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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. Welcome back to our committee study.

We have three guests in the first hour. First up we have Dr. Marnin Heisel.

Mr. Heisel, can you hear us all right?

Dr. Marnin Heisel (Research Director and Associate Professor, Department of Phychiatry, University of Western Ontario, As an Individual): Yes, I can, thank you.

The Chair: Since you are coming to committee by video conference, we're going to have you go first. Go ahead—

Mr. Young has a point of order.

Mr. Terence Young (Oakville, CPC): Chair, there was a witness I hoped could appear by teleconference from Europe, Dr. Peter Gøtzsche. The explanation that the clerk, Mr. Chaplin, gave me was that he had attempted to communicate with him and there was some reason he wasn't available. It was with regard to translation or something to do with the teleconference.

Was that it?

Can I get a description?

The Chair: Do you want it right now? We are tight for time.

Mr. Terence Young: I do want it now, thank you, Chair.

The Chair: Okay, sure. We can take as long as you want.

The Clerk of the Committee (Mr. Andrew Bartholomew Chaplin): Sir, we didn't have time to set up a video conference, and in the second hour, when we were to ask him to appear, we already had a witness appearing by teleconference in French, and we don't have the capacity to do English and French at the same time.

Mr. Terence Young: Is there no other date that he could appear? Is this the last day?

The Clerk: Today is the last day, sir.

Mr. Terence Young: Okay, thank you, Chair.

The Chair: Dr. Heisel, go ahead, sir.

Dr. Marnin Heisel: Thank you very much.

Honourable chairman, vice-chairs, and members of the House of Commons Standing Committee on Health, I'm very pleased to join you this afternoon to discuss mental health care and suicide prevention in Canada. I commend you for seeking input on these issues of critical importance to the health of Canadians, and I applaud the government's decision to continue supporting the Mental Health Commission of Canada over the coming decade and beyond.

My name is Marnin Heisel. I'm a clinical psychologist, and associate professor and director of research in the Department of Psychiatry at Western University, and a research scientist with the Lawson Health Research Institute in London. My area of research expertise is the study of suicide and its prevention, with specific focus on older adults and other at-risk populations.

In the field of suicide prevention we say that suicide prevention is everyone's business. Globally, over 800,000 lives are lost to suicide every year. In Canada, approximately 4,000 people die by suicide annually, exceeding 10 deaths every day.

Suicide affects all sex, age, and socio-demographic groups, but does so inequitably. Men account for the vast majority of Canadians lost to suicide, with rates highest for those in their middle and older years, and especially for those of European-American background. Between the years 2000-2011, there was a 29% increase in the number of older men and women who died by suicide in Canada. This increase at least partly represents a shifting population demographic; however, we need to work at decreasing the number and rate of suicide, and can't allow them to continue increasing among our most vulnerable groups.

Suicide risk is also high for Canadians living with mental disorders, addictions, a history of trauma, and other factors. We've known these facts to be true for decades, and we have a good understanding of various psychological, social, and biological risk factors for suicide. However, we have much less information on evidence-supported models of suicide risk, of how best to intervene to prevent suicide, and perhaps even less still about how to effectively promote mental health, well-being, and psychological resilience.

Thankfully, this is changing. There's a growing movement among clinical and public health researchers to conduct innovative suicide prevention and intervention research. For instance, my colleagues and I have adapted a psychotherapeutic intervention for older adults at risk for suicide. We've conducted a knowledge translation study, training front line providers who work with at-risk older adults. We're conducting an upstream preventive intervention study of meaning-centred groups for community-residing men concerned with their transition to retirement. I'm facilitating one of these groups this evening, which is unfortunately what prevents me from joining you in person today. These are just a few examples.

There's a growing focus on electronically enhanced therapy for at-risk individuals, interventions with veterans in the military, individuals who self-harm, individuals with a history of trauma, and the list goes on. This is necessary and highly promising work that needs to continue, and to incorporate strong elements of knowledge translation and dissemination to health care administrators and providers, and to incorporate collaborative input from individuals with lived experience.

Learning how best to prevent suicide necessitates expenditure of resources in the form of people, ideas, finances, and political will. I'm very pleased that the Federal Framework for Suicide Prevention Act officially recognizes suicide as a Canadian mental health and public health priority, and outlines the need to raise public awareness, share information, and disseminate statistics about suicide to enhance collaboration and knowledge translation, define best practices, and promote evidence-based approaches for suicide prevention.

With these aims in mind, in 2012 a suicide prevention think tank was convened in Ottawa, serving as an inaugural meeting of the National Collaborative for Suicide Prevention, with representation from researchers, clinicians, government agencies, non-government organizations, and Canadians with lived experience. I had the honour of presenting this research on our knowledge translation study with colleagues at the Canadian Coalition for Seniors' Mental Health. For the last two years I've represented the Canadian Psychological Association on the steering committee of the National Collaborative for Suicide Prevention.

Canada does not currently have a coherent focus for suicide prevention research or intervention. Health care providers and administrators are thus left with a paucity of resources to help them decide how best to respond to the growing need for approaches to detect, monitor, and reduce risk for suicide among their clientele. Hospitals are now required to have processes and procedures in place for suicide risk detection and intervention. Sadly, many lack the expertise or resources to implement these procedures in a sensitive and effective fashion. Although we have the benefit of a strong and dedicated mental health care workforce in Canada, we nevertheless lack clear evidence for proven approaches for translating existing knowledge on suicide prevention into effective service delivery.

● (1535)

All too often I hear the stories of people who present themselves to their health care providers, clinics, and emergency departments but find themselves unable to access timely care and are transferred from service to service, being given recommendations for seeking out mental health services that do not exist in their communities, or being discharged without a clear treatment plan or sensitive follow-up.

Families frequently entrust their suicidal loved ones to our health care facilities for protection. Yet Canadians die by suicide in our hospitals and other facilities, sometimes even when under close observation. Others do so soon after leaving hospital. Some say this is unavoidable. I hope you'll join me in saying that it is unacceptable and that together we will do something to change it.

Given the need for enhanced development and implementation of rigorous evidence-supported approaches to suicide prevention, I propose creating a Canada-wide suicide prevention research network. The primary aim of this innovative network would be to bring together Canada's research scientists, clinicians, policy experts, advocates, and those with lived experience to integrate and quickly disseminate knowledge on suicide and its prevention across diverse content areas, methods, populations, and approaches; to facilitate implementation of large multi-centre and population studies; to respond quickly and effectively to the needs of individuals, communities, families, and government agencies; to train future generations of Canadian suicidologists; to inform sensitive and safe health care practices; and ultimately to help meet our vision for a Canada without suicide. Such a network could thus help ensure successful implementation of the Federal Framework for Suicide Prevention Act and advance collaborative scientific discovery and action to prevent suicide in Canada and ultimately help enhance our nation's health and well-being.

Together with my colleagues at the Mental Health Commission of Canada, the Public Health Agency of Canada, and CIHR's Institute of Neurosciences, Mental Health and Addiction, we will be holding a full-day meeting of more than 40 leading Canadian experts on suicide and its prevention next month in Montreal to begin the process of establishing a new set of Canadian strategic research priorities for suicide prevention. This meeting builds on the successes of a meeting in 2003, with support from the federal government, and aims to benefit from what we've learned over the past decade and focus on where we need to go in coming years. I'm very optimistic about this meeting and aware that, in order to succeed, we need to move beyond setting priorities to implementing them.

In closing, I thank you for your attention and respectfully request your support for three initiatives that can help enhance suicide prevention in Canada.

Briefly, the first is dedicated research funding for suicide prevention. There's great potential value in creating a national suicide prevention research portfolio with dedicated funds for operating and knowledge translation grants, career support for trainees, postdoctoral fellows, new investigators through mid- and senior-career individuals, CIHR or Canada research chairs in suicide prevention, and a national centre of excellence in suicide prevention. Funds could be shared among various government agencies and other funders.

The second is the Canadian suicide prevention research network. For our network to develop and succeed, it too requires dedicated support. We're making great progress in beginning the process of setting strategic research priorities, but this could not have been achieved without the invaluable assistance and support of government agencies; and we have farther to go.

