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Chair

Mrs. Joy Smith

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● (0845)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Ladies and gentlemen, I ask you to please take your seats. We're right on time, but we have a lot of very important information to go through today.

I'm going to introduce to you, from the Canadian Association for Suicide Prevention, Ms. Dammy Damstrom-Albach. She is the president. Welcome.

We have Ms. Jennifer Fodden. She is from the Lesbian Gay Bi Trans Youth Line. Welcome.

From the University of Western Ontario, we have Dr. Marnin Heisel, associate professor and research scientist, Department of Psychiatry. He is running late. His plane will be landing shortly, so he'll be joining us in a little while.

As an individual, we have Dr. Brian Mishara, director of the Centre for Research and Intervention on Suicide and Euthanasia. Welcome.

And I want to welcome a very good friend of ours, Ms. Denise Batters, the wife of Dave Batters, one of our members who was with us a few years ago.

We are going to begin with Ms. Dammy Damstrom-Albach, please.

Ms. Dammy Damstrom-Albach (President, Canadian Association for Suicide Prevention): Good morning, and thank you very much for allowing me to address the committee.

As you are by now well aware, as many as 10 Canadians die each day by suicide, and these mostly preventable deaths devastate the lives of so many others. On that basis alone, our government should play a significant role in suicide prevention. However, this role and the government's response to suicide must be in keeping not only with the seriousness but also with the breadth and the complexities of this issue.

This requires an approach that is authentic, multi-faceted, and nuanced, an approach specific to suicide prevention, intervention, and “postvention”, which of necessity focuses particular attention and action beyond simple inclusion in a broader initiative. Positive outcomes demonstrating our government's true commitment to suicide prevention depend upon specific, comprehensive, and concrete action, and eventually upon appropriate funding as well. While we understand funding for suicide prevention is not part of today's discussion and cannot be tied to a private member's bill, we all appreciate that it must at some point enter in.

Bill C-300 is a first step. Because of this bill, as well as that tabled by Megan Leslie and the recent motion put forward by Bob Rae, Parliament at last has broken its silence on suicide to join in a national conversation. We are very grateful for that.

However, I believe we owe it to Canadians to figure out what it will take to do this right. We must use this bill as a compass to chart our best direction, not take half measures. We know parliamentarians of every stripe are deeply concerned, and many have been personally touched by suicide in some way, as we saw last October when so many spoke of the tragedy of suicide and the need for bold action.

We are told that for every suicide death, there are at least 10 close others whose lives are profoundly impacted. That is 100 Canadians every day. Think about what that means over a decade. Many of these survivors suffer in silence and may themselves become vulnerable to suicide, particularly without compassionate and knowledgeable care and support.

Yet suicides are for the most part preventable. There are solutions, though they are rarely quick or simple. Suicide prevention in Canada is fragmented. The work began with dedicated individuals and small organizations scattered all across the country, and this remains reflected in our current state. There is no national vision unifying our efforts and few mechanisms that allow us to learn from and build on our knowledge and experience. At times, knowledge is confined to special interest or otherwise privileged groups and not easily accessible or transferable to grassroots organizations, front-line workers, and survivors.

When it comes to suicide prevention in Canada, the right hand often does not know what the left hand is doing, even though there are investments being made and great things being done in pockets all across the country. Because of this, good investments can fail to have broad impact, and their usefulness is then diminished.

Indeed, our government has made some focused investments in suicide prevention, but there is no structure to facilitate benefits spreading to all the places where they could be useful. A case in point is the recent announcement by the federal Minister of Health regarding a $300,000 grant to research best practices. This decision was made with the very best of intentions. However, in the absence of a framework and coordinating body, the government was unaware that similar exercises had taken place in other countries and that in 2003 the Canadian Institutes of Health Research had commissioned Dr. Jennifer White to undertake a Canadian suicide research review. This report identified substantial Canadian contributions to the suicide knowledge base and identified important research gaps. Hopefully, the upcoming research will build on Dr. White's 2003 report. In fact, an update of this report, with the addition of the global picture from similar recent reviews, would likely have been more sensible, along with funds directed to addressing some of the gaps already identified.

The assumption that simply making gathered knowledge available means that it will be swiftly put into action ignores the transitional steps needed to turn evidence-based knowledge into useful, practical application. Furthermore, the rapid gathering of this information could have been done in a few weeks by a simple request to SIEC, the Suicide Information and Education Centre, and to Crise to provide the latest material compiled across the globe.

● (0850)

We may well be spending $300,000 to reinvent the wheel. The government cannot be faulted, because there is no structure or appointed body to inform such decisions, nor is there any such structure to ensure that stakeholders across Canada have equal access to gathered information and the capacity to translate it into policy, implement it in practice, and then evaluate the outcome and feed the results back to others who need to learn from them.

This is where the federal government comes in. It is not a small role that the government must assume. It must function as both catalyst and glue to stimulate and cement the needed connections. Suicide prevention requires all levels of government to unite in support of the community groups, survivors, those with lived experience, and the thousands of volunteers who have long done the lion's share of this work. The national government must step forward to do its portion.

The federal government can also address fragmentation by honouring the 1996 UN guidelines on suicide prevention. Surely Canada's approach must be consistent with these guidelines, which clearly state that the litmus test of a country's commitment to suicide prevention is the appointing of a national coordinating body to promote collaboration and collective action and regularly report on progress.

Let us take full advantage of the wonderful opportunity we've been given thanks to the non-partisan leadership of people like Harold Albrecht, Megan Leslie, and Bob Rae. Bill C-300 is a good beginning. However, we need to extend our reach to be sure we do all that we can do for those Canadians whose lives have been or may be touched by suicide. Bill C-300 recognizes that suicide is a public health priority; however, it places most of its emphasis on knowledge exchange.

While this is one essential element of a comprehensive approach, knowledge exchange cannot stand alone. At a minimum, we must also consider establishing a national implementation support team to advance a comprehensive federal, provincial, territorial, public, and private response to suicide prevention. We must develop policies aimed at reducing access to lethal means. We must create guidelines and action initiatives to improve public awareness, knowledge, education, and training about suicide. And we must support an enhanced information system to disseminate information about suicide and suicide prevention.

● (0855)

The Chair: I have to ask you to wrap up because you're over your time.

Ms. Dammy Damstrom-Albach: Clearly, all of the things that CASP is hoping for will require funding, sufficient funds to transform our compassion into action. Our action must be guided by research evidence, practice, and lived experience, and it must be informed by current Canadian data about suicide rates, trends, and risks.

The Chair: Thank you. I'm sorry.

We'll have to go now to Ms. Jennifer Fodden.

Ms. Jennifer Fodden (Executive Director, Lesbian Gay Bi Trans Youth Line): Thank you to the members of the Standing Committee on Health for inviting me to provide testimony this morning.

I appreciate the opportunity to highlight for the committee the particular perspective of lesbian, gay, bisexual, transgender, transsexual, and two-spirit people, which I will hereafter refer to as LGBT for brevity's sake, and our community's relationship with the ideas being discussed today, suicide and suicide prevention.

There are many factors that contribute to a person's risk of suicide ideation and attempts, and while many of these are individual factors, there are also special populations of people that research and experience have shown to be more likely to contemplate, to attempt, and, sadly, to succeed at taking their own lives.

First nations and Inuit peoples and LGBT people represent two of the communities at greatly disproportionate risk relative to the general population. I urge the committee to seek to understand the unique and important factors that affect first nations and Inuit peoples at your next session. Today, I will attempt to present to you the sad reality of the impact of suicide on my community of LGBT people.

I'll begin with a bit of background about myself. I have a master's degree in counselling psychology and I have worked in child and adolescent mental health for 12 years. I'm the executive director of the Lesbian Gay Bi Trans Youth Line. We provide peer support services to youth aged 26 and under throughout the province of Ontario. We serve approximately 6,000 youth each year, providing online and telephone listening, support, information and access to local resources whenever possible. Our services are provided by highly trained youth volunteers who themselves identify as members of the LGBT community.

We do not provide crisis services per se, but the work we do is suicide prevention work at its heart. We provide relief from isolation and we provide acceptance and non-judgmental listening. We provide access to community. Even if it's communicated just by a voice on the phone or an online chat window, it offers a glimpse of hope that can have a significant impact on those who are reaching out.

I want to emphasize for you today the profound ways that the LGBT community is affected by suicide. I have drawn from a number of reliable and peer-reviewed research resources for this presentation today. I will happily share these with the clerk's office if the committee would like access to them after today's meeting.

I'll not overwhelm you with statistics, but I will put before you some of the most stark and revealing numbers. Meta-analysis studies have found that sexual minority individuals were two and a half times more likely than heterosexuals to have attempted suicide. A recent Canadian study estimated that the risk of suicide among LGB youth is 14 times higher than for their heterosexual peers. A large and statistically representative study of trans people in Ontario found that 77% had seriously considered suicide and 45% had attempted suicide. Trans youth were found to be at greatest risk of suicide, as were those who had experienced physical or sexual assault.

What can explain these staggering figures? I want to impress upon the committee that it is not the fact of being lesbian, gay, bisexual, trans, or two-spirit that imposes these risks upon a person's psychological well-being. Rather, it is being a member of a group that experiences oppression, exclusion, omission, and hate that leads to this sad reality.

