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Chair

Mr. Ben Lobb

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● (1530)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good afternoon ladies and gentlemen. It's 3:30. We're going to begin our committee meeting.

We have two panels this afternoon. We have three guests in our first panel. We're going to go right to our first guest, Dr. Anthony Phillips, who is appearing by video conference.

Go ahead, sir. You can begin your presentation.

Dr. Anthony G. Phillips (Scientific Director, Institute of Neurosciences, Mental Health and Addiction, Canadian Institutes of Health Research): I'd like very much to thank the committee for this invitation, which will allow me to discuss the issue of mental health and to speak to you about how the Government of Canada is supporting research to address the needs of individuals suffering from mental illness and substance misuse.

As this committee knows well, the Canadian Institutes of Health Research, or CIHR as it's often known, is the Government of Canada's agency responsible for providing health research support to ensure excellence in settings that are in universities, hospitals, and research centres across Canada.

To achieve its mandate, CIHR supports research in part through a unique interdisciplinary structure made up of 13 virtual institutes. The mission of CIHR's Institute of Neurosciences, Mental Health and Addiction, of which I'm currently the scientific director, is to foster excellence in innovation and ethically responsible research aiming to increase our knowledge of the functioning and disorders of the brain and the mind, as well as the spinal cord, the sensory motor systems of the body, and of mental health and mental illness and all forms of addiction that can arise from disorders of the brain.

Between the fiscal years 2006-07 and 2013-14, CIHR invested more than $475 million in mental health research and related behavioural conditions. This included a number of investments in major initiatives that are addressing the needs of populations most at risk of suffering from these conditions. One good example is CIHR's key initiative, which we refer to as the strategy for patient-oriented research, also known as SPOR. The primary objective of this initiative is to foster evidence-informed health care by bringing innovative diagnostic and therapeutic approaches to the point of care, as well as, of course, generating new knowledge that can improve the health of Canadians.

Through SPOR, CIHR is working with many partners to establish research networks to generate the research evidence and innovations that are needed to improve patient health and the functioning of health care systems. The very first SPOR network supported by CIHR is in the area of youth and adolescent mental health. This network aims to improve the care provided to young Canadians with mental illness issues by translating promising research findings into practice and policy. This initiative represents an investment of $25 million over five years, and importantly, it's a partnership between CIHR and the Graham Boeckh Foundation of Montreal, each of which has contributed $12.5 million.

CIHR is also working with partners to improve suicide prevention activities among aboriginal communities. For example, last March, CIHR in partnership with the Government of Nunavut, the Inuit Circumpolar Council, and other federal and international partners hosted a circumpolar mental wellness symposium on suicide prevention in the Arctic. This was held under the auspices of the Arctic Council. This unique gathering brought together researchers, community members, practitioners, policy-makers, and most importantly, youth from across the Arctic regions to identify and share best practices in order to promote mental wellness and to prevent suicide.

ln June 2012, CIHR also launched the pathways to health equity for aboriginal peoples signature initiative. This pathways initiative aims to support the development, implementation, and scale-up of interventions and programs focusing on improving aboriginal people's health and wellness in four key areas, one of which is suicide prevention.

● (1535)

For an example of an initiative in this area, we can point to Dr. Susan Chatwood at the Institute for Circumpolar Health Research in Yellowknife. She is studying existing mental health programs in the Arctic to determine what different regions can learn from one another to address this critically important issue.

CIHR also supports a number of initiatives aimed at addressing issues of substance misuse. Indeed on May 1, 2015, in Edmonton I had the pleasure to announce with the Minister of Health the creation of the Canadian research initiative in substance misuse. This will be a national network aimed at improving the health of Canadians living with issues related to substance misuse.

This initiative, which represents an initial federal investment of $7.2 million over five years, is unique in the sense that it focuses on the transfer and implementation of new evidence-based approaches to reduce the risk of substance misuse and its effects on health, including the development of addiction, overdose, and sadly, death. Researchers supported through this initiative will work closely with service providers and representatives of people living with substance misuse issues to better ensure the health outcomes for the people facing these problems.

ln conclusion, Mr. Chair, let me assure you that CIHR is committed to continue working with public and private partners in support of research in these important areas related to mental health and addiction. The overall aim, of course, is to improve the research and to translate this new knowledge into improved services, especially treatment, for those suffering from mental ill health issues.

Again, I commend you and your colleagues for taking up this study, and I wish to thank you for providing me with the opportunity to speak on this important issue. Of course, I will be pleased to answer any of your questions.

Thank you very much.

The Chair: Thank you very much.

We have two more panellists before we get to the questions. If you could stay tuned until 4:30, that would be great.

Next up is Sony Perron.

Go ahead, sir.

Mr. Sony Perron (Senior Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health): Thank you, Mr. Chair, for the opportunity to provide an overview of the programs and services supported by Health Canada in the area of mental health and wellness for first nations and the Inuit.

[*Translation*]

Health Canada recognizes that addressing mental health and addictions issues are important health priorities for First Nations and Inuit. Consequently, the department is investing more than $300 million this year on a suite of mental wellness programs and services.

Programming includes mental health promotion, addictions and suicide prevention, other crisis response services, treatment and after-care services, and supports to eligible former students of Indian residential schools and their families.

Health Canada is working with partners so that efforts to support individuals, families and communities around mental health care are coordinated and include family support, employment and training, education and social services.

Building on best practices, we know that efforts to support individuals, families and communities should be culturally safe and community-driven. We can find lasting solutions only if we work together with our partners, including First Nations and Inuit organizations and, most importantly, the communities themselves.

[*English*]

Mental health promotion and suicide prevention research emphasizes the need for comprehensive and multi-layered interventions across a continuum of wellness. Interventions at each of the individual, family, and community, and federal, provincial, and territorial levels have been found to be most effective.

We have worked with the Assembly of First Nations and mental wellness leaders to develop the first nations mental wellness continuum framework. Through this process, communities were engaged and brought their ideas to the table.

From these discussions, culture emerged as a foundational component. Community innovation, partnerships across government, collaboration and coordination across sectors, and linkages between programs and services were also identified as being crucial for moving forward.

This framework has been ratified by the Assembly of First Nations' chiefs of assembly and was released by the AFN in January 2015. We are now working with the Inuit Tapiriit Kanatami to develop a mental wellness continuum for the Inuit.

Health Canada is a partner in implementing the first nations mental wellness continuum framework, which calls for integrated models of service delivery that focus on community strengths and indigenous knowledge.

Moving forward, we will look at ways to strengthen the federal mental wellness programming with our partners to meet community-specific needs, such as moving away from siloed program approaches toward more coordinated and effective approaches, and through closer integration between federal, provincial, and territorial programs.

● (1540)

[*Translation*]

We are also supporting mental wellness teams, which provide specialized treatment to a group of First Nations communities facing mental health issues. These teams seek to increase access to a range of mental wellness services including outreach, assessment, treatment, counselling, case management, referral and aftercare.

Through the National Aboriginal Youth Suicide Prevention Strategy we support screening for depression in schools; education and training for front-line workers to reduce stigma and increase community awareness; referral and intervention training; crisis services; follow-up and support for at-risk youth; and cultural and traditional activities to promote protective factors and to reduce risk factors.

Since 2008, we have supported a range of services to former students of Indian residential school and their families so they may safely address emotional health and wellness issues related to the disclosure of childhood abuse. For example, in 2013-14 alone, Health Canada supported approximately 630,000 emotional and cultural support services to former students and their families, and 47,000 professional mental health counselling sessions.

[*English*]

On February 20, 2015, Minister Ambrose announced an investment to prevent, detect, and combat family violence and child abuse. Health Canada's investment will support enhanced access to mental health counselling for first nations victims of violence who are in contact with shelters, and will support the improvement of services to first nations and Inuit victims of violence so that services are better coordinated, more trauma informed, and culturally appropriate.

Thank you for your attention. I am pleased to take your questions afterward.

The Chair: Thank you very much.

From the Public Health Agency of Canada, we have Kimberly Elmslie. Go ahead.

Ms. Kimberly Elmslie (Assistant Deputy Minister, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada): Thank you very much, Mr. Chair.

[*Translation*]

Thank you for the opportunity to highlight the Public Health Agency of Canada's work to improve the mental well-being of Canadians. We are working closely with our partners to contribute to the implementation of the Mental Health Strategy for Canada.

[*English*]

An important public health role is the monitoring of mental illness and mental health among Canadians. The agency's system for surveillance of mental illness tracks a number of mental illnesses, such as mood disorders and anxiety disorders. This system includes complementary data, such as self-inflicted injuries, for example, suicidal behaviour, and child maltreatment.

These data tell us that, as you know, mental illness affects many Canadians. In fact, our most recent data indicate that at least one in three Canadians will experience mental illness during their lifetime and one in seven use health services for mental illness annually. Furthermore, approximately 4,000 Canadians die by suicide each year, and there are many more suicide attempts.

In order to prevent duplication and to leverage work that is under way across the country, the agency participates in the mental health and addictions data collaborative with our colleagues at the Mental Health Commission of Canada and other national mental health data partners.

In budget 2013 there was a reallocation of $2 million of agency funding over a three-year period for the purpose of improving our data collection and ensuring that we were reporting as comprehensively as possible on mental illness and mental health. As part of these improvements, the agency is working with the Mental Health Commission of Canada to improve specifically the data we have and can provide to Canadians on positive mental health and well-being.