Third is access to psychological services for all Canadians. This week *The Globe and Mail* published a series of articles calling for increased access to mental health services, including psychological services. I find the movement towards personalized medicine compelling in arguing for the need to tailor medical interventions to individual characteristics. Yet it's nothing new, in that mental health providers have been doing this for years. Psychologists engage in truly personalized health care, providing in-depth individual assessment, treatment planning, implementation, and evaluation; taking into consideration clients' personal and family histories, development, and functioning.

● (1540)

Ideally, all three initiatives would work in concert, establishing a network of researchers, identifying key research priorities, and providing the necessary support to conduct and disseminate innovative and effective research with strong health implications to be implemented in health care services. For instance, research is promising regarding the role of psychotherapy in reducing suicide thoughts and behaviour. Psychotherapy, I feel, is necessary for many if not most individuals at risk for suicide, yet many Canadians cannot afford it.

I thank you very much for your attention.

The Chair: Thank you very much.

Next up, from the Canadian Coalition for Seniors' Mental Health, we have the director, Bonnie Schroeder.

Go ahead, please.

Ms. Bonnie Schroeder (Director, Canadian Coalition for Seniors' Mental Health): Thank you for inviting the coalition to take part in this consultation on mental health in Canada. I'm very pleased and honoured to represent the coalition.

As a brief introduction, the CCSMH, as we are known, is a national coalition sponsored by the Canadian Academy of Geriatric Psychiatry, with approximately 2,000 members across this country representing older adults, caregivers, and family members, as well as health professionals and decision-makers across multiple sectors and levels of government. Our mission is to promote mental health of seniors by connecting people, ideas, and resources. Our primary strategic goal is to ensure that seniors' mental health is recognized as a key Canadian health and wellness issue.

As you know, Canada is in the midst of a significant and permanent demographic shift to an aging population that will have profound impacts on our physical, mental, social, and economic well-being. From a public health perspective, we see older adults who are living well into retirement and more engaged in their health. On the flip side, more Canadians are living longer with chronic conditions, frailty, cognitive impairment, and mental illness.

This demographic shift will continue to have a significant impact on Canada's health care system, with mental health care systems particularly vulnerable. While there is a growing need for an appropriate range of physical and mental health services for seniors at home, in the community, and in long-term care settings, our current health care system is limited in its capacity to meet the needs of our aging population.

Mental health concerns in later life are a growing concern given the impact on older adults and their families, as well as society as a whole. We assert that mental illness in later life is not a normal part of aging, yet we know that the prevalence rate of mental illness increases as we age. The Mental Health Commission report, “Making the Case for Investing in Mental Health in Canada”, noted that 65% of men and 70% of women who reach 90 years of age or more have experienced or will experience a mental illness in their lifetime. Approximately 1.6 million older adults are living with mental illness today. By 2041, the number will jump to over 2.8 million of Canadians over the age of 60.

Based on these costly tolls on seniors' families and governments, it's the combination of seniors' physical and mental health that needs to be addressed. Interventions targeted and tailored to identify, connect, and support older adults and their families who are experiencing physical and mental health challenges can play a role in preventing depression, reducing anxiety, reducing substance use and harm, preventing suicide, and reducing stigma and the negative consequences associated with these mental health challenges.

We will be presenting a written brief, but for the purposes of this presentation, I'll be focusing on addictions and stigma in later life and will defer to Dr. Marnin Heisel in regard to suicide.

For older adults, alcohol and psychotropic prescription medication for anxiety, sleep, and pain are more of a concern. Findings from the "Canadian Addiction Survey" of 2004 indicated that 16% of adults aged 65 and older report heavy drinking: more than 14 drinks per week for men, and nine for women. Almost half of these heavy drinkers report consuming more than five drinks on one occasion at least once a month. Alcohol overuse in older adults is associated with poor mental health functioning and increased suicide risk. Other studies have found that seniors using alcohol and taking psychotropic drugs are at increased risk for hip fractures and injuries due to falls and motor vehicle collisions.

In preparing for this presentation, I consulted with board members of the Canadian Academy of Geriatric Psychiatry about what they see in their day-to-day practice. One board member and doctor noted the following:

> Addictions, treatment, and housing are particularly poorly resourced for the elderly. Those with persistent addictions often lead to cognitive sequelae secondary to traumatic brain injury, nutritional deficiencies, and multiple medical illnesses. This triply damned group—old, addicted, and demented—is not a very sexy group to provide services for, yet merits a more focused intervention.

He noted that in his community this group of older adults often ended up homeless or in nursing homes without any service providers seeing the complexity of their situation.

● (1545)

Therefore, older adults often present with multiple medical conditions, exacerbated by alcohol, that may not fit the expected profile of the chronic drinker. Drinking can increase later in life as well, for a variety of reasons—loneliness, grief, or a way of self-medicating emotional pain. While substance use is known to decrease with aging, men report much higher rates of alcohol than women in all age categories. However, given the physical changes associated with aging, older adults may be more vulnerable to the negative effects of even low-use drinking on cognitive, emotional, and physical health. The economic and social costs of substance abuse in Canada is estimated at $39.8 billion. It's not clear what the costs are associated with older adults.

Despite this research, access to current data on the prevalence of alcohol and other drug use in later life is pretty slim. From the 2013 results of the Canadian tobacco, alcohol, and drugs survey, data is only provided for under 25 or over 25, missing an opportunity to inform decisions about alcohol use and misuse in later life. That said, we are encouraged by the Canadian longitudinal study on aging dataset that will likely provide us with some of this information moving forward.

As a growing demographic, older adults uniquely experience the phenomenon of a double-whammy stigma due to the combination of mental health and aging. We know that ageism and stigma can create barriers to accessing care, to proper detection and assessment, and to good public discourse. This phenomenon was recognized in "Out of the Shadows at Last". The final report emphasized that symptoms of mental illness in later life are often attributed to growing older. In fact, recognition of ageism as a form of stigma was a pervasive theme throughout the standing committee report on aging.

I would also say that there is another level of stigma: sexism. Men are often diagnosed with alcohol and drug dependency and are at a higher risk of suicide. Depression and anxiety are also common comorbid diagnoses, yet, as noted by the Chief Public Health Officer's report, "Influencing Health—The Importance of Sex and Gender", mental illness among men is often underdiagnosed and under-reported. This is thought to be associated with a multitude of hypothesis factors—social, cultural, and biological—as well as stigma associated with a perceived weakness in men with mental illness.

This intersection of age, mental illness, and gender creates an opportunity to explore how we can improve mental health for all older Canadians, especially older men, and those who support them. Delayed and untreated mental illness in older men can impact the health system. In a recent Australian study of older men with depressive symptoms, they were at a higher risk of hospital admissions unrelated to their mental health condition, and were more likely to have long hospital stays and worse outcomes, than non-depressed patients. In Canada, hospital stays for mental illness are much longer for this age group than any other. The average stay is 29 days for older adults over the age of 60, compared with 16 days for adults 45 to 60 years of age.

How does this stigma play out in real life? To give you a brief example, we would argue that in the strong focus on youth suicide, we talk about the lost potential of a young person who dies by suicide, but our response to older adult suicide is deafening in its silence. We don't talk about the lost legacy of older adults.

You asked for a focus on coordinating efforts of stakeholders at the national level. I'll focus on best practices. With the funding from the Public Health Agency of Canada, the coalition led the development of the first national interdisciplinary guidelines on depression, delirium, suicide risk and prevention, and mental health in long-term care. These guidelines were authored by a team of researchers and health providers from across disciplines, who reviewed international and national literature and synthesized the evidence.

● (1550)

Since the release in 2006, thousands of copies have been disseminated both electronically and in print across Canada and in over 60 countries. To support the knowledge translation and implementation of the guideline recommendations, again with the support of the Public Health Agency of Canada, we were able to create a variety of companion tools, including clinical pocket cards, resource guides for seniors and their families, and educational modules and tool kits for health care providers. We currently have updated the delirium and mental health and long-term care guidelines and are working on the update of the suicide and depression guideline.