LGBT people experience stigma and discrimination, and this stigma can have a variety of negative consequences throughout their life span. LGBT people are also targets of sexual and physical assault, harassment, and hate crimes. These pressures, as well as the stress of sometimes concealing one's orientation or modifying behaviour or appearance in anticipation of homophobia and violence, have a negative effect on mental and physical health. Family rejection in adolescence has been linked to increased substance use, depression, and attempted suicide.

Trans people experience even more significant social marginalization in our society. For many who cannot pass as cisgender, or non-trans, the added visibility leaves them more susceptible to harassment and abuse. The cumulative impact of erasure, pathologization, and exclusion leave trans people, and trans youth in particular, vulnerable to suicide. That is what research has been able to demonstrate.

But not all of this is a surprise to those of us in this room. In recent months and years, there have been many stories that have captured the attention of our country's media and viewers at home. There have been stories of young lives ended, just when they ought to be getting started. We have heard tell of homophobic bullying and tormenting that has taken place in schools and online among university students and pre-teens. We have seen video clips filmed by bright and talented young people full of spark whose will to go on has been broken.

● (0900)

As a community, we grieve each of these losses deeply and sincerely. We know that for every one of these LGBT lives lost, there are many more whose stories won't be told because they've taken their secret pain to the grave.

At the Lesbian Gay Bi Trans Youth Line it is not uncommon for our callers to speak about times they had attempted but somehow, thankfully, fallen short of succeeding and ending their lives, and more common still to hear contemplations. Ending it all can seem a very real option to far too many of our kids.

This all sounds very bleak, and indeed it paints a picture of communities in crisis. It is stories like these that have brought us all here today to undertake the important work of making suicide prevention a priority for all, a matter of public health and safety.

The bill before the committee proposes many helpful elements, and I congratulate the authors on some of the following elements in particular. Paragraph 1 of the preamble specifically outlines that suicide “can be influenced by societal attitudes and conditions”, which is the very essence of what I am presenting to you today.

I put to you that you should consider naming the societal attitudes that you refer to in this paragraph more directly: homophobia, transphobia, and racism. Alternatively, naming the communities and populations that are known to be disproportionately affected by this issue could strengthen the impact of this bill.

I offer strong support for paragraphs 3 and 4 of the preamble, particularly the naming of communities as agents of action in both the prevention of suicide and after care of survivors impacted by suicide.

I stand firmly behind the use of knowledge transfer and exchange as mechanisms for change in our public attitude toward suicide, and I urge the government to utilize the research and resources that are available from sources such as Rainbow Health Ontario and Trans PULSE to inform the tools and resources that this bill will stimulate so that the concerns and realities of LGBT individuals and communities are made visible to the general population.

Finally, I urge the committee to look not only to research bodies but also to communities as sources of valuable information, healing, and prevention. Building communities of, with, and for our most vulnerable people can provide the safety net that will ensure LGBT individuals do not become statistics.

Thank you.

The Chair: Right on time. How did you ever do that? Thank you so very much.

Now we'll go to Denise Batters.

Denise, is your video ready to go now? Okay.

All the members do have transcripts. We will begin, then.

[*Video Presentation*]

● (0905)

The Chair: Thank you for coming today. It's going to help a lot of people.

Mrs. Denise Batters (As an Individual): Thank you. It's wonderful to be here.

Good morning, Madam Chair and committee members. I'm so honoured to be here today.

That news story played last month throughout Saskatchewan on Bell's "Let's Talk Day". You saw a quick synopsis of why I find myself here today, but here is a little more of my story.

My husband, Dave Batters, and I first met in 1989, in Saskatoon, crossing the street at a political convention. Dave was first elected as the federal member of Parliament for Palliser in June 2004, and he was re-elected in 2006. In fact, Dave was a member of this very committee in his second term in office.

In 2008 Dave became quite ill with severe anxiety and depression. He also overcame a dependency on his prescription medication used to reduce his anxiety and help him sleep.

Shortly before the federal election was called in September 2008, Dave announced he would not run for re-election. He publicly announced why, disclosing the battle he had been waging.

In his words, taken from his press release, he said:

> I make this very personal disclosure with the hope that others who suffer from these conditions will seek the assistance they need. There is still a stigma attached to such illnesses and I want to make sure people realize these are conditions that can strike anyone and need to be treated.

Tragically, Dave took his own life on June 29, 2009. Taking a cue from his openness about his illness, we issued a press release disclosing that, sadly, Dave had died by suicide.

Prime Minister Stephen Harper attended Dave's funeral and gave a very important speech. He not only described some of Dave's great personal qualities that made him a valued friend and colleague in the caucus, but he also talked about depression and suicide. One of the most fitting lines of this speech was this:

> Depression can strike the sturdiest of souls. It cares not how much you have achieved or how much you have to live for.

In 2010 we held a golf tournament in Dave's memory. I wanted to have the money raised go to a cause that might help someone like Dave. I wanted to produce a TV commercial that targets men between 30 and 50 years old suffering from anxiety and depression. Our golf tournament raised $20,000, and we produced that TV commercial, which ran in Saskatchewan for many weeks. This 30-second ad is still available on YouTube; just search "Dave Batters". Please view it there and post the link on your Facebook and Twitter pages. I would love to get the number of hits up on this very important message of awareness.

In the Prime Minister's video message sent to our golf tournament, he said:

> By publicly revealing his struggle with anxiety and depression, Dave reminded everyone who suffers from mental illness that they are not alone. This is a message that needs to be heard, not just by victims of mental illness, but by everyone, to deepen the well of understanding and support for those battling this disease. This is Dave Batters' legacy.

Many men suffering with severe anxiety and depression think they are alone in their suffering. They think no one else could possibly have felt like this before. We must let them know they are not alone.

Also, many of these people feel they are a huge burden to everyone, and everyone would be better off without them. That is why so many of them resort to this final choice. They need to know their family and friends want to help and don't consider them to be a burden. For those of us now without those loved ones in our lives, we would do anything we could to have them back with us.

Soon after Dave died in June 2009, my counsellor warned me not to get involved with a cause too soon. He knew invitations to get involved would come early and often for me, given my openness about Dave's suicide. That was good advice. But in 2010, when Dave's friends approached me about the golf tournament, the time seemed right for a cause.

I think my difficult journey has been assisted because I was open that Dave had died by suicide. So many people feel that the stigmatized nature of suicide prevents them from discussing the death of their loved one. Some deny the cause of death, or even lie about it. Everyone goes through their own grieving process, and with suicide there are so many difficult and conflicting emotions involved for the bereaved.

I want to talk about Dave, particularly with people who knew him and loved him. I have had many people say to me, "I wasn't sure if I should mention Dave to you, because I thought that might be painful for you." However, there is nothing that brightens my day more than hearing a new story about Dave. He was such a funny, friendly person. He deserves to be remembered often for all of those great qualities.

Madam Chair and committee members, from my personal perspective, when I look at Mr. Albrecht's bill, these are the two most important aspects of it: the stated goal for increased public awareness and knowledge about suicide, and the federal framework that promotes consultations and collaboration on this urgent health issue all across Canada.

● (0910)

There are many outstanding groups doing good work in pockets across the country. There's a great need for better coordination of these efforts. I believe this will help to give the most important thing of all: hope to Canadians like Dave.

Thank you very much.

The Chair: Thank you very much, Denise.

Dr. Mishara, thank you for joining us. Please give us your presentation. You have seven minutes.

Prof. Brian Mishara (Director, Centre for Research and Intervention on Suicide and Euthanasia, Université du Québec à Montréal, As an Individual): I'm going to speak in French, if that is all right.

[*Translation*]

In 1987, the report of the National Task Force on Suicide in Canada provided in its conclusion a series of 40 specific recommendations to prevent suicide in Canada. I was part of the group of experts tasked with revising and updating that first report from the group of experts. Health Canada issued that new version in 1994. Seven years later, we could only reiterate the same 40 recommendations because nothing had been done. Since then, none of the 40 recommendations have been implemented.

Today, close to 30 countries have a national suicide prevention strategy, and the WHO recommends that all countries develop one.

I'm a researcher. Research shows that national strategies have an impact on suicide. For example, a study published in 2011 in *Social Science and Medicine* focused on the suicide rate in 21 countries between 1980 and 2004. In those 25 years, the suicide rate dropped each year by 1,384 out of 100,000 residents, or by 6.6% a year. According to the study, if Canada, with a population of 34 million, had a national strategy like that of other countries, the number of deaths by suicide would decrease by 476. If we consider the financial impact of health and mental health care and the psychological and emotional impact of deaths by suicide, the possibility of saving 476 lives a year may justify major investments in suicide prevention.

Bill C-300 is a good start and indicates that Canada wants to be among a growing number of countries that have invested in a national suicide prevention program. A number of Canadian provinces have already made great strides. In 1998, Quebec created the Stratégie québécoise d'action face au suicide. Between 1998 and 2008, there was a decrease in the suicide rate for all age groups. The rate for youths in Quebec dropped by half compared with 1998.

Certainly, the provinces have a responsibility when it comes to health and mental health. Suicide prevention is part of that. But significant steps at the federal level can contribute considerably to decreasing the suicide rate in Canada. Think about the medication that causes the most deaths by suicide: it's acetaminophen, Tylenol, which is available over the counter in large quantities. In England and in a number of other European countries, a simple regulation aimed at controlling the quantity of pills in a single container that a person can purchase resulted in a lower number of poisonings, whether intentional or unintentional, caused by this medication. The fact that fewer dangerous medications are available at home has reduced the risk for suicidal individuals. This kind of policy doesn't cost the government anything and offers an increased probability of saving lives.