We now have a set of indicators of positive mental health for Canadians that forms the foundation for monitoring changes in mental health over time and the factors that influence these changes at the individual, family, community, and societal levels. These include measuring and monitoring personal coping skills among Canadians, positive family relationships, and supportive community environments. We know that 65% of Canadians have very good or excellent self-rated mental health and 82% are satisfied with life. Canadians also have strong ties to the community: 87% of adults believe that their neighbourhood is a place where people help each other. By gathering and analyzing these data, we will be able to share more information about the factors that help us take care of our mental health and help prevent mental illness.

Another important priority for the agency is suicide prevention. The enactment of An Act respecting a Federal Framework for Suicide Prevention in December 2012 served an important role in raising the visibility of this issue in Canada and underscored that suicide is a public health issue. The federal framework for suicide prevention will focus on improving information, collaboration, and resources for Canadians and on equipping those working to prevent suicide with the latest information on best practices.

Our discussions with our partners and stakeholders highlighted that fragmentation of information is one of the most important barriers to their work. Effective suicide prevention requires involvement from all sectors, including governments, non-governmental organizations, communities, academia, and the private sector. The framework will provide the basis for partnership on concrete activities, and we look forward to working with the Mental Health Commission of Canada in achieving the framework's objectives.

Public health also focuses on improving the mental well-being of Canadians before mental health problems or challenges begin to emerge. Another key role for the agency is leading national activities that promote positive mental health, such as the agency's programs that build resilience in individuals and communities. We invest approximately $112 million a year in community-based programs that serve families living in conditions of risk, including poverty, social isolation, substance abuse, and family violence.

● (1545)

These programs address factors that affect mental health, including parenting skills, early childhood development, healthy pregnancies, and mental health issues such as post-partum depression. When we create supportive environments, there is a positive impact on mental health.

Supporting innovation in mental health promotion is a priority for us. Large-scale projects are under way across Canada to promote mental health, reaching children, youth, and families across the country. These projects, still under way, have already shown us positive changes in child and youth resilience, self-esteem and self-image, as well as in coping and social skills. For example, some of our school-based interventions have reduced aggressive behaviour, relationship violence, and alcohol abuse. They've improved school environments, and have been implemented in teaching curricula.

Our work builds on our international commitments, including Canada's support of the World Health Organization's resolution in support of a comprehensive mental health action plan for 2013 to 2020. Reducing mental health risks, such as exposure to domestic violence and child abuse, is a priority. As my colleague just indicated, Minister Ambrose recently announced an investment of $100 million over 10 years specifically to address the health needs of victims of family violence. This investment includes support for community-based projects to help victims rebuild both their physical and mental health following experiences of family violence.

● (1550)

[*Translation*]

Our public health work in mental health and suicide prevention involves a wide range of partners who are leading initiatives to better serve mental health needs of Canadians. We are partners with the Mental Health Commission of Canada and our work aligns with the Mental Health Strategy for Canada.

Thank you.

[*English*]

The Chair: Thank you very much.

We've had our presentations. Now we'll go into our question round.

First up is Mr. Rankin. Go ahead, sir.

Mr. Murray Rankin (Victoria, NDP): Thank you to all of the witnesses, both remote and here. We appreciate it. This is the first day of our study of the mental health issue in Canada, and I'm very grateful to you for leading it off.

Dr. Phillips in Vancouver, you spoke about SPOR, the strategy for patient-oriented research. You talked as well about the Arctic symposium dealing with issues of youth suicide in the north, and then the pathways initiative about aboriginal people. One of the issues you mentioned is suicide prevention. We've heard that there are 4,000 suicides a year in Canada, of which I suspect a large number are aboriginal peoples.

What best practices have you been able to identify from either of those initiatives that might help us better understand the suicide issue among aboriginal youth?

Dr. Anthony G. Phillips: Thank you for the question.

The meeting that was held in the circumpolar region I think revealed a very real and important truth, that there is no one size fits all to address this important question. It's very important that approaches be based and anchored in the traditions of the society, the elements of the society, in which the problem resides. It's very important that the communities become engaged in recognizing the issues at hand, recognizing some of the issues that may predispose someone to attempt to take their life. Very much the initial message is that the social and environmental determinants of these disorders need to be given very strong prominence.

Having said that, at the other end of the spectrum, when we're delving into basic biological issues that might explain tendencies to commit suicide, some of the best work in the world is being done in Canada at McGill University by Gustavo Turecki and his colleagues. They have evidence now clearly indicating that early childhood adversity can affect epigenetic factors. I won't give you a lecture on epigenetics, but the key here is that we now are gaining a better understanding of how environment can influence the way in which our genetic code is read out. It doesn't change the code, but it changes the way in which genetic information can influence the structure of the brain, and hence our thoughts and actions. This is really, really promising, because epigenetics also could lead to biomarkers of a tendency towards suicidal behaviour, and perhaps to, in the long run, interventions.

Finally, the other point I would make is it's very clear that there's a close relationship between depression and suicide in all elements of Canadian society. Recognition of the need to treat early and effectively the first incidences of depression I think will also be an important step.

I hope that answers, in part, your question.

Mr. Murray Rankin: It does. It's very helpful.

I have a short amount of time, Mr. Perron, and I'd like to ask you a question.

In your remarks you talked about the fact that the legacy of Indian residential schools, to no one's surprise, is a great contributor to this issue of mental unwellness. You said that in 2013-14 alone, Health Canada supported approximately 630,000 emotional and cultural support services to former students. What is the nature of the support that you're alluding to in your remarks?

● (1555)

Mr. Sony Perron: As part of the Indian residential school resolution process, part of the commitment from the federal government was to support emotional support during the resolution process. This goes in different ways. We are funding professionals, like social workers, psychologists, and psychiatrists to support and do one-on-one or family consultation services. We also have provided funding to local and regional organizations to organize culturally appropriate support.

This will involve local health workers and traditional healers supporting the community to try to help people go through this difficult process.

Mr. Murray Rankin: Substance abuse was one of the areas referred to by Dr. Phillips. I think you would agree, and I'm sure Ms. Elmslie would agree as well, that's a contributing factor, or a cause and effect; who knows which. I'm sure there are people who can argue that for a long time.

I live in Victoria, British Columbia. Across the way we have in Vancouver the Downtown Eastside harm reduction process, the needle exchange program that has saved so many lives. We are unable seemingly to get one in our community. Has there been a study that Dr. Phillips and the CIHR may have done on the issue of the benefits, if any, of harm reduction processes like the Insite centre? Have you looked at it? Has the Public Health Agency examined the impact of these on the substance abuse crisis in cities like mine?

Mr. Sony Perron: Maybe I will begin by adding two things. First, there is a recognition that we are dealing with a problem that is multi-faceted and involved in terms of substance abuse. Years ago in the first nations and Inuit health branch, we were talking about alcohol abuse and our programs were all geared towards that. Over the last 10 years we have reformed a lot of our programs to take a multi-substance and multi-addiction approach, because the reality has changed. People are facing often multiple abuses.

Mr. Murray Rankin: Have you examined the reality of safe injection sites? That's the question.

Mr. Sony Perron: No, we haven't done that. The reality is our operation is mostly on the reserve. We do not have a program in the cities.

Mr. Murray Rankin: Has the Public Health Agency looked at this? Has the Public Health Agency done a cost-benefit, a best practices, or some analysis of these?

Ms. Kimberly Elmslie: No, we have not. That would be a research question that we would look to our colleagues in the research community to address.

Mr. Murray Rankin: Dr. Phillips, you live in Vancouver, I presume. Could you talk about any research you might have done?

Dr. Anthony G. Phillips: There are published papers, some of which have been supported by CIHR, that point to a clear health benefit from reduced overdoses. That's a different issue than you're alluding to, which is harm reduction. There is evidence and I could send you the appropriate papers, if you wish.

Mr. Murray Rankin: I would appreciate that.

Thank you, Mr. Chair. Am I out of time?

The Chair: Yes, you are.

Ms. McLeod, *pour cinq minutes*.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): I have a number of questions for all of our panel members. Thank you, first of all, for some great presentations.

Mr. Perron, I'm going to start with you.

Back in the 1980s I was a fairly new graduate nurse and took one of my earlier jobs in a first nations remote community. In the first week I was there, and I remember this so clearly, there were three suicides. It was one of those sort of clusters. It was very difficult and very traumatic for the community.

Do we have statistics? We're hearing about a lot of programs and a lot of attempts to support mental health and suicide prevention. Are we making a difference yet?

Mr. Sony Perron: I think we are. We have in terms of surveillance of that specific problem of suicide. It's something that is a challenge and it's a challenge throughout Canada in general. It's even more of a challenge in first nations or aboriginal communities because the mechanisms to report and track, and say that a suicide was in a first nations community, or in an aboriginal community, or that it's an Inuit person, are weak. We need to invest and do better there.

In some regions of the country, we have better data than others to track this reality. What we can do is measure the success of some of the initiatives on the ground. For example, we have youth suicide prevention programs, and the initiatives that have been run in various regions of the country that have changed the dynamic in some communities and curbed some of the problems. You were mentioning the number of suicides. We see these phenomena happening. Now there is a better resilience to respond to this reality. We have some mental crisis intervention teams that can help them cope.

● (1600)

Mrs. Cathy McLeod: You wouldn't say that in the 1980s you had an incident right here and it's now here. You don't have that information.

Mr. Sony Perron: Unfortunately, the data are not strong enough to do that.

Mrs. Cathy McLeod: This leads me to the Public Health Agency of Canada.

