HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 013 • 2nd SESSION • 41st PARLIAMENT

EVIDENCE

Tuesday, February 11, 2014

Chair

Mr. Ben Lobb

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● (0845)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good morning, ladies and gentlemen. I thank everybody for attending this morning.

We have two witnesses here this morning on our continuing study of prescription drug abuse. Today we have Carol Hopkins and Peter Dinsdale.

Ms. Hopkins, if you're ready to start we'll get you to present. You have about 10 minutes to do your presentation. We have two witnesses today, normally we have four, so if you need to go over by a few minutes, that's okay.

Ms. Carol Hopkins (Executive Director, National Native Addictions Partnership Foundation): [*Witness speaks in Ojibwe*]

I'm from the Lunaapeew nation, otherwise known as the Delaware first nation of southwestern Ontario. I'm the executive director of the National Native Addictions Partnership Foundation. Thank you for the invitation to speak with you today.

I want to cover five different areas today if I have enough time. I want to give you an overview of some of the issues related to addressing prescription drug abuse with first nation communities, a little about public health, primary health care, and community development and those linkages. I want to talk to you about collaboration and integration, and then look at a systems approach and our broader ecological systems approach.

In terms of issues, common strategies to address prescription drug abuse are not readily available in first nation communities and are even more challenging in rural and isolated areas. For example, there's no public health or comprehensive primary health care systems in first nation communities. There's a lack of coordination and collaboration between public health and primary health care systems and first nation communities. There's a lack of coordination across jurisdictions: provincial, territorial, and federal health authorities. There's little understanding of the benefits of pharmacological interventions to address prescription drug abuse issues among first nations people.

There's also a lack of and no access to withdrawal management and opiate medication-assisted treatment such as methadone, buprenorphine, or naloxone, specifically as they are linked to or working in collaboration with first nation communities and community health programs. When methadone maintenance treatment is available, clients from first nation communities often have to travel long distances, putting strains on medical travel budgets administered by first nation communities, and this adds up to significant daily costs.

There's a lack of appreciation of the impacts of colonization among prescribers and service providers. Therefore there's a lack of trauma-informed care to first nations people.

Approaches to health promotion, prescription drug abuse prevention and treatment don't often consider broader issues such as the relationships between addictions, mental health, co-morbidities, concurrent disorders, pain, and chronic disease. Some of the impacts of those issues are increased use of alcohol to manage withdrawal and increased use of heroin. There's an increased risk of blood-borne communicable diseases, and there are accidental overdoses and deaths, and increased violence.

First nations children are 15 times more likely than the rest of Canada to be in care in the child welfare system. Drug trafficking is almost four times higher than the rest of Canada, according to Public Safety Canada. Rates of domestic violence are five times higher than in the rest of Canada, and mental health and addiction issues certainly play a significant role in employability.

The change required to address prescription drug abuse issues requires change in the way governments do business. We need more horizontal work across governments and between government departments with first nations as key partners. We need support for a comprehensive framework that can be used to guide communities, regions, tribal councils, health authorities, provincial and territorial governments, and federal departments in knowing how to adapt, optimize, and realign programs and services to be more responsible and flexible in meeting the needs of first nations people.

We need to recognize that first nation communities aim to achieve wellness, and that this perception of health is often distinctly different than a medicalized model of health because the first nations' focus on wellness is more holistic. It promotes an equal balance between mental, physical, emotional, and spiritual aspects of life.

The issues among public health, primary care, and community development are that they don't often work together, especially when it comes to working with first nation communities.

● (0850)

But there is good evidence that there are great benefits when they do collaborate—public health, primary care, and first nation communities—specifically in the areas of maternal child programs, communicable disease prevention and control, health promotion and health protection, chronic disease prevention and management, programs specific to youth, programs specific to women, and substance use and mental health issues.

Solutions have to focus on the social determinants of health for first nation communities, and they have to include and be reflective of indigenous knowledge and culturally relevant evidence. There's a need for increased support for protective factors, such as appreciation of culture and linkages to cultural identity, use of our traditional first nation languages, culturally relevant education, access to high school, recreational activities, and linkages to cultural practitioners and elders.

We need resources and policies focused on community development and capacity building, and increased support to identify, develop, promote, and evaluate evidence-informed and culturally safe practices. We need comprehensive workforce development in first nation communities.

One of the systems approaches that has been developed culminated over four years in the creation of what is known as “Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada”. This was a collaboration between the Assembly of First Nations, Health Canada, and the National Native Addictions Partnership Foundation. It describes an integrated, culturally relevant, client-focused system of services and supports for addressing substance use issues for first nations. The framework identifies best and promising practices to strengthen and support programs at the community, regional, and national levels and across related jurisdictions. The framework implementation to date has focused on strengthening a system of care; improving the quality of programming that currently exists in the national native alcohol and drug abuse program and the national youth solvent abuse program; ensuring better measurement, oversight, and research; and enhancing coordination and integration at all levels. The implementation of the framework represents an opportunity to support a comprehensive response to prescription drug abuse issues for first nations.

An example of some promising practices is this framework was used to inform a discussion between the Ontario Ministry of Health and Long-Term Care, the Chiefs of Ontario, and the first nations and Inuit health branch of Health Canada. There have also been community development programs in place, called mental wellness development teams in Ontario, that have a focus on community development and show promising practices.

There have been culture-based opioid replacement therapy programs, where first nations have invested their own funds in Suboxone for opioid replacement therapy, because it wasn't readily available to match the needs of the community. The community has found that it's easier to store than methadone, and easier to dispense in remote communities. They found it worked well with holistic treatment programs that were land-based programs that included counselling with cultural practitioners, culturally relevant community development initiatives, and life skills development.

Currently we're in the process of developing a broader ecological systems approach. It's called the first nations mental wellness continuum framework. It's currently under way, and it describes the vision for first nations mental wellness with culture as the foundation. It emphasizes first nations' strengths and capacities. It provides advice on policy and program changes that should be made to improve first nations mental wellness outcomes, and it focuses on cultural values, sacred knowledge, indigenous knowledge, language, practices of first nations, and understanding that these are essential to the social determinants of health for individuals, families, and overall community wellness. It has five themes, identified after regional discussions, national discussions, and discussions with federal government departments.

● (0855)

The first theme is that culture has to be the foundation. Two is community development and ownership, and the others are quality health systems and competent service delivery, collaboration with partners, and enhanced flexible funding investments.

What we've heard to date is that new investments are needed in addition to the realignment of existing resources. Also needed is improved information-sharing among federal departments, improved coordination of programs and services, and the mapping of authorities to see where collaboration is possible. There is a need for more flexible ongoing funding to support community-identified needs. There is a need to build on what is working in first nation communities, and align federal programs and services that impact mental health and addiction services for first nation communities.

Overall some of the key aims are to move from an examination of our deficits as first nation communities to a discovery of our strengths by focusing on culture. From the use of evidence absent of indigenous world views, values, and culture, we need to move to indigenous knowledge that sets the foundation for evidence in approaches for addressing prescription drug abuse. It also involves moving from a focus on inputs for individuals to a focus on outcomes for families and communities, and finally, moving from uncoordinated and fragmented services to integrated models for funding and service delivery.

I'm not sure where I am in time but I'm just going to keep talking until you cut me off.

The Chair: You're slightly over already, which is okay. Do you have 30 seconds or a minute to wrap up?

Ms. Carol Hopkins: Okay.

The Chair: If that's okay, or thereabouts.

Ms. Carol Hopkins: Some of the priorities for first nations are the provision of medically assisted treatment, and so greater access to methadone, buprenorphine, and naloxone maintenance. Withdrawal management is also absent from the first nations system and there's a reliance on provincial government services that often don't have enough services to address the needs of first nations people.

