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Chair

Mr. Andy Fillmore

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● (1550)

[*English*]

The Chair (Mr. Andy Fillmore (Halifax, Lib.)): I call the meeting to order.

Good afternoon, everyone, and welcome to the meeting. Thanks, everyone, for showing up today.

We're very pleased today to have a representative from ITK with us: Natan Obed, president. We also have Jack Hicks, adjunct professor, community health and epidemiology, University of Saskatchewan. It's wonderful to have you both with us.

I'm happy to offer you 10 minutes each.

I understand, Mr. Hicks, that you're going to go first, and that you've got a PowerPoint presentation.

I will just let you know about my cards. You have 10 minutes. I'll show a yellow card at nine minutes and a red card is when I'll ask you to finish up. Thank you very much for that.

Mr. Hicks, please, you have the floor.

Mr. Jack Hicks (Adjunct Professor, Community Health and Epidemiology, University of Saskatchewan, As an Individual): Thank you very much for the invitation. It's a pleasure to be here with you on traditional Algonquin territory.

I think the reason I was invited was that when I was living in Nunavut, I was the government suicide prevention adviser. At that time I had the opportunity to work very closely with Natan Obed, whom I hold in the highest regard, so it's always a pleasure to be presenting with Natan.

I've shown this graph hundreds of times, and every time I look at it, it fills me with sadness and with shame, frankly, as a Canadian. What this shows us is the evolution of the rate of suicide by Inuit living in Nunavut from below the national average in the 1960s and 1970s up to the present day. For the last 15 years the rate has been just under 10 times the national average.

I heard Cathy McLeod ask about trends. The reason I can do this is that in the territories, death certificates are coded by ethnicity. The reason you don't have something similar to this for first nations in the provinces is that in the provinces, no death certificates are coded by ethnicity. This is a rare example of being able to document a pretty serious epidemiological transition from a low-suicide-rate society to a high-suicide-rate community.

The rate is highly structured by age and sex. The most at-risk population is young men. This is not the structure of most of the society. It's also structured by geography, so the red dots are the communities with the highest rates. You'll see they're overwhelmingly in the Qikiqtani region, plus one community in the west. I think this is explainable based on modern social history.

It's an odd thing to talk about mental health outcomes of individual ethnic groups, I realize, but if we look at the United States, where we do have data broken out by ethnicity, we see, for example—however uncomfortable we might feel about the concept of race as used in the United States—that this official government data shows that black people in the United States die by suicide at a much lower rate than white people do. We can talk about that, but it's a fact.

If we put Canada in for comparison, as a whole, because we don't have this kind of data, we come in between the two. Asians and Hispanics are much closer to blacks than to whites.

If we add in the American Indian and Alaska native population—that's the official coding, American Indian and Alaska native—it's very interesting. At the national level, white people and American Indian and Alaska natives have effectively the same rate of suicide across the United States, but it's structured differently, with much higher rates among younger people, among indigenous Americans, and among older white Americans.

If we look at the state level, we see that there's one state, Alaska, that has a rate of over 40 per 100,000, but there's another state, Texas, with 100,000 indigenous people, that has a rate of under four per 100,000. The rate varies massively in the United States at the state level only among American Indians and Alaska natives, not among other ethnicities.

The logic I take from that is that aboriginality per se is not a risk factor. It's the lived conditions of being aboriginal in different parts of the United States.

If we were to take Alaska out from the rest of the indigenous population, we see that actually a lot of the youth suicide is in Alaska and that in the southern states, youth suicide isn't as big a problem as it is in Alaska. If we take it one step further and put in Nunavut, we see the scale of Inuit youth suicide in Nunavut in comparison to Alaska and the rest of the United States. It's pretty shocking.

As we know, suicide behaviour is complex and multi-causal, but the WHO has said for years that it's a largely preventable public health problem. I think we should focus on both parts of that: largely preventable, and public health.