Other examples of possible actions that can be taken at the federal level include media awareness, particularly on the impact their reports have on suicide. This impact has been very well documented through a significant body of research. Encouraging early intervention to promote mental health in young people is another example.

The spirit of Bill C-300 is commendable, but the repercussions of this kind of legislation will be determined by the resources available to implement it and how the authorities, which are called relevant entities within the Government of Canada, will invest competent resources to carry out the tasks set out in the legislation.

This bill is very different from the national suicide prevention strategies elsewhere in the world that have had a considerable impact on the suicide rate. The national strategies that have been successful have not given an existing entity the mandate of dealing with suicide prevention; instead, they have created a governmental or para-governmental organization responsible for the strategy.

Those entities had sufficient funding to interact with the provincial, governmental and non-governmental authorities to develop a concerted action on suicide prevention. However, all the strategies that have been successful received good funding from governments for pilot projects, monitoring and various activities.

Without specific funding allocated to suicide prevention, Bill C-300 risks having the same impact as the report entitled *Suicide in Canada* and the updated report. It was a lot of fine words, but the federal government has taken almost no action in terms of suicide prevention.

Canada has an enormous amount of suicide prevention resources. We are exporters of knowledge in this area. Our research is often used elsewhere. We can learn from the success and experiences at the provincial and local level, but the federal government also has a role to play, as I have already mentioned. I'll repeat that the government just wasted $300,000 to draft existing documents, which have been written recently elsewhere in the world. Lack of coordination seems to be a common occurrence.

Instead of palming the mandate off on a relevant entity within the Government of Canada, I recommend that the bill be amended to create a governmental authority that would be responsible for implementing the legislation. I also recommend adding that this entity make recommendations on changes to Canada's legislation, policies and practices to encourage a decrease in suicide.

Furthermore, I find that the timeframe suggested, which provides for an initial report in four years, must be replaced and that an annual report should be requested. I know that it takes time to establish a strategy. However, other countries in the world have generally taken one or two years to create a national strategy that has involved thousands of stakeholders, given the small amount—

● (0920)

[*English*]

The Chair: I'm sorry, sir, you're over time and I have to ask you to wrap up. Thank you.

[*Translation*]

Prof. Brian Mishara: I don't see any reason why we can't start implementing this legislation in Canada in under two years.

[*English*]

The Chair: Thank you so very much.

Now we'll go to our seven-minute Qs and As, and we'll begin with Ms. Davies.

Ms. Libby Davies (Vancouver East, NDP): Thank you, Chairperson, and my thanks to all the witnesses for being here today.

This is our second meeting on this important issue, and I think we all feel compelled from the testimony we've heard to take much stronger action.

Ms. Batters, thank you for coming and for being so courageous in sharing the experience you went through. I know it's not easy to speak out. I think there is a notion out there that MPs live in this other world, and that we're not connected. For you to be able to explain what happened to Dave and describe how we all suffer from the same ailments, conditions, and mental health issues as the general population helps to connect us with our community and our broader society. I want to thank you for how forthright you've been.

A couple of questions come to mind. To you, Mrs. Batters, who have dealt with this issue publicly, I wonder if you could say a little more about what you think is the immediate first step. We're aware of the stigma. We're aware of how hard it is sometimes for people to come forward to seek the help they need. From what you've learned in working with people, how do you see that important first step? How can we reinforce that in our local communities?

I'll also add another question about whether we need a new national coordinating body. Ms. Albach, you spoke about the UN guidelines and the need for a national coordinating body. I'm curious to know how that works with the Mental Health Commission. We do have the Canadian Mental Health Commission. We hear they're coming out with a strategy in a few months. How do these two things fit together? Do we need a separate entity in Canada that will undertake this, or is this something that's part of the commission's coordination and works?

Those are my two questions. I'd like to begin with Mrs. Batters.

Mrs. Denise Batters: As to a first step, the reason we made the commercial was to encourage those men who might feel as if they are alone, as if no one else could have possibly felt like this before. The main message at the end of the commercial is that you are not alone. There is help. Please reach out. That might be something as simple as answering the phone when your friends are calling, or it might mean something a little bigger, like making an appointment with a counsellor or a psychologist to help you, or talking to your family doctor about your condition. So there is the awareness.

In recent years, the stigma surrounding depression and mental illness has improved. I think Dave was a trailblazer on that. This was someone who was currently suffering with these things and was a member of Parliament. He issued a press release. He could have just said he was retiring and not explained, but he thought he owed it to his constituents to explain himself. He thought describing what he was going through would help people. That's why he did it, and I took a cue from that. To say that I'm brave in doing this is not true: I took my cue from Dave. He was very brave in what he did. That's why I thought we could be open about the fact that it was suicide.

Does that answer?

● (0925)

Ms. Dammy Damstrom-Albach: In response to your question, Libby, I believe that the reason we need a national coordinating body is in order to specifically focus on suicide.

Now, that's not to say that it isn't crucial that we work in cooperation with the Mental Health Commission of Canada, and indeed CASP is certainly doing that.

I think there is one piece that's very important in what I see so far in working with the Mental Health Commission of Canada. Certainly suicide is addressed here and there when you look at the work that's being done to date. But the real concern is that if it's scattered, without particular focus, then it may continue to support the fragmentation that we see all across Canada.

In national strategies that have been most effective—Scotland, the United States, and Ireland are very good examples—we see that they have actually set up a national coordinating body or a national implementation team that works often as an entity under a larger group that's responsible for broader mental health initiatives and mental illness prevention work in a country. But there's specific focus, within that, on suicide that is very particular.

Our concern, certainly, is that whatever work is done needs to fall under the umbrella, perhaps, of the Mental Health Commission of Canada. But it really needs specific focus on suicide because it crosses so many jurisdictions and boundaries. It needs particular focus and I think a particular action plan in order that we can do the kind of preventative work that we need. Also, provide the appropriate supports to people who have been touched by suicide, who have lost loved ones to suicide. Focus on the kinds of intervention that are required, and certainly that includes the support of community wellness. It includes upstream initiatives that support mental well-being, but it also means that we have to intervene more directly with people who are experiencing suicidal ideation, with people who are making suicide attempts.

I almost imagine that it works a little bit like a Russian doll. Perhaps the Mental Health Commission is the largest doll, but there's a suicide prevention focus and strategy and national coordinating body that fits inside that Russian doll, if that metaphor is helpful.

The Chair: Thank you so much for your comments.

Ms. Libby Davies: Do I have more time?

The Chair: No, I'm sorry, Ms. Davies.

Joining us now is Dr. Heisel, who has made a valiant attempt to be here on committee, and we want to thank him for that. I'm just going to pause with the questions right now and listen to his seven-minute presentation, and then we'll go to our next member on the list, who is Dr. Carrie.

Dr. Heisel, please.

Dr. Marnin Heisel (Associate Professor and Research Scientist, Department of Psychiatry and Department of Epidemiology and Biostatistics, University of Western Ontario): Thank you very much.

I apologize for being late and for not having heard my colleagues' presentations. I hope I do not duplicate much.

Honourable members of the standing committee and colleagues, my name is Dr. Marnin Heisel. I'm a clinical psychologist and associate professor at the University of Western Ontario and a research scientist.

My area of research expertise is in the study of suicide and its prevention, with a specific focus on enhancing older-adult psychological resiliency and well-being, improving the psychological assessment and treatment of those at risk for suicide, and developing, disseminating, and evaluating knowledge translation materials regarding late-life suicide prevention.

I'll focus my comments briefly this morning on the potential benefits of creating a viable and sustainable Canadian federal framework for the prevention of suicide, enhancing suicide prevention among Canada's older adults, and highlighting the critical importance of promoting innovation and excellence in the research, development, evaluation, and translation of approaches designed to enhance suicide risk detection and intervention.

According to the WHO, one million lives annually are lost to suicide worldwide. According to Statistics Canada, nearly 4,000 individuals died by suicide in this country in 2008, a figure that we know underestimates the true number lost to suicide but still more than triples the number of those who died by homicide and HIV combined in this country. Far fewer funds are spent on suicide prevention initiatives than on these other important and worthy causes, necessitating a clear response from our federal, provincial, and territorial governments.

Whereas the estimated direct and indirect annual costs of suicide and self-harm in Canada exceeded $2.4 billion in 2004, we cannot put a price tag on the loss of a single human life, let alone on those of thousands. However, we can now all ensure that funds are devoted to creating a sustainable framework for the prevention of suicide for all Canadians.

Suicide is a tragic equalizer. It affects us all, irrespective of age, sex, social class, religion, culture, ethnicity, nation of origin, or sexual orientation. Yet suicide is not distributed equally. Adults over the age of 65 have high rates of suicide and employ lethal means of self-harm, with a high intent to die. Over 6,000 North Americans over the age of 65 die by suicide every year, a number that appears to be increasing with the aging of the baby boomers, a birth cohort exceeding 75 million North Americans and carrying a high lifetime suicide rate.

By 2031, 20% to 25% of all Canadians will be over the age of 65. We're thus now entering an unprecedented period in our history in which a vast population at elevated risk for suicide is reaching a stage of life during which suicide risk is high, and we are not prepared. We do not have a surveillance system in place for detecting or documenting the presence and severity of suicidal thoughts, plans, or behaviour. Our national mortality statistics are incomplete and do not account for provincial differences in the classification of deaths by suicide. Our mental health care system contains numerous gaps through which our most vulnerable routinely fall.

Every year tens of thousands of Canadians join the legions of those of us who have lost loved ones, friends, colleagues, acquaintances, and clients to suicide.