We need to have a focus on outcomes that are reflective of cultures, such as investment in spiritual wellness that promotes health, emotional wellness that promotes belonging, mental wellness that promotes having meaning in one's life, and physical wellness that facilitates having purpose in one's life. If hope, belonging, meaning, and purpose were our targeted outcomes of any approaches to addressing prescription drug abuse we would be promoting an indigenous wellness framework.

● (0900)

The Chair: Thank you.

Very good, Ms. Hopkins.

Next up is Mr. Dinsdale for 10 minutes or thereabouts.

Mr. Peter Dinsdale (Chief Executive Officer, Assembly of First Nations): Thank you very much, and good morning. On behalf of the national chief and the national executive of the Assembly of First Nations, thank you very much for inviting us here to speak. I'd like to acknowledge, of course, that we're gathered here in traditional Algonquin territory and thank them for allowing us to gather here and do this work today.

I want to say at the outset that I'm joined by some very capable and knowledgeable staff who are here supporting me: Judy Whiteduck, Marie Frawley-Henry, and Jennifer Robinson. So I want to acknowledge them in reference to pulling this together.

It is my pleasure to speak before you today on the government's role in addressing prescription drug abuse in first nation communities.

First, I want to speak to the framework in which we operate. The UN Declaration on the Rights of Indigenous Peoples, in article 23, states:

> Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Secondly, it has long been the goal of the Assembly of First Nations to close the gap in health outcomes between first nations and the general Canadian population. We're pleased to see that this objective is shared by Health Canada as demonstrated by the expressed mandate to address health barriers, disease threats, and maintain levels of health comparable to other Canadians. So we're simpatico.

While we clearly share the similar objectives, the facts remain that first nations people continue to suffer disproportionately with poor health, both mentally and physically.

Thirdly, any consideration of the government's role in addressing prescription drug abuse has to begin with an understanding of the history of colonialism and its effects on first nations and their interactions with the government. In Canada, this history includes legislation such as the Indian Act, the creation of the reserve system, the various legal status apparatus in which we operate, residential schools, the sixties scoop, inadequate services to those living on reserves, continued racism, and the lack of understanding of their experiences or consideration of the effects of all these experiences.

Further, we also need to acknowledge the connection between historical, cultural, economic, political, and legal factors affecting the well-being of first nations people, namely, through the social determinants of health. While the social determinants of health approach is necessary in policy discussions and the government's role in addressing prescription drug abuse, it's not efficient in and of itself and must be implemented in accordance with the values, attitudes, and aspirations of first nations peoples. This is in addition to the utilization of traditional and western practices and service delivery aimed at first nations. Programs and services designed without first nations involvement simply will not work for us. Programs and services must be community-based and community-designed with a strong understanding of the diverse needs, because no two communities are the same.

The system of health we need to create and the system of health care must ensure that the sustainability of resources is matched to population growth and health needs. Additionally, policies and programs must be consistent with the inherent treaty and aboriginal rights as defined in section 35 of the Constitution Act.

So with respect to mental wellness, over the years first nation communities and leadership have been calling for a coordinated and comprehensive approach to mental wellness programming. This has been evident by the numerous resolutions that have been passed at our assemblies that give us our mandate and policy direction. Other national initiatives and organizations such as the Mental Health Commission of Canada have also identified the description of a continuum of mental wellness services for first nations as a high priority. We've worked closely with them in developing strategic directions that state things such as the recognition of distinct cultures and mental health needs of first nations, Inuit, and Métis outlines the importance of a distinction-based program within mental health. The strategy was released in May 2012.

However, it is imperative that this process be undertaken through a coordinated approach that involves the full participation of first nations as partners at every level of the process. For example, the Assembly of First Nations has partnered with the first nations and Inuit health branch to jointly develop a first nations mental wellness continuum framework ensuring that the unique needs of first nations in remote, rural, and isolated communities are taken into consideration. As a result, we expect and anticipate the government will work together with us in support of first nations mental wellness approaches along that continuum.

The government's role in addressing non-insured health benefits includes the need to improve access to that program, regardless of where first nations reside.

● (0905)

More importantly, we want to register the current and alarming state of the non-insured health benefits program, which demonstrates more than ever the need for profound changes in the administration of these benefits to meet the needs of first nations and not merely the fiscal interest of the country.

In 2011, the Assembly of First Nations requested that the Senate Standing Committee on Social Affairs, Science and Technology undertake a comprehensive review of the non-insured health benefits. This request was denied.

As a result, in 2012, the chiefs in assembly requested the Standing Committee on Health undertake this review. Again, this request was denied. This led to a further resolution from our chiefs, mandating the AFN to call for a joint review of the non-insured health benefits program, in collaboration with Health Canada. This request is ongoing. We wrote to the minister in January 2013, requesting action on the resolution. The letter called for a meeting between the national chiefs and the minister to begin discussions on conducting a comprehensive joint review of the program. We have just been informed that in the very near future, the national chiefs and the Minister of Health will be meeting for the first time to begin to do this work.

Another key issue relates to OxyContin, a long-acting oxycodone drug that was discontinued in Canada in 2012. Following the withdrawal, the generic oxycodone recently became available in Canada, and Health Canada approved new generic formulations of it. These new formulations are addictive, and they are not tamper resistant. As such, they will impact first nations that are struggling with this ongoing addiction. The misuse of oxycodone is merely one aspect of a larger health crisis within our communities. It has disastrous consequences all across first nations, and I think most notably in Northern Ontario, as has been demonstrated through the media.

Therefore, sustainable and sufficient investments must be made across a broad range of social and health services, including basic infrastructure such as housing and others, and the ability to access mental health support services and addiction recovery services.

Currently, our engagement with the government is occurring through partnerships and strategies that include a multi-pronged approach on preventing prescription drug abuse. The AFN works with the first nations and Inuit health branch's program areas, which include prescription drug abuse strategies to specific first nation communities in the areas of prevention, treatment, and enforcement. These include the first nations and Inuit mental wellness strategic action plan, the national anti-drug strategy, the national native alcohol and drug abuse program, and the national youth solvent abuse program.

In addition to our partnership with the first nations and Inuit health branch, we have also participated on the prescription drug abuse coordinating committee with the Canadian Centre on Substance Abuse. To date, projects such as Honouring Our Strengths—as we referred to earlier, which was produced in partnership with FNIHB and the National Native Addictions Partnership Foundation—and First Do No Harm are the most recent efforts to jointly develop a first nations mental wellness continuum framework that illustrates that the foundation of a systems-based approach to prescription drug abuse programs begins with individuals, families, and communities as well as many other key stakeholders and players.

More recently, we participated in a symposium held last month with Minister Ambrose to discuss resource gaps and opportunities for collaboration in the areas of prevention, treatment, and enforcement related to prescription drug abuse. We welcome continued engagement and encourage continued collaborative efforts to address prescription drug abuse within the mental wellness continuum so that first nation communities can adapt, reform, and realign their mental wellness programs and services according to their priorities.

We continue to call for flexible and sustainable long-term funding to ensure that the solutions to prescription drug abuse are community-driven, so that our families can continue to heal from the impacts of colonization and move forward on the path to mental wellness.

Finally, we reiterate our call for a joint review on the non-insured health benefits program. First nations are the youngest, fastest-growing populations in Canada. This work is in all of our interest. Strong and healthy first nations make for a strong and healthy Canada.

Thank you very much.

The Chair: Thank you very much, Mr. Dinsdale.

That'll conclude our presentations.

First up for a seven-minute round of questions is Ms. Davies.

Go ahead, please.

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

Thank you, Ms. Hopkins and Mr. Dinsdale, for two very informative and I would say comprehensive presentations. You covered a lot of ground. Thank you for providing that information. First of all, I want to say to both of you that I really appreciate and value the approach you take, which is based on community development and comprehensive overall wellness.