We need to look in terms of cohorts of people who die by suicide. For example, people whose first suicide attempt, whether it's to completion or not, is later in life have one basket of risk factors. People who attempt as teenagers or in their early twenties have a different pattern of risk factors. In our higher-risk indigenous communities, keeping in mind that the rate is very high among our community, it's the basket of risk factors for young people that we need to be thinking about.

● (1555)

We did do a five-year, CIHR-funded follow-back study in Nunavut, supported by everybody. We looked at all 120 deaths in four years, matched with case controls. The reports are online. We did not find risk factors that were unique to Inuit. We found the usual risk factors, operating at a much higher level in some cases.

The conclusion is that mental health matters. There's a need to focus on families and communities as well as individual-level issues.

As I mentioned, I was part of the team, with Natan, that developed the “Nunavut Suicide Prevention Strategy”, which I think we're very proud of. It was very well received when it came out. There is a link to it. Unfortunately, the initial years of implementation have not gone well. However, as you may know, last year the Nunavut government declared a state of suicide crisis and created the world's first minister responsible for suicide prevention position. We're hoping that things will be taken more seriously in the near future.

I want to show you rates for Inuit and Nunavut, and Inuit and Greenland, and point something out. We have data from Greenland for the period 1900 to 1930 from the first chief medical officer of health, which is a rate of 3 per 100,000. I've gone through RCMP files, and I've calculated a rate of 20 for the period of 1925 to 1945.

However, in the Arctic, starting in the late sixties and early seventies, the rate takes off everywhere across Inuit societies. Let me point out that it was not the people who were coerced into settled communities by the government as adults who started dying by suicide: it was the first generation of children to grow up in the settlements in those early days, where there was a lot happening in terms of power and people being bossed around.

There is very interesting data from New Zealand, more detailed data than we have for Canada, showing that Maori have transitioned from a society with lower than national norms use of mental health services and lower than national norms of suicide behaviour to higher rates. However, if you do the analysis—and the data from the Christchurch human development study is linked at the bottom—and you control for socio-economic childhood disadvantage, family adversity, and other socio-economic factors, “Maoriness” disappears.

People aren't not well because they're Maori; they're not well because one section of the Maori community is poor, with low educational outcomes and high rates of substance abuse. There are a lot of Maori who don't fit that profile, but the kids of those Maori who are in trouble in their lives grow up in trouble, just like other people's kids in those conditions grow up in trouble. That's changing. It teaches us that when we talk about mental health outcomes among Maori, we know too much to be able to talk about the Maori as if it's one group of people. There are Maori who are doing well and there are Maori who are not doing well, just like everybody else.

In the new Australian indigenous strategy that accompanies the national strategy, we see the focus on the developmental precursors of suicide and suicide behaviour. Understanding that early childhood adversity can put people on a pathway to trouble in life, the end result of which might be suicide behaviour, invest upstream and take a public health approach so that fewer people need services as teenagers and adults.

I watched the video of the meeting on May 31. I heard several references to Quebec. Canada is a backwards country when it comes to suicide prevention. We're one of the few developed countries to not have a national strategy. However, within Canada, we have one of the greatest success stories in the world. That's why the International Association for Suicide Prevention met in Montreal last year to talk about Quebec. It is fantastic to cut a province's rate of youth suicide in half in a decade, and I hope you look into how they did it. I can suggest people you might want to talk to about that.

I've taken the liberty of coming up with six short references for you, which I can deliver in one minute.

Number one, carefully recommend the landmark 2014 WHO report, “Preventing suicide: A global imperative”. Yes, it took the WHO too long to release this report, but it's great. It's weak on indigenous peoples, but it's a great report generally.

● (1600)

Second, when it comes to elevated rates of suicide behaviour in some indigenous communities—because let's be clear that not all indigenous communities have high rates of suicide in this country, and we know that—take a look at the evidence, pay attention to the realities of social disadvantage, unresolved grief, early childhood adversities, and the need for culturally appropriate mental health care.