You talked about doing some significant work in terms of data collection. It sounds like we might be heading in a good direction. What are your challenges still around appropriate data collection?

Ms. Kimberly Elmslie: As with most national data collection, we are always challenged by identifying comparable data across the country. For that reason, we work with our colleagues in the provinces and territories on developing specific indicators so that we can all collect the data in the same way and report on them in the same way.

We have, and have had for some time, good data on the occurrences of specific mental illnesses. We have started to supplement those data where we can, and Statistics Canada, of course, is a great help to us through the national surveys it does. When we want to know more about the factors that are affecting resilience or some of the more complex measures of positive mental health, that's where the work that we have started to do with the Mental Health Commission of Canada and with our other partners is really important to us. At the end of the day, what our experts tell us is that the ability of children, as they develop through early childhood, to develop those coping skills and the ability of parents to develop parenting skills are the precursors to the resilience to deal with life's adversities down the road and to develop positive mental health.

That is why we are focused now on work that will establish what indicators Canada needs to measure over the long term to be able to say that we are going in the right direction in developing our population so that we have positive mental health.

Mrs. Cathy McLeod: Something like the suicide rate.... Would you say that's not showing up on death certificates? Do we have a good sense of the suicide rate? I would think we should.

Ms. Kimberly Elmslie: Yes, we do, if the suicide is reported on the death certificate. That's the question that we look at when we are looking at the quality of our data. Are we getting good reporting that the cause of death was suicide? That's not always the case, and it's not always consistent.

The other thing we worry about is understanding attempted suicide and getting better data on those types of variables as well.

As you can imagine, in this field of mental health and understanding Canadians' mental health and the factors that influence it, there are many complications that affect the complexity of the data that we are working on now. I think that we'll see a lot of progress in this area over the next year. The Mental Health Commission has already released a framework of indicators, and from a public health perspective we are developing ours as well. These two pieces of work will come together. Our objective is that very soon we'll be able to report on the mental health of Canadians in a comprehensive way.

Mrs. Cathy McLeod: You said one in three. I've always heard the number one in five.

Ms. Kimberly Elmslie: Yes. Our most recent data indicate one in three. Those data come from the Statistics Canada Canadian community health survey. As this information gets out into the public domain more and more and is reinforced, you'll start to see that number change from one in five to one in three.

Mrs. Cathy McLeod: Mr. Phillips, the patient-specific research that is now happening, or SPOR, is a big shift. Are you doing things now that haven't been done in the past to really try to analyze this issue and move the bar on it? Is that a fair comment?

Dr. Anthony G. Phillips: SPOR, the strategy for patient-oriented research, is emphasizing the need for more translational research.

We invest about half a billion dollars a year in generating a better understanding of all the determinants of health, but obviously people are looking for the translation of that knowledge, where appropriate, into better diagnosis and better treatment. That's the overarching theme about SPOR. The way in which it is being transacted is through a partnership with many different groups in Canada, especially the provinces, which of course have responsibility for delivering the health care services to Canadians.

We have just finalized eight support units in different geographic regions of Canada that will provide an infrastructure for ensuring, for example, a better clinical trial structure or a better analysis of the effectiveness or ineffectiveness of interventions. The difference that you might be looking for here is a strong commitment by CIHR to more translational research. That's what SPOR represents.

● (1605)

The Chair: Thank you very much.

Ms. Fry, go ahead.

Hon. Hedy Fry (Vancouver Centre, Lib.): I'm really glad to see that CIHR is doing work on SPOR. Transnational research is the kind of stuff that Canada can do very well, mainly because we have all that data based in the public administration banks in each province. I think that's really important.

Is one of the partners you're working with the Mental Health Commission of Canada?

Dr. Anthony G. Phillips: Sorry, is the question for me?

Hon. Hedy Fry: Yes. Is one of the partners the Mental Health Commission of Canada?

Dr. Anthony G. Phillips: The Mental Health Commission of Canada, of course, is not in the research area, but obviously it's doing an extremely important job for Canada in terms of developing a national policy for dealing with mental health issues.

Shortly after its inception, I invited the executive of the Mental Health Commission of Canada to come to the advisory board meeting for our institute and that was really productive. At that very early stage, which was probably now about five years ago, I suggested and they certainly were open to this, that we should choose an area where we could work together collaboratively. That area was suicide research.

We then engaged the Institute of Gender and Health to partner with us, and there was an assessment of the extent of the problem. Fast forward, both with the Public Health Agency of Canada and also the Mental Health Commission of Canada and ourselves, we're hosting what I think will be quite an innovative workshop in Montreal in only a month's time, in which we're going to try to canvass the community. Very many different stakeholders are coming together to try to develop a strategy for research on suicide. That's a partnership with the Mental Health Commission and PHAC as well.

Hon. Hedy Fry: That's good, because I think one of the problems we face in a country as large as this, and with our provincial and other jurisdictions, is that we have gaps in our research and we tend to overlap in research. I think the Mental Health Commission may not be doing “traditional” research, but a lot of the programs they've put in, like At Home/Chez Soi, etc., can tell us how it impacts communities. I'm glad to hear you're working with them.

I want to ask the Public Health Agency of Canada a question. It's not an in-your-face question. It's simply that you've been collecting all this data. You and Health Canada have been looking at a whole lot of things.

At the same time, UNICEF just posted its report. You talked about coping skills and you talked about the fact that young people have a tendency to be the happiest. Actually, that's not true. The UNICEF report said that Canada ranked 24 out of 29 of the rich countries of the world in terms of happiness in their children. Canada's children are among the unhappiest in the world, and they say they cannot talk to their parents. That ranks them at 25 out of 28 in the world.

I think this is an issue. You have to have some relationship with your family, as you talked about, and we've dropped seven places in terms of that happiness index for children and children's relationships with their parents. We also have 35% of children in Canada, ranking us 21 out of 29 in the world, who are complaining about being bullied not only at school, but everywhere in the community.

I know that Rome is never changed in a day, but the bottom line is that this has been going on now for quite a while. What do you see as the barriers to being able to get what you're doing, and the data you're collecting, and the groups you're working with, to translate into actually positive outcomes for Canadian children? Your data, you said, is very difficult to come by, but are you actually working very closely? This is a place where provinces, schools, etc., should come together and start looking at this. What are your challenges to getting this done? Why are we dropping so much in terms of children's happiness and children's relationship data, and what do you think should be done about it?

● (1610)

Ms. Kimberly Elmslie: That's a great question. One of the most important things we're learning as we do our surveillance and we bring the results of our analysis to those who are developing programs and making a difference in communities is that we need to be better integrated. We need to join up the efforts that we're making in surveillance with the efforts that communities are putting forward to address their own unique needs, because there is no one size fits all as you well know. That's where our focus is right now.

I talked to you about our investments in innovation in mental health promotion. We've decided to put a focus on school-based interventions. There are a lot of areas, as you can imagine, that you could focus on in terms of positive mental health, but we've decided that with our innovation money, we're going to focus on the school setting. Why? Because that's where many factors get integrated. That's where kids come into the school and they're either bullied by their classmates, or they may come from home environments that are not conducive to their positive mental well-being and it can be the school system that becomes the most supportive environment for them.

I think we've turned a page on the way we work together in mental health and the prevention of mental illness. We've turned that page because in Canada we have the Mental Health Commission which is really leading the way in helping us understand what needs to be integrated and why. As you know, data can be used in a variety of different ways. I am trained as an epidemiologist. When I look at comparisons among countries, I always say to myself, the context within which these data are collected and the way they are reported are essential to us having an accurate interpretation of what they mean. While we get good signals—

Hon. Hedy Fry: Sorry, I was just going to say that I recognize that epidemiology is different and it involves comparing, but that's all we do. We compare and contrast all the time in Canada. We say, “Look, we're number one in the world.” So they're using the same thing that they can't criticize now.

The point is there were three questions that were subjectively asked of the children themselves. They were asked, “Are you happy?” and Canada ranked 24 out of 29.

I'm glad to hear that you're focused on school-based intervention, because I agree with you that this is really the most important place we can focus on.

You said that better integration of efforts is needed. I would really like to know what the barriers are to that integration of effort. Certainly as a federation, the provinces, territories, and the federal government should be able to work really closely in integrating that kind of information and not allowing this old thing of falling through the cracks to occur. What is the biggest barrier you see to this integration of effort?

Ms. Kimberly Elmslie: I think often the barrier is not having a clear agenda on how we want to move forward together. We now have a mental health strategy for Canada, and that's a really important foundation to get us all rowing in the same direction.

Hon. Hedy Fry: I'm hoping that the Mental Health Commission will not just be renewed for 10 years; it's doing such excellent work, I'm hoping it's going to get some of the money it was asking for as well.

The Chair: Thank you very much. There was an extra minute just for you, Ms. Fry.

Mr. Lizon.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you to all the witnesses for appearing before the committee and providing us with your valuable input.

The first question I have is for Mr. Phillips. You mentioned substance abuse or misuse several times. Are we making any progress in research to effectively address the issue?

Dr. Anthony G. Phillips: Yes, I think we are, and it comes in several different forms. Obviously, people would like to see a decrease in the misuse of these substances, and that's not happening right away. One thing I can say with certainty is that we have a much clearer understanding now of how the adventurous use of drugs can transform itself into a dependency and a very serious habit. We know the neurobiology of these processes now, which we didn't know, I'd say, 10 years ago. Once you know the underlying biological basis of an important transition such as the development of a habit or a dependency on drugs, then perhaps you can use other interventions to uncouple or change that habit structure. There's a lot of work going on in that area.