Carol, one of the issues that you touched on is moving from individuals to looking at families in communities and at outcomes. In one of the communities that I represent—the Downtown Eastside, where there's a high aboriginal population—that's absolutely the way we have to go. It doesn't really matter what program it is; it's the approach that's taken. I appreciate that you've put that point forward, and in the reports that you have done, it keeps coming through.

We have two national programs, the national native alcohol and drug abuse program and the youth solvent abuse program, which you mentioned. Then, of course, there's the non-Insured health benefits program. How well, if at all, do those programs reflect this approach that you are talking about?

What you are saying so clearly is critical, if we're going to change anything. Are those programs moving in this direction, would you say, or are we stalled? What can we do to encourage these national programs to reflect the delivery model and model of community ownership and development that you spoke about today?

● (0910)

Ms. Carol Hopkins: Both of the national programs that you refer to, the national native alcohol and drug abuse program and the national youth solvent addiction program, are residential treatment programs primarily focused on treatment for individuals. Some of the programs provide treatment for whole families in residential environments. Many of these programs are reprofiling so that they have capacity to address prescription drug abuse issues. The Honouring Our Strengths renewal framework is a framework that sets out a vision for reprofiling services, using existing funds, to be more community-based.

However, the funding that is available in both national programs isn't enough to expand to community-based services, although the Honouring Our Strengths renewal framework certainly does promote a continuum of care. Across Canada, different regions have reviewed the services in their regions through NNADAP and YSAP, and some have reprofiled so that they are more community-based. Primarily, those systems consist of 56 treatment centres across Canada; that is, residential treatment programs. Not all of them have the capacity to address prescription drug abuse.

Ms. Libby Davies: Are they all on reserve, or are some of them off reserve as well?

Ms. Carol Hopkins: A majority of them are on reserve.

Ms. Libby Davies: In B.C. we have the new agreement on health care with aboriginal people. It's pretty new, so there's still obviously a lot of evaluation taking place. I don't know how much you are involved in or aware of that agreement, but do you have a sense at all that the new agreement and the way programs will be delivered will produce a fundamental change? When you talked about community development mental health awareness teams, I think you were speaking about Ontario. Do you have any sense that this new agreement in B.C. is going to address some of the issues of mental health, addiction, prescription misuse, and so on, with that kind of model, doing so from a community development point of view?

Mr. Peter Dinsdale: Just recently I had conversations with the chair of the First Nations Health Council around some of these issues. Of course, this is very new; they are months into it. His description of it is that it allows them to focus their priorities on areas in which they need funding. He said that in previous developments, there occurred a lot of infrastructure development in association with which there weren't necessarily enough services in communities themselves. So they're going to reprofile some of the work they're doing in their existing envelopes to focus on community-based services.

The mix between the amount of health programs and others is to be determined by that council, but I think it has great potential to do exactly what you're talking about, to reprofile resources and use this ability to focus on community-based solutions.

Ms. Libby Davies: Do I have time for just one short question?

● (0915)

The Chair: You have a minute and a half.

Ms. Libby Davies: Thank you for that. I think it's something that we should watch very closely because it does put forward a sense of hope that changes can come about.

I guess the last point I'd like to make, Mr. Dinsdale, is that I'm glad there is a meeting that's going to take place. You say it's been requested for a while. This issue of a joint review of the non-insured health benefits, depending on what comes out of that meeting I would hope very much that you might keep this committee apprised of whether or not progress is being made. We are the Standing Committee on Health and this is a direct federal responsibility so there's a clear jurisdictional issue. As you say it should be done in partnership and it should be comprehensive. So I think it would be very helpful if you could keep us apprised of that, given that there is a meeting now taking place and maybe it's something that we can help in terms of communication, or to take it up in some way. We hear your frustration that this is something that you requested for a long time and it hasn't yet happened.

Mr. Peter Dinsdale: Very quickly...absolutely. You should also know that we are also doing regional and national work on the non-insured health benefits program to strategize on our side, the first nations political leadership side, including a national forum to be held in Toronto in March, which is meant to be the culmination of a bunch of regional conversations. So we can certainly inform the clerk of it. If you're available to come and attend we'd welcome having any of the committee members.

The Chair: Very good.

Ms. Adams you have seven minutes, please.

Ms. Eve Adams (Mississauga—Brampton South, CPC): Thank you very much for joining us today. All members of our committee were very eager actually to hear from you. It was a priority to ensure that you would come and present today so thank you very much for coming to Ottawa.

Ms. Hopkins, I would also like to thank you for partnering with Health Canada to create “Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada”. I know that the Minister of Health found the information here very important, so thank you for this very good work.

The federal government does currently fund a number of projects when it comes to prevention and treatment. As you can imagine we'd like to focus our resources on best practices and share those nationwide. Can you tell me which programs you think—if you would both please speak to this—are the most worthwhile?

Ms. Carol Hopkins: We are currently in the process of conducting some research around the impacts of culture-based interventions to address substance use issues. We're looking forward to gathering evidence over time about the impacts of culture-based interventions.

We have some good preliminary data on the outcome of residential treatment programs for first nations. Where those programs offer culturally based services there's a good indication that at least 65% of people leaving treatment going back into first nation communities are able to maintain a good level of wellness—meaning they're not using their primary choice of substance, and they're at least reducing another substance because first nations people are polysubstance users.

In terms of community-based programs there has not been enough investment in community-based services to get a good sense about the most effective programs. They're going based on what happens in residential treatment and the conversations that we've had over the development of the HOS renewal framework, and the recent first nations mental wellness continuum framework. First nations people are saying that culture has to be central—that's the HOS renewal framework—and in the first nations mental wellness continuum framework it says culture has to be the foundation. It can't be an add-on. It can't be the adaptation of western-based approaches. It has to be the foundation.

If we're going to make any significant long-term gains then that requires culture that is not marginalized in the workforce. So for example, cultural practitioners and elders have to be central. There has to be good collaboration across health care providers.

Ms. Eve Adams: Thank you.

Mr. Dinsdale.

Mr. Peter Dinsdale: That's the great thing about speaking after Carol, I don't have to say as much.

One of the things I may add though is that the B.C. agreement—the health devolution agreement—may really hold some promise for consideration across the country. I think here is an example where first nations themselves can set priorities to focus on local community control and to have local community responses as opposed to a one-size-fits-all national program, which sometimes is well-intentioned but sometimes will not be directly aligned at the community level. I think that will be an important agreement to watch and an important agreement to see how it does impact that kind of ability.

● (0920)

Ms. Eve Adams: You know, the non-insured health benefits program takes the opportunity to look at individuals who might be at a higher risk for abusing substances and starts monitoring the types of substances that are being dispensed to that individual.

We've seen some very good results. I'm going through some of the numbers here. Somewhere there's a 10% decrease in opiate use. Some others are citing 20%. Have you had a similarly positive experience with that?

Mr. Peter Dinsdale: Certainly we don't get that kind of direct feedback at our level. What we hear about are the delisted programs and the things that aren't being funded by non-insured health benefits. I think our engagement is slightly different.

We certainly encourage and support those monitoring programs that do help in this regard.

Ms. Carol Hopkins: I just remembered one other example.

Ms. Eve Adams: Yes.

Ms. Carol Hopkins: We were funded by the provincial government of Manitoba to develop a school-based early intervention program that we then trained first nation community workers—both addictions workers and school personnel—to deliver. That program has had good success in terms of the outcomes in reduction of prescription drug use by youth in grades 7 and 8 in first nation communities.

In the schools, we've now trained over 40 first nation communities to use this program, and it has been well accepted and received. It has replaced the health curriculum in the first nations' schools because it matches provincial education standards related to health. It also aligns well with the Province of Manitoba in their health outcomes studies for school-age children.

It has also served as an alternative measures program for youth in trouble with the justice system.

Ms. Eve Adams: Thank you.