There's a lot of prejudice, but there's a lot of nonsense spoken in the media about the root causes of suicide in indigenous behaviours. Some of it is pretty unpleasant in its characterization of indigenous peoples. You have to get down to actual results. There is substantial evidence, clear and compelling evidence the size of the Himalayas, on the relationship between poverty and socio-economic inequality with mental health outcomes and suicide behaviour. The world isn't always as complicated as some people make it out to be.

I would urge the federal government to act on the WHO's recommendations and Quebec's success by developing and implementing a national strategy for suicide prevention. Mr. McLeod asked on May 31, “Where is the strategy?” You can make a strategy happen for everybody, not just indigenous peoples.

I would urge you to allow the national indigenous organizations to determine the character of what suicide prevention should consist of in their regions. Nobody has given more thought to suicide prevention in Inuit communities than Inuit themselves.

I would urge the federal government to support ITK's forthcoming national Inuit suicide prevention strategy with the allocation of resources commensurate with the high social burden of suicide behaviour in Inuit communities. If Inuit youth had been dying at this rate from HIV/AIDS, there would have been a coordinated federal intervention, because it's a communicable disease. How do we explain the lack of action on shocking levels of teen suicide for 25 years? Let's get over it; let's do it.

Finally, on a personal level, I am an ASIST trainer. I teach two-day applied suicide intervention skills training workshops. I think it's great. I wouldn't do it if I didn't think it was great. I encourage you as individuals back in your home communities to take ASIST. You won't regret it, and if you'd like to know how you can do that, drop me a line, and I'll make it happen for you.

Thank you for your attention.

The Chair: Thanks very much, Mr. Hicks. That 10 minutes went very quickly.

Natan, please, you have the floor.

Mr. Natan Obed (President, Inuit Tapiriit Kanatami): Thank you.

My name is Natan Obed. I'm the president of Inuit Tapiriit Kanatami, the national representational organization for Canada's 60,000 Inuit.

The first objective in our 2016-2019 strategic plan is to take action to prevent suicide among Inuit. It is a priority of the highest degree for our national organization and for all Inuit in Canada to do something meaningful to prevent suicide.

I want to open by talking about how it affects each and every one of us.

This is a huge difference between the Inuit population, or anyone who lives within an Inuit community, and those who live in southern Canada. Each one of us is personally affected by suicide, and this comes from a very early age. It affects our entire life course, and it is something that is always with us. Imagine a scenario in which you grow up understanding how to die by suicide; you have friends, family members, and loved ones who have died by suicide; and suicide is normalized in your community to the extent that it is used sometimes even as a bargaining tactic, or something that is a threat, rather than a situation that is not normal and one that demands immediate attention and mobilization from communities and from governments.

We all live in this reality, and not one of us wants to see another day that we live in this reality. What you are doing here, and what the House did in its special debate, is being watched by all Inuit. We do hope that it translates into action to prevent suicide for Inuit moving forward.

I also want to recognize all of those people in our communities, from the 1970s to today, who have done amazing work to prevent suicide with absolutely no help or little help. It goes from the faith-based community to those who are champions in our community for people who are at risk. That doesn't necessarily mean there is no mental health system, but for too many years individuals in our communities have had to pick up an enormous burden of caring for the mental wellness and mental health of many of those who are at most at risk in our communities. That is something that will continue to exist, but it should not be the only way that suicide prevention happens, in many cases, in many of our communities.

Over the past two months, there has been a national discussion about suicide prevention and suicide by indigenous peoples. I was at the special debate and I listened to many well-meaning members of Parliament talk about how important this issue is. I would say that I came away frustrated, and have continued to be frustrated, by the way in which the discussion has happened to date. It is as if indigenous suicide and Inuit suicide is something completely outside of a public health context, and somehow the answers only lie with us and us alone.

Many times when we as the national Inuit organization or when individuals who are Inuit are asked by well-meaning Canadians what needs to be done, the response those people are looking for is one that has nothing to do with creating social equity, nothing to do with providing mental health services, and nothing that goes beyond historical or intergenerational trauma. What they're looking for, in many cases, is a particular component of suicide prevention that is indigenous only, that usually has something to do with on-land camps or cultural continuity, that is relatively cheap, and that has nothing to do with the relationship between government services and overarching populations and their overarching health. We need to change that discussion.

