HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

# Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities

HUMA • NUMBER 037 • 1st SESSION • 42nd PARLIAMENT

**EVIDENCE**

## Tuesday, January 31, 2017

## Chair

**Mr. Bryan May**

# Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities

**Tuesday, January 31, 2017**

● (1100)

[*English*]

**The Chair (Mr. Bryan May (Cambridge, Lib.)):** Good morning, everybody.

Welcome back. I hope everyone on the committee, the staff, and interpreters has had a nice break, is recharged, and ready to get back at it because we're not starting off slowly, to put it lightly. We're getting right back into the study.

Pursuant to Standing Order 108(2) and the motion adopted by the committee on Monday, June 13, 2016, the committee is resuming its study on poverty reduction strategies.

We are very pleased today to have a very full panel for our meeting. From the Department of Employment and Social Development, we have Doug Murphy, director general, social policy, strategic and service policy branch. From Statistics Canada, we have François Nault, director of health statistics; and Jennifer Ali, chief, health statistics division. From the Department of Health, we have Sony Perron, senior assistant deputy minister, first nations and Inuit health branch, as well as Dr. Patricia Wiebe, medical specialist in mental health from the population health and wellness division, first nations and Inuit health branch. Last but not least, from the Public Health Agency of Canada, we have Anna Romano, director general, centre for health promotion, health promotion and chronic disease prevention branch.

Thank you all for being here. It's incredibly cold outside, so thank you for all being here. We're going to get started right away with opening statements. We do have a full complement here today, so we will keep statements to seven minutes.

Starting off today, Mr. Murphy, the floor is yours for the next seven minutes.

**Mr. Doug Murphy (Director General, Social Development Policy, Department of Employment and Social Development):** Thank you very much, chair and members of the committee. It really is a pleasure to be here.

I'm going to provide a bit of broad context on the government's poverty reduction strategy just to set the table for my colleagues, so to speak, who will also talk about this important issue in some depth.

As you are aware, the government has committed to developing a poverty reduction strategy that will set targets to reduce poverty, and to measure and publicly report on that progress. As you also know, poverty reduction strategies are not uncommon in Canada. Provinces, territories, and municipalities already have strategies, and for the Government of Canada it will be important to build on their progress in this area.

As a first step, a discussion paper towards the poverty reduction strategy was tabled on October 4 before this committee by Minister Jean-Yves Duclos. You may recall that the purpose of this paper is to provide a frame for our forthcoming discussions and a national dialogue on the subject of poverty reduction in Canada. It is a truly collaborative effort, so I'd like to thank my colleagues who are here, because they played a very important role in the development of that dialogue paper and I think the panel is entirely appropriate to discuss these important issues.

The paper explores the various dimensions of poverty: income, housing, employment, education, health, and inclusion. It also talks about the groups that are more at risk of living in poverty, called vulnerable groups because they are more vulnerable to poverty.

Overall, I think the message of the paper is that poverty is a complex issue and its solution will require a multi-dimensional approach. One thing that comes through—and I think it'll be an important topic today—is the connection between poverty and health, which moves in both directions. When individuals live in poverty, they are more likely to experience poor health; and at the same time, when individuals are in poor health, they're more likely to experience poverty than those who are in good health. It becomes more difficult to attend post-secondary education, to participate in one's community, and to secure a job.

While the connection is multi-faceted and complex, an important factor in reducing poverty will be supporting Canadians with mental health issues. My own department has a number of programs that either directly or indirectly support individuals with mental health issues. There's the homelessness partnering strategy. The link and the relationship between mental health and living in homelessness is well documented. We also provide income support programs such as employment insurance sickness benefits and the Canada pension plan disability program.

As for the next steps in the poverty reduction strategy, one of the things that we're doing is an important project called the tackling poverty together project. This will be rolling out via case studies in six communities across Canada: Saint John; Trois-Rivières; Toronto, Regent Park; Winnipeg; Yellowknife; and Tisdale.

One of the real purposes of this project is to speak to people with the lived experience of poverty, to understand what's working, what's not, and what could be improved. As we talk to the people with the lived experience of poverty, mental health issues will undoubtedly come to the fore.

We're also developing a longer term public engagement strategy, which we hope to launch shortly. Again, we'll be speaking with experts through round tables, but we'll also be speaking to people with the lived experience of poverty, people who are experiencing it on the ground; and we'll undoubtedly be hearing about the link between mental health and poverty in Canada.

In conclusion, I would like to thank the committee for inviting us here, and I'll turn it over to my colleagues in Statistics Canada to provide a statistical overview of mental health in Canada.

● (1105)

**The Chair:** Thank you very much.

We are going to move over to StatsCan now.

I am sorry, I did not ask before. Is it François?

The floor is yours for the next seven minutes, sir. Go ahead.

● (1110)

[*Translation*]

**Mr. François Nault (Director, Health Statistics, Statistics Canada):** Thank you, Mr. Chair. My colleague Jennifer Ali, who is a mental health statistics expert, is going to do the presentation.

It will be our pleasure to reply to questions in either official language.

[*English*]

**Dr. Jennifer Ali (Chief, Health Statistics Division, Statistics Canada):** Good morning, Mr. Chair and committee members. Thanks for the opportunity to share with you some information about mental health in Canada.

The most recent comprehensive data on the mental health of Canadians comes from the 2012 Canadian community health survey on mental health. Most of the data for this presentation comes from that survey. It covers people aged 15 and older in all provinces, but not the territories, aboriginal reserves and settlements, the Canadian Armed Forces, or the homeless. Since it is a cross-sectional survey, I will talk about associations, but will not be able to draw conclusions about causation.

I'll be referring to mental or substance use disorders. In this survey, respondents were not asked to self-identify. Instead, they were asked a series of questions about symptoms experienced and the types of behaviours they engaged in. Then, based on their responses, they were classified as having met the criteria for a mental or substance use disorder.

Unless otherwise noted, disorders discussed in this presentation are based on having met the criteria for a disorder in the 12 months prior to the survey. Six disorders were measured in the survey: depression, bipolar disorder, generalized anxiety disorder, alcohol abuse or dependence, cannabis abuse or dependence, and other drug abuse or dependence.

We have provided a profile on how mental and substance use disorders vary across a number of demographic and social groups. Since there are too many graphs to go into detail on each, I'll start with a summary of the results and then draw your attention to several key findings, leaving the details in some of the charts for your reference or questions later.

To summarize the main points of all the charts to come, many people experience a mental health problem at some point in their lives. Women have higher rates of mental disorders while men have higher rates of substance use disorders. Vulnerable groups include youth, people who aren't married or common law, single parents, those with low incomes, aboriginal people, those with a history of homelessness, and those who had childhood maltreatment. Immigrants were an exception in that they have lower rates of disorder compared to the Canadian born.

Now that I've given away the main points, I'll focus on a few of the slides in more detail. On slide 5, overall, about 10% of people met the criteria for one of the disorders in the past 12 months. The proportion of Canadians with a mental disorder was about double that of those with a substance use disorder, 6% versus 3%. While not shown on this chart, it is important to note that about 1% of Canadians had both a mental and substance use disorder.

On slide 6, the numbers we've been looking at refer to the 10% of people who experienced a mental or substance use disorder in the year before they were interviewed. To add some context, about a third of Canadians reported having experienced symptoms of a disorder at some point in their lives. The good news is that we can see that most of these people didn't experience symptoms in the 12 months prior to the interview.

Moving on to the prevalence among certain age groups on slide 7, we see that overall those aged 15 to 24 were at a higher risk of having a disorder, almost one in five. The overall rates of disorders then declined as age increased. This contrast by age is mostly attributable to substance use disorders. Those aged 15 to 24 show a higher prevalence of substance use disorders than any other age group.

While not shown here, 3% of those between the ages of 15 and 24 had both a mental and substance use disorder, a significantly higher proportion than the overall average, which was 1%. By contrast, the proportion of people with a mental disorder was about equal for all age groups, with the exception of those aged 65 and older.

On slide 8, when taking income into consideration, a larger proportion of those with an annual household income under $20,000 had a mental or substance use disorder compared to all other income groups. Just under 20% of Canadians with an annual income of less than $20,000 reported a disorder, while for all other income groups, the range was between 8% and 11%.

In relation to income and disorders, it is of interest to note that there was a higher prevalence of disorders among those who relied primarily on social benefits as their main source of income. More specifically, about three in 10 Canadians who stated that social benefits were their main source of income had a disorder compared to one in 10 of those who relied primarily on employment.

● (1115)

We know that household income has different implications, depending on a number of factors, such as family size and location, so we asked respondents if they felt their income was enough to cover their basic expenses. Those who said they had difficulty covering basic expenses were more than twice as likely to have had a disorder than those who felt their income was sufficient.

On slide 9, related to the finding on social benefits, we see that people who were permanently unable to work had higher rates of mental or substance use disorders than those with other working statuses.

Slide 13 looks at rates of disorder among parents with children under 18 living at home. We see that single parents experienced rates of mental or substance use disorders about double that of their married or common-law counterparts.