I have just a quick question. In terms of the delisting, Mr. Dinsdale—just to follow up—since OxyContin was delisted in 2012, the number of clients receiving long-acting opioids has actually declined by 10%, and that was the entire purpose of removing a number of drugs from the formulary. So, for instance, generic Ritalin and OxyContin were removed, Demerol was removed, Tylenol with codeine was removed, but at the same time, alternative therapies that have a lower risk of abuse have had more open access.

Have you noticed that?

Mr. Peter Dinsdale: I think we're very supportive of that, of the delisting of those that are obviously being abused through different kinds of systems. I think the challenge is where there's this replacement generic drug that is a replacement that actually has the same potential for addictive properties. So I think we need the same vigilance in making sure that things that replace what has been taken off aren't being used in a similar manner as those that were delisted. I think that's part of the caution we're raising in our briefing as well.

Ms. Eve Adams: Thank you very much.

The Chair: Very good.

Now I'd like to welcome Ms. Murray to our committee this morning. You have seven minutes.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you.

Thank you for the wealth of information that you were both able to squeeze into your 10-minute presentations. Would the AFN be recommending a reversal of the approvals of these replacement prescription drugs that are potentially also addictive?

Mr. Peter Dinsdale: Absolutely. There's a new generic formula of oxycodone that has been approved, and that new generic formula, we understand, is not tamper resistant and can be used. So of course we would look at that no longer being available.

Ms. Joyce Murray: So that's a clear recommendation by the organization.

Mr. Dinsdale, you talked about the need to recognize the causes of the health gap, and I think Ms. Hopkins also talked about some of the history of first nations residential schools and so on.

So what would that look like, the need to recognize the causes of the health gap? Are you asking for anything specific? Is it a statement?

What would recognizing it so that it's clear and an agreed-upon part of the whole systemic problem...? Is there a specific ask on that level from AFN? Ms. Hopkins could answer that as well.

● (0925)

Ms. Carol Hopkins: Yes, for certain. For instance, first nation communities are funded on a per capita basis. If we're going to be able to provide the resources for first nation communities, then we need to consider needs-based planning and formula funding.

Ms. Joyce Murray: Specifically about recognizing the cost of health care, what you're saying is that it's not about a statement or essentially an assertion that we recognize that. You're saying it should be in how funding is allocated. Actually I had a question as to whether resources for addictions treatment and health and wellness are keeping up with population growth. When you use the word “reprofiling” quite a bit that seems to mean that it may not be, that the additional funding that's identified, that may be needed for this, isn't there. So you're having to figure out what you can squeeze to do that.

Also, Mr. Dinsdale, if you have a thought about my first question, what does it look like to recognize that?

Mr. Peter Dinsdale: I don't think there's been one action that got us to this situation today and there won't be one reaction that gets us out of this situation today. I think frankly the residential school apology, the example of the kind of recognition of programs potentially in areas like education, we'll see this afternoon, I guess, if it's confirmed....

So much other work needs to take place, whether it's housing, employment and training, or all these other outcomes that exist. I think taking that into account, it can't simply be this one health strategy that will resolve everything. It operates within a framework where you don't have clean drinking water. You can't wash your hands in your home.

To bring together certain southern concepts of health care, drop them into a northern community with these kinds of challenges, you need to take into account the entire spectrum that you're coming into. I think that's somewhat what we're speaking of.

Ms. Joyce Murray: Okay. I think I understand better. I'm the critic for national defence. We've been working a lot with the issue and challenges of ill and injured soldiers. I think there's a clear recognition that the causes of operational stress injury are experiences the members have when they're out on operations. You can say there's a complex set of health challenges that come from that, but there is a trauma-related injury. So I heard that also from Ms. Hopkins—trauma informed. In understanding that this is a mental injury, perhaps, that occurred for the forces members, we are also recognizing that there are, in a way, those trauma-related mental injuries that may have occurred from abuse and trauma experienced by aboriginal peoples. I was thinking about the correlation there.

I do have another question that also comes from the concerns we have in the national defence committee. Some of the roles for experts to support the injured forces members have just not been put in place. Even the numbers that were identified by health experts in 2003, we're still almost 60 experts short.

When you're talking about community-based services and services driven by communities—comprehensive mental wellness approach—is there a challenge of not being able to have the medical expertise that's needed? Is it a recruitment problem? Is it a possible hiring freeze problem? It turns out in National Defence the 2010 hiring freeze is now being identified as one of the key reasons that 50 positions haven't been filled, even though there are people available to fill them. Are those same kinds of challenges occurring on the ground?

Ms. Carol Hopkins: On the ground in first nation communities you have a nurse, not always a nurse practitioner, who is the only resource for primary health care. If you have the nurse in the community who can't manage or is not licensed to take care of opioid replacement therapy, it's not an issue of personnel. There are first nation communities in northern Ontario where they don't have nurse practitioners and they have somebody flying up from Toronto on a regular basis to administer the opioid replacement therapy. That's northern Ontario.

There are other communities across Canada that don't have those kinds of resources, that don't have financial resources to support that, or any kind of comprehensive response. There are no doctors, no pharmacies. There is no transportation to methadone maintenance. Yet prescription drugs find their way into these communities quite readily. The access and availability is there, but the resources to respond to them are absent, both in funding as well as in personnel. Relationships with governments provincial, health care systems....

● (0930)

Ms. Joyce Murray: The funding for the positions and the recruitment could be a combination.

Do I have time for another question?

The Chair: You do not in this round, no. Thank you.

Mr. Young, go ahead, sir, for seven minutes.

Mr. Terence Young (Oakville, CPC): Thank you, Chair.

Thank you both for being here today.

Carol Hopkins, I'd like to ask you what the extent of the problem is, on the front lines, of prescription drug abuse amongst first nations. I'm talking about OxyContin, morphine, methadone, codeine.

Ms. Carol Hopkins: Thank you for that question.

We actually don't know. We don't have any prevalence data. It's absent for most of Canada. There is some information, but there is absolutely no prevalence data for first nations in Canada. That is something that we need to look at. We have been talking about it, but we haven't had the resources to do it.

Mr. Terence Young: We're operating with a study from 2008 to 2010, the first nations regional health survey, which says that 4.7% of first nations people aged 18 and older on reserve or in northern first nation communities reported use of illegal heroin or prescription opioids—morphine, etc. But that was at least three years ago. Could it be higher?

Ms. Carol Hopkins: Currently in the national native alcohol and drug abuse program, we know that at least 30% of the clients in residential treatment report an opioid use, but there is no distinction between the opioids and heroin, for example. When I say that we don't have good prevalence data, I mean that we don't know what different types of drugs are being used. We don't have data that tells us specifically how they access the drug, how they use it, or what the impacts are on themselves as well as on their families and their communities.

Mr. Terence Young: When they go into treatment, doesn't anyone ask them what drugs they've been taking?

Ms. Carol Hopkins: Yes.

Mr. Terence Young: Where does that information go?

Ms. Carol Hopkins: That's what I'm saying. In the national native alcohol and drug abuse program, we know that there are four top substances of use, alcohol being one, but also marijuana, cocaine, and opiates. But the way the question is asked, it doesn't distinguish between oxycodone and heroin, for example.

Mr. Terence Young: Okay. Thank you.

You talked about access to high schools and links to elders, which sound very positive. I know there are high schools, for example in Ontario, in which parents are more involved in the school and sometimes even sing in the same choir as the students. That happens in our schools here in southern Ontario as well.

With this new first nations education act, there is $1.9 billion in new funding available in the coming years, with a 4.5% increase per year. Is there an opportunity there for life skills development? You talked about that. It occurred to me that this would mean bringing together youth with elders—life skills development, building self-esteem. Does this new first nations education act present an opportunity to do that? Could it?

Mr. Peter Dinsdale: In fact there is no new first nations education act. There is a rejection of the previous first nation education act and a commitment to introduce a first nations control of first nations education act. That agreement was based upon the Prime Minister and the national chief outlining five conditions for moving forward. So we don't currently have an act, per se. That's the first thing.