For our part, Inuit Tapiriit Kanatami will release a national Inuit suicide prevention strategy on July 27.

● (1605)

In this strategy we talk about why suicide happens the way it does in our communities and also what is necessary to prevent suicide in Inuit communities.

You might find this strange, but our people do not have one common, united narrative about why suicide happens in our communities. Many times the discussions happen about the final step by somebody who was at risk of suicide, who was thinking of suicide, and who then attempts or completes suicide. All the discussion about why it happened is just in that particular moment when we live in an environment of suicide. From the time many of our children are in the womb, they're at risk of suicide in a different way because of the environment in which our children grow up and the environment in which our people live.

The discussion about why suicide is the way it is is as follows.

We have to do a great deal to achieve social equity. Our society has gone through massive historical changes in the last 50 to 60 years. As Jack Hicks mentioned, you can see the suicide rates elevating in the 1970s, corresponding to the first generation of children who grew up in communities. We need to do more to ensure that we have proper education systems, proper mental health systems, and justice systems that reflect our needs; that we address violence and sexual abuse in our communities; and that we end poverty. Social equity is that first societal step that we need to take. It is necessary to improve our mental health and ultimately to prevent suicide.

Then it gets to the community level, where a number of different things happen in normal communities that do not happen in our communities: programs and services, connections between generations, things that allow for coping skills to be created, and things that build resilience.

From the evidence base, we think of risk factors and protective factors. We have societal risk factors and individual risk factors. We do not have the appropriate measures in the protective factors that build resilience in our communities for our society as a whole to come through hard times. Every individual will go through difficult times in their lives. It is a lifetime of experiences and a lifetime of relationships with your family, with you, with your mental health system and health systems in general, and in your communities, that craft the responses to those difficult times. We need to do more to ensure that there are supports at the community level for all our community members to overcome hardship.

On the individual level, we have a number of different things we can do to provide mental health services and support for those at risk of suicide. That means improving some of our mental health acts, improving mental health services at the community level, and incorporating Inuit-specific healing practices within the mental health continuum. We need a mental health continuum to overcome the challenges that people face on a day-to-day basis. When people are experiencing acute stress—and this gets to the individual level, where a lot of the discussion about suicide takes place in suicide prevention—we need people who can help, and we need interventions for those who are at risk.

There are usually three ways to break down suicide prevention: prevention, interventions, and post-interventions.

At the intervention stage, when people are at the most risk, programs like ASIST, which arm community members with the ability to identify those at risk and link them to care, are great examples of how we can prevent suicide in a way that we have not done previously. Our strategy will present actions that will create meaningful change in our community and will prevent suicide.

I'd like to leave with an association between what has happened in relation to lung cancer over the past 50 to 60 years with what must happen with Inuit suicide prevention in the coming 50 to 60 years.

● (1610)

In the beginning, there was not even a recognition of the causes of lung cancer, especially in relation to smoking, but over the course of generations and upstream investments in public health measures to ensure that people knew the risks and took mitigative actions so that they would not develop lung cancer, we have arrived at a very different place. Those who do have lung cancer, we treat. We treat through radiation and medication, and we also have palliative care for those who are beyond that stage of treatment.

It is as if today, with Inuit suicide prevention, we allow only for very small, palliative care-type interventions for our people. We do not have the requisite upstream investments in social equity. We do not have the requisite interventions, mental health facilities, and mental health continuum of care for Inuit that would allow people to get through difficult times and to have positive mental health. We certainly don't have enough to ensure that our communities can be healthy, happy, and productive in the way we believe we were before we moved the communities and before all this colonization happened.

I look forward to working with each and every one of you to make the meaningful changes necessary to prevent suicide of Inuit.

Nakurmiik.

● (1615)

The Chair: Thank you very much, Mr. Obed and Mr. Hicks.