We also co-authored with the Mental Health Commission of Canada the 2011 guidelines for comprehensive mental health services for older adults in Canada. The guidelines recommended a model—

The Chair: Ms. Schroeder, we're at 11 minutes. Could you sum up pretty soon.

Ms. Bonnie Schroeder: I'll leave that there.

For recommendations, based on this evidence and the guidelines for mental health services that look at a comprehensive package, we focus on strategy. We urge the federal government to ensure that seniors' mental health issues remain a priority in the national mental health strategy. In addition, we recommend the federal government establish a national seniors strategy with a strong emphasis on protecting and promoting the physical and mental health of Canadians.

From a system capacity standpoint, the coalition recommends reorienting the system from a disease management perspective to more promotion of mental health and prevention of mental disorders, chronic conditions, and disabilities, with adequate allocation of resources across all settings.

The coalition is committed to ensuring that older adults have access to mental health care services, including mental health promotion, with a strong focus on supporting older adults living with chronic health conditions, family caregivers, and prevention in later life.

Thank you.

● (1555)

The Chair: Great. Thank you very much.

Next up is the Canadian Psychological Association.

Dr. Karen Cohen, go ahead.

Dr. Karen R. Cohen (Chief Executive Officer, Canadian Psychological Association): Thank you.

Good afternoon, Mr. Chair and committee members. My name is Dr. Karen Cohen. I'm the chief executive officer of the Canadian Psychological Association or CPA.

CPA is the national association of Canada's scientists and practitioners of psychology. Approximately 18,000 psychologists are registered to practise in Canada. This makes psychologists the largest regulated, specialized mental health care providers in the country.

Psychologists are employed by publicly funded institutions inclusive of hospitals, family health teams, and primary care practices, schools, universities, and correctional facilities. However, with cuts to human resources in the public sector, psychologists increasingly work in private practice.

Their scope of practice includes the assessment and diagnosis of mental disorders and cognitive functioning, the development and evaluation of treatment protocols and programs, the delivery and supervision of treatment, and research.

We are pleased that in the 2015 federal budget the Government of Canada indicated its intention to renew the Mental Health Commission's mandate for 10 years. CPA has a long history of involvement with the commission from providing support for its creation, sitting on advisory committees, and providing input on past and current projects. This new investment will hopefully give the commission a mandate to implement the recommendations of the mental health strategy. The strategy scoped out the changes that Canada needs to make to enhance the mental health and well-being of its citizens. It's now time to make change happen.

The strategy called for increased access to evidence-based psychotherapies by service providers qualified to deliver them. We hope that the commission will work with governments and other stakeholders to move this important recommendation forward.

Research has demonstrated that psychological treatments are effective for a wide range of mental health disorders such as depression, anxiety, eating disorders, and substance abuse. They are less expensive than, and at least as effective as, medication for a number of common mental health conditions. They work better than medication for some kinds of anxiety. They lead to less relapse of depression when compared to treatment with medication alone. They lead to patients who better follow through on treatment, feel less burdened by their illness, and have lower suicide rates when used with medication for bipolar disorder. They help to prevent relapse when included in the services and supports for persons living with schizophrenia. And, finally, they reduce depression and anxiety in people with heart disease, which when combined with medical treatment, leads to lower rates of heart-related deaths.

Despite this evidence, there are significant gaps in service and care when it comes to mental health. Canada has no parity in its public funding of mental and physical health care. Canada's mental health strategy tells us that spending on mental health in Canada has been measured at only 7% of total health spending. Psychological services are not covered by our public health insurance plans. Canadians either pay out of pocket or rely on the private health insurance plans provided by employers. Coverage through private plans is almost always too little for a clinically meaningful amount of service.

Erin Anderssen from *The Globe and Mail* hit the nail on the head this week when she wrote about this health crisis. She stated, “We have the evidence...Why aren't we providing evidence-based care?”

Access to treatment should not depend on your employment benefits or your income level. Those who cannot afford to pay for treatment end up on long wait lists, they have to depend on prescription medications, or they simply do not get help at all. If we want a health care system that will deliver cost and clinically effective care, then we must re-vision policies, programs, and funding structures through which health care is provided.

CPA commissioned a report by a group of health economists that proposed several models of delivering enhanced access to psychological services for Canadians. The report provides a business case for improved access to psychological services based on demonstrating positive return on investment and proposed service that yields desired outcomes. It looked at countries like the United Kingdom, Australia, the Netherlands, and Finland that have programs that make psychological services accessible through public health systems.

A 2012 report on the U.K.'s improving access to psychological therapies program says it has treated over 1.1 million people, with a recovery rate in excess of 45%. Some 45,000 people have moved off sick pay and benefits. Savings from the program in 2015 are estimated at £272 million for the National Health Service and £700 million for the entire public sector. By the end of 2016-17, the net financial benefit of the program is pegged at £4.6 billion and judged attributable to prevention, early intervention, and a reduction in absenteeism.

Mental disorders that are addressed promptly and effectively will yield a cost offset from their treatments. That can include fewer medical visits and interventions, and decreases in short- or long-term disability. On the other hand, untreated or undertreated disorders cost the workplace tens of billions of dollars annually.

Accessing needed psychological care affects people across their lifespan.

● (1600)

The May 2015 report from the Canadian Institute for Health Information showed that emergency room visits and hospitalization rates for children and youth with mental disorders have increased since 2006, particularly for those between the ages of 10 and 17 with mood and anxiety disorders. Use of psychotropic medications has increased as well. A 2011 report from the Canadian Policy Network and CIHI shows that the strongest evidence for return on investment in mental health involves services and supports that are geared to children and youth and that reduce conduct disorders and depression, deliver parenting skills, provide anti-bullying and anti-stigma education, promote health in schools, and provide screening in primary health care settings for depression and alcohol misuse.

Canada's population is aging and seniors will also face barriers to accessing necessary psychological care. While many of us will age in relatively good health, others will face a wide range of cognitive, emotional, and physical challenges that include dementia, depression, anxiety, chronic disease management, and end-of-life care. As many as 20% of seniors are living with a mental illness. Depression occurs in about 40% of patients who have had a stroke. Up to 44% of residents in long-term care homes have been diagnosed with depression and 80% to 90% have a mental illness or cognitive impairment.

Canada has taken some very important steps to improve the mental health of Canadians. Campaigns and public conversations deliver the message that Canadians can and should seek help for their mental health problems. Collectively, we are reducing the stigma of mental health and substance use disorders. However, only about one-third of Canadians seek and receive such help. While stigma may be one barrier, access to care is another.

It is time Canada walked the talk and made needed treatments and supports available. We need a health care system that is nimble enough to respond to the health needs of our citizens, deliver evidence-based care, and hold us accountable for care delivered. To accomplish these goals, innovation is needed.

The federal government has an important role to play in Canada's mental health. This role includes delivering care in jurisdictions under its authority, increasing or targeting mental health transfers to provinces and territories, and collaborating with provinces and territories in delivering effective innovations in health promotion, illness prevention, and health care delivery.

To ensure that innovations in mental health care delivery happen, the federal government can set up an innovation fund to assist provinces and territories in developing sustainable mental health infrastructure across Canada that will bring psychological care to Canadians who need it. The fund could, for example, be used by the provinces and territories to adapt the United Kingdom's improved access to psychological therapy programs here in Canada and to expand the role of primary health care in meeting mental health needs.

Finally, investment in research and training for students is also critical to the success of Canada's health system, the success of which will depend on its ability to effectively respond to the changing health needs of Canadians. While research into the biomedical causes and treatments of mental disorders is important, research into the psychosocial determinants and treatments is equally important. Like many more long-standing health conditions, mental disorders involve a complex interplay of biological, social, and psychological determinants and depend on a team of providers, services, and factors for their treatment and management.

Canada is poised to do better by the mental health of Canadians. The Canadian Psychological Association is very pleased to participate in this work.