Certainly the previous act talked about parents being involved, much like a school board, where they would help guide the culture and language programming that would take place in the schools.

Yes, I think there would be opportunities, if that flows forward to the new act.

What's really important about this new process is how much regions are going to be able to help drive some of this development. The previous criticism was that it was unilateral—"one size fits all" everywhere. This new approach really will be allowing regions to develop those systems—within a framework; I think that's important.

Mr. Terence Young: We heard that young people become addicted to oxycodone or OxyContin in, for instance, my community when they go to the dentist to get their wisdom teeth out.

I want to ask you how young people get addicted to prescription drugs, opioids, amongst first nations.

● (0935)

Ms. Carol Hopkins: It's through illicit use. Some of the young people going into the national youth solvent addiction program have gained access to prescription drugs through illegal access. Some of them actually have been in treatment at age 15 and have had a mouthful of decay. They have never had access to a dentist or seen a dentist, so are using prescription drugs to self-medicate because their mouth is full of decaying teeth and they are having their teeth removed at 15 years of age because they're all rotten.

Mr. Terence Young: Are there any programs now that are working by way of prevention? What is working now, if anything?

Ms. Carol Hopkins: The one program that I'm most familiar with, as I said earlier, is a school-based early intervention program that was developed for grades 7 and 8. It's actually being used by some first nation communities for early high school—grades 9 and 10—as well.

Mr. Terence Young: So what might work better by way of front-line programming? Do you have any ideas of things you would like to implement as soon as possible?

Ms. Carol Hopkins: Yes. It's hard to say any one thing. As Peter said earlier, there is no magic bullet: a systems approach, coordinated services, collaboration across jurisdictions, more inclusion of culture.

Mr. Terence Young: I heard those things, but those are big subjects.

Ms. Carol Hopkins: They are. It's a big issue.

Mr. Terence Young: You could write a chapter on each one. I'm just trying to think of how you can turn those concepts that are so important into practical programs to help young people avoid recreational use, or if they already have a problem, to get off drugs and build their own self-esteem, etc.

Ms. Carol Hopkins: The community wellness development programs show promising results as well. They are community development initiatives that are designed specifically to the needs of first nation communities. They are multiprofessional teams going into first nation communities, in collaboration with the cultural supports and resources that are there, to identify strategies that address where the community places its priorities.

Mr. Terence Young: Are there any roadblocks to that happening right now?

Ms. Carol Hopkins: It's funding, ongoing funding.

Mr. Peter Dinsdale: On that as well, I think there have been some examples, more in urban areas, of programs like the cultural connections for aboriginal youth, which has recently merged with the urban aboriginal strategy, which really provides youth with an opportunity to develop culture, recreation, and physical activity programs. We don't have comparable programs on reserve. I think gym and recreation programs, those kinds of things, would really provide alternative venues for youth to do more positive things and certainly be engaged in things kids everywhere like to do.

Mr. Terence Young: We have that problem in Halton as well.

Mr. Peter Dinsdale: Absolutely.

Mr. Terence Young: The schools have stopped teaching phys. ed., basically, so young people aren't getting exercise. That leads to other health issues as well.

Maybe I could ask you on the big picture—

The Chair: Mr. Young, I'm sorry.

Mr. Terence Young: Am I out of time already?

The Chair: Yes, sir, sorry about that.

We're now entering into our five-minute rounds.

Next up, Mr. Morin. Go ahead, please, sir.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you, Mr. Chair.

[*English*]

The Chair: Oh, sorry, pardon me, I'll reset the clock there. Just for the sake of the time, I'd ask you to put on your headpiece and we'll just do a quick run-through to make sure everything is working

[*Translation*]

Mr. Dany Morin: Can our witnesses hear the English interpretation?

[*English*]

The Chair: Okay, that's good. We just want to make sure that all the time is fair and equitable around here.

Go ahead, sir, five minutes.

[*Translation*]

Mr. Dany Morin: Thank you, Mr. Chair.

I would also like to thank the two witnesses for joining us today.

In your presentations, you talked about financial needs, about what investments should be made to improve the health of first nations and, more specifically, to fight this scourge of prescription drug abuse.

With that in mind, what are your thoughts on the fact that, according to its report on plans and priorities, the federal government wants to cut $653.8 million, or 17.3%, of Health Canada's budget, over the next three years?

Do you think there is some hope that the federal government will provide you with financial assistance to help you carry out your projects and, potentially, develop new programs or ways to improve the health of first nations? Do you rather believe that those cuts unfortunately mean that first nations will have to wait, as they have been doing for a very long time, to get what they deserve?

● (0940)

[*English*]

Mr. Peter Dinsdale: Trying to sidestep the minefield here a little bit, I don't think there is any question it certainly is problematic.

The kinds of cuts that are being sustained now by regional and national organizations as a result of budget 2012 cuts will absolutely have an impact. Our core funding has gone down by about 50% in the last six years. Our project funding will probably take another 30% cut next year, so the ability to hire staff to prepare these briefings and engage with organizations will be greatly diminished.

It's not just us. That's my personal example I can speak to. It's even worse for some of the regional bodies that have gone from about $2 million budgets down to $500,000. We've seen massive layoffs in Saskatchewan recently and I think we will see that across the country.

It's absolutely going to have an impact on our ability to analyze, to participate, and to advocate in the way that we have.

We get asked all the time why continue to push and engage in an environment where on one hand they're offering to work, and on the other hand they're taking away your basic capacity to do anything. It is a real challenge.

The national chief made a decision that we need to work hard on the work. There are all these challenges around us. We're going to continue to focus on our priorities. We are seeing some results in the education, or we believe we'll see some results in education. This is another example where we need to push to be very clear.

There is no question, we operate in a challenging environment. It is not going away. This isn't really a partisan thing. The 2% cap, frankly, which froze education funding and froze funding to other health areas and other recreation and housing areas, was implemented by a different coloured government than the one that's here today. In our view, we need to work with whatever government is there, and work in whatever challenging environment is there.

Yes, it's problematic, but we're going to do the best with what we have.

Mr. Dany Morin: How about you, Carol? Have you anything to add?

Ms. Carol Hopkins: Yes, I would say that the current trend is toward collaboration among first nations and federal and provincial governments so that there are pooled resources and coordination across federal government departments. There are many federal government departments that have responsibility for wellness in first nation communities and the limited flexibility in the way the funding authorities are currently applied can be addressed by coordinating spending across federal government departments. For example, first nations and Inuit health branch, in addressing mental health, and ANC, on its family violence initiatives, both focused on community development. These are opportunities where we can make some gain with collaboration and coordinated efforts.

Mr. Dany Morin: Thank you for that answer because it leads to my next question.

Peter, you mentioned in your presentation that it is important for first nation organizations to be actively involved in decisions affecting the people you represent. Is it the case now? Do you think that, even though the money might not be there, you are at least part of the decision-making process, or not?

The Chair: Just a brief answer, Mr. Dinsdale, we are right up on the time—

Mr. Peter Dinsdale: On this issue, that's absolutely where we're pushing. The meeting with the minister will be important in this regard. We talked about different areas....

Things like the first nations mental wellness continuum are areas where there are opportunities to collaborate in the ways you are talking about. The First Do No Harm project as well is another example of the collaboration. We need more of them.

The Chair: Thank you very much.

Next up is Mr. Lunney, please, for five minutes.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you, Mr. Chair.

I thank our witnesses, Carol and Peter, for being with us today. It's a very important subject that obviously we're all concerned about.

I just want to go back to the beginning of your presentation, Carol, where you said something about first nation communities seeking to embrace wellness. I think there is a lot of this concept of wellness in traditional native herbal remedies and traditional knowledge of stuff out of the woods that was around a ways back that could bear some further investigation today. I know we have it where I am on the west coast. There is a lot of interest in that, and some of the elders are quite well versed in some of the traditional remedies.