We are going to go into a round of seven-minute questions, and I will use the cards just as we have done.

Before we get started, we had hoped to go from 3:30 to 5:00 with you, 90 minutes, but we had to start 20 minutes early. If the committee members agree, I am going to split that 20 minutes between you and our committee work, which comes afterward. I am going to propose that we go until 5:10 with your questioning and then have committee business from 5:10 to 5:30, if that is okay with everybody.

The first question is from Michael McLeod, please.

Mr. Michael McLeod (Northwest Territories, Lib.): Thank you, Mr. Chair, and thank you to Mr. Hicks and Mr. Obed for their presentations.

This is a huge issue across the north, as you have indicated. I am from the Northwest Territories. I chair the northern caucus, and we have had several discussions on this—not in a lot of detail, as you have presented here today, but just looking at and comparing the issue in our ridings. We recognize that Nunavut has a crisis situation, and in the Northwest Territories we have a crisis situation. Labrador has indicated that they have serious issues in that area, to the point where it is also a crisis situation.

Then we look at the Yukon, and it is not quite the same, so we automatically try to point to.... Is it because they have roads? Is it because they are not as isolated? Is the quality of living better there? It is really hard. I think everybody is trying to point to the actual issue, but it is a big, broad issue. It is something that is intertwined in many aspects of living in a small community, in an aboriginal community, and the lack of opportunity, the poverty, and all these things come to the forefront.

I still wanted to check with you and hear what you have to say about the factor of isolation and how that plays into suicide. I read your report. It is a very good report, and I appreciate it. It brought a lot of information forward. You look at it from different angles, but I don't hear you say anything about isolation.

Mr. Jack Hicks: Thank you for the question.

If you look at the map that I have, you'll see there are many isolated communities in Nunavut with not very elevated rates compared to other parts of Nunavut, so I don't think it's isolation in and of itself. There's a general pattern that northern first nations people have lower rates than Inuit. Dene in the Northwest Territories have a lower rate than Inuvialuit. In northern Quebec, the Cree have a lower rate than the Inuit, and they share a land claim.

There are larger factors at work. I can't claim to have come up with an explanation for all of them, but I don't think there's any evidence that isolation, per se, is a factor. However, across the north, for Inuit, we are seeing that the rates for suicide of young men are falling in the cities and that it's in some of the more traditional—which is a strange term—communities where they are the highest, which is kind of the reverse of the way some people might think it would be. From a cultural continuity perspective, Inuit, generally speaking, have very high levels of cultural continuity, as do Dene, but if it's only about cultural continuity, then how come some of these smaller communities have higher rates than Iqaluit? In Greenland and in Alaska, it's very much the case.

I think a lot of it has to do with the realities of being a young man in today's world and how you see the future—how you've grown up, whether your family was happy, what your peers are like, whether you can see a future that makes sense for you. Can you see a path to being happy and healthy? Can you see graduating from high school, getting a job, getting an apartment, getting a girlfriend, getting a boat? You're still an Inuk and you still speak Inuktitut. You still go hunting.

There are communities where there is just a lot less hope, and I think in part it's because of weaker services and more trauma from the past, but isolation, in and of itself.... I'm not sure how we would wrap our heads around that.

● (1620)

Mr. Michael McLeod: It's a difficult one. I look at the communities in the north and I look at my hometown where we've never had a suicide, and I look at another community that has never had a suicide. We have road access, but there is another community, Déline, where they've not had a child in court for 14 years. They are doing a lot of things right.

If I ask what the connection is, what the link is, there's a cultural connection to the land. There's hunting and fishing. I get excited and think, “Well, that's the solution”, but then I look at all the communities around it and see that they all have the same thing too, yet they have issues in this area. I don't know if there's one area we can point to.

I'm glad that you mentioned this needs to be dealt with from many angles: education, opportunity. All these things have to play a role.

I'm really interested in seeing your report come forward. I'm very interested in seeing how we would deliver programs and services, how we would include mental health services, treatment, and all these things that need to be in a community.