I'll just add that my counterparts in the United States have the National Institute on Drug Abuse in the NIH, and I work very closely with the director of that institute.

I made reference to something called CRISM, the Canadian research initiative in substance misuse. This is designed to be a partnership with the Americans, so that whether we make a discovery in Canada that shows promise in treatment of addiction or whether the Americans make a discovery, it can be rapidly translated into each community. I have a great deal of hope that the way forward is through partnerships not only with the researchers in Canada, but also internationally, so that we can quickly recognize breakthroughs and move effectively to bring them into practice.

● (1615)

Mr. Wladyslaw Lizon: That leads me to my second question. You mentioned that you collaborate and partner with the Americans. Are there any other researchers in the world that you partner with to exchange information or do joint projects?

Dr. Anthony G. Phillips: Yes. We have a number of very important partnerships.

I am responsible for the partnerships between CIHR and its counterpart in China, called the National Natural Science Foundation. We have established over a 10-year period a very effective partnership with China. It came as a bit of a surprise to me when I met with the head of that agency and asked what their most pressing issues were. I was thinking cancer, or whatever. He said that one of the most serious problems in China is heroin addiction, that they have more than one million people addicted, and that anything we could do to help them with that problem would be most welcome.

We also work very closely with the European Union. In fact, we're one of the few, other than Israel, I believe, non-European countries that has a formal research partnership with the EU.

On another dimension of mental health, dementia, the loss of cognitive functioning later in life, which of course is a mental ill-health issue, we're partnered with the European Commission on the joint program in neurodegeneration in dementia, and we have a very active research collaboration in that area.

International partnerships are very important for CIHR, and Canadians are punching way above their weight.

I have one final statistic on this is in terms of the research papers that are published in Canada. Over 50% of the papers we publish are in partnership with an international researcher.

Mr. Wladyslaw Lizon: Thank you very much.

My other question is on those personal coping skills you mentioned in your remarks. Maybe it's a very basic question. Can you help me understand how you help young people develop those skills? What is important?

Madam Fry mentioned bullying and difficult situations. I remember from my young years in school that bullying was there. However, I think the way society has changed is that parents now, and probably that includes me, have become more protective of their children.

My parents were not as protective. We were quite independent, and we had to deal with most situations on our own, sometimes with the help of friends or siblings. This was not put on the shoulders of a school unless it came to the point where the school had to step in and deal with it.

Can you elaborate on this? What are the issues? How can we go forward, and what's the best way to resolve it?

● (1620)

Ms. Kimberly Elmslie: I'd be glad to.

From the point of view of what's happening in schools today, we hear from partners who are working in schools, who are teachers, and who are designing curricula for schools, that bullying is a significant issue affecting the health and well-being of schoolchildren. In fact, we have funded an organization called PreVAiL that works as a research organization to prevent violence and to develop curricula for teachers so that they can, in the school setting, do a better job of helping students both understand bullying and how to prevent it and cope with bullying.

From the evidence that we have, and from the evidence that comes from surveys, like the health behaviour in school-age children survey that the World Health Organization administers, there's a significant problem in our schools with violence and with children being bullied and threatened. It's something that we at the Public Health Agency take very seriously from the perspective of our role in helping equip communities, and schools as part of communities, with the tools they need to understand this issue and do something about it.

In the children's programs that we're responsible for, we're focused on kids who are in very vulnerable situations, single-parent families, those who may be living in conditions that are not conducive to them developing, as children, the skills that other kids that come from more advantaged circumstances develop. In those situations, what our funding programs do is support on-the-ground community programs for kids and families, so they can come into a safe situation, talk about the issues that are affecting them, and get the help and support they need to develop the positive mental health skills that will see them into the future.

The evaluations that we've done of these programs are showing such good effect for these kids. When you visit these sites, you see the caring environment that is safe and where other kids of the same age are working with counsellors, and their parents are learning how to deal with difficult situations, you can see the value and the need for communities to advance these programs for vulnerable kids.

We come at it in two ways.

The Chair: Thank you.

Ms. Moore.

[*Translation*]

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Thank you, Mr. Chair.

My questions are for Mr. Perron and Ms. Elmslie.

What tools are used to evaluate your programs? How do you know if they are effective and if they meet the needs? Can you provide us with evaluations of different programs that have been carried out? Do you have examples of changes made to programs as a result of an evaluation?

You can go first, Mr. Perron.

Mr. Sony Perron: Thank you. That is an excellent question.

There is the National Native Alcohol and Drug Abuse Program, or NNADAP. I am sorry, but I cannot think of the program's French name right now.

We use certain indicators for this program. At the end of a treatment, for example, we can see whether or not an individual has abandoned one or more elements of their substance dependence.

We look at the same result after six months in order to see how the person is doing with their dependency. Such indicators are very common in treatment programs. We stick to that.

However, it is very difficult to conduct long-term follow-up of clients. There are limits to what we can do in that regard. We monitor these types of indicators to determine whether or not the results of treatment centres or programs we support are as good as those that exist for the general population and those that serve a non-aboriginal population.

There are also more activity-based programs, such as the suicide prevention program. These are often activities that have been developed in each region of the country. We conduct campaigns specific to these activities or projects. We will develop performance indicators to determine how many people, youth and families were involved in the program. What was the type of intervention? We often have to obtain the participants' opinions to determine how the program impacted them. Does it reinforce or diminish the problems in their environment? Does it give them more opportunities to deal with the difficulties that may be related to mental health or dependency issues? There are those types of indicators.

There are evaluations, but it is extremely difficult to know the long-term effect of these measures. That is the reason for our work with the Assembly of First Nations. By building a mental wellness framework we can determine how to reorganize these programs.

Over the past 25 years, Health Canada developed siloed programs on a piecemeal basis. We also tried to develop programs that would be the same across the country.

In consultation and partnership with many partners and experts, we are trying to use best practices in the framework developed in conjunction with the Assembly of First Nations. We want to define the overall framework and the fundamental components in this regard.

For example, culture was defined as one of the foundational elements for building resilience and recreating the connection with the environment, history and family to give purpose or better sense of purpose to life in the community. It is a matter of putting culture at the centre of all this and inviting communities that manage these programs to reposition the programs that we fund. These programs are not defined. They could be adjusted based on needs if they work within this framework and if all components are involved.

The evaluations revealed another reality. We are convinced that it is extremely important for an intervention to be firmly rooted in the communities and to have community control in order for it to be successful. However, there are types of specialized services that need to be provided at another level. Thus, we have started investing in mental wellness teams that provide more specialized services that can support a number of communities. We have also started providing crisis response because we cannot expect the organizations to have the capacity to deal with major crises.

The evaluations also made it possible for us to identify the gaps in what we were funding. Programs were adjusted over the years to create this new type of intervention. Mental wellness teams help communities supplement the services offered. As a result of the evaluations We make changes to what is provided based on the evaluations. I would say that the mental wellness framework developed by the First Nations, with the support of Health Canada, is a guide for the short term. Across the country, this guide is being received enthusiastically with a view to developing and repositioning programs so that services are offered more effectively in the long term. Therefore, I would say that the evaluations are useful.

The lessons learned over the past 10, 15 and 20 years that gave us direction are entrenched in this framework. Thus, I would invite the committee members to take a look at this. We are very proud of having developed the framework with the Assembly of First Nations.

We are now doing the same thing with the Inuit. In fact, if we believe that culture is foundational, we must also respect the fact that the Inuit have a different culture. We must therefore establish a framework based on their reality and their culture. That is what we are going to do.

That is something else we have learned over the past 20 years. Programs developed in Ottawa where we try to do the same thing just about everywhere are limited if we are unable to adapt them to the realities of the communities, environments and cultures in which we work.

● (1625)

[*English*]

The Chair: Thank you.

Mr. Wilks.

Mr. David Wilks (Kootenay—Columbia, CPC): I thank the witnesses.

Each one of you in your speeches to us today didn't use the one word I wanted to hear, and that was “stigma”. As a person who is in long-term recovery, I would like to hear from each one of you what your agencies are doing to remove stigma from either addiction recovery or mental health recovery.

I'll start with you, Dr. Phillips.

Dr. Anthony G. Phillips: CIHR recognizes the importance of dealing effectively with stigma and the role that it plays as a barrier, obviously, to effective access to appropriate services. We have supported research at Queen's University with Dr. Elmslie, who is indeed a very well-known pioneer in creating a better understanding of stigma, how to diffuse it, and then how to assess whether or not there is a change in attitude that leads to better access to care.

This is an active area of research. There's a long way to go. But in the last five years, and this is now just a personal impression, I'm getting a very real impression that the stigma that's long been associated with both mental ill health and addiction is slowly weakening. That's a really promising sign. But we really do need to do more research. I apologize for not making that a high priority in our opening statement, but it is in practice, so thank you.

● (1630)

Mr. David Wilks: Mr. Perron.

Mr. Sony Perron: This is an excellent question. I think in the programming that we are offering there has never been a hidden agenda to say this is not an existing problem. It's an existing problem, but we have missed an element that appears now in this framework, which is moving forward with helping people to participate actively in their community and in the economy.

There was one thing that we fell short of in the program. We were dealing with the crisis, dealing with the addiction problem, but then not really looking much at the aftercare and the support in the community. This is something that we are adding to the program, because to deal with the pure element of stigma we need to help the clients, those who are affected by these problems, to take back their lives and be active on the economic side, by going back to school... supporting there.