Anyway, I wanted to follow up with that. I would suggest it is probably something we could all look into, remedies that culturally would fit better in a first nations setting than some of the other strategies that have been developed for other communities.

The national chief is from the area that I represent, or I'm from his traditional territory, depending on how you want to look at this. His family is from Ahousaht on the west coast. Their Nuu-chah-nulth first nation language has a word that we sometimes think about. It's called *hishuk ish tsawalk*. If you are familiar with the Nuu-chah-nulth language, it simply means everything is one; we are a part of nature and nature is a part of us. So looking at a more holistic approach and a natural approach, there may be some remedies here that would be helpful. I think there are perhaps some things that could bear some investigation.

We had some discussion earlier about programs that are in place, strategies that have been developed that were discussed by some of my colleagues. But looking at the national anti-drug strategy in a general sense, at the grassroots level we look for support in community groups, youth groups, and others in providing kids with information about the dangers of drugs. Building on this approach to include prescription drugs could likely be done very efficiently. I'm wondering if you could speak to the level of coordination with community groups working to keep youth off drugs and how prescription drugs relate to other drugs.

● (0945)

Ms. Carol Hopkins: That's actually another void, a great absence. That was actually one of the key items identified in national discussions on the first nations mental wellness continuum framework, where first nations people across Canada were talking about the absence of literature and information, whether it be social media or otherwise, in first nation communities to educate young people about the harms associated with prescription drug use.

Mr. James Lunney: Just on the policing side of things, then, what challenges do the leaders and enforcement agencies face in preventing the illegal diversion of prescription drugs?

Mr. Peter Dinsdale: Certainly this is a whole other area of first nations policing and the ability of band constables through the various agreements we're seeing across the country. Again, there is a reduction of funding in these areas and fewer band constables being available in first nations, so it's a real challenge around the policing side.

I think it's something we need to look at, and I think the enforcement of it will have to be multijurisdictional, of course, because they are not being produced on a first nation. They are being delivered through various mechanisms on the first nations. So I think it's about cooperation and coordination as much as anything.

Mr. James Lunney: Let's come back to a line that my colleague Mr. Young was on earlier. You mentioned teams going out to help, and I think you were talking about professional teams going out to reserves to talk.

I'm thinking of a different type of team involvement, and it's young people being involved in terms of sports capacity and so on. I know on the west coast, some of the young people where the reserves are not so far from the rest of the community really engage in basketball initiatives, for example, hockey initiatives, team sports with some very positive role models from the professional realm. We have a former Globetrotter working with people on the island now. It really has young people engaged in developing skills. I'm wondering about those programs. Are you aware of programs like that, which offer good role models and just getting kids involved in the kinds of activities that keep them away from drugs and into more productive things that other young people benefit from?

Mr. Peter Dinsdale: In fact, that's part of what I was referring to.

We're very fortunate to have as an ambassador for something we call IndigenAction, Waneek Horn-Miller, to go out and talk to youth about the importance of how she became an Olympian and the level to which sport was important to her in her upbringing. She talks quite openly about how it prevented some of the other challenges in the community that she grew up in. The national chief really wants sport to be something we do a lot of work on. We'll have a national sports summit coming up soon to bring us together. There are a couple of national organizations, the Aboriginal Sport...and the other one I can't remember their name. They are doing some work in this area and want to bring together and coordinate a national strategy. There used to be a national physical activity and recreation strategy coordinated through the Department of Canadian Heritage through their sport authorities. What it didn't do, in my view, was to provide the funding to do exactly what you're talking about, to provide those outlets. If we had more schools on reserve we could use those gymnasiums to do those kinds of things and simply have programming to put in place. In part, that's the more holistic conversation we need to have.

I want to touch on something very briefly. I don't have a lot of time and I'm not trying to take it all. But when you talked about the importance of traditional healers and medicines and the different ways we approach things, often we speak in code. I don't even realize that we do it sometimes. When we say “local community-based approaches” that's really what we're talking about. It's the ability for an elder from that community or from a neighbouring committee to come in to meet with them to bring them together around issues, to be available for a specific kind of healing of this nature.

There are many traditional societies doing this kind of work. How do we cooperate with western-based methods? We hear a lot about people getting diagnosed for cancers, diabetes, and other things. It really works best when there's a blend of western medicine and traditional concepts. It's about merging them together because both have values and different approaches and each work for different people in different ways. When we say “community-based approaches”, because there are so many different cultures and approaches, it's the ability to support them to do what's really going to work best.

● (0950)

The Chair: Thank you very much.

Briefly, Ms. Hopkins.

Ms. Carol Hopkins: Thank you, Mr. Chair.

Youth who are leaving the youth solvent abuse treatment programs have had a greater understanding about colonization. We call it decolonization. They now understand that the ills they face in their communities are not there simply because they're native. They understand the context of those. They engage in culturally-specific types of activities, for example, sweat lodge ceremonies and other activities. They find ways to be able to sustain that when they go home. The youth who continue to practice cultural interventions at home in their community maintain their wellness more long term.

The Chair: Very good.

You're going to need your earpiece for this round of questions.

Ms. Morin, you have five minutes, please.

[*Translation*]

Ms. Isabelle Morin (Notre-Dame-de-Grâce—Lachine, NDP): Thank you very much, Mr. Chair.

I want to thank both of you for your testimony.

I really liked the fact that you did not just talk about health, but also about well-being, which is not something we have heard discussed since the beginning. This is a very good sign for me because it reflects the will to not only be healthy, but also be in a state of well-being.

Ms. Hopkins, you said that a significant portion of health care spending goes to travel. Since health professionals are not on site and community members always have to travel far, leave the reserve or community to have access to care, I assume that they must constantly feel that using that care is only for emergency situations. Sometimes, I even wonder whether I must really go to a clinic or whether I can wait. If I also had to travel far for that care, I would be facing an additional obstacle. What you said really affected me.

Do you have any potential solutions when it comes to this? How can we ensure better accessibility so that this health care can be provided closer to your communities? When people are in a state of well-being, they don't need illicit drugs because they feel good. What can be done to improve the situation?

Perhaps both of you have some solutions to suggest.

[*English*]

Mr. Peter Dinsdale: We're seeing some interesting headway being made in telehealth or use of other technologies to diagnose early, to stabilize prior to having to leave. Absolutely, it's a challenge not having health care professionals in the community to stabilize whatever is required remotely and to diagnose and treat. Frankly, it's a disincentive to even go in the first place—why am I going to go to the nursing station, they're just going to tell me to get on a plane or go; or they can't do anything for me, the nurse doesn't know how to deal with this; or maybe they will not even be here today, they'll be here in two days, depending. Certainly, access is a critical issue.

Ms. Carol Hopkins: Where there have been partnerships between provincial health authorities and first nation communities, they have been able to provide opiate substitute maintenance therapy in the first nation community, and it has worked well. Other communities, though, with the formulary changes, with the introduction of generic OxyContin, the formulary didn't keep up in terms of opiate replacement therapy. Access to Suboxone buprenorphine didn't match. There is definitely a need because that, as I said earlier, has shown promising results in remote and isolated first nation communities. It's easy to manage, and it's easier to store than methadone.

[*Translation*]

Ms. Isabelle Morin: I would like to see some relevant figures. You said that travel costs account for a large portion of your health care budget. Do you have any figures to share with us? How much money do those costs account for?

● (0955)

[*English*]

Ms. Carol Hopkins: For first nations people who are on methadone maintenance therapy, that requires daily travel outside of a first nation community to the local pharmacy. The health transportation budget has limits in terms of medical transportation for first nations clients. Communities have come up with creative strategies to pool resources to support that daily travel for people to access opiate replacement therapy. I don't know what the numbers are, however.

Mr. Peter Dinsdale: We simply don't get access to those numbers at our office.

[*Translation*]

Ms. Isabelle Morin: I have one last question for you.