The burgeoning older-adult population will have a dramatic increase in impact on mental health care services for decades to come. Research findings over the last 40 years have consistently shown that up to three-quarters of older adults who died by suicide had seen a family physician or general practitioner in the prior month, and did so significantly more frequently than those who did not die by suicide. The majority of older adults requiring mental health services seek care in primary health care contexts, rather than from mental health specialists. Yet our primary care system was not designed to assess psychopathology or deliver complex mental health care to at-risk older adults.

Multi-centre clinical intervention trials indicate that providing collaborative mental health care to older adults in a primary care medical setting can enhance detection and treatment of depression, increase uptake of mental health services, reduce or resolve thoughts of suicide, and reduce mortality risk. Nevertheless, many primary care providers erroneously believe that depressive symptoms reflect an expected response to age-related transitions and losses, rather than a treatable mental disorder, and neither initiate nor refer at-risk older adults for care.

● (0930)

Clinical guidelines for older adults at risk for suicide recommend interdisciplinary care provision, including access to psychotherapy services and medication where indicated. Unfortunately, many at-risk older adults never receive interdisciplinary care.

In Canada today we lack a sufficient workforce of health care providers trained in gerontology or geriatrics. Geriatric psychiatry is only now receiving recognition as a subspecialty, and geropsychology is at a far earlier stage of development in this country than in the United States. There's a documented need for comprehensive mental health care services for older Canadians and recognition that we have an insufficient body of providers to meet recommended benchmarks for care.

The nature of our mental health system is such that individuals lacking financial resources or extended health care benefits typically cannot access psychological services. In this regard, our American neighbours are in better shape than we are. This is despite the fact that psychological service provision has been shown to create medical cost offsets, reducing or averting usual cost to the health care system.

We must acknowledge that the Canadian mental health care system is two-tiered. Those who can afford private practice services, in addition to those covered by provincial and territorial health care systems, receive far better health care than those who can't. Such social inequity flies in the face of the spirit of universal health care and begs to be rectified.

The field of suicide prevention and research among older adults is in a relatively early stage of development, beginning largely with the study of risk factors. As of 10 to 15 years ago, little data existed on factors protective against suicide risk among older adults or that confer resiliency to suicide in the face of stressors, losses, and other harms. Older adult-specific assessments tools and interventions did not exist.

With research funding from the Canadian government and mental health and suicide prevention foundations, my colleagues and I have begun addressing these gaps. Development of the Canadian federal framework for suicide prevention, dedicated to supporting ongoing knowledge creation and translation can help—

● (0935)

The Chair: Dr. Heisel, you're over time, so could you wrap up, please?

Thank you.

Dr. Marnin Heisel: Certainly.

Development of the Canadian federal framework for suicide prevention, dedicated to supporting ongoing knowledge creation and translation can help ensure ongoing funding for research focusing on suicide prevention across levels.

Thank you very much.

The Chair: I'm very glad that you did make it. Your testimony was very important today.

We'll now go on to our next person, who is Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

I want to start off by thanking the witnesses for being here for this very important topic. I want to thank Harold for being here, for introducing this bill.

I want to start off, too, by thanking Denise for being here.

I want to thank you particularly for bringing the video. I'm like you. I like seeing Dave. I like hearing his voice.

I think you know we were elected in the same year; we had about the same number of votes that we won by.

Mrs. Denise Batters: Sometimes people even mistook you for him a little bit, and vice versa.

Mr. Colin Carrie: Actually that is it, and I think that caused Dave a lot of distress. He kept telling me how much better looking he was than I was.

He was a courageous guy. We all miss him.

I want to thank you for your courage, especially about getting the message out. That's what I want to talk to you about first.

How important is it to be open about mental illness, especially with family members?

Mrs. Denise Batters: I think it's extremely important. It encourages that person who's in this terrible frame of mind to speak about it, and when they start to speak about it, that's likely when help will occur.

As well, I know from different support groups I've been involved in since Dave passed away that it's also very important to be open about the fact that a death is by suicide.

I mean, everyone handles things differently. I've had support group members tell me, “You know, my loved one died a few months before Dave and we lied about it. We said it was a stroke. We said it was a heart attack—something like that. We didn't feel we could properly grieve until we started telling the truth about how that person died.”

I think openness is very important.

Mr. Colin Carrie: Thank you.

I am wondering what advice you would give spouses who have a husband or a wife who suffers from anxiety and depression. How can you communicate to them the warning signs?

Mrs. Denise Batters: I'm certainly not a doctor, but at the same time it's trying to keep them speaking about it, and open. Isolation is something that draws them further inward and makes them also think there's no other option.

That is the timeframe when usually hope.... As long as you can try to preserve hope. Hope is the main thing for these people. If they have hope, they can go on another day. If they lose hope...you don't have much if you don't have hope.

As far as advice that I would give, keep the communication as open as you can, so that person knows they can speak to you about it and they don't have to feel judged. Especially for men, they're used to being, in a lot of cases, the main salary of the family. They're used to being the ones taking charge. They don't want to feel weak or unmanly.

Like I said in the video, this is not about being weak or unmanly; this is a health issue. To me, it's no different than if you have cancer.

Mr. Colin Carrie: You speak about hope. I wonder if you could elaborate a little bit more about the golf tournament. We saw the video that you produced. Where do the funds go that you raise through the golf tournament? Could you elaborate a little more on that?

Mrs. Denise Batters: We've set up a bank account. It was all very low key. It was just a few of my friends and Dave's friends. Andrew Scheer, who is now Speaker Andrew Scheer, was actually one of the people who helped organize the golf tournament.

We just decided to do this, and then I said, “Let's have the money go to something that would help somebody like Dave.” I really had it in my head that I wanted to do a TV commercial. I was just thinking about times when somebody like Dave was likely to be at his or her lowest. It's fine for people to say, all you need is exercise or fresh air, that'll make you feel better. But if someone is in a deep depression, they probably cannot even get out of bed or off their couch.

So I thought about those kinds of people, and I thought maybe it was a situation where all they're doing is blankly looking at a TV screen, maybe not even paying attention to what program is on. But perhaps if they see this commercial, it would kind of twig with them because it's a guy they can relate to—both the actor in the commercial, and then when Dave's picture is shown at the end—and that just seems familiar to them and they realize they can talk about it with their friends. If their friends ask them, sincerely, “Are you all right?”, they can admit, “No, I'm not all right.” To me, that's the main part of the commercial. When one sees it, that's the major focus of the commercial, which is the man admitting that no, he's not all right.

● (0940)

Mr. Colin Carrie: Thank you very much.

Mrs. Denise Batters: I wanted to add just one other short thing about that. For me, the story that happened with Dave is such a tragedy that to not have some good come out of it is not the ending he would have wanted and that I want for him.

Mr. Colin Carrie: I think his legacy lives on through you and all the work that you do, and we do sincerely thank you for that.

I wonder if I can ask Dr. Heisel as well, since you are here.... I spoke to Denise, and Denise said she's not a doctor, but I know the work you've done. I wonder if you can elaborate. I know you were cut off a little bit in your opening comments, but could you elaborate on some of the warning signs that we should all be looking for, especially among the older adults who suffer from depression and anxiety?

Dr. Marnin Heisel: Thank you.

We know there are a variety of warning signs and things to be aware of. Certainly, signs and symptoms of depression can be an indicator that somebody is at risk. It can include somebody appearing depressed, down, sad, having concentration difficulties, missing appointments, no longer appearing interested in things that used to be of interest to them, and related things like that.

We know, however, with older adults specifically, many older adults can experience a major depressive disorder or a clinical depression without appearing sad or without necessarily feeling sad. We know that with older adults, rather than through psychological symptoms like sadness, depression, loss, etc., many will tend to experience depression through bodily symptoms like aches, pains, and those sorts of difficulties. So certainly we encourage providers who are working with older adults, who are appearing, say, in a primary care medical practice repeatedly for sort of vague symptoms, to begin asking questions about what sorts of things are going on in their lives, how they're feeling, how they're doing, and that sort of thing.

The Chair: Thank you, Dr. Heisel.

With the permission of the committee, Mr. Albrecht would like to ask one question.

Is that okay with the committee?

Some hon. members: Agreed.

The Chair: Thank you.

Mr. Albrecht.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Thank you, Madam Chair, and my thanks to all the witnesses for your expertise and for being here today.

You folks are the ones who have been on the front lines of this for years. I simply have the honour of being the parliamentarian who happened to be in the draw of private members' bills in the order of precedence.

Dr. Mishara, one of your concerns was that if there isn't a specific para-government agency charged with the responsibility of taking this task on, it might get lost again. I share your concern, but I need to make you aware that a private member's bill doesn't have teeth. A private member's bill cannot compel the government to spend money. I was trying to get a foot in the door. I am saying this is something the Government of Canada, through one of its agencies—perhaps Health, perhaps the Mental Health Commission—needs to take responsibility for. At some point, the government will charge a specific subagency within that responsibility. That's my hope and my goal. Just to clarify, we're not able to actually set up a commission from a private member's bill.

Jennifer, I share your concerns about not having identified specific groups. I need to tell you it was my intention not to do that, primarily because I was concerned that somewhere down the road we may have neglected a number of groups that were at significant risk. We all know that the aboriginal community is at high risk. You mentioned the LGBT community. We know that the military, and in fact my former profession of dentistry, is at very high risk. We did not address some of those, but we share your concern and we're hopeful that the group who is charged with this will put into place targeted initiatives that will be of help to those specific communities.