The connection with the other types of programs in the provincial and territorial services is also very important, because if we only take a health approach to it, we deal with the health issue. Really if we want to bring those who are affected by mental health and addiction issues back into having control of their lives, we need to have a connection with these other programs to help people move forward in their lives after they have been dealing with a crisis or an addiction problem.

Maybe this is not a straight answer to stigma, because we are so immersed in trying to deal with the issue that the element of stigma is not always coming up front. I think the way to deal with stigma is the addition of these components into our intervention, which is to help the person to move ahead with his or her life after treatment and deal with the addiction problem or crisis.

Mr. David Wilks: Before I let you answer, Ms. Elmslie, I'd like to give one suggestion to each of you, which is that within your research, start involving those who are in recovery, because with all due respect, we think differently. If you're dealing with someone in recovery and you have someone who has gone through recovery, you can't bluff them. I would suggest that.

Thank you very much.

Over to you, Ms. Elmslie, on stigma.

Ms. Kimberly Elmslie: One of the things I learned at the Arctic Council meeting on suicide prevention was that hope and stigma reduction go hand in hand. The youth who were there really brought that home to me. It was something that really affected me, and I've been thinking about it a lot since then: how you do need to join up the ways that we think about stigma reduction by providing better information and engaging people in dialogue and on the hope dimension of a life after depression and a life that allows you to recover. Those are now fundamentals in the way, from a public health perspective as we design our mental health programs, we think about stigma.

It's not an isolated thing. It's part of the whole constellation of mental health and mental illness and recovery and prevention of suicide. Dialogue, for us, is part of the programmatic lens that we take to these things so that we're not separating and marginalizing the suicide discussion, the stigma discussion over here. It gets built into the programmatic development of the work that we do in public health.

The Chair: Thank you.

Right on time, Mr. Wilks.

That concludes the first half of our meeting today. We're going to suspend for a couple of minutes and be right back.

● (1630)

———————— (Pause) ————————

● (1635)

The Chair: We're back in session.

In the second hour of our meeting this afternoon, we have the Mental Health Commission of Canada. We have Louise Bradley and Jennifer Vornbrock here. They have 10 minutes to provide a presentation and then there'll be questions and answers to follow.

Go ahead.

[*Translation*]

Ms. Louise Bradley (President and Chief Executive Officer, Mental Health Commission of Canada): Thank you and have a good afternoon.

[*English*]

Mr. Chair and committee members, I'm delighted to be here today.

My name is Louise Bradley. I'm the president and CEO of the Mental Health Commission of Canada. I'd like to acknowledge my colleague, Jennifer Vornbrock, the vice-president of our knowledge and innovation team.

Let me begin by providing you with a brief background on the commission and its mandate. The commission was created in 2007, prompted by the work of the Senate Standing Committee on Social Affairs, Science and Technology and its study “Out of the Shadows at Last”, which called for a national commission on mental health.

The commission has a mandate to improve the mental health system and change the attitudes and behaviours of Canadians around mental illness. The commission is a coordinating agent, aligning and promoting the interests of governments, organizations, and persons with mental illness and their families. Our work brings together leaders and experts in mental health and facilitates widespread uptake on ideas, policies, and programs.

I'm pleased to report that in the 2015 federal budget, the Government of Canada indicated its intention to renew the commission's mandate for 10 more years beginning in 2017. The commission is thrilled to have the opportunity to continue its work, led by our new board chair, the Honourable Michael Wilson. Mr. Wilson has used his considerable talent and influence to champion mental health as a private citizen. Given his accomplishments to date, we can't wait to see what he's able to achieve with the full weight of the commission and our many partners behind him.

The commission's work continues to be guided by the mental health strategy for Canada, which was released in 2012. The strategy lays out actions to improve mental health care and its associated systems through six strategic directions. Since the release of the strategy, the commission has worked hard to ensure the strategy's uptake, sharing its recommendations with stakeholders across the country and around the world. I've heard from provincial and territorial governments that the strategy has become a foundational document and is used by them to develop their own mental health plans and priorities.

The reach of the strategy has been incredible, but the commission knows there are still barriers to its implementation across Canada. To assist in the implementation process, the commission initiated its own review of the strategy. After speaking with stakeholders and government officials, the commission has determined that the following actions would help drive the strategy forward: the coordination of mental health services and resources, including the integration of mental health, primary care, housing supports, and substance use services; the creation of an action plan, based on common priorities from the strategy, that demonstrates the next steps for those trying to implement it; and the improvement of mental health data, which includes better monitoring of current trends and the identification of data gaps. The commission looks forward to working with stakeholders and government to carry out these actions over the next decade.

The commission has also taken every opportunity to capitalize on the strategy as a guide for the expansion of our work. The issue of suicide prevention is of paramount importance, and we have been working on this issue for years utilizing our anti-stigma initiative called Opening Minds, workplace mental health programs, and knowledge exchange to provide tools and promote best practices.

We know that there is widespread support for this issue among parliamentarians, demonstrated by the recently passed Bill C-300, an Act respecting a Federal Framework for Suicide Prevention, which had support from all parties. Many of you also know about the #308conversations initiative launched last year by the commission and championed by member of Parliament Harold Albrecht. The campaign called upon all 308 federal members of Parliament to host a meeting in their respective communities with a focus on suicide prevention. The goal was to get people talking and to gather information about what interventions are available in communities.

As the second phase of this initiative building on the work of our anti-stigma initiative Opening Minds, the commission is developing a community-based model for suicide prevention. This model aims to adapt and implement an existing and effective suicide prevention program in the Canadian context. The model, developed by Dr. Ulrich Hegerl, is a multi-level, community-based suicide prevention initiative that has shown to be effective in reducing suicide by more than 24% over two years in a test community. The commission is currently working with stakeholders to determine the implementation of this initiative across Canada.

● (1640)

The initiative will build on another key commission program, At Home/Chez Soi, a participatory research project. At Home/Chez Soi demonstrated positive, cost-effective results for the housing first approach to homelessness, which provides persons who are homeless and have chronic mental health issues with immediate access to subsidized housing. Its participants were some of the most vulnerable Canadians who are highly stigmatized and who reported feeling isolated and being at high risk for suicide. At Home/Chez Soi demonstrated that people with chronic mental illness who receive no-barrier housing are more likely to stay housed and to report an improved quality of life. It also showed that for every $10 invested in housing first services for high-needs participants, the community saved almost $22 in avoided costs.

Because of its success, the Government of Canada decided to invest $600 million in the housing first approach through its homelessness partnering strategy. Through its innovative research, the commission was able to offer tangible and cost-effective approaches to improving the lives of Canadians who are homeless and have a chronic mental illness.

As part of our leadership on mental health systems transformation, the commission has also placed an emphasis on knowledge exchange and the sharing of best practices. At the heart of this work is the commission's Knowledge Exchange Centre, KEC, which provides numerous information-sharing hubs both online and through in-person gatherings. The KEC shares information about the commission's initiatives and additional best practices, ensuring that the information gets to the right people and that they know how to use it.

The KEC is also dedicated to improving the data and resources related to mental health. Next month they will continue with their launch of a set of national indicators on mental health that will provide crucial data on self-harm rates, the prevalence of specific mental illnesses, suicide rates, and rates of access to services. This data also identifies mental health indicators for subpopulations, such as LGBTQ youth and new Canadians. This information allows us to gauge areas in which the needs of Canadians are being met and in which there's room for improvement.

As you can see, the commission is working hard, as hard as it ever has, and we are ready to start making long-term plans for the next phase of our work. The commission is currently seeking advice from the Government of Canada, Health Canada, and other key partners about our new mandate. We've also been consulting with stakeholders and provincial and territorial leaders across the country to discuss shared priorities.

These discussions will form the basis of the mental health action plan for Canada, which provides goals and priorities for the implementation of the strategy. Just as the strategy guided the last decade of work, the mental health action plan for Canada will set the tone for the next one. By following through on the action plan, the commission can address urgent mental health issues, including suicide prevention, access, mental health supports for first responders, seniors, diverse populations, children, and youth.

In closing, I commend the members of this committee for identifying future actions at the federal level. There is still a great deal of work to be done. As with the commission's renewed efforts, it is the perfect time to redouble our efforts. This new chapter marks a time of pivotal change in Canada's mental health landscape, with more energy for system transformation than ever before.

I look forward to working with all of you and all Canadians as we continue our work towards our common goal of improving the mental health of Canadians.

Merci beaucoup.

● (1645)

The Chair: Thank you very much.

Mr. Rankin, you may have seven minutes.

Mr. Murray Rankin: Thank you so much for your presentation.

You mentioned initially, Ms. Bradley, the issue of suicide prevention and the 24% reduction in a test community, if I heard you properly, which is an extraordinarily positive development. Was that community comprised of aboriginal and non-aboriginal people? What was the community you were referring to?

Ms. Louise Bradley: Actually, the first test site was in Germany. It was then replicated in 17 other countries, but not in Canada.

Mr. Murray Rankin: Is there a similar success record in Canada that you can point to?

Ms. Louise Bradley: Well, what we're proposing is that we would do that study in Canada and try to implement it here with a Canadian nuance. That is the proposal we are looking at for suicide prevention going forward.

Mr. Murray Rankin: Does part of your strategy address the unique cultural issues we heard about in the last panel that pertain to aboriginal and Inuit peoples?

Ms. Louise Bradley: I think we absolutely have to.