You talked a lot about the impacts of colonization. You also talked to my colleague about decolonization. Can you tell us more about the direct impact of all that on the illicit use of subscription drugs?

[*English*]

Ms. Carol Hopkins: The impacts of colonization through reserve systems, loss of income, a change of economy, residential schools, and the child welfare system have perpetuated over generations. It has left significant mental health issues amongst first nations people.

Now you have generations of whole communities that don't understand the impacts of the Indian Act, they don't understand the creation of reserve systems, and they don't understand residential schools. With the Truth and Reconciliation Commission of Canada, first nations people are just now talking about their experiences in residential school systems. We've had four generations of people and families, whole communities, who have never talked about their residential school experience, whether it's physical abuse, sexual abuse, loss of family, loss of their language, loss of connection to their culture. So they are marginalized in mainstream society and they are also marginalized in their own community.

They don't have an understanding of the context, so they take on and they internalize that oppression and have a negative perception of themselves as first nations people. They believe that the issues they are facing are simply because they're native.

There is nothing in our education system that talks about colonization, until perhaps you're lucky enough to go to post-secondary education and you're in a first-nation-specific program. It's the first time you're learning about colonization or residential schools or the scoop of the 1960s. In programs, whether they are on reserve or they have been primarily through the national native alcohol and drug abuse program, that context is given. But it's given also with the teachings from first nations culture so that our own truth, which is connected to our stories of creation that talk about the strength of who we are as a people, is used to replace the negative images.

It's a transition of belief about self from this negative image, so that you have some context to our evidence that is held within our creation stories that says the Creator made us to be these whole, healthy people. So I can now replace one image for another and have a sense of hope that I can create a different future for myself, that I don't have to be all of the issues that you might see in a community.

The Chair: Thank you very much.

Mr. Wilks, please, you have five minutes.

Mr. David Wilks (Kootenay—Columbia, CPC): Thanks, Mr. Chair.

I thank the witnesses for being here today.

You talked about elders in the first nation communities, which brings me back to a story from 1984 that I need to allude to. I was stationed with the RCMP in New Aiyansh. At the time, a constable by the name of Alex Angus was in Greenville. I went down to Greenville one day to talk to Alex and went into the detachment there. Inside one of the cabinets was a big bag of dope. I asked Alex where he got it. He said that he took it from a young fellow. I asked him what he did and if he had charged the young fellow. He said, “No, we went for a walk”. I said, “A walk?” He said, “Yes, a three-day walk”. I said, “A three-day walk? And...?” He said, “He won't do it again.”

This brings up the fact that in our society, in our white society, we don't recognize the value of elders and the opportunities that bring us forward. I want you to talk a little about the importance in your culture of healing circles and of sweat lodges, from the perspective of how we can use that to—“influence” is a bad word, but I'm going to use that word—influence the youth to understand where the elders have come from, from the past, and how they can learn from it.

● (1000)

Mr. Peter Dinsdale: Maybe I'll start.

I think the first thing we need to acknowledge is how diverse all the nations are, so I think it's their own cultural traditions that are most important. It's the raising of.... To decolonize or to bring back our culture to the youth will raise their self-esteem, and they will be proud of their culture and become traditional dancers and have different roles in their communities. I know that in the Ahousaht and communities like that there is certainly a hereditary chief system, which is a great way for them to get young people back in and engaged and to have leadership positions. It does so many things.

The nations are so diverse. It's important that we don't try to go to Ahousaht and bring them a sweat lodge, because they don't sweat. It's similar across the country. That shows the importance of going out and really engaging with that local community and of bringing elders together to ask them what the best approach is, to ask them how to constitute it. It may seem weird that they hold a community meeting or a forum, or that they go and do the ceremony somewhere, or that they ground it spiritually before they go out and do something else, but it's a process we have to do to respect our laws and our traditions and how we move forward as well.

Ms. Carol Hopkins: The youth solvent addiction program, as I said earlier, has shown promising results with youth who participate in culture, and recently we have become involved in a CIHR-funded research project that looks at culture as an intervention.

We do have various cultures across the country. There are 11 different language families. Within those language families, we have a number of different nations. All of those nations have their specific ways of practising. It's tied to their language, it's tied to their land, and it's tied to the nation of people that they are.

However, through this cultures intervention research project, we've talked to elders and cultural practitioners from coast to coast, and we've been able to identify at least 22 different descriptions of common ways in which culture is practised. We are looking at those 22 different ways of intervening, supporting, and promoting wellness through culture to develop a broader understanding.

In the youth solvent addiction program, I used to be the director of a youth treatment centre. In Canada, for youth who go into residential treatment, at best at least 50% of them will complete. In the program I ran, there was 100% completion. These were kids who had high rates of suicide ideation, had been involved in the justice system, had issues of sexual abuse, had been in treatment at least three previous times, and had high rates of substance use, including prescription drugs. They completed treatment, and 86% of them maintained their wellness post-treatment at three-, six-, and twelve-month follow-ups, because of the cultural interventions they participated in while in treatment.

Treatment and the introduction to culture can't ever replace what they're encouraged to go home and find in their own nation, but it certainly is an introduction. The introduction to culture, based on strengths, gives them a new perspective, and there are many different cultures. Like I said, there are 22 different ways in which culture has played a role in supporting wellness.

Mr. David Wilks: Thank you.

The Chair: Thank you. That was very interesting.

Moving to the next round, we have Ms. Davies. She may share her time with a colleague, but it's five minutes.

Ms. Libby Davies: I'll try to ask a question briefly.

First of all, with regard to the Royal Commission on Aboriginal Peoples from 1996 or 1997, one recommendation that always stood out in my mind was the one that said there should be 10,000 first nations health care providers trained to be part of local community health and wellness. I've often wondered, how far did we get? Did we even get up to 500? I don't know. That's just a little bit of history that I remember.

I want to come back to the issue of pain management. It seems to me there's a very fine balance here. On the one hand, we're dealing with prescription misuse. But if we come down too hard, rigidly taking away drugs, or don't make them accessible to people, or don't believe people, actually, when they are in pain....

This is a huge issue for people with addictions. People don't believe them when they say they're in pain. It's like, “Oh, you just want to get drugs.” So if we come down too hard, we're actually not creating a better situation, we're making it worse.

How do we create that balance? That's one of the things I think we have to struggle with. To me, part of the answer might be, and I'm interested in your opinion here, where those decisions are made. I mean, you could say there's some big national decision to take away this drug, or take away that drug, but the more local we make it in terms of that individual and what they need, are we not then striking a better balance?

Pain management is a real issue. If you take it away from people, then yes, they'll turn to illegal means. What else do they have? People are suffering.

I just wondered if you could respond to that. How do we approach this question of the right balance between not being too rigid and not having a system that's so open that, yes, it can be abused easily?

● (1005)

Mr. Peter Dinsdale: I certainly agree with your suggestion that the more local, the better. I think for the people in the community, partnerships with community health nurses and with the community members themselves are likely the best approach from a first nations perspective.

The closer we can get to that model, where it's not just “take your pills and go” but a matter of ongoing maintenance, conversation, and observation, frankly, in the community, the better off we'll be.

Ms. Carol Hopkins: Better prescriber education; cultural competency; standards for prescribers that will lead to better prevention, better monitoring systems, and better screening; brief interventions tools specific to first nations people so that there's better understanding around the differences between psychological pain and physical pain; and better access to opiate replacement therapy will certainly make a difference as well.

Ms. Libby Davies: Thank you.

Mr. Dany Morin: I'd like to end with a brief question. Both of you spoke briefly about the holistic approach. In Canada we are used to a different medical approach. Could you add anything that you haven't spoken about on the holistic approach that Health Canada should help you facilitate?

