even teachers, for example, who spend so much time with children, don't necessarily, or wouldn't necessarily, recognize those signs.

Our efforts are around working with researchers, and working with parents and their children. Much of the work being done through grants and contributions is in the community setting. They are pilot-testing initiatives that look at better resilience, and at better relationships and how you forge relationships. Even something like social skills can provide a child with better resilience when confronting something later on in life.

With seniors, for example, the challenges are a bit different. Seniors experience isolation. There, again, primary care providers may take it for granted that a person is an adult and is responsible, and should be okay to manage his or her own health at that age. On a personal note, my mother, for example, is experiencing a lot of challenges in her eighties. The Public Health Agency developed a series of guidelines on seniors' mental health for physicians. They are on recognizing the signs and on the means for intervening appropriately and sensitively but nevertheless firmly, so that people are not left feeling that they're alone and unable to confront the challenges in their lives.

● (1030)

The Chair: You have one minute.

Mrs. Kelly Block: Okay. I guess I just want to reflect, again, on what I shared and the fact that I think perhaps what might have guided our lack of action with my brother, although it might have been subconscious, was the stigma around suicide. I know that I said this happened 24 years ago. I'm just wondering if any one of you would be willing to comment on how far we've come since that point in time. I think you all also mentioned stigma.

Ms. Marla Israel: I'll start. On stigma, I think the efforts of the Mental Health Commission in their anti-stigma campaign, have gone quite a ways to highlight the issue and to not be afraid to talk about it openly. I think you can't find a better way to orchestrate those terms than the Senate report on mental health, “Out of the Shadows at Last”.

Have we come a long way in terms of recognizing, or at least being able to talk openly about challenges? I would say, yes, but I think there's still a ways to go.

The Chair: I'm sorry. I have to go to Dr. Fry now. We've gone over time. I know you had another comment.

Dr. Fry, with your time, do you mind if...?

Hon. Hedy Fry: Thank you very much, Ms. Israel.

Sorry, did you want me to allow...?

The Chair: Colonel Jetly had another comment.

Hon. Hedy Fry: All right. Please be quick.

LCol Suzanne Bailey (National Practice Leader, Social Work and Mental Health Training, Department of National Defence): I was just going to comment that in the Canadian Forces, we've struggled with stigma. I mean, you can imagine that in a population that's largely male and out there doing things that most of us in our society wouldn't volunteer to do, stigma has been a big issue.

We're at the point now where there's probably not an organization in Canada where it's as comfortable and routine to talk about mental health and stigma, as it is in the Canadian Forces.

Hon. Hedy Fry: Thank you.

Ms. Israel asked us to comment on the issue of seniors and suicide, and I don't think we can really blame this on primary care providers. Let me finish, Ms. Israel. I think the issue of isolation among seniors is not a simple one. We need to deal with the issue of seniors without sweeping it under the carpet. You can't just wait until somebody is depressed, isolated, and despairing before you intervene. You have to look at the root causes. Why are seniors isolated and despairing? Why are seniors living in poverty? What are we doing about that?

The concept of isolated seniors.... I have so many seniors in my riding whose families don't even visit them. They live so far away. There doesn't seem to be time in our busy lives to take care of our parents and our grandparents. I think that's something we need to talk about, a societal change and how government can help to make sure seniors are not left in isolation. I think there's no one answer to this problem. There are many answers. How we pull those together is going to be an interesting issue as we talk about a strategy. A strategy is not just for Health Canada to do. It's going to have to broaden itself to all kinds of other areas—social, etc.

I wanted to go to the armed forces, because post-traumatic stress disorder is a big issue for me. I live in Vancouver, and I have so many veterans whom I meet with regularly who suffer from post-traumatic stress disorder and who have absolutely no resources. So the concept we have of a very low percentage of veterans dealing with post-traumatic stress disorder for me is not a reality. There are many of them, especially young men and women coming in from the Afghan war and from a lot of the recent wars. I think there isn't any assistance.

For instance, there is a remarkable program going on at UBC right now, which I would like to see replicated because its outcomes are excellent. It's being paid for—not by the federal government or by any government at all—by the Poppy Fund, which is the money we raise from buying poppies. We cannot afford, when we send our men and women out there to fight for us.... We cannot just allow the Poppy Fund to look after them.

When you have something that works and when it is saving lives —and this is. I have seen the work done. I have seen the videos. I have seen young men break down in tears, because they come home and they're violent and they attack their families and their family system is breaking down and they don't know what's happened, because of the trauma they experienced watching their buddy being blown up right next to them. There is nothing for them when they come back.

I really would like to know what it is that the armed forces proposes to do for what I consider to be a really urgent issue. This is not only about suicide. This is about family violence. This is about an inability to fit into your society when you come back. This is about all the things we know of current post-traumatic stress disorder. We can't let our young men and women down. What is it you propose to do?

● (1035)

Col Rakesh Jetly: Respectfully, we aren't letting our young people down. We have the highest ratio of mental health professionals to soldiers in all of NATO. We have evidence-based programs. We have education programs, transition programs, and third location decompression. We are preparing people for the transition back home, as well as preparing the families back home. We provide evidence-based treatments. Most people are responding to the treatment that we provide. It's going to detract a little bit from the purpose of this panel, but we can certainly discuss it at a future time.