We know what some of the rates are. We know that approximately 12% of the 4,000 people who tragically die by suicide per year are children and youth, and we know those numbers are much more highly represented in the north.

Part of our research strategy going forward in looking at this would definitely include northern aboriginal communities.

Mr. Murray Rankin: I want to talk about that. Four thousand a year is such a staggering figure, and you said that 12% are children and youth.

There are two questions. One, are statistics kept on the number of suicide attempts, which I know are much more than that, and do you have that data? Two, do you break that out as regards aboriginal and Inuit peoples?

Ms. Louise Bradley: I will correct myself. It is 14% of those between the ages of 10 and 24.

We do have figures on suicide attempts as well as people who complete suicide. I don't have those exact figures, but I could certainly get them for you.

Mr. Murray Rankin: Do you have a breakdown on aboriginal and Inuit peoples?

Ms. Louise Bradley: We do have some of the geographical breakdown.

I think the key point here is that when we are looking at the 14%, or the 528 people who die by suicide in ages 10 to 24, a lot more work still needs to be done. In part of the going forward with our research, I think we would certainly be targeting and getting those specific numbers.

We heard the questions in the earlier session about stigma. I'm not sure that we know all of the numbers exactly due to the effect of stigma.

● (1650)

Mr. Murray Rankin: Do you have a statistical breakdown on first responders? We've heard a great deal about firefighters, police, and paramedics who are apparently taking their lives in record numbers. At least that's the data I've heard about from their representatives.

Do you track that information? Do you have data on first responder suicide rates and attempts?

Ms. Louise Bradley: We don't. The commission does not have that. The indicators report that I was talking about earlier is us more or less mining the data that is existing in the country.

Your point is certainly well taken about first responders. We are targeting that group and are doing interventions with regard to that, so I can speak to that quite well.

Mr. Murray Rankin: Okay.

We had testimony this morning from the Public Health Agency of Canada. In their report they say that the agency invests $112 million a year in community-based programs. We've heard from Health Canada about some of the programs they are running, and there's Veterans Affairs on post-traumatic stress. Now we have the Canadian Mental Health Commission and its attempt to create a national strategy, if I'm understanding you properly.

To what extent will your work supplant the work that's already being undertaken by these other agencies? In other words, do you see yourself within the Government of Canada playing a coordinating role?

Ms. Louise Bradley: Well, we already are playing a coordination role, and the strategy is well in place. It is now reflected in approximately nine of the thirteen provinces and territories, so that work is well under way.

The strategy was actually developed with the consultation of thousands of people, including our important stakeholders, such as the Public Health Agency, Health Canada, and others.

One of the key pieces of the work we do is that everything we do is done in collaboration or partnership with somebody else. In fact, we have well over 250 partnerships. We have been asked to continue that role by our stakeholders, and by the provincial and territorial governments.

We have only been in existence for eight years. We've achieved a great deal, but I think we're headed in the right direction.

So the short answer is yes, there is a strong coordinating role for the commission. It's one we've begun and we hope to continue.

Mr. Murray Rankin: You're doing excellent work, and I commend you for it.

I want to ask you to speak a little longer, in the one minute I have left, about the important analysis you did on the At Home/Chez Soi program and housing first, which is hugely important in the community I represent. Could you talk a little more about some of the insights you've gained?

Ms. Louise Bradley: This was the largest research demonstration project in the world on homelessness and the mentally ill. I could take up the rest of our time here and then some talking about it, but one of the key pieces we have learned from that is the idea of recovery. My colleague from Public Health commented earlier on the whole issue of recovery and hope, and that is nonetheless important, in fact, even more so in our northen communities.

We have certainly learned, because we studied, that these were probably the most chronically ill people in this country. We had close to 2,000 participants in the program. It was highly successful. If we can show that there is hope and support and a change in the way that people live their lives in that population, then there surely is the same for the rest of the country.

Mr. Murray Rankin: Thank you for your excellent work.

Ms. Louise Bradley: Thank you.

The Chair: Next up is Mr. Young.

Sir, go ahead.

Mr. Terence Young (Oakville, CPC): Thank you for being here today.

Ms. Bradley, any discussion of mental health ends up being about suicide and also ends up being about substance abuse, addiction, and prescription drugs. There is a whole range of prescription drugs that are known to cause suicide. The acne drug, Accutane, is one of them, but most of them are antidepressants, and all the big pharma companies have at least one SSRI and SNRI.

Antidepressants are well known to cause serotonin syndrome, which is agitation, rapid heartbeat, seizures, and death, if you happen to suffer from that. They cause alcohol and drug abuse. They cause suicide. They cause bizarre acts of violence. In every school shooting that I have researched, the shooter was either on antidepressants or was withdrawing from them. These things generally do not get covered in the news. In fact, the German pilot who just crashed a jet into a mountain in Europe was taking antidepressants. He intentionally did that.

The U.S. military in Afghanistan had more suicides than soldiers who died in battle. That was also true of the British military in 2012, more soldiers dying of suicide than being killed in battle. It was the same with the Australian defence force, more suicides than soldiers dying in battle. U.S. veterans coming back from Iraq at one point were committing suicide approximately one every hour, so it was about 22 a day, and apparently, one out of four soldiers in Iraq was actually on antidepressants while in battle or they had been taken off the battlefield.

During that time, which was 2001 to 2009, the military orders for antidepressants from the drug companies went up 76%.

These are pretty stunning figures, and of course, no previous wars had any number of suicides like this. Of course, they didn't have antidepressants during the Vietnam War or World War II. However, the correlation between antidepressants and suicide is quite obvious, yet no one is talking about it and no one is doing anything about it.

Our authorities are sitting back and watching it happen. Our military doctors are dishing out these drugs and watching the soldiers go into battle on drugs that say right on the label they might make you suicidal or violent, and they cause psychotic reactions that result in suicides and murders, especially when soldiers come home. The most dangerous time is when you stop taking the antidepressants or when you increase the dose, which I guess sometimes happens when soldiers come home.

Now antidepressants are prescribed very widely in Canada. In some age groups, one out of four Canadians is on an antidepressant. We're the third-highest users in the world of antidepressants.

I want to ask you whether anyone has, to your knowledge, conducted research on the correlation between people who are on antidepressants or have been on them and are withdrawing from them and suicide.

● (1655)

Ms. Louise Bradley: I can't really speak with any authority on this specific topic. My background is mental health nursing, but I can say just as my own personal opinion that it's not surprising that people who die by suicide have been taking antidepressants, since there's such a large correlation between people who are depressed and who die by suicide. So that isn't—

Mr. Terence Young: Well, I've heard this argument before many times. It's what the doctors say. I'm talking about a product that says right on the label.... If it was in plain language it would say, “This drug might make you want to kill yourself”. One of them, I think it's Effexor, says that this drug can cause homicidal ideation. In plain language that is that this drug might make you want to kill others.

They're dying of suicide after taking drugs that warn of suicide, and everybody says, “Oh, they were depressed.” It just doesn't make any sense, so I wanted to ask you, why the denial?

Ms. Louise Bradley: I'm not aware of any particular studies. That isn't to say there isn't one occurring, but that isn't part of the specific mandate of the commission. But if it is part of the cause of suicides in this country and elsewhere, you're right that it has to be studied.

I will add also that I have seen people very close to me as well as people I have had as patients whose lives have been saved through the use of antidepressants.

Mr. Terence Young: That's the drug company line. That's what they always say: they save a lot of lives. They can't prove it, but they say it, so I've heard it a lot.

I knew Sara Carlin, who in 2007 started taking Paxil, reacted to it, and started taking drugs, which is part of the abnormal behaviour listed right on the label of the drug. She quit her hockey team, quit university, and got into cocaine. One night she came home at two o'clock after a drinking bout and hanged herself in her parents' house. There was no doubt that Paxil was the contributing factor. In fact, right on the label it says that Paxil might cause suicidal ideation.

● (1700)

Ms. Louise Bradley: I think your point is well taken. Part of the study that we are recommending, or part of the project that we are looking at implementing, looks at the whole issue of access—

Mr. Terence Young: Access or—

Ms. Louise Bradley: Access to means, so it's anything from bridge structures to—

Mr. Terence Young: Okay, I'm talking about how doctors hand it to people, tell them it's safe and effective, and they commit suicide.

I'd like to make a recommendation for consideration by you today, that you investigate anything you're involved with. You have this situation, investigate it thoroughly from unbiased sources, not doctors who work for drug companies or get paid on the side from drug companies, look at the correlation with suicides. I think, and I've been studying this for 14 years, there's a direct correlation. I think it's obvious, and the people who are prescribing the drugs and the people who are selling them are in denial because they're making so much money selling those drugs.

Ms. Louise Bradley: Okay, the issue of suicide is certainly a very complex one and a very important one, and we'll certainly take that into consideration as we go forward. Thank you.

The Chair: Thank you, that's right on time.

Ms. Fry.

Hon. Hedy Fry: Before I ask any questions, I want to congratulate the Mental Health Commission of Canada on the excellent work you've done in eight years. In eight years you have improved outcomes in mental health more than any other thing that has ever been done in this country in the last eight years.

I was going to ask you a question about a 10-year renewal of your mandate, whether or not you knew what resources were going to be given to you, and how you were going to be able to move forward on that. You say you are currently speaking with the government, so I won't put you in the difficult position of asking you a question like that.