I'm not convinced that a political organization should be delivering these types of programs. Programs or delivery agents such as friendship centres and Aboriginal Head Start aren't tied in with the political community organizations. They're independent. I'm just wondering if there's been any thought to how programs and services could be delivered in communities, other than by government.

Mr. Natan Obed: I'll start with your first question.

Instead of trying to spitball about what possible scenarios underlie why there are elevated rates of suicide in some communities rather than others, we have chosen to focus on the established evidence on what the risk factors are for suicide. We do have some Inuit-specific research findings, such as child physical and sexual abuse, early teen cannabis use, and low education attainment. No matter what scenarios play out in the varying rates across Inuit Nunangat, we know that if we apply the evidence, we will do what is best for our society as a whole.

On the other part, about what organizations are best suited for the delivery of services, the national strategy that ITK will be releasing does not imagine that ITK will be delivering programs or services in Inuit communities or nationally. We are in many ways trying to create an overarching unification for all Inuit on this issue and then leverage the role we can play at the national level to ensure transformative action at our community levels.

The Chair: Thank you.

The next question is from David Yurdiga, please.

Mr. David Yurdiga (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

Mr. Obed, Mr. Hicks, thank you for presenting today. The information you've sent was very informative, and I think if we can act together and get everybody involved, we can make a difference.

In my community, we have some communities that have the same sort of economy, but one does better than the other. As my colleague, Mr. McLeod, mentioned, what is it? That's the thing we're trying to figure out. What makes one community different from the other? Some people attribute it to leadership. I'm not sure if leadership plays a big role in the rate of suicide if one leader is more active than another in providing services for youth. Is one of the key components the lack of leadership, or maybe a lack of resources for the leadership to implement different programs?

Mr. Obed, do you have any comments on the leadership role that different communities play?

● (1625)

Mr. Natan Obed: There have been a number of discussions over the past decade about best practices in suicide prevention. It's difficult, because the area of research around suicide prevention is highly subjective. There are many differing views about what constitutes suicide prevention. The mere fact that there have not been completed suicides in a community does not imply that there is a high level of suicidal ideation in those communities. We know very little about suicidal ideation, or those who think of suicide, in relation to what we know about death by suicide. I think the conversation has to be informed by as much evidence as we possibly can have.

With regard to leadership in a community or on a region-by-region basis within the indigenous community of Canada, yes, there are amazing things that are happening. We should definitely work to find those great things that have happened, or are happening, and we should replicate them.

In the end, we're talking about social equity. At the base of this issue is social inequity. We can talk around this issue all we want, but if we don't provide health care, housing, education, and a basic level of security for all Canadians and all indigenous Canadians, then this issue is not going to be addressed the way that it could be.

Mr. David Yurdiga: Thank you.

If I come from a small remote community of, say, 150 people, what type of schooling can I receive, and what type of economic opportunity is there for me to build a home and provide for my family? Essentially, what opportunities are there if I live in a remote community?

Mr. Natan Obed: The right to be educated until grade 12 in many of our Inuit communities wasn't realized until sometime in the early 1990's. In many cases, people were in residential schools until that time period. Now every single one of our communities has educational opportunities.

There are many communities that do not allow for any of their students to go directly into the programs of their choice within post-secondary education because of the lack of infrastructure and the inability for different schools to teach some of the core curricula that are prerequisites for some university courses. We have challenges in providing education, but I believe the education systems are a lot better than they ever were, and they continue to improve.

In terms of opportunities in small communities, there are different ways of thinking about opportunities. Many Inuit want to live in a mixed economy. They want to have some wage-based employment, yet also enough time and opportunity to live on the land and provide sustenance for their families with country food, or to provide their families and themselves with the connection to the land that allows for them to have positive mental health.

Yes, there need to be more opportunities for Inuit, especially in small communities, but also we have to rethink what constitutes a successful community. Our small communities can thrive. It's a matter of understanding how to provide the supports and the equity to ensure they have that opportunity.

● (1630)

Mr. David Yurdiga: Thank you.