On slide 14, we see that immigrants are a group that is overall better off, with rates of disorder that are half that of those born in Canada. This may mask vulnerable subgroups such as refugees, but we don't have this data by subgroup. Although it's not shown on this slide, we also looked at visible minority status. There are no differences by visible minority status once immigrant status is taken into consideration. Before that, the visible minorities had lower rates.

Moving to slide 16, this last comparison has to do with childhood experience of maltreatment. Previous research has suggested a link between early childhood maltreatment and an increased likelihood of developing a disorder. In this survey, childhood maltreatment was measured as experiencing specific types of physical maltreatment or sexual abuse at least once before the age of 16. Results from the survey are consistent with previous research, as they indicate that almost 14% of adults who had experienced childhood maltreatment had a disorder, compared to 6% among those who had not experienced maltreatment—more than double.

To sum up, as I mentioned earlier, other vulnerable groups that we have provided data for but have not discussed in detail include aboriginal people; single, divorced, and separated people; and people with a history of homelessness.

I hope this mental health profile of Canadians is useful for your work.

**The Chair:** Thank you very much.

From the Department of Health, is it Sony or Patricia who is going to start us off?

Sony Perron, the next seven minutes are yours.

**Mr. Sony Perron (Senior Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health):** Thank you very much.

Good morning, Mr. Chair and members of the committee. I am the senior assistant deputy minister for the first nations and Inuit health branch at Health Canada.

[*Translation*]

This is the first time I appear before your committee. I am delighted to have this opportunity to speak with you this morning.

Before continuing my presentation, allow me to introduce Dr. Patricia Wiebe; Dr. Wiebe is a mental health medical specialist, and works in our branch.

[*English*]

Today, I will provide you with a general overview of our mandate and programming, and then I will be ready to answer your questions related to mental wellness through innovative approaches in the context of poverty reduction.

Health Canada, through the first nations and Inuit health branch, is committed to working with first nations, Inuit, and provincial and territorial partners to ensure that first nations and Inuit communities and individuals have access to a broad range of quality health programs and services that are responsive to their needs and priorities. First nations and Inuit face historical and ongoing impacts of colonization, including intergenerational impacts of Indian residential schools and disconnection from the strengths of culture and indigenous world views.

[*Translation*]

As you know, first nations and Inuit grapple with serious health challenges. When we compare them to the general Canadian population, we see that they have a shorter life expectancy, a higher rate of chronic and infectious diseases, as well as higher rates of mortality and suicide.

They must also overcome greater challenges when it comes to the social determinants of health, such as higher unemployment rates, less schooling, and higher rates of overcrowded housing.

● (1120)

[*English*]

It is widely acknowledged across Canada that substantial disparities exist between population needs for addictions and mental health services and the currently available services. This gap is even wider with respect to indigenous populations.

To emphasize the topic that brings us here together, I would like to share some information about the mental health programs and services funded by our branch that provide support to indigenous individuals, families, and communities and that may also impact those with disabilities and indirectly contribute to poverty reduction. I will also talk about the framework that guides Health Canada programs, intervention, and services approach that helps to improve access to these important services.

Health Canada is investing over $300 million annually to support the mental wellness needs of first nations and Inuit communities. These include activities that address mental health promotion, addictions, and suicide prevention, crisis response services, mental health counselling benefits, treatment and after care, and support for eligible former Indian residential school students and their families so that they can safely address a broad spectrum of wellness issues related to the impacts of these schools.

These programs and services aim to reduce risk factors associated with mental health and to promote proactive factors, such as resilience-building behaviour, in order to improve health outcomes associated with mental wellness. The majority of the services are delivered by community health organizations, first nations treatment centres, or independent mental health counsellors. Health Canada acts as a funder for these services.

During the summer of 2016 an additional $69 million investment over three years was announced to address mental wellness needs in first nations and Inuit communities. This investment supports first nations and Inuit communities to enhance capacity at the local and regional level to provide essential mental health services that respond to current crises. These investments are being guided by the first nations mental wellness continuum framework and the national Inuit suicide prevention strategy, which were collaboratively developed by and with first nations and Inuit partners.

The development of the first nations mental wellness continuum framework, for example, has been recognized in itself as a best practice for its extensive consensus building and validation process, with first nations leading the dialogue. It speaks to the needs for a transformative whole-of-government approach that promotes mental wellness, reconciliation, and healing. It outlines a holistic approach to a continuum of mental wellness services with first nations culture as a foundation. First nations national and regional partners work in close collaboration with other federal departments to support the implementation of the continuum at the community, regional, and national levels. The continuum is grounded in indigenous social determinants of health and provides an understanding and a process for partners to plan, implement, and share responsibilities on critical elements beyond the direct control of the health system.

The national Inuit suicide prevention strategy has been developed by the Inuit Tapiriit Kanatami on its own. To support this Inuit-led approach, the Minister of Health announced in July 2016, on the same day ITK launched this important framework, additional funding over three years. Community development, ownership, and capacity building must be present at all levels of service delivery to ensure that programs and services are relevant, effective, flexible, sustainable, and based on community needs and priorities.

[*Translation*]

The recent unfortunate events in the Wapekeka community again reminded us that it is important and urgent that we work with mental health professionals, authorities and local stakeholders as well as with our provincial partners so as to provide adapted, timely assistance to the families and members of the communities that are facing serious crises such as the one in that community.

[*English*]

In addition to responding to the Wapekeka crisis, we are continuing to work with the community to find longer-term and culturally appropriate solutions that will foster hope and mental wellness.

Culture is an important indigenous social determinant of health and a key factor in achieving community wellness. Health Canada supports land-based programming as one example that uses culture as a foundation to help individuals, families, and communities strengthen their relationship to the land and traditional culture. This, in turn, helps to achieve a balance of mental, physical, emotional, and spiritual well-being, by building resilience and addressing risk factors.

We have made investments for the deployment of telehealth solutions, and now most of the health centres and nursing stations are equipped with telehealth technology. An analysis done in 2015-16 indicated that there were over 14,000 successful telehealth sessions in first nations communities, offering a wide range of health services, including case conferencing and patient education. Furthermore, clinical consultations such as mental health sessions represent 9% of all clinical sessions in Alberta, and 13% in Manitoba.

Technology can help improve access to mental health services. It is particularly important to explore these avenues where communities are facing challenges in terms of service availability.

In line with the government's priority to engage on a nation-to-nation basis, what is needed is a consistent and progressive relationship between all levels of government and indigenous leaders that embodies mutual respect and partnership. Wellness in a community is a shared responsibility that can only be achieved and maintained through a fully collaborative approach to care that addresses indigenous social determinants of health and is rooted in culture and self-determination.

To achieve results, mental health services must be culturally safe, and developed and delivered with community partners. We have an obligation to explore new ways to deliver these services in order to be responsive to the need.

Dr. Wiebe and I will be happy to answer your questions. Thank you very much for your time this morning.

● (1125)

[*Translation*]

**The Chair:** Thank you very much, Mr. Perron.

[*English*]

My colleagues, I'm sure, are looking forward to asking some questions.

Moving on, last but not least, from the Public Health Agency of Canada, we have Anna Romano.

**Ms. Anna Romano (Director General, Centre for Health Promotion, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada):** Thank you, Mr. Chair.

I appreciate the opportunity to address this committee on behalf of the Public Health Agency of Canada.

Let me begin my remarks with some important definitions that I think will illustrate the public health imperative of supporting and improving mental health. Mental health is defined by the World Health Organization as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."

Mental illness, on the other hand, refers to mental health problems that are typically diagnosed and treated by mental health professionals. They include depression and anxiety as the two most common mental illnesses, as well as other less common ones, such as schizophrenia.

We know that mental illness is a significant contributor to poverty. In turn, the experience of poverty can negatively affect mental health. The World Health Organization has recently highlighted that the experience of poverty, inadequate housing, and problems finding work or getting an education are risks for poor mental health.

Understanding the impact of social and economic factors on mental health is key to developing effective public health programs. At the Public Health Agency we work upstream to help strengthen protective factors that promote positive mental health by helping Canadians build resilience and coping skills and prevent mental illness. Alongside other poverty reduction strategies, strong mental health can help break cycles of poverty.

The agency's work to promote mental health includes surveillance, testing programs—also known as "intervention research"—and support to community-based programs for vulnerable populations such as children, youth, survivors of violence, and seniors.

I would like to spend the next few minutes telling you about some of the investments the agency is making in these areas.

Given our focus on prevention and promotion, supporting vulnerable children and youth is a public health priority. Our suite of prenatal and parenting support programs reaches 278,000 at-risk children and parents in over 3,000 communities across the country each year.

We invest about $112 million dollars annually in three programs: the Canada prenatal nutrition program, the community action program for children, and the aboriginal head start in urban and northern communities. Families using these programs are facing challenging life circumstances, such as low income, lone or young parenthood, social or geographic isolation, situations of violence or neglect, as well as substance abuse problems. These programs support positive parenting, parental involvement, attachment, resilience, and healthy relationships, all of which are protective factors associated with positive mental health.

We know from program evaluations and participant surveys that these programs have a significant positive impact on both parents and their children, including improving mental health.