Thank you for the opportunity to present to this committee

The Chair: Very good, thank you very much.

Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Mr. Chair, I wonder if we would have consent for both of these rounds to be five minutes just to ensure that we not only get around in here but also have time, because, as I understand it, we have committee business to deal with.

The Chair: You're reading my mind.

Mr. Rankin.

Mr. Murray Rankin (Victoria, NDP): Agreed.

Some hon. members: Agreed.

The Chair: Okay, seeing unanimous consent, we'll carry on.

Ms. Morin, la parole c'est à vous pour cinq minutes.

● (1605)

[*Translation*]

Ms. Isabelle Morin (Notre-Dame-de-Grâce—Lachine, NDP): Since we only have five minutes, my questions will be short.

Ms. Schroeder, I am very interested in the mental health of seniors. The numbers you gave us are very troubling. Many seniors tell me about the obstacles they are facing. You talked at length about shame, which we often hear about. It is not always easy for children to realize that their parents have mental health problems. They wonder how to meet with responders and how to help their parents.

Your approach is much more centred on cooperation. You mentioned a few practical examples. If you know of any model initiatives on awareness, prevention and reducing the stigma, could you tell us about them? What could we do? What are the model initiatives? What is the role of the Mental Health Commission of Canada in sharing these initiatives?

You also talked about housing, which I think is very important. I sometimes receive people at my office who tell me that they have trouble finding housing. This is a challenge first, because they are seniors and, second, because they have mental health problems. It is very difficult for them to find housing. Do you have solutions to suggest to us?

[*English*]

Ms. Bonnie Schroeder: Merci. I'm going to respond in English.

You raised three points. You asked about family caregivers, collaborative initiatives, and housing. Let's start with caregivers.

We know that, in the recent Mental Health Commission data indicators report, it was reported that 16% of caregivers report distress caring for someone receiving publicly funded home care. We know that number jumps for people caring for someone with depression, end of life, dementia, and aggressive behaviours. It increases exponentially. I do think we need to talk about not only caring for a senior regarding mental health, but we need to also think about the mental health of family caregivers. I think it's very important, and I will get into more of that in the written brief.

That being said, we know there's the emotional toll. We also know working caregivers really are struggling to juggle both work and care, and we're pleased with the federal government, through the Employment and Social Development Canada, for bringing in the employers for caregivers plan and working with businesses to bring this to the forefront, recognizing cost to bottom line, recruitment, turnover, and the like. I think it is a very important population that we need to address.

You talked about collaborative initiatives we've developed. We have our guidelines around stigma, which I think is really key. We developed anti-stigma training for providers, including a video, with the support of the Mental Health Commission of Canada, and the video was recently released. I will highlight two initiatives in our network. The Canadian Mental Health Association in Ontario adapted and piloted and evaluated a community-based mental health promotion program called Living Life to the Full. It found significant clinical improvement in mood, well-being, and quality-of-life indicators for this program, and we think it shows some real promising practice to protect and promote the mental wellness of seniors.

The other one is the Fountain of Health program, in Nova Scotia, which looks at seniors' mental health promotion along five domains: mental health, physical activity, positive thinking, and I forget the other two, but it's a great community-based initiative. So those would be three.

With regard to housing, care in home is critical, I think, and sometimes seniors cannot live independently in their own home. Where do they need to go if they're living with both physical and mental health problems? Long-term care is, again, a struggle to get into, and the statistics that Dr. Cohen mentioned are key. We see a much higher acuity and complexity in long-term care. So what are other options? Assisted living, retirement homes, and home care are options to support seniors living independently in their own homes.

● (1610)

The Chair: Great, thank you.

Go ahead, Mr. Young.

Mr. Terence Young: Thank you, Chair.

Thank you, everyone, for your time today.

I'd like to ask Dr. Heisel a question about psychiatric drugs, if I may.

All antidepressants warn right on their labels that, due to risk of akathisia, abnormal behaviour, etc., the patient will be at risk of suicide, and they all say on their labels that the patients should be monitored closely for suicidal ideation, which no doctor has the time to do. It simply doesn't happen.

I personally know two young people who have hung themselves after taking antidepressants, but who were given no safety warnings, one of them after withdrawing from an antidepressant and the other one four days after first being prescribed an antidepressant.

When they're first given an antidepressant, most patients get no warnings that they will become dependent and might have to take the drug for the rest of their life. I've never heard of a patient who's been prescribed an antidepressant and the doctor said, “By the way, you'll probably have to take this for the rest of your life”, or “You're going to go through months of terrible withdrawal symptoms, horrible withdrawal symptoms”. In fact, the drug companies don't even call it withdrawal; they euphemistically refer to as “discontinuation symptoms”.

We know that antidepressants ruin patients' sex lives—many patients are unable to enjoy sexual relations when they're on antidepressants. And we know that one in ten Canadians is on these drugs, such as Paxil, Prozac, Effexor, Wellbutrin, Celexa, Lexapro, Zoloft, Cymbalta, and Luvox, and maybe a couple of others, and most of them, if not all, are being treated for mental health issues.

We've heard evidence in this committee that psychiatric drugs often worsen the mental health of the thousands of patients who are on them, and I think, really, it's no wonder.

What should be done to make sure patients only get psychiatric drugs when they are monitored closely for suicide and other serious adverse effects?

Dr. Marnin Heisel: Thank you very much.

I won't be able to answer all of the points you've raised, but I think in many ways you're echoing the comment that my colleagues and I have raised already, which is that, unfortunately as it currently stands, Canadians often don't have access to psychological treatment. As a result, the route that many Canadians will take to get access to mental health service is either to go through a family physician, walk-in clinic, or to present themselves to an emergency department to get referred to, if they're fortunate, a psychiatrist. Then they often have to deal with long waiting lists and then, because of the inordinately long waiting lists, they're restricted in the amount of time and attention they receive from the psychiatrist.

I'm happy to see it when it works well. My colleagues and I have psychiatrists we work with who are extremely knowledgeable, capable, and caring providers with excellent skills.

Mr. Terence Young: Excuse me, one second. I'd just like to get another question or comment in.

So we have lots of family physicians prescribing these drugs without safety warnings who don't understand that they should be monitoring the patients closely. Maybe they shouldn't be prescribing these drugs to patients.

Dr. Marnin Heisel: That's certainly a thought. I certainly agree that it's important to have a high level of understanding and training and experience, including supervised experience, in providing mental health care. Part of the challenge, as I think I've noted, is that there just aren't enough providers—at least not enough psychiatrists—to go around.

I think to come back to the point that Dr. Cohen and I were raising before that whereas medications can be helpful, many times medications aren't actually cheaper. Many times they don't actually reduce the length or duration of care, and many alternative approaches, including psychotherapy and other psychological interventions, such as group work, etc., can be highly effective. So I agree. I think that we cannot rely exclusively on medication for treatment of mental disorders—

Mr. Terence Young: But I'm saying more than that. I'm not saying that we can't just rely on drugs. I'm saying that in many cases, the patient shouldn't be prescribed these drugs because these will worsen their conditions. Would you agree with that?

● (1615)

Dr. Marnin Heisel: I do under some circumstances, definitely. I agree that some people should not be on the medications they're provided and that we do need good alternatives—and we have them.

Mr. Terence Young: Okay.

You said that there's been a 29% increase—

The Chair: Thank you, Mr. Young.

Mr. Terence Young: You said there's been a 29% increase in suicide of older people. What percentage of those patients are on psychiatric drugs?

Dr. Marnin Heisel: I'm afraid I don't know off the top of my head. What I will say, though, based on a retrospective study done by a colleague in Sweden, is that among older adults who died by suicide, approximately half were receiving some form of mental health care and many of those were receiving antidepressants.

The Chair: Okay, thank you very much.

Ms. St-Denis.

[*Translation*]

Ms. Lise St-Denis (Saint-Maurice—Champlain, Lib.): Thank you, Mr. Chair.

Thank you very much to all the witnesses.

I don't usually sit on this committee. I am replacing someone.

When you talk about our seniors, I would like to know whether I am considered one or not. How do you describe a senior? That is my first question.