Again, At Home/Chez Soi and all the work you've been doing in decreasing stigma has moved things miles in the last few years. Do you do any work on bipolar disorders with groups like the Schizophrenia Society and work with people who have a pathology? If so, perhaps you can tell me what you see as the next step that one should take in dealing with not simply the hospitalization of people with pathological problems, but also the ability to look at how we can support them instead of—as we know some provinces are considering doing—going back into institutionalization, which everyone knows was not the answer. Have you done any work on that? What do you see as good recommendations with these particular groups?

The second thing I want to ask you about is the absolutely severe policy with respect to the very few people in this country who are in prison because they committed a crime of violence because of mental illness, and the whole concept that these people should be locked up and the key thrown away. Have you done any work with people who are in correctional institutions and who have a concurrent mental illness?

I wonder if you could tell me about anything you know about both of those areas and what you see as a recommendation for dealing with them, and what you see as the biggest challenges right now to moving that agenda forward.

Ms. Louise Bradley: With regard to the Schizophrenia Society of Canada and the various ones in each of the provinces, we do work quite closely with them. We work very closely with the Mood Disorders Society of Canada along with the, I think, 17 members of CAMIMH, the Canadian Alliance on Mental Illness and Mental Health, and I know that you're familiar with that. So, yes, we work very closely.

We have stayed away to some degree from specific diagnoses, although there's a recognition that schizophrenia and bipolar disorder are among the more complex and more difficult diagnoses to deal with. The one thing all of these have in common are issues like stigma, and so they have been part and parcel of the Opening Minds initiative that we've been carrying on since the beginning of the commission. We are continuing to do so with a focus on children and youth, the workplace, health care professionals, and the media. Certainly the way that media reports deaths by suicide and so forth is something that impacts all of these organizations. While we haven't taken a particular diagnosis or diagnostic category, we do work very closely with all of them and we know them all extremely well.

With regard to corrections or prison health, which I think you were referring to, and concurrent disorders, we know there is a much higher incidence of people with mental illnesses and substance use problems in the corrections population both provincially and federally. I'm hoping that during the next phase of the commission we may have an opportunity to look at that a little more closely. As I mentioned, we do have a large number of stakeholder groups. We've made more progress with some than with others. Going forward, that is a very large number, when you combine all of the provincial and federal institutions and then the people in the community who it impacts. We do recognize that it's an important area. We haven't really made that much headway, but we have been devoting our efforts to other areas. Certainly with At Home/Chez Soi, we followed the progress of that population as they went through the justice system including corrections, so in that one area I would say we have made some progress, but we do need to do further work.

● (1705)

Hon. Hedy Fry: What do you see with regard to the challenges facing a lot of people with psychoses who are coming out of, say, hospitalization and needing support systems in the community? What is your recommendation with regard to that? Institutionalization is not it.

Ms. Louise Bradley: I think I mentioned the three areas that we need to focus on. One is the integration of services and I think that's true for anybody who's coming out of a program, particularly an institutionalized one. There needs to be a conduit and a clear handover to community services. You'll note that in the strategy, the last part deals with access. Certainly that is something that I think, as a commission, we are going to have to pay more attention to going forward. It's one thing to say that these people should be referred to a community program or community service, and because we're breaking down the barriers of stigma that people are going for services more, but if they don't exist, they can't access them. It is an extremely important integration so that it isn't broken and so that they are able to follow up their care in the community, be it through primary health care, collaborative care centres, mental health centres, or otherwise.

The Chair: Mr. Albrecht, go ahead sir.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Thank you to the commission for your work and for being here today.

Before I get into my questions, I have noticed an error. On page 3 of your briefing notes, I think there's a word that should not be there. In the passage “reducing suicide prevention by 24%”, the word “prevention” does not fit in that sentence. It should be “reducing suicide”, not “reducing suicide prevention”. That's just in case it's in the record forever.

Ms. Louise Bradley: Thank you.

Mr. Harold Albrecht: But again, thank you for your work.

Two words have come out today that I think are important. One is “stigma”, and the other, for me, is “hope”. I'm so glad that has been highlighted already.

The #308conversations campaign has certainly provided a venue for many of our community personnel who are working in suicide prevention initiatives and mental health fields, and for people who have actually experienced suicide in their families to come and talk. In my area, four members of Parliament came together and hosted one of these conversations. We had roughly 100 people there for an all-morning event. It was certainly important. The personal one-on-one conversations, the social media, the activity around that, and the print and broadcast media all helped to highlight and in that way remove a lot of the stigma that's evident. We had front-line workers, volunteers, hockey and baseball coaches, school board personnel in terms of training for teachers and so on—all were important. We finished the afternoon with a safeTALK model. We actually received personal training in that.

I have two questions relating to #308conversations. First, I think originally you were hoping to have it from May to August 2014. You extended it to May 2015. At this point, do you have a number on how many members of Parliament actually did participate in that initiative?

● (1710)

Ms. Louise Bradley: Do you have that information, Jennifer?

Ms. Jennifer Vornbrock (Vice-President, Knowledge and Innovation, Mental Health Commission of Canada): Yes, I do.

Thank you for the question. I want to thank you and to acknowledge your leadership on this issue.

We are closing in on around 60 members of Parliament. We have extended it to continue into the end of the spring session, with some very promising mention of some members of Parliament trying to do this over the summer. We had tried to do it last summer and held the event, but we didn't build, I think, the significant momentum that we have now.

As you know, you yourself participated in some video vignettes, and you and some members from all parties have shared your experiences. The hope is that by sharing your stories and your experiences, as you just described, you'll be able to encourage your colleagues who may or may not feel comfortable. We've heard about all sorts of experiences. Some have had big sessions like yours, with 100 members. Others have had more kitchen table conversations.

Mr. Harold Albrecht: Sure. I just think they're all so crucial. If there's anything we can do around this table as members of this committee, I would urge at least our group to make sure we host one.

If there's some way we can partner with you to increase that number from 60 to 300-and...well, at least to 300....

Ms. Jennifer Vornbrock: To 338.

Voices: Oh, oh!

Mr. Harold Albrecht: Well, 338 after the election; exactly.

This is somewhat related to the social media thing. I know that the Mental Health Commission of Canada has over 10,000 Twitter followers. Unfortunately, @MHCC_308 only has 600 and something. I'm wondering how we can increase that. I know it's a time-limited initiative, but the more we can do to increase that social media perspective, I think that would be great.

I don't know if you have ideas as to how we might be able to increase those numbers and get the word out.

Ms. Jennifer Vornbrock: We have an interim report on #308conversations coming up. As well, we're sharing the video vignettes. Another significant opportunity to profile the leadership that Canada and our members of Parliament are showing on this issue is that we've just signed an agreement with the World Health Organization to take #308conversations international. We also have had some early preliminary conversations with the U.S. to see members of Congress actually taking on the notion or idea. I think it will be #435conversations with members of Congress.

As we begin to build some momentum on the notion and the concept of #308conversations, I think then you'll start to get some trending, if you will, to use social media terms.

Mr. Harold Albrecht: Great.

Do I still have a bit of time?

The Chair: You have three minutes.

Mr. Harold Albrecht: Three more minutes? I'm way off.

Ms. Jennifer Vornbrock: We're talking fast.

Mr. Harold Albrecht: On the issue of media and online tools, what sort of encouragement is given to some of the current online tools that are available in terms of mental health and suicide prevention initiatives? I'm familiar with one of them, called Your Life Counts, but there are probably dozens of them.

Are there any coordinating efforts by the Mental Health Commission of Canada or PHAC or any federal group that would in some way resource and be a point of initial information for these online tools that are available?

Ms. Jennifer Vornbrock: As Ms. Bradley has shared, the commission is very interested in implementing the model that's been used in 55 European cities. That model has five components. One of the core components is this notion of public awareness. We've been working very closely with the Public Health Agency to determine what's best in class around a lot of these online tools—training, workshops, education, training for gatekeepers, and public awareness—what's the right messaging in media and social marketing.

I think the opportunity in implementing this model and working closely with PHAC, working with the Canadian Association for Suicide Prevention and working with others is that we can really determine and harness where the best knowledge lies and make sure that we focus our efforts on knowledge exchange, knowledge translation, and knowledge transfer, core parts of the Mental Health Commission's mandate.

● (1715)

Mr. Harold Albrecht: That's great to hear, because one of the things that seems apparent to me since my initial entry into this field, sort of serendipitously, is the better cooperation among the different agencies and groups that are out there. You know, too often we're protecting our own turf, to get our own thing, and I'm so thankful to see the Mental Health Commission of Canada, PHAC, and others working together collaboratively and actually making a big difference.

As a quick comment in relation to some of the comments that were made in the previous session regarding happiness and basic prevention skills, I'll never forget hearing Dr. David Goldbloom, your former vice-chair, I think.

Ms. Louise Bradley: Chair.

Mr. Harold Albrecht: It was so counterintuitive but so simple, and I think it illustrates the importance of going back to basics on a number of these things. He pointed out that one of the best protective factors in preparing us for good mental health is having the family take a meal around a table together. I thought that really doesn't take rocket science to do it.

I wonder if you want to comment on that at all, or if you've heard him say that as well.

Ms. Louise Bradley: Yes, I have heard him say that and I think it's a very good point. We sometimes look to very complex ways and think things have to be researched for a long time before implementing them.

I think the community model that we are talking about speaks to that very well, because we believe the answers lie in the respective communities. The answers are not going to be the same for Iqaluit as they are for Vancouver, but the principles are often the same. Sometimes they can be very simple things, like you and others heard in your #308conversations, that a lot can be done that can make a difference. I'm not surprised that we've seen the reduction in the rates in the cities they have tried this on, which is why we are so hopeful that it will work here in Canada.