Hon. Hedy Fry: Well, it's not. I know many veterans who have attempted suicide. They're not getting the help they need. This is not about trying to be in your face. This is about suggesting that there isn't enough out there, if we're talking about suicide prevention. Let's honestly look at this issue. This is not about blaming. This is about looking at the fact that there are so many people who are not getting help. If we do this, how are we going to coordinate the fact that we need to be dealing with post-traumatic stress disorder before they go out to the theatre of war, not after?

We need to talk openly and with a view to getting this thing changed for all of us. That's all I'm suggesting. It's not about bashing anybody here.

LCol Suzanne Bailey: Absolutely, we recognize that need to provide the education before they go. I think most of you will have seen the little booklets we've handed around as part of a six-phase pre- and post-deployment education program, where we actually spend a full day with all troops before they go overseas and we talk about mental health. We talk about what will be the behaviours that they'll see in themselves and their buddies—not the diagnostic symptoms but the actual behaviour they'll see in somebody they work with every day—and then we talk about what they can do either as a buddy or as a leader to support that person who may be struggling. Very simple early non-medical interventions can be very effective when they're out there and away from immediate medical resources.

What we're finding is that with the pre-deployment training, as well as the transition and reintegration training we provide in Cypress, soldiers are now coming into mental health services much earlier than they used to. In the early 2000s, they were waiting about five to seven years after they noticed they were struggling with an issue. Now at about the three- to six-month mark, about 50% of those who could benefit from treatment during their screening have already sought care on their own. So we're seeing a big shift towards earlier recognition and earlier acceptance that, okay, they do need to get some help and they'll go and get that. It tends to be more effective when they come and get that treatment earlier.

Hon. Hedy Fry: Do I have a minute?

The Chair: No, you don't. You're just about out. You have 30 seconds.

Are you finished, Dr. Fry?

Hon. Hedy Fry: No, I'm not. I have one more question.

We see stigma as one of the biggest problems. People are afraid to say that they have reached the end of their tether, that they need help. There is no place that builds that culture more than the military. As I have heard from many soldiers, there is, in the military, the idea that you're macho and you're soldiering on, and you must not fall and you cannot fail. No one is blaming that culture, because everyone is supposed to be tough, strong, and face all the odds.

Are you doing anything to deal with the culture, to try to soften it just a little?

LCol Suzanne Bailey: Absolutely. That was the intent behind the Chief of the Defence Staff's “Be the Difference” campaign in June 2009, where he got up and did a presentation and press conferences with the theme that it was okay to suffer from a mental illness and to ask for help, and that we in the military need to get better at asking for help when we need it.

● (1040)

The Chair: Thank you.

We'll now go to Mr. Gill. Mr. Gill, you only have time for one question. We have to suspend to pass our budget.

Mr. Parm Gill (Brampton—Springdale, CPC): Thank you, Madam Chair, and my thanks to the witnesses for being here with us today.

I want to acknowledge the work by our colleague, Mr. Harold Albrecht, in addressing this very troubling issue.

My question is for the Public Health Agency of Canada and the Department of Health. Many people who suffer from depression or are at the risk of suicide don't seek help for a variety of reasons. Some aren't even aware that they're depressed. What are some of the challenges and solutions for treating people in these situations?

Ms. Marla Israel: I think some of the answer has come out already in discussions with the Mental Health Commission of Canada. I think being able to recognize the early warning signs is important. Mental illness can sometimes be the result of a person's social situation, his family life, or his having suffered some form of abuse.

What leads individuals to commit suicide is one of the most complex problems posed—not only for researchers but also for public health practitioners. We talked about some of these things today. We need to address stigma head-on so that people who are depressed can feel comfortable enough to approach a gatekeeper or a physician. I do think physicians are part of the solution. I think that teachers are part of the solution too. Individuals who feel comfortable talking about their problems and seeking either medical treatment or other forms of treatment are important as well. As a society, creating the conditions in which people can feel comfortable talking about these issues will go a long way towards ensuring that we can move forward.

Ms. Kathy Langlois (Director General, Community Programs Directorate, First Nations and Inuit Health Branch, Department of Health): With regard to first nations and Inuit, the evidence has clearly shown—and this is supported in our national aboriginal youth suicide prevention strategy—that the solution lies in providing some hope for the youth in our communities. Some of this has to do with recognizing identity and having a sense of control of oneself, one's future, and one's community. Our colleagues from the Mental Health Commission of Canada referenced the notion of governance.

The Chair: Thank you so much. I know we could talk about this for another four hours, and I wish we had the time to do that. Unfortunately, we have to do what we need to do. I want to thank all the witnesses very much.

I'm going to suspend for one minute. We need to go into a brief budget discussion on our witnesses. I want to thank you again. You have made insightful comments on this important bill. If there are any conversations, I'd like to ask that they be done outside. We'd really appreciate that.

All of us appreciate your work so very much.

I'll suspend right now for one minute.

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