My second point has to do with the shame related to aging. It might be more appropriate perhaps to talk about “difficulty”. You did not talk about loneliness when you gave the definition of people who are ashamed to grow older, whether by drinking, by taking drugs or in any other way.

Furthermore, what is your main expectation from the federal framework for suicide prevention?

My last question is for the three of you. If you had to choose one priority only in what you are proposing to the government, what would it be? From everything you have said, what is the most important aspect in the prevention of suicide among seniors? Of course, an increase in the budget would be appreciated, but I don't think that's all. I think you might expect something else and I would like to know what it is.

[*English*]

Ms. Bonnie Schroeder: I'm assuming you're directing a couple of those questions to me?

Dr. Marnin Heisel: Is that question—

Ms. Bonnie Schroeder: I'll throw it to you, Marnin.

Most of the research on seniors looks either at those 55 and older or 65 and older. But we are all aging and know that cohorts are going to move through. Our current cohort of baby boomers going over that 65 threshold is one group, but what do we need to do to prepare for the next wave of seniors at that line, knowing that their life experience and cohort experiences are very different?

So I think we need to look at this from a life course. You might be in that cohort. I'm looking forward to that. That's where we play with those lines.

You talked about the shame and difficulty around the stigma. I know we participated in the National Seniors Council's round tables on social isolation and the impact of social isolation, both in terms of the quality and quantity of the social contact of older adults. We know that fewer contacts and quality of contacts increase the risk for mental health issues. I think we're wanting to take those psychosocial aspects of aging and mental health: hence, the positive thinking, the changing of our internalized stigma, drawing from the Fountain of Health's experience, talking about positive aging.

I'll throw suicide prevention to you, Marnin—the top three.

Dr. Marnin Heisel: Okay, thank you.

First I'll say, in talking about seniors, I certainly didn't mean you in particular, so no.

In terms of issues of shame, solitude, etc., I think it comes back to the issue that we as a society, unfortunately, we do not treat older people well. Many times older people feel that there is no place for them in our society. We focus on youth and on productivity, and we mistake and mis-equate the value of a human being with their productivity in the workforce, and that's something we have to change. Quite frankly, if we change that I think it would do a world of good in terms of suicide prevention.

I'll say quickly that in one study of healthy aging, we asked many questions but also one simple question: how old do you feel? What we found is that their actual age wasn't really associated all that much with their felt age. People, however, who felt older tended to do worse. They tended to score significantly higher on measures of depression and loneliness, as you mentioned, and even thoughts of suicide. It really isn't as much how old somebody is, but how old somebody feels, and there is research showing that people tend to feel older if they're not doing well from a health perspective, which again supports the need for prevention, health and mental health, and good care.

Out of the three things I raised, what do I think would be most helpful to prevent suicide among older adults? Clearly, enhancing access to quality care and, yes, including enhanced access to psychotherapy and psychological care.

Briefly, as a follow-up to Mr. Young's question, for our psychotherapy study of older adults at risk for suicide, the majority were recruited from psychiatric services. All were either on antidepressants or mood stabilizer medications and were still struggling with thoughts of suicide.

With the addition of psychotherapy, a sensitive and supportive approach, and an evidence-based psychotherapy, we were able to help effect a significant reduction, if not elimination, of thoughts of suicide; a significant reduction in depressive symptom severity; and a significant improvement in psychological well-being, including a sense of meaning in life. So, again, not to say that one isn't helpful or that both together can't be, but I think we've only been focusing on one approach, the medicinal approach, for financial reasons, large waiting lists, etc., and we have to move beyond that.

Thank you for your thoughtful questions.

● (1620)

The Chair: Thank you very much.

I'd like to officially invite Ms. St-Denis to the Generation X, if you'd like. If that works for you, we can bring in a Generation X.

Ms. McLeod, wrap it up here.

Mrs. Cathy McLeod: Thank you.

I want to make one quick observation and then ask a specific question that I hope the panel can think about.

First of all, I think we've all seen models that are very effective. There are primary care models attached to the family physician. It might be a mental health counsellor. There might be psychiatric shared care. As I understand it, those seem to be a very effective way of dealing with mental health in a family practice setting.

Now, having said that, that is within provincial jurisdiction. I know that provinces are making various strides in that direction. I think it certainly is a model that's been shown to give that care and attention to people who need that focus. It's not necessarily always the family doctor who's doing it in that team-based approach.

As well, as you're aware, the Mental Health Commission of Canada's mandate has been renewed. I've seen some amazing work that they've done with psychological health and safety standards in the workplace and how that's translated into a tool book.

Could you maybe tell me, just within a sentence or two so that I can get all three people in, what you would perceive to be important for perhaps some focus within their expanded mandate?

Dr. Heisel, maybe you could start. Then we'll go to the other two.

Dr. Marnin Heisel: Just briefly, yes, the literature certainly supports experienced support in collaborative care, shared care, involving mental health care providers in family health clinics. Part of the challenge is that many people don't have access to that, but when they do, it can work effectively. In fact I was involved in some of those programs 15 or 16 years ago as a trainee.

In terms of the Mental Health Commission, I agree, I think they've done wonderful work. They do wonderful work in connecting up various groups, in disseminating information, and in supporting research, knowledge translation, and care. I think those are some of the key things they need to continue doing. I look forward to continuing to work with them on that, specifically around the issue of suicide prevention but not exclusively.

Mrs. Cathy McLeod: Thank you.

Dr. Cohen.

Dr. Karen R. Cohen: I think one of the really significant next steps for the Mental Health Commission would be around implementation. They came out with a number of guidelines. You mentioned, of course, the strategy, and the psychological safety in the workplace guidelines. The great challenge that will require a lot of collaboration, horizontally and vertically and across jurisdictions, will be making the change happen.

● (1625)

Mrs. Cathy McLeod: Thank you.

Ms. Schroeder.

Ms. Bonnie Schroeder: I would concur with Dr. Cohen about the implementation. We've developed some great tools and resources, such as the caregiver guidelines, seniors mental health services, and anti-stigma, but again, without resources and opportunity to come together and do it in a coordinated way, that implementation is key.

Mrs. Cathy McLeod: Thanks.

The Chair: Thank you very much.

That will conclude the first hour of our meeting today. We'll suspend for a minute or two before we come back with our new witnesses.

● (1625)

(Pause)

● (1625)

The Chair: We're back in session.

We have two guests this hour. I understand that we have a video conference set up, as well as a teleconference.

We'll start with you Monsieur Beaulieu by teleconference, and then we'll go to Mr. Carleton.

[*Translation*]

Mr. Ghislain Beaulieu (President, Fondation Martin-Bradley): Good afternoon.

My name is Ghislain Beaulieu and I am the president and founding member of the Fondation Martin-Bradley. This foundation was created in March 2008 to help the mental health sector, which we feel is the poor cousin of the health care sector.

The foundation was launched as a result of a personal family experience. I have a son with a mental illness; he has schizophrenia. My wife and I decided to help the mental health sector by creating this foundation.

At the outset, we found a family who had previously gone through the experience and who lost a son because of mental illness. They are a well-known family from Rouyn-Noranda, the Bradley family. They agreed to contribute to the cause by going back over painful memories, by lending their name to the foundation and by making a significant investment. At first, they invested $500,000 in the foundation. Five years later, they contributed $500,000 more. They have already invested $1 million in the foundation.

The other step was to form a diversified and credible board from the public. This board is made up of nine people. Afterwards, we met with all the organizations that work in the mental health sector in our region to see if they needed help and, if our help was welcome, what their challenges were and what projects they would like to work on in the future.

We also met with representatives from the local health care network, the regional health care agency at the time, to make sure that we would bring added value to the system. We did not want to make up for the potential budget cuts in the health care system.

The mission of the foundation is to help organizations that support those affected by mental illness with various chosen projects. We never give money directly to people. We have a project selection committee that is independent of the foundation's board. Once a year, after a project competition, the members of that committee make recommendations about the projects they suggest that we support.