The Public Health Agency is also evaluating mental health promotion interventions to understand what types of interventions work, for whom, and in which context. Specifically, we invest $1.5 million per year on projects focused on children, youth, and their families that increase protective factors for mental health such as social support for vulnerable parents, secure parent-child attachment, resilience, the ability to resolve conflicts, and the ability to create healthy relationships. For example, the fourth R is a school-based prevention program that promotes healthy relationships amongst youth. The program includes role modelling of relationship skills, peer mentoring, bullying prevention, sessions on safe use of social media, as well as lessons to address and prevent dating violence.

The agency also supports community-based projects that strengthen both the physical and mental health of survivors of family violence. Poverty, unemployment, and economic stress are among the many risk factors for family violence. Family violence can cause serious health and social problems throughout the lifespan of a victim, including increased risk of behavioural problems in children, drug and alcohol use and attempted suicide in teens, and mental illness.

The agency supports projects across the country that reach vulnerable populations including street involved youth, indigenous and northern populations, and parents and children affected by violence. These projects also test the effectiveness of innovative health promotion approaches by measuring changes in mental health outcomes such as anxiety, depression, and post-traumatic stress injuries.

● (1130)

Poor mental health can impact Canadians at every stage of life, and seniors are no exception. Seniors with low incomes are more likely to experience social isolation, loneliness, and depression as well as ill health and a shorter lifespan. As you have heard from other experts, poverty reduction is not just about income support. It is as much about strengthening the bonds of community and having the ability to access the social supports around you. This is why the Public Health Agency continues to work closely with provinces and territories as well as the World Health Organization on the age-friendly communities initiative. In Canada this initiative has strengthened social inclusion in over 1,000 communities by bringing together seniors, caregivers, governments, and other stakeholders to help seniors remain active, engaged, and healthy in their communities.

The agency also works with partners to raise awareness and develop resources on seniors' mental health. For example, the agency provided funding to the Canadian Coalition for Seniors' Mental Health in collaboration with Shoppers Drug Mart to develop resources for seniors and their families on a range of seniors' mental health issues and to provide continuing education to pharmacists to support the dissemination of this information.

I will conclude here by emphasizing that investing in mental health promotion can help contribute to the reduction of poverty, but breaking the cycle of poverty and poor health requires a multi-disciplinary approach, given the complexity of the challenge.

Thank you for your attention and the time and energy you're devoting to this topic. I'd be pleased to answer any questions.

**The Chair:** Thank you very much.

Thank you to all of you for those opening remarks and for staying on time.

Before we get started I want to just welcome MP Glen Motz. I know you're just sitting in today, but I'm very interested to hear of your experience with Medicine Hat, where we're going in a couple of weeks. So welcome aboard.

It's good to see Brigitte Sansoucy and MP Vecchio sitting in as well.

I want to take a moment to welcome the newly minted parliamentary secretary, Adam Vaughan. I'm very excited to have you here, and obviously given what we're going to be dealing with in the coming weeks and months, you'll be a huge resource for us.

Apparently, as of this morning, it is official that MP Dhillon will be joining us on this committee.

So welcome to everybody. Thank you.

Okay, Dan. For the record, welcome back, Dan.

On that note, over to MP Vecchio for six minutes.

**Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC):** Thanks very much for coming out today.

Prior to become a member of Parliament, I was honoured to work in one of the MP's offices, and during the recession we saw a skyrocketing number of disability applications for the Canada pension plan. I have a couple of questions on that.

When we're looking at it, first of all, is there a way of dissecting those applications that were submitted based on mental health versus physical health? Did we see an increase in mental health issues over disability, because that's one thing I really did notice personally in the Elgin—Middlesex—London area?

Secondly, have you seen a correlation between the high unemployment rate and a high number of claims for the disability benefits, or is it just within our own riding that we saw that?

Whoever wants to answer, please go ahead.

Actually, I'll start with StatsCan. You may have information on that.

● (1135)

**Mr. François Nault:** I'm afraid we don't.

**Mrs. Karen Vecchio:** You don't?

Anyone else? Doug?

**Mr. Doug Murphy:** Yes. Those are interesting questions. I will have to go back to the program experts on those issues and we'll provide a response to the committee. Thank you.

**Mrs. Karen Vecchio:** I greatly appreciate that. Thanks very much.

Do you have any information concerning the positive impact on an individual's mental health from attaining meaningful employment? Is there any information on that? Once you see people become employed, do you see their well-being improve? Is there any information on that?

**Ms. Anna Romano:** Maybe I'll just take it at a very high level. I don't know if StatsCan would have any data in that regard.

Employment would be a very important “social determinant” of health, as we call it in the public health world. If you have a job and you're contributing, your mental health tends to be more positive. I'm sure there likely are statistics that provide some evidence of that. Again, we could probably follow up with something on that.

**Mrs. Karen Vecchio:** Fantastic.

**Mr. François Nault:** Just to add to that, our surveys are cross-sectional. We ask people at the same time whether they are employed or not and we assess their mental health. On slide 9, you can see that a lower proportion of people who declare a disorder are employed, but the statistics don't allow us to do the kind of thing you are suggesting: to show whether you return to better mental health once you have a job. It would require longitudinal data where we know a person's state before employment and measure their state after employment, but that we don't have.

**Mrs. Karen Vecchio:** It's not a problem.

Just looking at slide 13 from StatsCan, with the single parent information, I find it very interesting. We do recognize that there are a lot of issues for parents and single parents with poverty issues. Is there any data to show the mental health of those people who fall into that category of single parent because at one time they may have been married or separated, whatever the case may be? Is there any information that can show what they were before becoming single parents, showing where the mental health decline may have been due to poverty? Is there any information on that?

**Mr. François Nault:** Again, I think the question would be answered by what we call a longitudinal survey where we take a measurement at one point and then a measurement at the second point and try to disentangle what came first. These are very expensive surveys. I don't think we....

**Mrs. Karen Vecchio:** It's not a problem. I'm just going to carry on.

I come to this table with five children, so I feel as if I deal with mental health every day. It's true; sometimes it's my own.

Pierre and I have spoken about this. We've seen a real amount of effort put into the education and well-being of children, including counsellors at school and a variety of things like that. Is there any information by which we can show the decline in mental health of our youth? We've seen large statistics showing more substance abuse, more depression and anxiety. Is there some way we can weigh that back and compare it to data from the 1980s and 1990s? Do we have any information like that?

It may not have been of the scope. I don't think mental health was.... I went to high school in the 1980s. I don't think we focused on that. There were similar pressures at the time. Things have changed, and we recognize that. I'm trying to see if there is anything showing that we do put a lot of wellness into our schools right now. I'm wondering what the impact on our schools is and what the trigger actually was to put that in. We must have had some sort of trigger saying we need more for the schools. What forced that? Does anyone know?

**Dr. Jennifer Ali:** I'm not sure. I don't have that information, but there was a study that was released by Statistics Canada earlier this month that looked at depression and suicide among people aged 15 to 24. It also looked at people who sought help for their problems and looked at whom they asked. That study showed that the people aged 15 to 24 consulted a number of different sources, but 61% to 63% of those who sought help asked for informal sources, which included friends, family members, school teachers or principles, and co-workers. It was interesting that, of those who used that source, 88% of those who consulted a teacher or school principle thought it was very helpful or somewhat helpful. It shows that having those resources is very useful for helping people who are having problems.

● (1140)

**The Chair:** Thank you.

Go ahead, if it's very brief.

**Mr. Doug Murphy:** I have some information for the member: 30.9% of Canada pension plan disability claims are for mental disorders. I'm told that's on the rise. We'll get the additional information the member asked for.

**The Chair:** Excellent. Thank you.

We will go over to MP Long for six minutes.

**Mr. Wayne Long (Saint John—Rothesay, Lib.):** Thank you, Chair.

Welcome back, colleagues.

Thank you to the witnesses for great presentations.

I am from Saint John, New Brunswick, and, obviously, I was thrilled when Minister Duclos came to Saint John on September 3, I believe, to announce that Saint John would be one of the cities in the tackling poverty together study.

Mr. Murphy, for the sake of the committee, can you elaborate briefly on the expectations of the tackling poverty together initiative and how you see that tying in, especially tying in mental health, with respect to the poverty reduction strategy?

**Mr. Doug Murphy:** The tackling poverty together project is really looking at qualitative research. It's talking to people, because we can't capture everything through quantitative statistics. It's to do a deep dive into how people in key Canadian communities are experiencing poverty, and how the current programming actually helps them, and where it can be improved.

As I mentioned, it's about talking to people with the lived experience of poverty, and as we know and as we've heard from several people, people with mental health conditions are disproportionately represented in that.

**Mr. Wayne Long:** I'll jump in.

Will you make sure, on the tackling poverty together initiative, that you are talking to a lot of lived-experience people? Is that a priority?

**Mr. Doug Murphy:** That's almost the key priority of the tackling poverty together strategy.

**Mr. Wayne Long:** Thank you.

Ms. Romano, thanks for the presentation. I thought it was great.

I'm a rookie MP, and we're learning, but one of the frustrations I have at times is that there is a federal initiative, and then it filters through to the province, and at times it gets lost from the province out to the front line.