Ms. Carol Hopkins: The example I can give—it's currently being researched for its impact—is from northern Ontario, where first nation communities purchased Suboxone because it was easier to manage and also provided land-based treatment. Out on the land, returning to culture, working with elders, such culture-specific interventions as sweat lodge ceremonies, the use of natural medicines for withdrawal management—those are all examples of that holistic approach. It attends to the individual within their family and their whole community, their connection to their land, their connection to their identity, their connection to culture, and it manages as well the physical symptoms with withdrawal.

That has also been followed up with reintegration back into the community by helping those individuals find meaningful roles within the family and the community so that they're contributing. There might not be enough economy to support employment, but if they can find ways to volunteer and contribute back to communities, they've found some success.

The Chair: That was perfect, five minutes right on the dot.

Mr. Lizon, you have five minutes.

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

Thank you, witnesses, for coming here this morning.

On this prescription drug abuse, we've been conducting this study for several months. We've heard from doctors and law enforcement officers, and now, thank you for coming.

It is a problem. I don't think it's a problem that's occurring only in Canada.

However, the first question I have is very specific to prescription drug abuse. In your presentation, you gave us a wide scope on substance abuse and other problems related to it, but can you tell this committee if there are any initiatives within first nation communities to monitor prescription drug use? That's not abuse, necessarily, because at some point if a person has a medical condition that needs certain medication—whether it's something natural that the community knows about or, in this case, opioids—it has to be prescribed by the doctor. Of course, the danger is that the person may get addicted to the medication.

Can you elaborate on this? What is your approach? Is there anything the communities are doing to prevent addiction to opioids that are needed to treat medical conditions?

● (1010)

Ms. Carol Hopkins: The non-insured health benefits data program collects information about the types of drugs that are being prescribed to members of a first nation community, and that's shared. Non-identifying information about the types of drugs that are prescribed to members of the community is shared with the communities themselves.

In the Atlantic region, some communities have worked with pharmacies and physicians to limit the number of prescription pills in the community at any one time. They've partnered on the way medication is shared. For example, changing from a prescription bottle to a blister pack helps them to monitor the number of prescription drugs in the community.

Again, partnering with provincial health authorities, so that opiate replacement therapy is delivered within the community in partnership with the first nations health programs and services, has been beneficial in terms of the community getting a better grasp on the level of prescription drugs available in a community at any one time.

Those initiatives have demonstrated a reduction in crime in the community, in that people are no longer into the addiction behaviours and the criminal activity to obtain the prescription drugs, because they have the availability of opiate replacement therapy.

Mr. Peter Dinsdale: The only other thing I'd add is that of course while first nations sometimes get information on an "after" basis, I think the ability of first nations to have better access to and control of the program from the outset is also a critical factor to look at. Again, I'd point to the B.C. health transfer that is taking place as having a great potential to do just that.

Mr. Wladyslaw Lizon: Is there anything that the communities are doing on the education side, especially for young people, to inform them about the potential dangers of drug use, drug abuse, and substance abuse?

Ms. Carol Hopkins: Yes. There was a program, the drug utilization prevention project, and it invested in Atlantic Canada, Ontario, and Alberta. Those programs were geared to, once again, a coordinated approach, with coordination and collaboration between first nation communities and provincial health authorities. A variety of initiatives under that drug utilization prevention program proved to be beneficial.

On a national level, is there a coordinated program? No, there isn't.

The Chair: Thank you Mr. Lizon.

Ms. Murray, you have five minutes.

Ms. Joyce Murray: Thank you.

It's been very helpful to hear the thinking that you've expressed around colonization. It occurs to me that just as with serving armed forces members, where we are wrestling with some percentage—15%, say—who respond to trauma with PTSD, post-traumatic stress disorder, it seems that there's a percentage of the community that is struggling with post-colonization stress disorder. When it can be really recognized that there is a systemic trauma that people are responding to, that helps, then, in moving forward.

In "Take a Stand", the analysis of the chiefs of Ontario, vulnerable groups were identified, including youth, of course, and people in chronic pain, seniors, younger males, people with mental health issues—

● (1015)

Ms. Carol Hopkins: And pregnant women.

Ms. Joyce Murray: —and pregnant women.

When you're talking about the culture-centric approach to prevention and support, and when you're talking about this being community driven, how are these different vulnerable groups addressed individually? Are you advocating or are you developing programs that address specific vulnerable groups, or is it a core approach with culture at the centre? In other words, do you adapt the approach for the groups or is it a...?

Ms. Carol Hopkins: Certainly, there are needs specific to pregnant women, so there is advocacy at this time to look at how we might address the specific needs of pregnant women. One of the projects that we had planned but got stalled because of funding cuts was to develop care pathways, so that service providers and communities would know how to best meet the needs of pregnant women who are at risk for opiate use or who are using opiates.

Looking at social determinants of health, all of the different programs in first nation communities that might come in contact with pregnant women would have a better understanding of how to provide brief intervention and referral services to other more appropriate care options. It's the same for youth.

Ms. Joyce Murray: So you're saying that the community-based, culture-based programs are being adapted to the specific groups as best as possible, given the resources.

Ms. Carol Hopkins: That's right.

Ms. Joyce Murray: I would like to understand this. Is there an analysis that connects employment levels in a community with susceptibility to prescription drug abuse and other addictive practices? To what degree is it also associated with loss of traditional employment and the failure to have a connection with the 21st-century economy in some of the remote communities?

Ms. Carol Hopkins: That's a big question.

Mr. Peter Dinsdale: I'm not aware of any specific study, but let me say that I think we've seen a spike in this kind of usage in the last historical while, and each generation is born into a baseline of a norm. If a child born today understands that community, what's happening today is the norm. For a child born 20 years ago, that is the baseline, the norm for that child as it grows up. So to say that from one generation to another the loss of those jobs, which may not have existed in those communities, has resulted in increased drug use.... I don't think there would necessarily be a correlation there. It's the broader disenfranchisement we're seeing—

Ms. Joyce Murray: Okay. I'm thinking about British Columbia, where some communities are partnering with the local mine or have a community-based forestry business. Some communities have been able to reduce their unemployment from 85%, which it was even 10 years ago, to a much healthier level. That's why I'm wondering. In communities that have been able to connect with the economy of today, potentially through their resources and their traditional territories, is that changing the profile of prescription drug abuse?

● (1020)

Mr. Peter Dinsdale: I think we've seen spikes in substance abuse when new waves of wealth have come into a community and have introduced drugs and all kinds of abuse. It's not so much when it leaves, when people are dealing with the loss; it's more the advancement of new money, with all the challenges it creates, that then creates usage. That has been our experience.

Ms. Joyce Murray: So it's more correlated with money, with wealth, than it is with employment or lack of employment.

Mr. Peter Dinsdale: Yes. It's because there's a change in the baseline. You had nothing before, and now there's all this new stuff in there.

The Chair: Thank you, Ms. Murray.

We're really at the end of our meeting here today, but if the committee doesn't mind, I have one quick question and one request.

My quick question is this. Other communities across Canada have had “take back the prescription drug” days, and I'm just curious if on reserve in your communities you've had that kind of day or if you know of any communities that have.

Mr. Peter Dinsdale: I haven't heard of it myself, but I can certainly go back and find out and let the committee know.

Ms. Carol Hopkins: I know that was something we supported in First Do No Harm, Canada's national strategy. We certainly were part of those discussions that promoted that initiative, but I'm not aware of any specific examples.

The Chair: Okay.

My request is related to the traditional methods of healing, specifically dealing with coping with pain or pain management. If there are any specific examples where person X, suffering from some injury, became addicted to whatever, and working through western plus traditional medicines saw a marked improvement, or if you have an area or case study that has worked very well, perhaps you could forward those examples to the committee. I think it would be very helpful to include them in our report.

With that, I appreciate the committee's latitude in letting me have a question.

We appreciate you folks taking the time to be here today. Thank you.

Our next meeting is on Thursday, if I'm not mistaken.

With that, the meeting is adjourned.

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