The foundation has a unifying role. The foundation helps to open doors and it is an agent of change. We support the outstanding work the organizations have done. We also dare to talk to the public about mental illness. We see that community organizations are key elements in the success of our health care systems. As partners, they are indispensable for the well-being of the health networks. The foundation is the link between those networks and the community.

Since 2008, the foundation has redistributed over $450,000 to organizations in support of various projects. Early this spring, we started building 24 housing units in Rouyn-Noranda for people with mental health issues. The foundation has contributed $100,000 to the project.

We translated books and stories adapted for children, which deal with various aspects of mental illness. We also provide training. This year, we also held a fundraiser where we gave 600 books to everyone who bought a ticket. It is the book called *Je suis une personne, pas une maladie* by Luc Vigneault, who is a fairly well-known personality in Quebec. This is our way of reducing the stigma and encouraging people to talk about it, to seek help and to be open about mental illnesses, which are increasingly present in our communities.

That sums up what our foundation does.

● (1630)

[*English*]

The Chair: Thank you very much.

Next up is Mr. Carleton.

Can you hear us okay?

Dr. R. Nicholas Carleton (Associate Professor, Department of Psychology, University of Regina, As an Individual): Yes, I can.

The Chair: Okay, go ahead, sir.

Dr. R. Nicholas Carleton: Good afternoon, and thank you for inviting me to speak with you today. I am Dr. Nicholas Carleton, a registered doctoral clinical psychologist and associate professor at the University of Regina. I have expertise in anxiety, trauma, and pain, having worked with traumatic responses for the last 15 years.

My research is supported by CIHR, and I maintain a small private practice, primarily treating RCMP officers who have PTSD. In addition, for the past few years I've been presenting to and advocating for Canadian first responder mental health.

Since World War I there have been tremendous efforts to improve our understanding of mental health, treatments for mental health disorders, and access to those treatments. We now know that mental health disorders are not the result of deficiencies in biology or character; instead, mental health is the result of a complex interplay among biological, psychological, and social elements of our reality. Our mental health influences our experiences, expectations, and behaviours. As such, it is difficult to overstate the importance of individual mental health to physical health and the health of our communities.

Despite these advances, as you've heard already, mental health disorders are pervasive and extremely costly. Fortunately, I believe we're all working toward common goals for reducing those personal, social, and economic costs by destigmatizing mental health and improving access to appropriately delivered, empirically supported treatments. For example, the MHCC strategy, action plan, opening minds initiative, and national standard. National professional and community associations have also engaged campaigns, such as Mind Your Mental Health by the Canadian Psychological Association; the Road to Mental Readiness by some military and policing organizations; Defeat Depression by the MDSC; and the Ride Don't Hide campaign by the Canadian Mental Health Association.

We have also seen increasing corporate commitments, notably Bell Canada with their Let's Talk media campaign, and their Canada chair in mental health and anti-stigma research at Queen's University. Canadians have also recognized the need for ongoing dedicated efforts to support our military, veterans, first responders, and their families.

We have come a particularly long way in supporting military mental health and will continue to do better. Recently, I have also seen first-hand the exceptional leadership of our first responder communities, such as the RCMP, the Canadian Association of Chiefs of Police, paramedic chiefs, and fire chiefs, as well as the International Association of Firefighters, to name a few. Indeed, we are seeing increasing demands from all first responders to provide ready access to evidence-based solutions, interventions, and preventive strategies for improving mental health.

The rationale should be quite clear: our first responder communities are reaching a tipping point. The dramatic increase in reported operational stress injuries is starting to overwhelm the stigma that has silenced so many of these citizens for so long.

Our first responders have unique workplace environments where trauma exposure is the rule, rather than the exception. The trauma exposure that first responders face is different than the military face —not better, not worse, just different. Our first responders are deployed at home in an environment of ongoing uncertainty, often for decades. They have a complex role providing both protection and law enforcement. We are also asking them to do more, such as community development, international policing, and first aid for mental health. Accordingly, first responders require dedicated and specialized resources for their own mental health.

Canadians already have an excellent and established mechanism for supporting and communicating research evidence to improve health: the Canadian Institute for Military and Veteran Health Research, often abbreviated as CIMVHR. It represents a network of 37 Canadian universities facilitating the development of new research, research capacity, and effective knowledge translation.

I'm pleased to say that the University of Regina, a founding member of CIMVHR, is working closely with CIMVHR, and researchers from other member universities, and international leaders to develop a dedicated Canadian first responder hub to support evidence-based policies, practices, and programming for mental health.

Research evidence supporting first responder mental health can also uniquely support mental health for all Canadians. The evidence to date suggests that given the right circumstances, anyone can develop an anxiety or mood disorder. The nature of first responder careers places them at higher risk; however, the nature of their training practices and workplace processes also offers mechanisms for understanding and improving everyone's mental health.

Solutions for first responders inform solutions for all of us. Moreover, our first responders are community leaders and role models who can facilitate transformations in attitudes and actions toward mental health at a grassroots level in every community across Canada.

Our RCMP and their Depot training facility offers an ideal opportunity for developing world-class, solution-focused, evidence-based strategies. A multi-university team of interdisciplinary researchers, supported by the new first responder hub, has conceptualized a prospective, longitudinal, comprehensive solution to do just that. The solution involves a transformative research project that builds on existing frameworks, like the Road to Mental Readiness and work by the MHCC.

● (1635)

The project has received ethical clearance, and the University of Regina-led team is working with the RCMP and our partner organizations to make it a reality. The highly visible project will produce research and results that can inform policies, practices, and programming, turning aspirational standards for mental health into actionable, measurable improvements for all Canadians.

The available research evidence already supports licensed and structured psychotherapy as critical for mental health care; however, we have insufficient professional capacity to offer appropriate services to all those in need. The solution requires that we do three things: first, ensure patients can and do access appropriate specialists who are correctly using evidence-based treatments; second, support the training of more specialists with appropriate credentials; and third, support research that improves evidence-based care and innovates models for care delivery.

Alternatives to these solutions risk diluting mental health care, creating false notions that all care is equal, and proliferating pseudo-scientific responses to mental health. Indeed, the ongoing proliferation of pseudo-science in mental health, as well as an overreliance on well-meaning persons with insufficient expertise, is already problematic. Many people are receiving care that is not empirically supported, and it is not good enough. Canadians deserve better, and we can do better. We have the mechanisms. We have the expertise.

Such efforts are under way. For example, the Canadian Association of Cognitive and Behavioural Therapies is working to certify practitioners and ensure access to evidence-based mental health care. Furthermore, our universities can and should be supported as foundations for collaborative research into even better evidence-based solutions to support our practitioners and therein our citizens.

That said, research should not be done to an organization or to a person. Research should be done with organizations and with people, not as an end point that produces a stand-alone report, but as an ongoing, prospective, collaborative, and, importantly, transformative solution to address a challenge.

The recent transformations to meet mental health challenges result from a convergence of factors. High-profile spokespersons, as well as leaders engaging in active organizational interventions, have helped to create a cultural shift. The research base has expanded since World War I, but we still have a long way to go to proceed as confidently as we must. There are new technologies that can improve communication, assessment, intervention, and even prevention.

We also have leaders, including all of you, who want to build on the initiatives I've highlighted today; however, a full and proper response to the calls for addressing modern mental health challenges will require increased and ongoing federal and provincial investment and involvement, as well as actions to ensure that evidence-based care is accessible.

This means investing in the new first responder hub and the research-based program for reducing PTSD and other operational stress injuries in our RCMP. This means investing in ongoing long-term research projects with interdisciplinary researchers so that we can speak with authority about variables associated with risk, resiliency, and recovery. This means investing in developing and credentialing experts to ensure the availability of evidence-based care, and also in the researchers and trainees who develop that evidence. This means investing in evidence-based prevention and early intervention.

Finally, this means investing in education to build increasingly stigma-free perceptions of mental health and knowledge about effective health care options into the mindsets of all Canadians, so that we truly change the conversation for future generations.