In your opinion, can you tell me how important it is that the federal and provincial governments, number one, are aligned? Also, what innovations do you see that could actually improve things so that our priorities get to the front lines through the provinces?

**Ms. Anna Romano:** Thank you for your question.

I'll speak to some of the programming we have at the Public Health Agency, in particular the maternal and child health programs I referenced earlier. In those cases, we work very closely with provinces and territories. We have a number of joint management committees that determine the priorities for the programming dollars so that we don't have a situation in which there is overlap in what the federal level is investing in and what provinces and territories are investing in. In particular we try to align our investment dollars so there aren't any major gaps.

I think I mentioned in my remarks that our focus tends to be on the most vulnerable and on where we have found there just isn't enough provincial and territorial programming to go around to reach some of those more vulnerable populations.

In terms of innovative approaches, this sounds pretty bureaucratic, but having those joint management committees in which you work together with provincial and territorial colleagues to set priorities has tended to work over the last 20 years for these programs.

● (1145)

**Mr. Wayne Long:** Are there any provinces you see that stand above the rest in delivering what's needed?

**Ms. Anna Romano:** Off the top of my head, one example is the age-friendly communities initiative that I spoke of earlier. We have an excellent working relationship with Quebec, which has really embraced that initiative. It's found in probably more communities there than anywhere else across the country. It's an example of having kind of led the way, whereas other provinces and territories might have different priorities.

I'm not sure if I totally answered your question.

**Mr. Wayne Long:** That's fine.

I'm going to switch over to StatsCan if you don't mind. I'll read a quick stat. It was in your slides too: “Eleven per cent of Canadians aged 15 to 24 experienced depression at some point in their lives, and fewer than half...sought professional help.”

When I was in my teens, I suffered greatly from anxiety. I can remember being at school, or university, or what have you, and I would never ever tell anybody that I did. If I was given a survey or something like that, or a call, I would never admit to that.

Can you share with me how comfortable you are that you are actually reaching those people. I know the slides are great. There's lots of good information there, but how are you really connecting with those people most in need? My fear in that case—and we'll talk about the homeless shelters in a second—and certainly with those who are experiencing anxiety and depression in their teen years, is that they don't come out. So how do you find them? How do you account for them?

**Dr. Jennifer Ali:** The sampling strategy that we use is a representative sampling strategy. The households are selected and then the people are selected from the household. So we haven't noted —

**Mr. Wayne Long:** I'll just jump in.

I get that. We've been part of those—

**The Chair:** Wayne, sorry. I have to cut you off a little bit there.

Can you make it really brief?

**Mr. Wayne Long:** I'll get it the next round.

**The Chair:** Okay. Thanks.

We'll move over to Madam Sansoucy.

[*Translation*]

**Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP):** Thank you, Mr. Chair.

I thank all of the witnesses for their presentations. They have explained very well how poverty can lead to mental health issues, and conversely, how mental health issues can lead to poverty.

Ms. Romano, thank you for your statement. It is always interesting to establish new definitions and to see that we are not reinventing the wheel. The World Health Organization has already documented these things very well.

As you pointed out, we have to remember the obvious, for instance the importance of understanding risk factors properly, whether it be poverty, inadequate housing, the difficulty of finding a job or being able to get an education; however, there are sometimes contradictions regarding these issues. I was surprised by a statistic showing that persons with higher levels of education were at greater risk. Information can sometimes raise questions.

You also said that it is important to look at root causes, because it is often tempting to only address the consequences. In the short term, we deal with the consequences, but as long as we do not deal with the causes of a problem, we will not solve it.

This leads in to my comments for the representatives of the Department of Health. Unfortunately, crises often remind us of the fundamentals, such as how to intervene, best practices, and long-acknowledged methods we need to implement. Unfortunately, crises are what remind us that we have to invest in this regard.

You concluded by speaking about the importance of constant, progressive co-operation, but it seems that there always have to be crises in order for us to remember that. I would like to hear you on the balance there should be between prevention and the necessary reactions to crisis situations. How can we be present on a daily basis in aboriginal communities, rather than waiting for a crisis to erupt before we decide to invest more? I need to hear what you have to say about this necessary balance.

● (1150)

**Mr. Sony Perron:** Thank you, very much. That is an excellent question.

I am going to try to provide a reply that is broad enough to address the scope of your question.

At the First Nations and Inuit Health Branch, our public health approach is to try to arrange things so that Inuit and first nations have institutions, or the capacity to provide services on an ongoing basis. I am not only talking about mental health services. Some services also target prevention, such as early childhood services. If we want a truly comprehensive mental health approach, we have to begin with prenatal health. We have to invest to help mothers, fathers, and families so as to provide them with the tools they need to support their children and foster their growth.

We provide a series of programs in first nations communities throughout the country. They are often delivered by the communities themselves. The early childhood programs include prenatal interventions intended to support families and parents. That is extremely important.

I spoke earlier about our direct mental health interventions. That component is extremely important. We have to support ongoing care and issue identification. Primary care in the communities helps to meet the needs as they arise.

The mistake that was made several decades ago was to believe that a sectoral approach managed by the government was the best way to organize services. We learned over time that self-determination, that is to say having the communities themselves control their programs and services, makes an enormous difference in quality and response.

Consequently we developed a mental health framework with the first nations, among others. We start with the basics, by trying to give hope and develop a sense of belonging and also a sense of making a contribution. These are crucial factors needed to repair the elemental fabric of the communities that was destroyed by colonization policies applied by our institutions for many years. And so broad-based action is needed for redress.

Over the past few years, our mental health approach has been to fund what we call mental health teams. They are comprised not only of social workers, psychologists or psychiatrists, but also include elders from the community. These grandparents or other persons intervene in a more traditional way. We try to combine all of the best health care practices used in the population. We integrate tradition and culture. We try to reconnect with the essentials. That is what was to some extent destroyed, and that is what undermines the resilience of families and communities.

I would say that 90% of the services provided and funded by the federal government in first nations communities are controlled by the communities themselves, through first nations organizations.

**Ms. Brigitte Sansoucy:** That approach reflects well on you.

Earlier, with a great deal of diplomacy, Ms. Romano answered a question regarding areas of provincial health jurisdiction. Eva Ottawa, who was appointed chair of the Quebec Council on the Status of Women while she was the Atikamekw Grand Chief, told me how difficult that situation is. Whether we like it or not, even if supporting the health of first nations is an area of federal jurisdiction, the situation is not simple. In Quebec, for instance, because of the youth protection system, children from indigenous communities were placed in non-indigenous foster homes. And so those children were completely uprooted.

Given that health is a matter of provincial jurisdiction, one wonders how that goal of involving first nations in all areas can be realized. That remains to be seen.

[*English*]

**The Chair:** We're well past the time, I'm afraid. I let you go on there. Maybe we can come back to that question in the next round. We'll move to MP Robillard, please.

[*Translation*]

**Mr. Yves Robillard (Marc-Aurèle-Fortin, Lib.):** Thank you, Mr. Chair.

My question is for Mr. Perron.

We know that there are specific cultural factors in each indigenous and Inuit community. Witnesses have told us that there is a direct link between the fact of being able to hold down a job, mental health and poverty reduction.

What is your opinion on this?

● (1155)

**Mr. Sony Perron:** It has been abundantly shown that employment conditions, education and social circumstances have an impact on mental health. That is clear. That is why the approach to mental health of the First Nations and Inuit Health Branch, developed with the first nations, is a comprehensive approach. Through it we attempt to cover all of these factors. We work with the communities, identify risk factors, and determine a service offer that aligns with all of that.

We cannot expect to solve mental health issues by only responding to crises or by deploying teams at certain given times. Services have to be available on an ongoing basis, and basic issues have to be dealt with. Housing, the level of available services in the communities, and education are essential factors if we are to achieve concrete results in improving mental health.

Specific, one-time interventions with mental health professionals will not bring about in-depth change in the communities. That is why Budget 2016 investments in the construction of new housing are an essential element. Indeed, when 15 or 20 family members live in the same swelling, additional problems will arise.

Investing in education is also extremely important. I think it is the responsibility of the Department of Health to work with the communities to ensure that mental health services are available. To obtain concrete results Canada-wide, it is crucial that we invest in the social determinants of health.

**Mr. Yves Robillard:** Thank you.

Mr. Murphy, the Housing First program of the Homelessness Partnering Strategy, or HPS, is targeted to persons who are either chronically or episodically homeless.

Is there a way of structuring a similar program aimed at persons who need similar mental health and other supports but are not yet homeless, in order to prevent them from falling into homelessness?

[*English*]

**Mr. Doug Murphy:** I'm just being handed something by my colleague.

The link right now is the homelessness issue. Whether that approach, like the wrap-around services, can be applied when homelessness is not the fundamental issue, I think is your question. That I will have to get back to the committee on. The Housing First approach, or the wrap-around services, dealing with the mental health conditions in the federal domain, has always been seen through the lens of homelessness, as the core aspect of our homelessness partnering strategy. To extend that when there isn't homelessness but there are mental health issues, I'm just not in a position at this point to respond. But it is an interesting observation.