Do you believe the lack of economic opportunities is linked to the increase in suicide rates? Do you think not being able to obtain a full-time job, not being able to provide for your family as you would like, is a contributing factor?

Mr. Natan Obed: I'd say that poverty is definitely a part of this discussion. The way it sometimes has been the solution to this issue is irresponsible, but economic development and economic opportunity are absolutely positives for families and for individuals.

Mr. Jack Hicks: Could I just follow up on that?

Mr. David Yurdiga: Sure.

Mr. Jack Hicks: If you look at the American data more closely, there's been a 24% increase in suicide in the United States in the last 15 years, driven by an increased rate among white people of living in newly economically depressed regions. There's a clear correlation between job losses, unemployment, social despair, and suicide.

I would note, however, that in Nunavut, many of our smallest communities are among the communities with our lowest suicide rate. It's not a simple correlation.

The Chair: We'll have to leave it there, David. We're out of time.

The next question is from Georgina Jolibois, please.

Ms. Georgina Jolibois (Desnethé—Missinippi—Churchill River, NDP): Thank you, Mr. Obed and Mr. Hicks. I appreciate your presentations.

I'm sitting here, and I too feel frustrated from a subjective perspective. Then, from the objective perspective, regardless, we in Canada, if you live in the north, such as the territories, or the mid-north, or the provinces.... I come from northern Saskatchewan. I feel frustrated, because every time we or our friends and families hear on the news that someone has died due to suicide, it's a painful process and it's not a very pleasant experience, yet when we look to services and programs and the different levels of solutions and areas that we need to look at....

I appreciate the report that you're talking about. I look forward to reading it, because I want to gain a thorough understanding of the difference you're experiencing with regard to the far north, the territories.

Subjectively, in your perspective, do elders play a key role in the healing process in your area?

Mr. Natan Obed: Thank you for the question.

Inuit had to have been—this is subjective as well—some of the most resilient people on the planet. The experiences that many Inuit had to go through to survive on the land is extraordinary. There are many accounts of Inuit who went through starvation, or the Spanish flu epidemics in the 1918-1919 period when whole communities were wiped out, except for some small children. The stories our elders tell us about what they had to go through to survive are powerful and uplifting in so many different ways. We need to harness that kind of resilience, try to understand the power of that resilience, and transfer that to those who live today. Elders have that key knowledge about why they responded to incredibly difficult situations in the way they did. Their wisdom and their life experience need to inform the way we think about this issue.

The very tenets of Inuit society, the foundation we live in—our people are saying we want to return to those ways. Our culture, our language, and our history are essential for our well-being. We need to ensure that we give our children and we give our societies our teachings and our perspective on the world. That sometimes is in relation to suicide prevention and sometimes is in relation to community development. It's getting back to the place where we were as a society, and to feeling as though we are fulfilled in the way we interact with all of our elders and fulfilled in the way our communities function.

I would say that Inuit history and our elders have a great role to play in informing Inuit society about how to be resilient, in informing us about how we can be healthy again, and, in relation to suicide prevention specifically, in supporting our society to heal from what it has gone through.

● (1635)

Ms. Georgina Jolibois: Do I have time for another question, Mr. Chair?

The Chair: Yes, go ahead.

Ms. Georgina Jolibois: As Canadians, here we are in this hearing, and from the objective point of view, where you've provided some feedback, what message can we carry with us to do our work as parliamentarians to make sure that we keep on track with the messages?

Mr. Natan Obed: First and foremost, I do not believe that it is respectful for the government to prescribe solutions for indigenous peoples when it comes to suicide.

As for many of the reasons that our communities are the way they are, it's because colonization and programs and policies of the Canadian government have created historic and intergenerational trauma. To now say, without true partnership with indigenous Canadians and representatives of indigenous Canadians, that the Canadian government will do this to prevent suicide is another form of speaking on our behalf and is not actually partnering in an Inuit-to-crown or nation-to-nation way.