Denise, I wanted to thank you for being here. Thank you for talking about your journey and mentioning hope. I certainly agree with Dr. Margaret Somerville, who said,“Hope is the oxygen of the human spirit; without it our spirit dies.” I want to applaud you for talking about it. I can say that speaking openly about our grief is one of the most healing things. I think it's counterintuitive for everybody: they don't want to talk about it. We can say this is one of the most healing opportunities we have, so thank you for that.

Dr. Mishara, you mentioned a number of public health initiatives that could be helpful in reducing suicide. You mentioned Tylenol packaging as an example. You mentioned drugs in the home. I was interested to hear Dr. David Goldbloom say that something as simple as eating with your family can be a long-term protective factor. I think these are the kinds of stories we need to be sharing in our research, in looking at how to carry our long-term strategies into effect.

Dr. Mishara, you mentioned Tylenol and drugs in the home. Could you share two or three other quick examples of public health initiatives that we could be implementing to reduce the incidence of suicide?

● (0945)

Prof. Brian Mishara: I think we've touched upon some of these things in some of the comments. For example, the highest-risk group for suicide is middle-aged men. Middle-aged men call suicide prevention help lines less often. They don't talk to their doctors about feeling depressed. If they seek mental health services, they wait until it's really severe instead of acting immediately. There's been research showing some public health campaigns with some of our male heroes doing what Denise Batters and others have done, that is, coming out and saying, “I was feeling depressed. I was feeling suicidal. I got help.” There's that sort of campaign, which the government does very well when it promotes exercise and other things.

The other area is in mental health promotion, which can start very young in life. Teenagers who kill themselves have a smaller number of coping mechanisms available to them when they're faced with difficult and stressful situations. This is something we don't teach. There are programs running around the world that have proven to be effective in helping children learn how to cope with everyday problems. So promoting these types of programs in schools can be very helpful.

Some of the things...they're just free. If you can buy only 10 Tylenol at a time, instead of getting a bottle of 50 or 100, you're going to save lives in Canada. And the drug companies will make more money. There are things the federal government can do at almost no cost, but it takes knowledgeable people who have the responsibility for making those sorts of proposals.

Mr. Harold Albrecht: Thank you, Madam Chair.

The Chair: Thank you so much.

I want to welcome Mr. Hsu to our committee. I don't think you've been here before. We're very pleased you're here. You're up next.

Mr. Ted Hsu (Kingston and the Islands, Lib.): Thank you, Madam Chair.

I understand this is a private member's bill and there are certain limits on what can be called for in terms of expenditures. As you know, it's not unheard of for the government to take up a private member's bill and turn it into a government bill.

My question is to Ms. Damstrom-Albach and others. Let me thank you all for coming here to testify today.

I'd like you to elaborate on what would be missing if we didn't adopt some of the amendments that have been suggested. In particular I'm interested in collecting data, keeping data, and asking whether we have enough good data—also in not only doing the research to collect data, but having objectives that are measured carefully and monitored to see if policies are working or not.

I invite you to comment on what will be missing if we don't adopt some of these suggested amendments.

● (0950)

Ms. Dammy Damstrom-Albach: You mentioned data. We know that if we were able to provide data on risk, death, and the kinds of impacts on Canadians in a more timely fashion than we're currently able to do, and share that data all across the country, we could see changes in risk factors and in what was going on for people. If there were a way to make sure that was broadly available, I believe it would make a difference.

For example, in Vancouver, where I work on a daily basis in a suicide prevention agency, although we used to think that women were less likely to use what we call “immediately lethal means”, we're seeing the families left behind by young women who are more frequently dying by hanging. Our sense is that's probably going on in other places across the country, but we don't actually have the data on that readily available. It is important to be able to compile that kind of information, share it broadly, and see if that is what's going on, so we can think about what we can do about this.

Another thing we're aware of—and I'm sure many members are aware of this—is that information is now regularly put forward on the Internet that advises people very specifically about how they can kill themselves, what would be lethal for them, and that suggests that people practise. When we look at what's going on for people who die by suicide, it would be really helpful to know in what circumstances people are actively researching lethal methods. Are there ways that have been developed, in Canada or other countries, to intervene effectively in that whole area of social networking and share that knowledge across the country?

The real challenge is that although an enormous amount of good research is being done in Canada and around the world, the mechanisms for making that research broadly available, particularly to grassroots organizations, are not necessarily consistent across the country. Work needs to be done so that front-line providers can take that research and figure out the best way to implement it into practice on the ground where change is necessary. When we focus on knowledge exchange, we have to look much more broadly at the work we do to determine how it's supported so that knowledge gets down to the front line where it can be used.

I think that's where a national coordinating body comes in that is charged with figuring out the best way to make that available to front-line providers and make sure that people on the front lines are learning what they need to learn to make evidence-based changes in practice that will make a difference. That's across the board, whether you're working with older adults, adults, or young people.

Those are some of the key things that I think we need to address in the bill.

Mr. Ted Hsu: Thank you. I'd like to invite....

Dr. Marnin Heisel: I might add a few comments as well, speaking as a researcher and as an empiricist. Without clear data, we don't know where we are now. If we don't know the scope of the problem, the full range of the problem now, how will we know if we've had a positive effect or if we've had no effect whatsoever?

Really, in order to be able to assess and then demonstrate the effectiveness of whatever it is we do with our strategies, our approaches, our framework, we have to have a good sense of where we are. And that requires better surveillance, better data collection than we have now.

Prof. Brian Mishara: I could just add that Canada is now moving in the right direction in terms of knowledge application. There's a big emphasis at the Canadian Institutes of Health Research on knowledge application.

The issue, again, is leadership and knowledgeable leadership. The example is that there's $300,000 that I feel is wasted, with good intentions to do some literature reviews, which already exist and which other people have done in the last year. It's just a question of not making strategic decisions in leadership.

Canada exports its expertise in suicide prevention. When the United States government, which supports a national network of suicide prevention help lines, was looking to have those evaluated, our university in Quebec got the mandate to do this, and from our offices in Quebec we listened to 2,611 telephone calls to stress centres across the United States.

But we don't have a national network in Canada to evaluate, and the government does not support such a network. It's a question that whatever funds are already out there should be used strategically to do things that will have an impact. As I mentioned, a lot of the things we can do don't cost anything.

● (0955)

The Chair: Thank you, Dr. Mishara. Those are very good comments.

I will now go to Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): Thank you, Madam Chair.

Denise, it's great to have you before the health committee. I had the pleasure of sitting on the health committee with Dave during my first term for a few years, and he was always hilarious. He always made meetings entertaining, regardless of the subject. It certainly is a tremendous loss to not have him.

I know you mentioned that he talked about stigma, and that seems to be one of the biggest obstacles when we discuss mental health.

I had the pleasure of attending a mental health meeting in Barrie last week because they're planning a golf tournament fundraiser in June, where they're going to have Shayne Corson, the former hockey player, talk about his depression as a means to.... Their slogan is "Let's Talk"; there needs to be more discussion around mental health. My question is this. What can we do to encourage those discussions? Obviously dialogue is going to help to bring down stigma.

I was thinking back to last summer. I know Mark Strahl mentioned Rick Rypien's death at our last meeting. I know there were also Derek Boogaard and Wade Belak who were front-page stories. If there's a silver lining in those tragedies, it's that it put more awareness than I can recollect on mental health. It was a front-page story for several days in the Toronto area with Wade Belak. It shocked people, because you saw people who were successful, talented, like Dave, who you'd have never thought in your wildest dreams would be suffering from mental health challenges.

What do you think we can do, as a federal government, to try to break down this stigma in particular, to make people more comfortable with having those conversations and asking those questions and seeking help?

Mrs. Denise Batters: I was mentioning earlier, when Ms. Davies asked me a question, that in recent years, stigma around depression and mental illness has seemed to be improving. But what I forgot to mention at the time was that while that is improving, I'd say that stigma related to suicide is kind of the final frontier of stigma.

What our family did was be very open about the fact that it was suicide. We issued a press release when we announced that Dave had died. The press release said that it was by suicide. We didn't try to sort of hide from that or wait for a report or something like that. Plus, the Prime Minister came to Dave's funeral and spoke about depression and suicide in his speech but also about Dave's life, because sometimes when people die by suicide, it becomes only about their deaths. You kind of forget about their lives. I think it's really important to remember their lives too.

When those hockey players' deaths happened this summer, the Rick Rypien one especially hit me hard, personally, because he played junior hockey in Regina, where we live. Dave and I, I know, would have gone to see him play many times when he played there and in Moose Jaw. And to think about this poor kid....

They had some sort of YouTube video or something like that about one of the last interviews he gave right before he went on a kind of leave of absence, or maybe right after he came back from a leave of absence from the NHL. Just watching him you could see that he was struggling to have hope, but he was trying to keep it together. To think that it had such a sad ending was terrible.

I think it is really necessary when people like that, who people can relate to, people like Dave.... I think some people, when Dave passed away, might have wondered if that guy was really the happy-go-lucky, friendly person everyone saw. Or was that a mask he was wearing to kind of hide this troubled, depressed individual? No, that was Dave. He was happy. Just the last year and a half of his life was when all these medical issues made a happy life tumble down so quickly.

Having those kinds of people and linking it.... You know, there's a lot of openness now about depression and mental illness, but not so much about suicide. We can't forget that suicide is the unfortunate consequence of depression and mental illness. All these groups are being very open with Let's Talk and that sort of thing but then are wanting to shy away from suicide. We should not shy away from the fact that it is the possible result if it goes untreated or is improperly treated.