**Mr. Yves Robillard:** Could you provide us with a complete answer further on?

**Mr. Doug Murphy:** Yes.

[*Translation*]

**Mr. Yves Robillard:** Mr. Chair, I am going to share my speaking time with Mr. Wayne Long.

[*English*]

**The Chair:** You have just under two minutes.

**Mr. Wayne Long:** Thank you to my colleague and the chair.

I'll go back to Stats Canada. With respect to teenagers who have depression or are experiencing anxiety, what has Stats Canada done differently, say, over the last five years to make sure you are reaching or hitting that group? What innovation have you shown to try to hit that group?

**Mr. François Nault:** I think it's a good question. My colleague had started to talk about the methodology. We have implemented the best methodology possible. We have also very good interviewers who are convincing people to answer the questions. Obviously, these are very sensitive questions. There's no doubt about it. Is there under-coverage? We try to control it as much as we can. We have very consistent results over time, so we're fairly confident in our numbers. Recently we have tried all kinds of different techniques such as behavioural economics to nudge people, to convince people to respond. We've been phoning. We're very persistent, phoning about 25 times to try to convince people to respond to the question. But the response rates have been declining for sure, so it is a challenge to make sure there isn't under-representation of those people who are the most vulnerable.

● (1200)

**The Chair:** Thank you very much.

Now over to Dan Ruimy for six minutes.

**Mr. Dan Ruimy (Pitt Meadows—Maple Ridge, Lib.):** Thank you very much, Mr. Chair, and thank you everybody for presenting.

This is very tough. On paper, from what you guys are saying, the programs seem great. It's not what I'm seeing in my riding, and that's a big concern. Is that a question of our failing? Is that a question of programs not reaching people? These are the concerns that we're trying to address.

The unemployment rate among people with serious mental illness is 70% to 90%, and there is therefore a 60% drop in the family's income when the primary earner is diagnosed with mental illness.

I'd like to talk a bit about the current EI system, and how it responds to this and assists unemployed Canadians with appropriate services. This is directed to Mr. Murphy. How do they get back into the workforce? What are we doing to help them?

**Mr. Doug Murphy:** Is your question specifically related to people with mental disabilities?

**Mr. Dan Ruimy:** Mental disability seems to be a major portion of the problem of poverty, and we know that they're closely interlinked. When we are trying to get people back to work, are we addressing that portion? Is Service Canada addressing that portion of the problem?

**Mr. Doug Murphy:** Yes. I apologize, but on that specific issue, I will have to get back to the committee with an answer.

**Mr. Dan Ruimy:** Okay.

Service Canada right now has a skills link training program, for instance, for youth at risk. How do we get youth back into the workforce? One of the problems we see is that we take somebody who has had all these mental health challenges and is struggling and in this pit of despair, and then we say, “Okay, here, we're going to give you some money and you're going to go to skills link training.” Do you think that would be an effective approach, or do you find there's a better approach to take? It's a tough question.

**Mr. Doug Murphy:** It is a tough question and it's not my area of expertise, but I can certainly go back to the people in Service Canada and our employment insurance policy and raise those issues with them.

**Mr. Dan Ruimy:** Okay.

I'm going to jump to Ms. Romano. Being with Health Canada, are you able to answer any of those questions? We're talking a lot about mental health, but we're not really doing a lot to help the ones who need it the most, especially the youth.

**Ms. Anna Romano:** Sure. I can maybe partially answer and then perhaps my colleague, Mr. Perron, can talk about some of the future investments we're thinking about making in the area of services.

Again, I want to make the distinction that at the Public Health Agency, we are trying to prevent people from becoming mentally ill. When I use the term “upstream”, I mean that many of the programs we have in place—you've probably heard the word “resilience” about eight times during our various presentations—are trying to get at the demand issue, decreasing the number of people who are actually trying to seek out those services once they're ill. I think it's widely recognized that.... My minister has made a big priority of improving access to mental health services. It's recognized that the demand is bigger than the supply.

I'll maybe have Sony speak to the health accord.

● (1205)

**Mr. Sony Perron:** To the extent I can.

**Ms. Anna Romano:** Yes, to the extent you can.

**Mr. Dan Ruimy:** We're playing hot potato here.

**Mr. Sony Perron:** It's a bit beyond the mandate of my branch, but what I can say is that, as you all know, the Minister of Health has in her mandate letter negotiating with the provinces and territories to, among other things, improve accessibility to mental health in Canada, so these discussions are under way. I'm pretty sure all the members of this committee are aware of how this is progressing with various provinces and territories.

I think this is a true commitment. There is great interest. I've been able to witness, in the discussions with provinces and territories, that they are concerned about that. At this stage I cannot really go further about the outcomes of the negotiations. I'm not directly involved in those. This is clearly an issue that is not only a concern of this table here. We have heard the same thing from provinces and territories, of course, and they are very interested in advancing on this front.

If I can speak about what my area of action is, which is a bit more specific to a segment of the population, it's about building service closer to home that is controlled by the community and supports them in adapting the service, trying to undo the bads of the past when we were trying to impose a similar model that exists, for example, off reserve in the mainstream population and just changing a couple of words to make it first nations relevant or Inuit relevant. We have to think in terms of cultural adaptation. We have to think about cultural control over this, rebuilding the foundation. We have, and we are trying to put these measures in our new programs.

We have to think about cultural safety as well. Various members of the committee were asking me questions about how the province would play in this. I think we have a challenge in Canada, not only the federal government but all governments together, to build cultural safety. When it comes to clients who have been dealing with specific issues—I'm thinking of first nations and Inuit, who have different backgrounds—when they face institutional services, whether they're provincial or federal services, these have to be culturally safe; otherwise, they won't show up.

One member of the committee mentioned that people do not access. I think we have to question, always, is it adapted? Is this something that is relevant to me? Sometimes it's a bit beyond the control of institutions like departments to deal with, but on the front line we need to look at that.

On the first nations and Inuit side, I think there has been a really big push in the last 10 years to deal with cultural safety and to make sure that the service providers understand that the individual who comes in front of them comes with a background and a story. We talk a lot about trauma related to the legacy of residential schools and other really sad policies that have affected their lives in the past. We have to invest a lot in building cultural safety and cultural adaptation so that the services offered are relevant.

We have seen recently in the coroner's report an indication that people are accessing services, but basically they do not follow up on them because, probably, there is a problem with acceptance of the system or the adaptation of the system to be responsive to their needs. We have to really work on this. It's not always more services. Often, it's adaptation of services so they're relevant to this segment of the population.

**The Chair:** Over to MP Poilievre, please.

**Hon. Pierre Poilievre (Carleton, CPC):** Thank you very much, everyone.

My first question is for Stats Canada. When will we get the 2015 LICO data?

**Mr. François Nault:** I'm not sure. I'll confirm that with my colleagues.

**Hon. Pierre Poilievre:** We're only up to date to 2014 right now. The tables don't go any further. We're now in 2017. I would hope that we'd soon see 2016 data, but we don't even have 2015. I think anything you could do to clarify—

**Mr. François Nault:** Yes. Normally surveys come out about a year or so after the end of the reference period. There was a collection during 2015. Processing the data is not my area. Normally it takes around 12 to 15 months. I assume it will be soon, but I'll double-check.

**Hon. Pierre Poilievre:** Thank you.

Page 9 of the Stats Canada deck here shows a very strong relationship between unemployment and mental and substance use disorders. Do you have any data that points to causality in that relationship?

● (1210)

**Mr. François Nault:** I don't think so. My colleague may.

Again, this is a cross-sectional survey. Typically, cross-sectional surveys are good for association. We know that the people who answered their employment status as such-and-such and their answers to disorders are such-and-such, so we can do the graph that you have in front of you. Causality really requires, as I said, going back to people so that we know what comes first and then we know the transition. If someone was in a given state of employment and—

**Hon. Pierre Poilievre:** Is there a reason why we haven't done that yet?

**Mr. François Nault:** Generally, it's the cost.

**Hon. Pierre Poilievre:** The associational data is not particularly useful unless there's causation.

**Mr. François Nault:** I agree, but the limitation is, I think, mostly cost. Launching those surveys is very costly. They are long-term. We have run a number of them in the past, where we follow people every second year or every year, and so forth, but right now I think we only have one left, and it's more about—

**Hon. Pierre Poilievre:** It would be a matter of finding out which comes first: unemployment or the disorder. If someone loses their job and then develops a disorder, then that's an indicator that the job loss was the cause and the disorder the effect, and vice versa.

A term used here is called “permanently unable to work”. There are 300,000 Canadians who are either severely disabled or very severely disabled who do work. How do we define “permanently unable to work”?

**Dr. Jennifer Ali:** In this survey, it was the people who are not in the labour force, unemployed, retired for reasons other.... Sorry, that's “No work”.

It's how they defined themselves and if they said they were “permanently unable to work”. It does not include people who are not in the labour force, unemployed, or retired for other reasons.

**Hon. Pierre Poilievre:** Do we just ask respondents, “Are you permanently unable to work?”

**Dr. Jennifer Ali:** It was part of the questions about their labour force status.

**Hon. Pierre Poilievre:** So just to be clear—

**Dr. Jennifer Ali:** If they said “Yes”, one of the response categories was “permanently unable to work”.

**Hon. Pierre Poilievre:** Basically, the respondent indicates that he or she is permanently unable to work, and then you record it as such.