We can do better. We must do better. The solutions are no longer aspirational. They are achievable. Working with our first responders as role models in all of our communities, we can develop and proliferate better assessments and better interventions and engage in preventative strategies that reduce risk, increase resiliency, and improve mental health for all Canadians.

We are ready when you are.

Thank you.

● (1640)

The Chair: Thank you very much.

Up first for *cinq minutes*, we have Ms. Moore.

Go ahead.

[*Translation*]

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Thank you very much.

My questions are for Mr. Beaulieu.

In your presentation, you talked about stories for children that deal with mental illness and that have been translated. I think you have translated four so far. Could you tell me what impact talking to children about mental illness has on society? In your view, are there enough tools right now that parents and teachers can use to talk about mental illness to children?

Mr. Ghislain Beaulieu: I don't think there are a lot of tools. In fact, that's what motivated us to translate the collection of books by Gayle Grass, who is from Ottawa and who is a member of the charity called Iris the Dragon. Before we had the books translated, we had them approved by our organizations, both from the schools and from the community. They assured us that they didn't have such tools and that they would be happy to be able to use them with children. These books, which are for young people between the ages of 6 and 12, are richly illustrated stories that allow children to talk to their parents about the various mental illnesses discussed.

We have translated four books so far; 2,000 copies of each book were distributed in schools, libraries, the offices of relevant professionals, and are still accessible. Families who hear about these books can contact us. We provide them free of charge to the people who need them.

● (1645)

Ms. Christine Moore: You often feature people dealing with mental health issues, but who have nonetheless been able to cope with them and have adapted well.

What impact does this have on individuals with mental illnesses?

Mr. Ghislain Beaulieu: It gives them hope for a complete recovery. In fact, we know that this is possible. Of course, a supervised approach is necessary to succeed. Yes, medication is important, but I think following up on the people who agree to take the medication is just as important as the medication itself. These people need to be able to continue to talk about their condition. If the medication needs to be adjusted, they definitely need to be able to say what side effects they are feeling. At any rate, that allows them to be confident enough to talk about mental illness and to treat it like any other disease.

When a person has diabetes, we are not afraid to ask them how they are feeling. In the case of mental illness, people have an opportunity to see individuals who are not afraid to show their condition, which in turn gives them the confidence to talk about it, to seek the necessary treatment and to follow the necessary therapy.

Ms. Christine Moore: Do you feel that the interventions sometimes focus too much on the cure—the medication—and sort of overlook the process of support, of adapting a lifestyle to a health status?

Mr. Ghislain Beaulieu: Yes, I think it is still not well understood. As I mentioned, there is more to it than medication. There is also an entire process around it, starting with a life plan. Someone who agrees to take their medication and continues to do so for a long time —as it is a lifelong disease—must be able to grasp the instructions for, and the effects of, taking medications. Yes, there are some adverse effects, but I think taking medication has many more positive effects than not taking it. People must be educated about that.

The sick person must receive permanent support, so to speak. They really need that support during the recovery stage. Without it, they may easily—and we see it often—stop taking their medication, telling themselves that they are doing well because of their own efforts and that they will be able to control their disease. Strong support and guidance—be it from therapists, advocacy groups or social workers—help them see on a regular basis that the disease is ever-present and that treatment is ongoing.

Ms. Christine Moore: Thank you. My time is unfortunately up. It was a pleasure to hear from you.

[*English*]

The Chair: Thank you.

Go ahead, Mr. Lizon.

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

You'll have to excuse me. I am losing my voice, but I hope you can hear me.

The first question I have is for Professor Carleton. Thank you for your presentation.

I want to ask you this, first of all. This committee conducted a study on prescription drug abuse, antidepressant abuse. On one hand we have become, I think, the country with third highest rate of consumption of antidepressants in the world. We know that some painkillers and antidepressants eventually lead to certain mental disorders. On the other hand, we have growing numbers of people with mental disorders. PTSD, for example, was not recognized until relatively recently. Therefore, professor, how do you put it together? You mentioned prevention and early intervention. How do you determine who needs help? How do you determine high-risk people?

I know the science may not be there. I will give you one short story before you answer. I also serve on the veterans affairs committee, and at a recent meeting someone was complaining that there's a case of a veteran who was first diagnosed with PTSD, and then he was reassessed by another doctor as having anxiety, and the person was told that was wrong. We have to rely on a doctor's opinion. Can you maybe elaborate on all these issues?

● (1650)

Dr. R. Nicholas Carleton: Thank you very much, Mr. Chair. I'd very much like to thank the member for his question. I will try to answer as much of that as I can.

There is certainly a complex relationship between psychopharmacology and psychotherapy. I believe that, in fact, there is a role for both. I do believe that we do not have enough research at this point to definitively speak to when and how we might engage one versus the other. We do have research, though, and several recent reviews and meta-analyses that indicate that psychotherapy is as effective or marginally more effective than pharmacotherapy for several different disorders.

If there are difficulties associated with side effects, certainly having broader, more readily available access to evidence-based psychotherapy might help us to reduce the pressure on psychiatry and physicians to provide psychopharmaceutical support when, in many cases, they don't have someone they can refer a patient to otherwise.

As for the question you asked about identifying the variables and engaging in prevention, you're right that we don't yet have the definitive results available to say that a certain variable needs to be changed or that we need to engage in a certain specific process. What we're hoping to do, starting very soon, is to engage in long-term prospective research, for example working with cadets before they engage in stressful and potentially traumatic events, measuring them before, measuring them during, and measuring them after these events. We can use that data to inform real solutions so that going forward, we can then help new eras of cadets by reducing their risk and increasing their resiliency.

As for the diagnostic differences, there are differences of opinion, of course, that go along with diagnoses. I think one of the best things we can do is to continue to support the education and increasing credentialling of persons involved with mental health. We need more legislation and restrictions on diagnoses, rather than providing more people with the capacity to diagnose, necessarily. We need to ensure that people are sufficiently educated and sufficiently experienced to make sure they're correct.

Mr. Wladyslaw Lizon: Thank you very much.

The Chair: Thank you.

Go ahead, Ms. St-Denis.

[*Translation*]

Ms. Lise St-Denis: Thank you, Mr. Chair.

I have two questions for Mr. Beaulieu.

A $1-million donation is really a lot of money. How did you resolve the potential issue with the health care system? You have received a lot of money in grants to address mental health problems. How did the health care system respond?

Do you provide funding to change people's attitudes? You could change attitudes with so much money.

I am very familiar with Rouyn-Noranda. People have their preconceived notions in small communities. The smaller the community, the more stigma there is; the larger the community, the less stigma there is. Have you set aside any funds for working on that aspect of mental health recognition?

Mr. Ghislain Beaulieu: Ms. St-Denis, first, I would say that $1 million is indeed a lot of money. To date, we have raised a total of more than $1.6 million for the foundation.

The health care system's response has been good. From the beginning, we sat down with its representatives to explain that we would be an extra player and not a substitute. So far, the response has been a positive one.

We are making sure that the projects we support are additional or complementary. We could be talking about pilot projects to innovate and improve the quality of life for those affected, or improve their environment. When selecting projects, we make sure not to be a substitute for what the state or governments were doing or should be doing. That is part of our method and one of our priorities.

You are right; our objective and priority are to educate the public and encourage their involvement. For instance, we have been organizing annual fundraisers over the past three or four years. Each year, 400 to 500 people buy a ticket and participate in our fundraising event, and we give them books on the topic to inform them and teach them things they can discuss with their children. As Ms. Moore mentioned earlier, we had four children's books translated. So children talk to their parents about it. I think children can often help us change habits.

In addition, guests of honour participate in our activities. Last year, Luc Vigneault was our honorary patron, and he gave a speech. He is a well-known name in these circles. He has schizophrenia, but he is doing well. He gives speeches and works in the community. I think those kinds of interventions open things up when it comes to discussing the disease, raising awareness, improving the situation, demystifying things and making people see that it's just a disease like any other and should be talked about.