● (1000)

Mr. Patrick Brown: Are there any help mechanisms you felt should have existed that would have helped someone like Dave?

Mrs. Denise Batters: I think, certainly, the type of awareness that exists now about depression and mental illness didn't really exist when Dave was coming out with that story in the fall of 2008. I think he was kind of a trailblazer and was one of the first people who came forward who was currently suffering with it, as I said before.

During that Bell Let's Talk Day, Michael Landsberg did an hour-long show. He had a few different sports heroes, including Clara Hughes and Stéphane Richer. Stéphane Richer was the one who really hit home with me. When I watched that show that night it was bittersweet, because I was really pleased to see that these people were coming forward and being so open. Stéphane Richer admitted in that interview that after he had just won a Stanley Cup, he was in the Stanley Cup parade, and four days later he attempted suicide. If that interview had been on four years ago, and Dave had seen that, I think that might have made a difference for somebody like him, because he would have been like "Yes, okay, somebody gets it. Somebody I can relate to understands what this is like, and I'm not the only one suffering this terrible disease that I can't talk about and that no one will understand."

Mr. Patrick Brown: Brian, you mentioned there not being a national network in Canada. Are there other jurisdictions that you believe are implementing this appropriately? Are there other countries we can look to as examples? It is an open question.

Prof. Brian Mishara: The United States subsidizes a national network and is also improving the quality of telephone help lines. Many European countries, as part of their national suicide prevention strategies, subsidize a national network with one phone number that anyone can call any time to be connected with help. It's a component of most of the 30-some countries that have national suicide prevention strategies.

Ms. Dammy Damstrom-Albach: If you're curious, I would also encourage you to look at Scotland's national suicide prevention strategy, which is called Choose Life. It has focused very specifically on strengthening resiliency and on populations at risk, but also particularly on reducing stigma by talking very openly about suicide and providing training and support to gatekeepers, the general public, clinicians and service providers, people who are working in substance abuse, and people who are engaged in any of the work around areas of vulnerability for the population.

They've taken a very positive focus by naming their strategy Choose Life, and they have those linkages between their national government, their local governments, and community agencies that are all working together with this strategy. It's become a very public thing. It's reduced the rate of suicide in Scotland by 14%.

The Chair: Thank you so much.

I hate to cut you off, but I've let each of you go over time, and we have to be mindful.

We're now about to go into our second round of Qs and As, and they're five minutes. To make you aware, they're cut down by two minutes. I want you to know that at 10:30 I will be suspending the meeting for a moment because we're going into committee business for 15 minutes on some very important motions.

Can we begin, please, with Dr. Sellah?

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): Thank you, Madam Chair.

Allow me, as chair of the women's caucus, to take this opportunity to wish all the women here a happy International Women's Day.

I would like to dive right into the matter. My question is for Professor Mishara. I find that you hit the bull's eye, you read my thoughts. We know that in Canada, some 3,700 people commit suicide every year, and 463 of those individuals are between the ages of 15 and 24. We know that a death isn't declared a suicide unless the person had clearly stated beforehand that he or she intended to commit suicide. It's even more tragic when we know that this rate is probably much higher.

In addition, more women than men commit suicide. This is something I'd like to bring up with the specialist, Dr. Heisel, afterwards.

You said that several countries have unfortunately been ahead of Canada in creating a national strategy. In your opinion, what is preventing us from adopting a national strategy here, in Canada? That's my first question.

And Ms. Fodden, you spoke about social attitudes. I am in full agreement with you. Know that if I'm talking like this, it's because I am a doctor by training. We know that, unfortunately, society does nothing at all when it comes to social attitudes toward minorities, regardless of the minority, be it sexual, cultural or something else.

Let's take the example of Ms. Batters. She spoke about her husband, who was very joyful and held a high-ranking position. I can tell you that, even in the medical community, people suffer in silence because society does nothing to demystify the issue, unfortunately. I think it's an illness because it has been scientifically proven that there's a deficit of certain serotonin and adrenalin receptors, and so on.

I find it appalling that the attitude we have is not aimed at demystifying mental health problems and, as a result, suicide.

My question is for both of you. Dr. Heisel, could you tell me why women's suicide attempts are more likely to be unsuccessful, whereas when men attempt suicide, it's fatal?

● (1005)

Prof. Brian Mishara: I will provide a brief answer to your question about what is preventing the creation of a national strategy in Canada: it's a lack of political willingness. One of the problems is that there aren't enough people to demand this kind of strategy, because of the stigma related to suicide in our society. It's only recently that people have dared admit that they were suicidal or that they needed help. Because the demands are so few, measures in that respect are considered less profitable than others, politically.

The prevention of mental health problems and intervention are inevitable when we talk about suicide prevention, but they are not the whole strategy. There are many other measures specific to suicide. That's why we need a national strategy.

[*English*]

The Chair: Thank you so very much.

We will now go to Mr. Strahl.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you very much.

It's good to be here. I'll echo Dr. Sellah's comments about International Women's Day. Certainly some of the most courageous women I've had the pleasure to meet have been witnesses here at this committee.

Denise, I put you in that category, certainly, today.

I'm going to try to get through this: I didn't have the pleasure of serving with Dave, but I know my family speaks very fondly of him and you.

I'll speak today as well for Ms. Block—who's lost her voice—as a Saskatchewan MP.

Dave had a lot of friends. He was well loved, and he certainly is missed.

Dave was in the system. It sounds like he did seek help and he did receive care. I don't know if he was ever hospitalized or anything for that care, but he wasn't one who avoided the system, and this kind of came out of nowhere.

Were there any gaps in that system? Dave was in it. Did you find any gaps in the system that we should be looking at as we examine the system, gaps that need to be filled?

● (1010)

Mrs. Denise Batters: I think some of that would certainly be outside the scope of the federal government. It was more a situation where, yes, he received treatment, but knowing the severity of what he was suffering with came too late. At a point when you lose hope, when the really great help....

If that great help had come at the beginning, I probably wouldn't be here today. But it was too late in the going, to the point where Dave had lost hope—unbeknownst to me; I'm trying to keep his hope up at all times and he's kind of putting a brave face on it.

There's one thing that I think would help early in the going. For many people who are depressed, medication is a good answer for them, and sometimes it's the only thing they need. For many other people, though, and I think Dave would fall into this category, having effective counselling and dealing with a psychologist or a counsellor for talk therapy is an integral part of the process.

That was the part that came too late for Dave.

Mr. Mark Strahl: You obviously were dealing with the Saskatchewan medical system. I guess that's always the struggle on this health committee, to determine what is the role of the federal government when you look at these. Obviously the delivery in Saskatchewan is the responsibility of the Government of Saskatchewan; it's the same for British Columbia, where I'm from.

What role do you think the federal government can play to help us make sure that there are fewer situations like Dave's? Obviously education is an important part of it. Are there other roles you see specifically for the federal government to take as we tackle this issue?

Mrs. Denise Batters: I think it's the exact things that are targeted by this bill, actually: the public awareness about suicide, and not just depression and mental illness but also suicide, as well as providing this federal framework. I think it's so needed. There is great work done by people with organizations like this, and volunteers, and other types of organizations throughout the country, but if you don't have a federal framework, you don't have people relaying those best practices and stories so that everyone can benefit from them. And it's not just that we have a really great situation in this province, or in this community; a terrible one would also really benefit from the knowledge of what's going on there.

So that, from my understanding of it, would be the best role the federal government could play.

Mr. Mark Strahl: You mentioned the golf tournament you had. Is there anything else planned for the future? Is there a Dave Batters foundation or anything like it that you're working with?

Mrs. Denise Batters: There's a bank account open, but it's depleted of funds right now, after we ran all the commercials. But, yes, I'm looking actually to have another golf tournament this year. Last year, we couldn't have it because a few of the people on the committee were extremely busy with different time commitments, one of them being the federal election. Then right when we got to the point where everyone had time, we had terrible weather in Saskatchewan last year, with lots of big rainstorms that totally flooded out a few of our courses. This year I'm hoping we can get back on track and resume that tournament, because it was such a great experience. It actually poured the day of the golf tournament part way through the day, but nobody cared. Everyone was just there for a great cause and to remember Dave, and it was such a good event.

I've also spoken to some large groups of people in Saskatchewan about Dave's story, including my church. They had a mother-daughter banquet, and they had 500 people at it. Ukrainian Catholics usually don't want to talk about these kinds of topics, but they came to ask me to speak at it. All the money they raised at that they put towards running the commercial for more time. So I did that.

I spoke to a bereavement group in Regina at Christmastime about how to have some hope for the holidays.

So, yes, I continue to do those kinds of things. I've done significant media in Saskatchewan about this topic and about our story. I think those kinds of things have really helped public awareness, and I want to continue that.

● (1015)

Mr. Mark Strahl: Thank you very much.

The Chair: Thank you, Mr. Strahl.

We'll now go to Dr. Morin.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you for your great presentations. The topic of study is a fairly emotional one.

My first question is for Ms. Jennifer Fodden.

You mentioned that the target clientele of your GLBT organization is mainly young people under the age of 26. This sub-population is made up of young people who may have difficulty accepting themselves because of their sexual orientation, their identity. It's often complicated by the fact that they are bullied, either at school, on the Internet, or in the street.

People on this committee may not know much about the difficulties that this sub-population experiences. Could you tell us what life is like for these GLBT youths who are bullied and who have difficulty accepting themselves?