**Dr. Jennifer Ali:** Yes, they self-identify.

**Hon. Pierre Poilievre:** According to your data there is a relationship between marital status and disorders. Have you done any longitudinal work to ascertain causality in that area?

**Mr. François Nault:** I'm afraid it is the same answer. As much as it would be fantastic to follow someone to see if someone goes from married to divorced, divorced to married, or single to married, and if the disorder has then changed or is reported changed. Again, we only have cross-sectional surveys.

**Hon. Pierre Poilievre:** Back to the causality between unemployment and disorders, I realize the cross-sectional survey before us does not provide us with that causality. However, is there other data in the possession of Stats Canada that can be used or matched up to indicate such causality?

**Mr. François Nault:** That's a very good question. Stats Canada is exploring administrative data as much as possible and linking that data. For instance, we would have discharge abstract data from hospitals. If someone has been in the hospital, we know the reason, so we can probably monitor something in that sense with the information on the admin record.

**Hon. Pierre Poilievre:** With the permission of the chair, given that you seem to be indicating that there might be such data and that such analysis might be possible, I would like to request that Stats Canada get back to the committee indicating its capacity to show levels of causality between unemployment and mental health disorders.

● (1215)

**Mr. François Nault:** I will look into getting it for you, but I'm a bit pessimistic that we will be able to show any causality. The exploration we are doing with admin data is really new, ongoing, and innovative in a way, but the information from administrative is also limited. So, I don't think that's so. On the file I described, the hospital data, I don't think there's anything about the person's employment. Can we link back to the census? Can we infer some causality if someone is employed on the 2011 census? If we find the person is hospitalized for a mental health reason, can we infer some causality there? I don't think that will happen.

But I will do my homework, and I will check with the analysts in StatsCan.

**The Chair:** Thank you so much.

Now we'll go over to MP Sangha, please.

**Mr. Ramesh Sangha (Brampton Centre, Lib.):** Thank you, Mr. Chair.

Thank you, everyone.

My first question is for Mr. Sony Perron.

You may answer or Dr. Patricia Wiebe may answer this question. During your submission you talked about first nations cultural involvement. You want to build resilience in the culture. You talked about putting the communities first to identify the issues. You also talked about the framework that you want to work with to do that.

The first nations mental wellness continuum framework has been jointly developed by first nations, the Inuit health branch of Health Canada, the Assembly of First Nations, as well as indigenous mental health leaders from the various first nations non-governmental organizations. This framework you're talking about is a coordinated comprehensive approach to mental health and addiction programs.

Can you give the committee further details of the main, key factors you are talking about for this framework that you are going to put into the community?

**Mr. Sony Perron:** Thank you.

I will say a few words to introduce this, and then I will ask Dr. Wiebe to maybe get into what is in this framework. First, following this committee appearance, we will bring to the clerk, if the chair agrees, a summary document that explains what the framework is about, because it's very comprehensive and we would not be doing it justice if we tried to explain in this room in a minute or two what the framework is about. We have a document we can give to the clerk for the information of the committee.

Second, we are basically using the framework to guide any of our actions. When we are putting new programming out, when we are working with partners to strengthen existing programming, we try to reposition this work in the framework. We are trying to revamp the old way of providing services and organizing programs and services in a way that is more comprehensive.

We did the co-development process with indigenous leaders. We worked with partners across the country to do that, and now we have a guide. There is less focus on what we should do and how we should do it. It's rather how we implement it now. This is what we are focusing on and we have a table that helps us to advance and support the communities to get the tools to do the work right under this framework.

I will ask Patricia to maybe talk a little bit about what is in this framework if the member of the committee is interested.

**Mr. Ramesh Sangha:** I think it would be a good idea to give the committee the complete paper on the framework so that the committee can look into that. Thank you.

The whole framework will be helpful for the committee to look at the issues regarding the poverty reduction strategies, which we are studying now.

● (1220)

**Mr. Sony Perron:** I think while it's very specific to first nations, the notion of having a framework that is comprehensive and that looks not only at the services themselves but at how we bring together all the elements that have an impact on the wellness of individuals, families, and communities is very important in the end.

I think we should always approach this really sensitive work around mental health and mental wellness with an attempt to understand where those who are targeted by these programs and these services are coming from. I think this is an example that is first nations-based. We are working with Inuit organizations to develop a similar tool that is Inuit-based, recognizing that the culture is very different and it needs to be adapted.

There might be some commonality and there will likely be commonality, but I think it's the adaptation that makes the difference. Approaching everybody with the same kind of filter and lens doesn't get the right results.

Patricia, do you want to add anything on this?

**Dr. Patricia Wiebe (Medical Specialist in Mental Health, Population Health and Wellness Division, First Nations and Inuit Health Branch, Department of Health):** Thank you, Sony.

If there are specific questions on the details of the framework, I'd be happy to speak to those, but essentially it's grounded in the social determinants of health, with culture as the foundation. Ultimately, first nations' partners have identified evidence to support hope, belonging, meaning, and purpose as the outcomes of how culture underpins all that we do.

**Mr. Ramesh Sangha:** So your main issue is that you want to go deep into the cultures and take the families with you and then involve them in the total framework and get things resolved?

**Mr. Sony Perron:** I think the basic principle within the framework is the recognition that people feel good, empowered, and well when there is a sense of hope for the future. This means that they contribute, that they are grounded, and that they can support their communities and their families. We have to work on these essential elements.

This comes with mental health support as well as with a number of other actions that will bring what we call “wellness” into these communities.

**Mr. Ramesh Sangha:** Prime Minister Trudeau recently met with the indigenous leaders in the north to discuss the growing suicide rates there. Across the country the rate of suicide among indigenous youth is five to seven times the national average, and it is eleven times the national average in Inuit communities.

Can you explain the factors contributing to the challenge of national aboriginal youth suicide prevention that he is faced with?

**Mr. Sony Perron:** This is a really difficult question.

I would say that the historical legacy of Indian residential schools and those policies are at the foundation of this. That's why the focus on culture and rebuilding culture, and giving back control to first nations and Inuit organizations to build their own programs and services is very important.

The Prime Minister met with leaders last summer to talk about this. Since then, a number of sad events have happened. Of course, since last June we have been implementing additional investments in mental wellness across the country. This includes three important elements.

First is sending a mental crisis intervention team to be able to support communities that are facing a crisis. This is the surge capacity when there is a crisis.

Second are the mental wellness teams to build ongoing service and support; to develop strategies at the community level; to be able to deal with it, prevent it, redress it, and to deal with healing prior to a crisis. It's not only crisis response.

The third element was a crisis line to enable people to reach out in their language, in English, in French, in Inuktitut, or in Cree, and to be able to access a counsellor at all times, 24 hours per day, if they are facing a crisis.

There were a number of preventive actions taken last summer, but also a number of responsive actions to the stage of crisis that, unfortunately, exists in communities.

**The Chair:** Thank you so much.

Sorry, we're well past the time.

We'll move to MP Motz, please.

You have five minutes.

**Mr. Glen Motz (Medicine Hat—Cardston—Warner, CPC):** Thank you, Mr. Chair.

First of all, I'm delighted to be here to study this particular issue. My 35 years in policing saw the issues of both homelessness and poverty front and centre operationally, for me personally and in my department. Also, serving on our housing board and being involved in our food bank has given me an opportunity to see first-hand how this is played out or not.

In the time that I have, I want to first address the department of health, and mostly Dr. Wiebe.

You spoke about the allocation of $300 million annually to first nations for health and wellness. How do you measure the impact of that money within our first nations reserves? Are you having success? If there are gaps in that service delivery, where are they? Are they by design, or are they in the community of delivery?

● (1225)

**Mr. Sony Perron:** I can start, and maybe ask Dr. Wiebe to complement it.

A large amount of this funding is going toward treatment centres for mental health and addictions. We are funding treatment centres across the country because it's part of the offer. We are measuring success in terms of indicators, one of which is quitting at least one substance after the treatment and after a certain period of time. We are monitoring that. These centres do as well, if not better sometimes, than similar treatment centres in the mainstream.

I would say it is very challenging. The target is not 100%, because sometimes there is need for retreatment. We have targets and measures on that to see how these treatment centres are performing. We are also measuring the demand and their capacity. There is need for more capacity in these treatment centres because the demand is high.

Communities are funded for prevention programs around mental health. We are targeting youth. Each community has a health plan that supports these programs. They have to report to us annually and every five years produce an evaluation of the performance of the programs. And because the program is not delivered exactly the same way in all communities, the assessments are done community by community.

We are monitoring macro-indicators, though, to see how the situation is evolving in Canada. The work that StatsCan is doing is really good, but as you can see in their statistics, they say they don't include first nations on reserve, for example. We are funding a regional health survey through a partnership with first nations across the country that produces data every, I think, three years to measure the evolution of a number of health and social factors on reserve to see how this is progressing. We see some progress there.