Mr. Harold Albrecht: Thanks for using that word again, “hope”.

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

[*Translation*]

I will now give the floor to Ms. Moore for five minutes.

Ms. Christine Moore: Thank you, Mr. Chair.

Ms. Bradley, you spoke a lot about stigmatization and the difficulties of integrating these people, especially those with more serious mental health issues. I was wondering if you have developed tools for this, especially for employers, that explain the needs of these people and how to work with them and integrate them into a living environment.

Have you also developed tools to explain mental health to youth and children? It could well be that a family member has a mental health issue. In such cases, how do you talk to a child or adolescent about this issue?

When I was a teenager, a student at my school suffered from schizophrenia. We were not told anything about that. We just had a fellow student who had an imaginary friend—

[*English*]

Ms. Louise Bradley: I am sorry, but the translation isn't coming through.

The Chair: Did you catch any of it?

Ms. Louise Bradley: Just the last few sentences.

The Chair: Okay.

[*Translation*]

Ms. Christine Moore: I remember that in high school there was someone who was schizophrenic and we were told nothing about her condition. It was assumed that we would understand the situation.

Have tools been developed in that respect?

[*English*]

Ms. Louise Bradley: Thank you for that excellent question.

Yes, we have done quite a bit of work in this area. I will tell you about one recent initiative that we embarked on specifically for teenagers. With our Opening Minds, our anti-stigma initiative, we have something that's called Headstrong. Last spring we brought together about 130 teenagers from every province and territory in the country. We've learned from our research in anti-stigma that the most effective thing to reduce stigma and how we think about people with mental illness and more importantly discrimination, the behaviours that result from it, is contact-based education.

We had these kids together for a whole week. They were exposed to peers with mental illness. We heard their stories and then we equipped them with education and a tool kit to go back to their own high schools to conduct similar summits. I was at one just a week ago in St. John's where one of the participants brought together over 400 students from every high school in the province of Newfoundland and Labrador. There was also another one in B.C., where it was a much higher number of course. There are plans to hold individual summits. It's a bit like a spiderweb going across the country.

We also work collaboratively with things like the Jack Project and other groups.

We do target youth in particular. In terms of our strategy, by the way, for any of you who don't want to read through the whole mental health strategy for Canada, if you read the youth version, it's about a third of the length and is very direct and straightforward. The youth council took the entire strategy and rewrote it in youth-speak, so to say. They have caricatures throughout all of the strategy, and neither Michael Wilson nor I was particularly happy with ours, but it was a wonderful initiative by our youth to talk about the impact of them in their school system.

I can speak to the workplace specifically as well. I will first see if I have answered your question or if you would like me to elaborate more.

● (1720)

The Chair: You have 40 seconds left, Ms. Moore.

Ms. Christine Moore: Maybe you could address the subject of the workplace.

Ms. Louise Bradley: Yes.

About a year and a half ago the commission, again the world's first and as far as we know still the only psychological safety standard in the workplace, was developed. We did this in partnership with subject-matter experts. We did it with the Canadian Standards Association, BNQ, and several other corporations. It addresses the whole issue of mental health in the workplace.

Once upon a time, and this probably still is for a large number, mental health was something outside that you did. It was separate. Yet the place where we spend most of our waking hours is fraught with mental health dangers, if you will, and the opportunity to have mental health promotion and prevention. The psychological safety standard for the workplace is designed just in the same way that we all have health standards in our workplaces. For example, we know that everybody in a construction site needs to wear a hard hat. The psychological safety standard actually looks at what's happening inside the hard hat. We now have a guide that shows companies, businesses, governments, and organizations how to implement the standard. It's a very comprehensive, easy-to-read, clear, outline as to how to do it. We're now halfway through a three-year study following 40 businesses and organizations that have implemented the standard to see about the costs, how it impacts morale, how it impacts disability, absenteeism, and that sort of thing. It's also been adopted in other countries around the world. We are continuing to pursue that, but it's a very promising initiative.

The Chair: Ms. McLeod.

Mrs. Cathy McLeod: Thank you for joining us here today and talking about where we're going to go next. I want to look backwards a bit. I think it's important to congratulate you on the workplace standard. In my prior role, I was at the provincial and territorial ministers meetings, where everyone endorsed the standard, both federally and provincially, in terms of encouraging its rollout. It's certainly something that has legs, and I'll be very interested to see how the results of the study actually turn out as you follow these 40 organizations.

I did host one of the #308conversations. It was interesting, because we were really left with this feeling that there needs to be something next. Of course, doing something next requires someone to take the leadership and actually do it. At some point, maybe not here, I'll have a brief comment in terms of what our group is doing next, because when you are the person who initiates, I think it's important to ask where we are going to take this. You've had some pretty powerful conversations, so to sort of drop them, where are you going as a community...? We're certainly going to be providing feedback to the commission. I think the letter was just signed off on. But where do we as a community go?

You can make a few comments about that, but really, I'm interested in the mental health action plan for Canada and how you perceive it addressing emerging issues within the health care system and really laying a foundation. Could you talk a bit about any of those issues?

● (1725)

Ms. Louise Bradley: Sure.

Jennifer, do you want to talk about the #308 one?

Ms. Jennifer Vornbrock: What I would probably want to say very quickly about the #308 is that we were really moved by the information that was provided from each of the communities. We got letters. We got stacks of information.

As Louise said in her opening remarks, and as we've spoken about here as well, our intention is to implement the community model next. What we're also seeing is the incredible amount of strength and resilience that already exists in each of the communities in a lot of work. What really needs to happen, as you just said, is to have an organization play a key coordination and leadership role. We believe that we're in a position now, as the co-chair of the national suicide collaborative, in working with all of our partners, to have the commission take on that role next as part of our next mandate. Our hope is to move forward with that.

Ms. Louise Bradley: Thank you very much for hosting one of the #308conversations. That was very important.

With regard to the mental health action plan, we have now hosted round table discussions in all but two or three provinces and territories, and our intent is to hold them in every province and territory.

We're hearing from people as to what they think needs to go forward. We think we know, but we don't know for sure. It's been a while since we've consulted with them on the strategy. We also have an online survey. We also have a mechanism for consulting with average Canadians next month. That will give us information from people who haven't traditionally been invested in the topic, but we would like to see that.

We don't want the strategy to sit on a shelf and collect dust, as lovely a document as it is. Even though we're two years ahead of plans, I think it's really important to now look at what this means and what it would look like to have the mental health strategy. What priorities should we concentrate on now and in the long term in order to really bring the strategy to life?

We've done a bit of a provincial and territorial environmental scan to see how well it is or it isn't happening. Of course, not surprisingly, it's done differently in each of the provinces. That's not to say that one is any better or worse than the others. They're simply different.

Where should we concentrate next? I think that's in line with our work on mental health indicators, which is the first time that we've had them identified in the country. That will really put us in good stead to present to our board of directors in June the findings of the culmination of all of these discussions, the survey findings, and our citizens panel. I think that's really where we need to go during the next phase of the commission's work, along with all our stakeholders and partners.

The Chair: Ms. Morin, go ahead.

[*Translation*]

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

I would like to thank the witnesses for being here today.

I asked my three colleagues if they knew anything about the 308meeting that you talked about earlier, but none of them did. I do not know what the problem was with that, but perhaps you could tell me more specifically what we could do to help you.

[*English*]

Ms. Louise Bradley: Which meeting? I'm sorry.

Ms. Isabelle Morin: The 308.

Ms. Louise Bradley: Oh, I see. Okay.

Yes. We believe that the answers lie within communities, so last spring we wrote to all 308 parliamentarians and outlined our intent. It's not an easy topic to discuss; we're aware of that. So what we provided for people were the tools needed to host a conversation. These included everything about where or how you could hold a meeting, questions you could put forward for discussion, and a mechanism to give feedback to the commission so that we could then share those results with all members of Parliament.

● (1730)

[*Translation*]

Ms. Isabelle Morin: All right. Thank you. One of my assistants probably did not see that, but I would be really happy to look into it.

In the document you provided on the Mental Health Strategy for Canada, you mention six strategic directions: promoting mental health; fostering recovery and upholding rights; access to the right services, treatments and supports; reducing disparity; working with First Nations, Inuit and Métis; and mobilizing leadership.

How did you allocate your budget to these six directions?

[*English*]

The Chair: Ms. Bradley, a brief response.

Ms. Louise Bradley: I think that's where we are hoping that our mental health action plan will help us.

One thing we have been very cognizant of at the commission is trying not to presuppose things beforehand, or that we or any experts have all of the answers. It's difficult, and it may be different in different parts of the country. I think there are always ways of grouping things under different headings, but the mental health action plan for Canada is designed to do just what you are asking in your question, and that is, how we prioritize and what should be dealt with first, and how we can engage with our stakeholders and governments across the country to help it come about.

The mental health strategy does have a very large number of recommendations in it. Those were made knowing that one size doesn't fit all. Each province or territory, or department within the federal government, is able to take the recommendations that speak to them most in order to make their own plan. We've worked with every single province and territory to help them develop those priorities.

The Chair: Great.

The bells are ringing. Our next job is to go vote.

Thank you to the Mental Health Commission of Canada for appearing today.

Thank you to the officials and to all our MPs who took the time to be here today. That's great.

We're going to close this meeting and we'll see you on Thursday.

The meeting is adjourned.

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