[*English*]

Ms. Jennifer Fodden: Thank you for your question.

We hear very commonly from young people who are struggling to find acceptance within themselves and from the members of their community. That can have a very profound impact on their mental health and the degree of hope they can hold onto for what life holds for them as they come into themselves and into their adult lives.

What I'd like to really emphasize to the committee is that it's not so much any one individual's actions that can have such a grievous impact on a person's sense of worth, but rather the attitudes of the community around the incident or around that person, where there's a benign neglect of the situation, where people turn a blind eye, people don't intervene or call a bully out on their behaviour to communicate to the person who's being targeted that in fact those ideas and ideals are not shared by the broader community. It's when school officials, other students, family members, and the community in general remain silent and don't intervene to let a young person know that they do have value, that they do have worth, and that as a community they can expect a life of their own design, that they can expect to experience love and a sense of value and opportunities. Those kinds of interventions, simple as they might sound, can be really enormously helpful. That's the kind of support we provide.

We operate out of Toronto, but we serve youth throughout Ontario, so we get phone calls from remote communities, where a person feels like the only individual they've ever met who might identify as lesbian or gay or bisexual or trans. They can hear one person 1,000 kilometres away say to them, “You're not abnormal. It's okay to experience the thoughts and feelings and desires you have.” Just to hear that person at a remote location say that and say, “There will be opportunities for you in this life”—and I can say that because I know, because I've been there myself—can be enormously powerful.

In terms of broader social change, we need to create a climate in schools where it's understood to be unacceptable to communicate homophobic and transphobic values on the playground or in the classrooms.

Certainly, those broader initiatives for social change help young people to understand that they do live in a country, in a society, where hate and oppression won't be tolerated.

[*Translation*]

Mr. Dany Morin: Thank you.

My next question focuses on what in some way is the negative consequence of the lack of intervention for GLBT youths. Ms. Batters said that, between age 30 and 50, some men experience mental health problems, especially GLBT individuals. Men or women lead a double life, never accept themselves, despite all these —

[*English*]

The Chair: Dr. Morin, you have 20 seconds.

[*Translation*]

Mr. Dany Morin: Could you tell us a little bit about that reality?

[*English*]

Ms. Jennifer Fodden: Certainly. Suicidal ideation is not the territory of the young alone. For individuals who are adults, who are living a life where they're working hard to protect what they feel is an unacceptable secret about themselves, it takes an enormous amount of energy and mental strain. Often we communicate to individuals that they have to choose between a sense of belonging in one community or another.

● (1020)

The Chair: Thank you, Ms. Fodden.

I'm sorry, you've gone over time.

Mr. Gill.

Mr. Parm Gill (Brampton—Springdale, CPC): Thank you, Madam Chair. I want to thank all of the witnesses for being here with us today and for the wonderful presentation, especially Denise.

Denise, I want to applaud your courage for being open about this and trying to help other Canadians with this problem.

I'm wondering if you can share with us—Dave may have shared—whether any of this had anything to do with his high-profile job or the position he was in. Obviously, at times it can be difficult for members to juggle family life and their job. I'm curious to know whether Dave may have discussed this with you or whether you had any conversation with Dave with regard to this.

He decided not to run before the 2008 election, and he was a member for about four years. I'm wondering whether you feel this problem was there before he was elected, or did his job have anything to do with it?

Mrs. Denise Batters: Dave was, if anyone knew him, a perfectionist. He was a perfectionist from the time he was a kid.

With that type-A personality he probably always had a certain level of anxiety in his life. Typically he was a high achiever, so he wasn't satisfied with anything other than being stellar at everything he did. He probably had a low level of anxiety throughout his life.

At the same time, he never knew how to leave a job or to have anything other than an absolute 24/7 work ethic. When you're an MP from Saskatchewan, as Mrs. Block can attest to, you don't have direct flights to Ottawa. So you get up at four in the morning on Monday, take that 6 a.m. flight, and when you get to Ottawa you can't just go and have a nap at the hotel; you have to go to question period right from the airport. You have a long day. It's that sort of thing. So there's the constant travel.

He was in a minority government for the entire time he served, and that was a huge difference. I'm happy to see now there's a majority and you have much more stability in your lives, hopefully, with the result of a majority. That was difficult, certainly. But there was the travel schedule, the constant changing of time zones.

Also, the first time Dave won, he won by 124 votes, and that never left his mind. Whereas sometimes people might want to go home on the weekend and not do any events and have a relaxing weekend, we were always going to events. We lost some balance in our life, definitely. Before he was an MP, we'd have date nights and that sort of thing. Date nights went a little bit the way of the dodo bird. Our date nights were now at banquets in Regina and Moose Jaw.

It's always important to keep balance in your life, no matter what your job is. That certainly was a contributing factor.

I mentioned that he had become dependent on prescription pills to help him sleep and to reduce the anxiety, and there's no doubt that was exacerbated during the time he was an MP.

Mr. Parm Gill: Thank you.

What would you say is the most important thing family members can do for their loved ones who are suffering from depression and potentially having suicidal thoughts?

Mrs. Denise Batters: As I stated earlier, have open communication with them. Do not give them the "snap out of it" speech. They would snap out of it if they could. They want to snap out of it. They're not able to. It's a health issue. It's brain chemistry. They need medical attention. They need other types of things to help them out. It's not a matter of just being wimpy or weak.

Mr. Parm Gill: What would you say are some of the obstacles families face when trying to communicate about mental health?

Mrs. Denise Batters: There's just a lack of knowledge, I think. Maybe some of the stigma that's been around for decades has stuck with them too, so maybe they think, well, I don't know, is the person just kind of weak and can they snap out of it? So again, lack of knowledge and that stigma thing are the major obstacles. Plus, they're trying to do everything they can for that person, and they may not know what to do. You just come to a point where you run out of options.

At the same time, you can only push this person so far. They have to want the help themselves or they're not going to stick with it.

● (1025)

Ms. Dammy Damstrom-Albach: I would just add quickly that in Vancouver we run a program out of where I work called Concerned Others. That program is to support the friends and family members of people who may be suicidal or expressing suicidal ideation or have made an attempt.

Again, if you have a national strategy and support for that, ideas like that, which are so effective, could be spread across the country —

The Chair: Excuse me, you didn't check with me. We were out of time when you started.

Ms. Dammy Damstrom-Albach: Oh, I'm sorry.

The Chair: Ms. Quach really wants to have a question, so I need to go over to her.

Maybe you can continue with this. I don't know. It's your turn.

[*Translation*]

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

I'd also like to thank the witnesses for giving us more information on the strategies that exist elsewhere in the world and what Canada has done over the years.

Professor Mishara, I found it very interesting that you spoke about the 40 recommendations in the previous reports. So far, little concrete action has been taken. The WHO recommends that each country develop a national strategy.This is what is being proposed here, although it is still just a proposal.

Which targets do you think should be given priority? In Quebec, our prevention has been very effective and has decreased the suicide rate in young people by half. I don't know if you have heard about the awareness campaign by Jasmin Roy, a very well known actor and host in Quebec. He is homosexual and was the victim of a lot of homophobia in his youth, adolescence and as he was entering adulthood. He wrote a very provocative book called *Osti de fif!*, which is a trendy and very common expression young people use, even though it is very destructive.

Could you please tell me about the targets that should be given priority?

Prof. Brian Mishara: The challenge comes from the fact that there isn't just one target. Everyone is interested in young people, but they aren't the ones who are most at risk; it's adult men. There are sub-groups as well, such as gay and lesbian individuals. Since there isn't a single target, we need coordination, an authority capable of determining the multiple targets and of ensuring that the information is spread everywhere.

Suicide is multi-determined. There are all kinds of risk factors, such as the lack of protection factors. There are various ways of lowering the suicide rate: we can control access to methods, we can provide help in crisis situations, telephone assistance, for example. The Internet is a new frontier for providing assistance. We can also apply the current legislation, such as Bill 141, which prohibits anyone from inciting or encouraging a person to commit suicide. This has never been applied when a person pushes another over the Internet to commit suicide.

There isn't just one target. I wouldn't dare say that one thing should be done instead of another. Suicide can affect everyone, and we need to act at multiple levels, simultaneously.

Ms. Anne Minh-Thu Quach: Thank you.

Ms. Batters, as others before me have done, I salute your great courage in coming here today after the very painful experience you have gone through.

You also mentioned fighting cultural prejudices. It is difficult to realize that you need help, to ask for it and to tell everyone that you have reached your limit. But, in order to regain a balance, it is healthy to recognize that you need help.

Do you think that we could make use of role models of different types, different cultures, different genders, and different ages as well, given that older people are said to be equally as affected? Have you thought of that for the awareness campaigns? You mentioned role models from sport, like Stéphane Richer.

● (1030)

[*English*]

Mrs. Denise Batters: Actually, I have thought about that, and that was specifically why I decided to target men between 30 and 50 in the commercial we did, and to have a guy who looked like a normal guy who would be playing hockey with his friends on the weekends and going out for coffee with a little group of friends. That's the target group I chose because of Dave, and because it seems to be borne out by the statistics that its the highest-risk group for completed suicides. Women, I think, attempt ten times more than men, but men are successful three times more than women, so that's the group I chose.

Certainly, having a diversity of different groups shown to have these role models who step forward, and that sort of thing, would definitely be very helpful. I think it's important, though, that when you're developing all these different groups, you remember the fact that middle-aged men are the highest-risk group, so they can't be forgotten. I think if they see all these different groups but none of them are like them at all, they will be less likely to seek help.