I'm not satisfied with this progress because the needs are so high, and we need to make some changes, but I believe the framework and the new way to approach mental wellness will bring some better results in the end, because we know that interventions that are grounded in culture, land-based interventions, are a huge success. Sometimes we have success evaluations on specific initiatives to try to identify best practices. It's not because it's a framework that is given to the community for them to plan. We are not developing tools to help them go to the right model.

I have to say that first nation and Inuit communities across the country are very creative, and they came with their solutions. Sometimes it's the propagation of these solutions and making sure we can extend them that is the challenge, because the real solutions are coming from them, and we are trying to encourage them with programs that are very flexible.

**Mr. Glen Motz:** Thank you.

I have the distinct privilege of serving the largest first nations reserve in Canada. One of the things that I'm beginning to realize is that they are very progressive in their thought, yet very poor in looking after their own people. I spent a considerable amount of time before I got to Ottawa, and since then, speaking with specific individuals from that reserve, and they tell me something different from what we hear in the mainstream.

This may ruffle a few feathers, but they never tell me that the conditions on the reserve are tied to residential schools. They never tell me that they're tied to their history. They're telling me they're tied to how they're not being looked after now on their reserve, by their own people. That's their disconnect.

When I talk to the youth, they've lost hope. Even the adults have lost hope. It isn't because of their history. Some of it's tied to the loss of culture. I get that, and I respect it; I think there's an element of that. But it's about their own people not looking after their own people. That's what they tell me.

I'm interested to hear you speak about the way forward, and the best way forward is a collaborative approach. How do you see that playing out? How does that roll out? How does that actually look on the ground in the Blood reserve when you're going to be playing out some of these mental health issues to help poverty reduction, potentially with a group of elected officials who don't always provide the resources? They have lots of them; they just don't transfer those to the people who need it the most.

How do you do a collaborative approach in those sorts of environments?

● (1230)

**The Chair:** We're actually over time, but I'm going to allow quick response on that.

**Mr. Sony Perron:** If you want me to speak briefly about the Blood reserve, there is one thing I will tell you.... I don't know the details about the operation, of course. I know only a portion of it. They have been very progressive in the strategy they have put forward on the opioid crisis, which is related to mental health and has caused devastation in their population. They have been very progressive in organizing the service and being really creative to integrate the pieces, taking what can come from the provincial government, what comes from the federal government, and organizing the service on their land.

I think the solution's being grounded there is what is important. It's to build plans that work in the community, trying to bring in all the assets and the strengths that are in the community. This is something they do really well. Not all communities have the same level of capacity. We are assisting them to advance their own plans. When there is a lack of capacity, we try to bring additional resources and capacity there to assist, but it's really a community-by-community approach.

This is probably as much as I can comment on that.

**The Chair:** Thank you.

MP Sansoucy, for three minutes.

[*Translation*]

**Ms. Brigitte Sansoucy:** Thank you, Mr. Chair.

I began working in the social services area in the beginning of the 90s. At that time, the social determinants of health were crucial to the identification of the best interventions to improve the health and well-being of the population. That was put aside during the next decade because of budget considerations. People then focused more on structures. That is why it does me good to hear representatives from the health and public health arenas talking about the social determinants of health.

My question is addressed to the Statistics Canada representatives. Over the past 20 years, we were told that one person out of five would face some mental health issue in the course of their lives. And yet on page 6 of your brief, you refer to a third of Canadians.

Do the data you have explain that increase? We have gone from one in five to one in three persons who will experience mental health issues in their lives.

How did such an increase come about?

[*English*]

**Dr. Jennifer Ali:** It's in English.

**Ms. Brigitte Sansoucy:** That's okay.

**Dr. Jennifer Ali:** The statistic that you mentioned previously was based on the 2002 Canadian community health survey on mental health, which measured different disorders. We're not able to measure all of the disorders in our 60-minute survey.

In 2012, we measured this suite of disorders. It included more substance use. It also included generalized anxiety disorder. With this suite of disorders, the number came to 33%, so the true prevalence of disorders that people in the Canadian population have experienced in their lifetime is higher than 33%, because there are disorders that we were not able to measure in the survey.

[*Translation*]

**Ms. Brigitte Sansoucy:** On page 14, one reads that immigrants have half as many disorders as the Canadian-born.

Based on your data, do you see anything that explains that fact? That is after all a spectacular gap.

**Mr. François Nault:** We see that immigrants are in better health, not only in better mental health but also better physical health. I think that that can be explained in large part by the fact that those immigrants were selected. They underwent a health examination at the beginning. And so they are certainly in better health than the average. I think that after ten or fifteen years their health levels—and that is probably true for mental health as well—meet up with those of the Canadian-born population. That said, it is clear that the initial selection has an effect.

As Ms. Ali said, it would be interesting to separate out the immigrants from the refugees, or from economic immigrants. We would probably see differences. However, if I recall correctly, the physical health of refugees is good. Once again, this is due to the selection of immigrants headed for Canada.

[*English*]

**The Chair:** Thank you. You'll get another shot, don't worry.

That wraps up that round. Just looking at the clock, I see we have time for six minutes from each. We do have a housekeeping issue that I want to leave a small amount of time for at the end.

Without further ado, it's over to Pierre Poilievre for six minutes. Are you going to share your time?

● (1235)

**Hon. Pierre Poilievre:** I think I'm going to share my time.

**The Chair:** Fantastic.

**Hon. Pierre Poilievre:** Who would like to have my time shared with them?

**The Chair:** I think Dan wanted it, but he left.

**Hon. Pierre Poilievre:** Dan's gone. Glen, do you want to go some more?

**Mr. Glen Motz:** I'll ask a couple of questions. Thank you.

Monsieur Robillard, you asked a question specifically about Housing First, and, Mr. Murphy, you responded. I can tell you that in the community I come from, Medicine Hat, which has a nationally recognized success in dealing with homelessness, Housing First works, and it works under its present structure. I would encourage you, as we explore what that looks like in Medicine Hat, on February 16, to ask the witnesses who will be available to specifically answer that question. Those who have gone through the program and those who administer the programs are.... It's remarkable how that particular type of strategy is making a difference in the lives of people who are impacted by both mental health issues and homelessness.

My experience has been that one usually precedes the other, and it's the same with employment. For the people I've dealt with professionally in my career, mental health issues usually preceded the loss of a job, homelessness, and poverty. As a nation, we have a significant amount of work to do. The largest number of new files or new caseload that we had, as a police service, when I retired a year ago, was mental health-related matters. Nothing grew larger on our stats than the time it took to deal with mental health issues.

Unequivocally, we readjusted our organization to respond to those issues, because we were ill-prepared. Our communities were ill-prepared. The supports we had were not adequate. We appreciate the words you used, Mr. Perron, about “collaborative approach”. As an organization, we had to evolve to be collaborative with mental health professionals and with other services, so that, together, we could change people's lives positively, so we no longer had people falling through the cracks. Mental health issues oftentimes led to criminality, but mental health issues do not make you a criminal. We tried to make sure that there was a distinction on that.

I'm sorry for taking the floor without asking a question, but I can tell you that the work this committee is doing.... I'm sorry. I'm emotional because I lived this. You have no idea about the impact that the decisions you make around this table moving forward are going to have on people's lives. We have to get it right. We can't just spend money. We have to involve agencies that want to make a difference. Everybody is fighting for the same dollar, and it doesn't always work. When you see.... You'll hear when you come to Medicine Hat—people's lives have been changed because a program worked, people cared, a difference was made. They were given a home first, and they had wraparound supports afterwards. When those things work, it changes communities. And when it changes communities, it saves money. It does. It saves vast amounts of money. If we do it right from this stage.... I dreamt of being here. When I was boots-on-the-ground in Medicine Hat, I dreamt of the decision-makers. I wished that you would do something different. Now that I'm here, I'm going to pinch myself. We have an opportunity to make a difference. Let's do it.

Thank you.

**The Chair:** You are more than welcome, sir.

I think that everyone around this table agrees. I think that the reason we have embarked on this and given it the amount of time and energy we have—we couldn't have said it better—is to make the right decisions moving forward. I think on a lot of committees politics comes into play. I haven't seen that with this study and this committee. Regardless of the political stripe, we're all here to do what's right for Canada, to leave the country better than the way we found it. I thank you for your passion.

I'm really looking forward to this trip. This has been on the calendar for some time, and I've been staring at it. I can't believe we're about to embark on it, specifically Medicine Hat. We fought to make sure that one was on the calendar because of the work that is being done on the ground there. We're all very, very excited to see if it's something that we can take beyond the borders of Medicine Hat and replicate across the country. Sometimes small decisions and small programs solve big problems. I think my expectation is to learn a lot when we go there.

Thank you for that, sir. I don't know how you follow that.

For your very first question at this committee, MP Anju Dhillon, the next six minutes, or however much you wish to take, is yours.

● (1240)

**Ms. Anju Dhillon (Dorval—Lachine—LaSalle, Lib.):** Thank you, Chair.

There is no way to follow what MP Motz said. Thank you, MP Motz, for your very poignant and emotional words. You brought back home to us exactly why we're here, why we ran, and why we work so hard to help others. It's because we have the opportunity to do so. On behalf of everybody in this room, thank you so much for touching us emotionally.