The Bradley family agreed to lend its name to the foundation we are in charge of. That's one example. They are very well-known people, community leaders. They agreed to talk about it and have attended every year. They visit organizations that carry out projects we fund. That accessibility helps us get closer to those who are affected. It breaks down prejudice and helps advance the cause.

● (1655)

Ms. Lise St-Denis: I have another question for you.

Do you have contacts with people from other municipalities—in Quebec or the rest of Canada—who are interested in your project?

Mr. Ghislain Beaulieu: Yes, regularly.

Mr. Vigneault is from Quebec City. He knows other people in the community. Last week, I met another speaker, Richard Langlois, who has bipolar disorder. He has written on the topic and gives speeches. We have been invited to participate in a conference in Quebec this fall to talk about how we started our foundation, what we do and how we do it.

I think what we do is fairly unique in Quebec, and it's starting to spread from our region. We are proud of that because it proves that a community can take matters into its own hands. We don't always have to wait for others for something to happen. We can challenge ourselves and take charge.

[*English*]

The Chair: Thank you very much.

Mr. Toet, for five minutes.

[*Translation*]

Mr. Ghislain Beaulieu: We must also be able to call on various governments to let them know that more can be done and that we can give them support.

[*English*]

The Chair: Okay, thank you.

Mr. Toet, five minutes.

Mr. Lawrence Toet (Elmwood—Transcona, CPC): Thank you, Mr. Chair.

I want to start with our guest, Dr. Carleton.

It's very intriguing. You talked quite a bit about preventative strategies. In fact, you even talked about reducing PTSD—rather than treating it further on, actually reducing it and preventing it. I've seen for a long time, even in our regular health care system, that we need a paradigm shift. We really don't have a health care system; we actually have a sick care system. We need to look much more at a prevention model. It was very interesting to hear you speak many times about preventative measures going forward. I think we have a unique opportunity in the mental health care field. We've had a lot of growth in the last number of years, but we are to some degree still in infancy, so we can point the direction the right way, rather than trying to chase from behind.

I just wondered about your thoughts on that and the work you're doing that is proving that out, and how you are focusing more on preventative care at the front end, and showing the results that we can have from that. I know you're early in that, but if you could share a little bit of that with us, it would be very appreciated.

● (1700)

Dr. R. Nicholas Carleton: Thank you, Mr. Chair. I'm very happy to answer the member's question and to emphatically support his comments. I agree that we need to engage in more preventative medicine, period, and certainly with mental health care I think prevention may very well be the key.

We can do a lot with prevention already in providing additional education. There are already cross-sectional studies, and even some nascent or prospective longitudinal studies that have provided us with some initial directions about what to target, because it's not as simple as identifying a virus or identifying bacteria and then wiping it out. It's more complicated than that with mental health, as I'm sure you know.

With the prospective and longitudinal research that we want to engage in, we want to be able to target specific aspects of individual vulnerabilities and resiliencies. So for example, there's a construct that we refer to as anxiety sensitivity. Anxiety sensitivity refers to how you respond to your own internal sensations associated with anxiety—heart palpitations, for example. How you respond to that can influence your subsequent anxiety responses, so that's one of the variables that we're very interested in researching, because it's also one that we can modify. So if we can broadly proliferate modification of that variable, we can reduce it as a risk factor and then build resiliency right into mental health and mental health care at a very fundamental level.

So variables like those we are very interested in studying, because we know how to change them. We're excited about the prospect that if we can demonstrate the success associated with that change, we can then encourage and support the use of those kinds of changes, not just for first responders but for all Canadian citizens.

Mr. Lawrence Toet: What about the whole-of-family approach? When I speak of that, I'm talking about the need to include all family members in the process. I think it's actually very beneficial even for younger children—I wouldn't say very young children—to have a better understanding of what's occurring and to be supportive in the family structure.

I just look back to the time at the end of the life of both my mother-in-law and father-in-law. They spent that time at the end with us in our household, and I see the positive impact that actually had on my children, being part of that process, understanding the need for care, and understanding the need for support.

Do you see that whole-of-family approach as something we should be looking at going forward?

Dr. R. Nicholas Carleton: Absolutely. Again, I would emphatically support that.

When I'm treating my own patients, one of the important things I speak to is the notion of how it's important to keep your family in the loop, so to speak, to make sure they have access to evidence-based education. There's a lot of misinformation out there, and I believe that misinformation is causing additional problems. For example, people still believe that post-traumatic stress disorder is a lifelong and unresolvable disorder, and that's simply not the case.

So there's a lot of misinformation. The more information we can provide not only to the individual who's having difficulties but also to their family members, the better our chances of supporting them in the long term for ongoing success with any mental health challenge are going to be.

The Chair: Mr. Toet, you have 10 seconds left.

Mr. Lawrence Toet: I think I'll pass.

The Chair: Okay.

He's too generous.

Ms. Morin, you have five minutes and ten seconds.

[*Translation*]

Ms. Isabelle Morin: Thank you very much, Mr. Chair.

Mr. Beaulieu, you talked a lot about housing, which I found very interesting. Could you tell us more about the importance of housing for someone with mental health problems? You also talked about older people living with those kinds of problems.

Can you tell us about the significance of those problems in terms of age? How does someone with mental health problems benefit from living in an apartment instead of in a centre where all those services are provided?

● (1705)

Mr. Ghislain Beaulieu: The benefit has to do with the individual's autonomy. By living in an apartment, they learn not to depend on others and to take care of themselves. Rehabilitation begins with having self-esteem, your own things and feeling responsible. When they live in an institution, they have no decisions to make and have no responsibilities. So it becomes difficult to make them fully self-sufficient.

I went through that with my son. Over a seven-year period when everything was going well thanks to medication, he owned a three-apartment building. He took good care of it and functioned quite normally. For people like him, it is really important to have that feeling of belonging and accountability to be able to continue their rehabilitation in the community.

Ms. Isabelle Morin: How many people who live in the housing you provide go on to live somewhere else without any assistance? Approximately how much time do they spend in your housing?

Mr. Ghislain Beaulieu: I cannot give you an answer yet because the project is in the construction phase. We will provide housing accommodations with minimal monitoring. I know that those who will live there will come from housing provided by an organization, such as Le Pont. That organization has apartments near its offices, and people are monitored around the clock. People will be monitored in the apartments under construction, but more loosely. The monitoring will not be done 24/7; it will be looser. I cannot give you those statistics, but the organizations we work with could.

Ms. Isabelle Morin: Does the approach change depending on whether the individual is a young adult or an older person?

Mr. Ghislain Beaulieu: Absolutely. In our experience, the earlier a young adult receives treatment, the less damage and consequences they will suffer, and the more possible autonomy and rehabilitation will become. Conversely, an older person may have stopped taking their medication, and their disease may have progressed. It is crucial for a young person to receive the right treatment as early as possible. They must receive strong support and guidance to reduce relapses to a minimum.

Ms. Isabelle Morin: My understanding is that families gave you substantial sums of money to help you establish your foundation. Now, you operate through fundraising. You are lucky to have had access to that money in your community.

What do you think the government's role is? If we wanted to apply your model in other cities, villages or communities in Canada, what kind of a role could the government play to help a similar project see the light of day?

Mr. Ghislain Beaulieu: I think the government must continue to strongly support the organizations. In our community, for instance, a number of organizations do a tremendous job. I call them “angels” because they work with limited funding, and they do it with a passion we don't really see among major networks and institutions. Those organizations are key partners for success, but they operate with very small budgets and teams.

The government must continue to help them, so that they won't have any operational problems, and so that they can develop projects and innovate in the field to continue improving the environment. The same goes for prevention. If organizations can do their work, they will be able to develop. That is where we, the foundations, come in to support the new developments. If the organizations are having operational problems, our community definitely loses important assets. I think the government's role is to properly support those organizations.

● (1710)

Ms. Isabelle Morin: Great. Thank you very much.

[*English*]

The Chair: That concludes this panel.

I thank both our guests.

We're going to suspend for a minute or two and then go in camera, as we have some committee business to work on.

We'll have to ask our guests at the back to leave, please.

When we come back, we'll be in camera.

[*Proceedings continue in camera*]