The Chair: Thank you so much to all the witnesses. Every witness contributed to this conversation in a very meaningful way, and I thank you for that.

I guess because we're emotionally connected to you, Denise, I especially thank you for your courage for coming here. We do miss Dave, but I think there are a lot of people who will have lives through his death, and through his courage in it. So there is some silver lining to this very sad occasion. Thank you very much for continuing on.

I'm going to suspend the committee now for one minute, and then we're going to go into our business. Thank you.

● _____ (Pause) _____ ●

The Chair: Could I ask you to please take your seats again?

We have a very timely and important motion before us by Ms. Quach.

Ms. Quach, would you please read it into the record?

[*Translation*]

Ms. Anne Minh-Thu Quach: I move: That the committee undertake a study on improved drug safety measures; that it hold at least five (5) meetings on this study to hear witnesses, including the Minister of Health; and that it report its findings to the House of Commons.

[*English*]

The Chair: Thank you so much.

We're open for discussion.

Dr. Morin is first.

[*Translation*]

Mr. Dany Morin: Madam Chair, I would like to move a friendly amendment. After the words “drug safety measures”, I would like to add “and develop a federal plan to address the current drug shortage”.

● (1035)

[*English*]

The Chair: Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Madam Chair.

I think there has been some discussion between Madame Quach and my assistant and we would like to change it to state something a little bit more specific:

> That the committee set three meetings aside after the Bill C-300 study to explain the role of government and industry in determining drug supply in this country, how the provinces and territories determine what drugs are required in their jurisdictions, and how industry responds to them, and the impact this has on stakeholders.

[*Translation*]

Mr. Dany Morin: A point of order.

Given that I have moved an amendment—

[*English*]

The Chair: Dr. Morin, just one moment, please.

Dr. Morin, go ahead.

[*Translation*]

Mr. Dany Morin: Given that I already have an amendment on the table, shouldn't we discuss my amendment before we move to Dr. Carrie's?

[*English*]

The Chair: The procedure is that we get everything on the table, and yours will be dealt with first, of course. You should know by now that that is the procedure. I know you're new, but not that new.

Okay, let's deal with yours first.

The clerk would like it in writing. Do you have it in writing, Dr. Morin?

Can we read Dr. Morin's out first, just so everyone is aware? Thank you. And you have Dr. Carrie's.

So we'll deal with Dr. Morin's first. Can you read it out, Dr. Morin? Is this your only copy?

Okay. The clerk will try then.

[*Translation*]

The Clerk of the Committee (Mrs. Mariane Beaudin): Tell me if I am incorrect. So it would read:

> That the committee undertake a study on improved drug safety measures and develop a federal plan to address the current drug shortage; that it hold at least five (5) meetings on this study to hear witnesses, including the Minister of Health; and that it report its findings to the House of Commons.

Is that right?

[*English*]

The Chair: Thank you.

Discussion? Madam Quach, go ahead.

[*Translation*]

Ms. Anne Minh-Thu Quach: Thank you.

I accept my colleague Dany Morin's friendly amendment. I feel that it is very important, given that we have been asking the government, specifically the Minister of Health, questions in the House about a plan to address the drug shortage.

I am sure you must know that Sandoz Canada, located in Boucherville, Quebec, is reducing its production at the moment. We know that, in mid-February, the United States Food and Drug Administration contacted Sandoz Canada and told them that they were not complying with quality standards for the drugs and that improvements had to be made in its production chain. The company agreed to make them. Then there was a fire. Since Sandoz Canada is the main supplier of medications to Quebec, specifically for surgery and for injections, more than 60% of the surgeries in two hospitals, those in Hull and Gatineau, were cancelled. In addition, a number of patients have to wait to have their treatments and to get their medications because of the impeding shortage.

At the moment, there is no plan to help those people. The minister said that she was going to import drugs. While we are waiting, we need a plan. It is very important that there be a plan—

[*English*]

The Chair: Ms. Quach, I don't mean to interrupt you, but if we want to get the motion through—it's a very important motion. If everyone is going to have a 15-minute speech, we will run out of time. We've got about six minutes.

[*Translation*]

Mr. Dany Morin: A point of order.

[*English*]

The Chair: I want to make sure, if you watch the time...this is a very important motion and I'd like to get it through today. That's all I'm saying.

If you run out of time, you're going to be disappointed. I just want to make you and all of the members aware of that.

● (1040)

[*Translation*]

Mr. Dany Morin: A point of order, Madam Chair.

I feel that you showed a lack of respect towards my colleague Ms. Quach when you rushed her and implied that she was making a 15-minute speech. She has the right to express herself in this committee and to explore her thoughts in depth.

Perhaps the clerk could tell us how long Ms. Quach spoke for. I feel that it was nowhere near the 15 minutes mentioned.

[*English*]

The Chair: Dr. Morin, I'm just trying to....

[*Translation*]

Mr. Dany Morin: I have not finished, Madam Chair.

[*English*]

The Chair: No, just for one moment. I'm trying to explain to you.

That's not a point of order, number one. Number two, I'd like to get this motion done. I've left this committee business open. This is an extremely important motion. If I don't get it done in the next five minutes, we will go on to the next meeting. So it depends on how much value you put on this motion. I'm trying to get it through. I'm trying to kindly remind you that none of us can do a 15-minute speech because we won't get the motion through. That's the only thing I'm saying.

If you want to talk it out and not pass it today, that's your prerogative.

[*Translation*]

Mr. Dany Morin: Once again, Madam Chair, I feel that our right to speak and to explore our thoughts in depth is not being treated with respect when our Conservative colleagues—

[*English*]

The Chair: There is no point of order.

Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Madam Chair.

I do want to thank my colleague for bringing up the issue of supply. I do agree that it's an extremely important thing that we bring forward. My understanding is that there was some conversation and the NDP was okay with the scope of what we did propose. There may be a slight difference, I believe. The NDP would like to have the minister here. One of the major differences, though, that I would point out is that the minister is coming here—I think at the next meeting. My colleague is open to ask the minister questions at the next meeting.

This particular issue with the supply is a little bit different from the safety issue. I think that is the issue we can deal with promptly. So I would ask the clerk to read out again what I put forward to see if that is acceptable to the NDP.

The Chair: I think we have to deal with Dr. Morin's first. If you have more discussion, we have two choices. You can continue to discuss or we can vote and go on to the next one. The first motion that came through...Ms. Quach. It's a very, very good motion; we all agree to that. We just want to make some decisions here, because this is the process. We only have four minutes.

Do you want to go to the vote now on this motion, or do you want more discussion?

Dr. Morin.

[*Translation*]

Mr. Dany Morin: Thank you for giving me the floor again, Madam Chair.

I feel that we all, on both sides of the table, are in favour of my colleague Ms. Quach's motion and we want to get it through. But we have to have the time to discuss it. As you have mentioned several times, the motion is very important. That is why I do not want to rush things.

I am very pleased that my Conservative colleagues are finally agreeing to take action on drug safety and the drug shortage.

As for the NDP, Ms. Quach raised the matter in the House for the first time on November 22, 2011. She was speaking to the Minister of Health on that occasion. I can even quote her words, which shows the extent to which drug safety is important for the NDP. She asked this question: “When will the Minister of Health require pharmaceutical companies to disclose this vital information to protect children who depend on these drugs?”

[*English*]

The Chair: Thank you.

Can we vote on this motion now? We're going to run out of time. We won't be able to get Ms. Quach's motion through.

[*Translation*]

Mr. Dany Morin: I have not finished, Madam Chair.

[*English*]

The Chair: Can I have a show of hands?

[*Translation*]

Mr. Dany Morin: No, Madam Chair. It is a very important motion.

[*English*]

The Chair: Okay, then, Mr. Morin, you don't want to get the motion through. You want to keep talking.

[*Translation*]

Mr. Dany Morin: No, I did not say that. On the contrary. Madam Chair, I have to remind you that you decided to set aside five minutes before the end of the meeting in order to discuss the meeting. If you had set aside more committee time in order to discuss it, I would have been delighted and each member of the committee wishing to speak could have done so without being constrained by time.

[*English*]

The Chair: Well, 15 minutes, with all due respect, is usually lots of time to push a motion through. Can we vote on this now?

[*Translation*]

Mr. Dany Morin: I haven't finished speaking, Madam Chair.

[*English*]

The Chair: You don't want to vote on it now.

[*Translation*]

Mr. Dany Morin: We are not going to vote before I finish saying what I have to say.

[*English*]

The Chair: Well, we're going to run out of time.

Okay, go ahead.

● (1045)

[*Translation*]

Mr. Dany Morin: Thank you.

The fact that Ms. Quach brought up this issue in the House and spoke to the Minister of Health about it on November 22, 2011 shows the extent to which drug safety and the drug shortage concern us in the NDP. Unfortunately, when Ms. Quach raised the question in the House, the Minister of Health gave no indication that she wanted to move forward. So I am pleased that the Conservative government is finally deciding to do something.

Moreover, this week, March 6, 2012 to be precise, my colleague Ms. Quach once again spoke as NDP deputy health critic. She said that not only were the Conservatives saddling provinces and territories—

[*English*]

Mr. Mark Strahl: On a point of order, we have to go to our next committee. I'd adopt a motion to adjourn.

The Chair: I am so sorry. We'll have to continue this another day. Regrettably, we couldn't get this motion through. My apologies.

The time is done. Our meeting is adjourned.

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