My question is for Ms. Romano. You mentioned that breaking the cycle of poverty and poor health requires a multi-disciplinary approach. Could you please explain what kind of approach you think would be good?

**Ms. Anna Romano:** Sure.

I think, based on the number of experts you've had before this committee, you've already figured out that in order to do something about poverty and to make a difference, we have to come at it from several sectors. As I mentioned in my remarks, it's not just about income. In the case of, for example, a senior who is living on their own, whether they have a high income or a low income, if they can't actually get out to access some of the social supports that are around them and are feeling isolated, then that will be a factor in terms of their mental health.

You're linking it to mental health, which I think is, again, a wise thing to do. You've heard the statistics on the connections between mental illness and poverty. We've talked a little bit about employment. In my remarks I talked about family violence. There are some connections to the justice system and to the educational system.

What we have found in our programming is that it's most effective when you can come at it from.... When I think about our maternal and child health programs, it's not just about the program in place for that child. When the teen mom brings her child into the centre, that mom is learning something about relationships, resiliency, and building very important social skills. Then that mom might go back home and talk to her extended family about that. It's when you can get at issues either in a school setting or a community setting so that it's not just the individual intervention that you're actually impacting the child, the parents, and then the broader community, including the school system, etc.

**Ms. Anju Dhillon:** You also mentioned that those on social assistance develop mental disorders or that they are benefiting from social assistance because they have mental disorders. Could you kindly just maybe tell us the link?

**Ms. Anna Romano:** I'm not sure that I made the link between social assistance....

Did I? I'm not 100% sure. Do you remember if you had a statistic on that?

● (1245)

**Dr. Jennifer Ali:** We have the statistic, but we don't have the causality or the reason.

**Ms. Anju Dhillon:** Okay.

I was sharing my time with MP Long, so go ahead.

**Mr. Wayne Long:** Thank you.

I'm going back to Stats Canada. You knew I was going back there. On slide 15, you refer to “Previously Homeless population” and have some statistics there: 22% of people with a history of homelessness reported a mental disorder.

My group in Saint John, New Brunswick, serves breakfast at the men's shelter every Saturday morning. I can tell you that, unfortunately, the percentage of those who are homeless who have issues, mental disorders, whatever you want to call these, is obviously much higher than 22%.

Just for the record, I'm glad that our government did reinstate the long-form census so that you can start to actually get some more information that we can use as government.

How are you reaching out and how are you collecting statistics, if you will, from shelters, from homeless people? Obviously, you're not going to get them through a cellphone. You're not going to get them at their house. Again, I'm down there at least once or twice a week. They're there. They're back on the streets. How are you accounting for them and what ideas would you have to account for them?

**Mr. François Nault:** They're a very difficult population to account for, that's for sure. I think that in our first slide we say that in the survey on mental health we have not captured the homeless population.

This slide is from another survey and it was a retrospective question. I think the question was whether there was a period in someone's life when they didn't have a place or a regular house or something. It's people living out of their cars or on the street and it's still a population that we're reaching. People who are maybe chronically homeless, we don't reach.

**Mr. Wayne Long:** Surely, it must have been discussed or thought of. Do you have ideas as to how you would reach out to that population in cities and get them counted in the system, get their numbers, that kind of thing? Are there other counting mechanisms that you could maybe partner with?

Mr. Murphy seems to want to jump in there.

**The Chair:** Be very brief, Mr. Murphy.

**Mr. Doug Murphy:** Yes. There is a homelessness information system that collects information from shelters.

**Mr. Wayne Long:** But does that system jive with this?

**Mr. Doug Murphy:** No, it does not.

**Mr. Wayne Long:** Okay.

**Mr. Doug Murphy:** But it does collect basic demographic information from over 200 shelters in Canada, so I don't know about the potential to—

**Mr. Wayne Long:** Is that not an issue, that obviously one side is not talking to the other side?

**Mr. Doug Murphy:** I think that's something we can explore.

**The Chair:** Thank you very much.

Now we'll go over to MP Sansoucy for six minutes.

[*Translation*]

**Ms. Brigitte Sansoucy:** Thank you, Mr. Chair.

I would also like to thank our colleague for his testimony. It will be a privilege for us to go to Medicine Hat and to meet with stakeholders on the ground. I agree with him entirely as to the importance of decisions we have to make and the impact they may have. I also think it is important to listen to the stakeholders who obtain results in the field.

My question is for Mr. Murphy and is in the same vein.

In your opening statement you shared consultations that are now ongoing, with more to come. The community organizations in my riding that are fighting homelessness had the opportunity in early fall to meet the minister in Sainte-Julie, Quebec. I know that the reports from these consultations are not yet finalized, but can you tell us what came out of these consultations with these stakeholders who work on the ground? After all, they are the ones who deal with people day after day who are grappling with poverty and mental health issues. What was the outcome of these consultations with the stakeholders and those organizations who work on the front lines?

● (1250)

[*English*]

**Mr. Doug Murphy:** Thank you. I believe those consultations were for the national housing strategy. I will have to get in touch with my colleagues from Canada Mortgage and Housing Corporation. We will be connecting the relevant information from that engagement—

[*Translation*]

**Ms. Brigitte Sansoucy:** We talked about the importance of multisectoriality and of implementing such an approach. How do you take that into account in your sector?

We saw that housing is crucial to the whole issue of poverty and mental health.

[*English*]

**Mr. Doug Murphy:** We will be having a series of engagements that will look at.... We won't be doing housing again, not specifically, because we are working with Canada Mortgage and Housing to identify the relevant issues that came out from that. However, we will be talking to people with the lived experience of poverty. We'll be talking to key stakeholders, and through communities, there will be engagement.

[*Translation*]

**Ms. Brigitte Sansoucy:** Fine. Thank you.

Mr. Perron, I want to take advantage of the brief time I have left to ask you a more specific question.

We broached the topic to some degree, but I would like you to tell us more. I am not referring to the discussions the minister held with the provinces.

How did you co-operate with provincial governments—for instance, I talked about youth protection services earlier—in order that your actions be complementary and aimed at the same goals?

**Mr. Sony Perron:** In most areas of the country we have a bilateral or trilateral approach. We include provincial partners, as well as first nations and Inuit partners. Our purpose is to ensure that our actions are as integrated as possible. For instance, we are making additional investments in mental health in Northern Ontario. We work in co-operation with the Government of Ontario because it has also announced additional investments. However, once communication has been established between the two governments, we work with the first nations so that issues are approached in a manner that respects their authority over the services.

Our co-operation models vary somewhat from one province to another. Earlier I mentioned the coroner's report on the situation on the North Shore in Quebec; this report was filed earlier this year, in January. The people in our regional offices are working with the provincial departments concerned and with the first nations. We have to determine how to respond to these agreements, and take steps.

One of the components of that recommendation is to adapt services. The response must be culturally safe, as you say in English. We are talking here about access to services. Services exist, but access or continuity is lacking. We have to ensure that the services offered to the community align with those offered in provincial institutions, so that those populations are also well served.

In each province we have bilateral and trilateral co-operation mechanisms in place. That is really very important, because it is impossible to offer comprehensive service if we do not work with the provinces. In Canada, the federal government funds additional services for first nations and Inuit peoples, but in practice the provincial and territorial authorities deliver health and social services. Consequently, we must work in close co-operation with them.

I think we have made a lot of progress over the past four or five years with regard to the transparency of our actions. Before intervening on health issues with first nations and Inuit peoples, we hold a lot of talks with our partners. It is far from perfect, but there is a high level of co-operation.

When there are unfortunate incidents in certain provinces, the first question I ask people is whether they communicated with our first nations partners and whether they were in contact with the community chief to determine whether there were needs to be met. The second question consists in verifying whether the province or territory is doing anything, and whether additional assistance is required. We have to try to align our services. When there is a lot of turbulence and chaos due to a crisis, we can quickly redress the situation because we have co-operation mechanisms in place to improve the situation. Not having coordination is pointless. In fact, I can say that this level of co-operation really works very well in most provinces.

[*English*]

**The Chair:** Thank you very much.

Before we adjourn, we're going to be going through the next two sections of the study, housing and neighbourhoods, fairly quickly as far as our calendar is concerned, because of the doubling up of sessions while we're travelling.

There's one logistical issue that I've been asked to address, and that is establishing a deadline for briefs. The last day of witnesses is going to be February 21. Obviously we want a later deadline to give organizations an opportunity to submit a brief if they aren't able to meet with us either here or during our travel. We want to give them some significant time, so we can even promote that while we're travelling—especially with Kuujjuaq, because we're not going to be able to hold meetings with witnesses up there. Having spoken with the clerks and the analysts, I think we can negotiate a little bit. March 3 is the proposed date.

Can I get agreement from everybody that it is sufficient? It's almost two weeks after the last witness statements. We'll add that to the website. There have been quite a few inquiries to the clerk from across the country asking when the deadline is for those submissions. We do need to get that out soon. Is there any discussion needed on that?

Seeing none, we'll move forward.

Thank you to all of our witnesses today.

And to all the committee members, welcome back. We didn't lose any strides with the break.

Thank you to all who made today possible: the analysts, the clerks, the interpreters, and all the technicians. Have a great day.

The meeting is adjourned.