The second part of this is that social equity is necessary. We have so much to do to be able to ensure that all Canadians have equity, and within the Inuit community there are very specific simple, straightforward measures that we can take to do that. As Canadians, we should all believe that we are.... We demand equity within Canada.

Ms. Georgina Jolibois: Thank you.

What message can we give to our youth?

Mr. Natan Obed: Thank you. That is a wonderful question.

Youth are often expected to come up with solutions in a vacuum within this issue, and I know that youth carry a tremendous burden already. There are expectations from their families, from their communities, and within themselves about who they are as indigenous people and, in my case, about who they are as Inuit. Often, I believe, we don't do enough to ensure that they have the necessary ingredients to succeed.

There are so many of our youth who have succeeded despite the systems that are undermining their potential and their ability to be strong and proud Inuit. I commend our Inuit youth for all they are doing and for all that they have said they want for society, but I also say that we need to demand a better future, and Inuit youth need to stand up and say, in very clear ways, that the realities they have lived through are not acceptable and that we can all do better to improve the lives of Inuit youth.

The Chair: Thank you.

Our next question is from Don Rusnak, please.

Mr. Don Rusnak (Thunder Bay—Rainy River, Lib.): Thank you for coming to the committee today. It's nice to see you again, Mr. Obed, and nice to meet you for the first time, Mr. Hicks.

Since we began this study, I've been hearing from a lot of people that suicide is simply a symptom in indigenous communities of all the problems that exist. Some people have been telling me that we need to work on a two-stage solution to the problem, with the first stage being getting in there with health workers and dealing with the problem in communities immediately, while the long-term solution is economic self-determination and creating the environment for the communities and the people within them to prosper.

What would you have this committee recommend to all our ministries, but most importantly to the Minister of Indigenous Affairs, to immediately help and then to prevent this from continuing in the long term?

● (1640)

Mr. Natan Obed: In the development of the national Inuit suicide prevention strategy, we have worked with Health Canada, and hopefully on day one, on July 27, there will be commitments from the Government of Canada to work with Inuit on the first steps toward suicide prevention. Across the government there are responsibilities. This is not just a health issue. This is an issue that has many different aspects.

I also want to respond to the discussion about self-determination.

Our objective is self-determination. The link between our rate of suicide and relative self-determination or self-determination within a governance model is something that I would say does not have an evidence base within the Inuit reality. Perhaps in other jurisdictions there is a clear correlation between self-government or self-determination and the suicide rate, but for Inuit....Greenland has been self-determining for some time. Its rate is elevated and is similar to the Canadian rate.

I believe that self-determination demands self-government and free, prior, and informed consent and a number of different concepts that this government is struggling with in trying to understand what it actually means for the relationship. We should go full steam ahead on all of those discussions. However, to tie self-determination directly to suicide prevention, I believe, is a stretch. Perhaps with greater research and greater understanding of this issue, there will be more concrete ties, but there are many holes in what we know about evidence on this, which is why we have tried, in the development of our strategy, to have a foundation of evidence rather than a broad grasping of different things that may sound plausible.

The Chair: You have three minutes.

Mr. Don Rusnak: The immediate solution, as I believe you said before, is to treat it as a public health policy and to have a strategy, working with the Inuit and working with organizations in the areas that you represent, to have culturally based and culturally sensitive workshops or programs for Inuit. Has that been attempted by any previous government? Has it been attempted in recent memory? If it has, what have the successes been?

Mr. Natan Obed: At the federal level, the only program I am aware of that has been introduced was the national aboriginal youth suicide prevention strategy. That was approximately 10 to 15 years ago, and there was an Inuit-specific framework associated with it. It largely funded community-based programming and was not specifically focused, in many cases, to counselling or intervention in suicide prevention.

What we need to do first is a better job of intervening for those who are at risk, and of identifying those at risk, ensuring that they have the care, the mental health services, and the supports they need.

With regard to postvention for those who have gone through trauma, virtually nothing has been done for Inuit who have experienced trauma in relation to suicide or who have attempted suicide but then not received any sort of follow-up.

There are some very specific immediate things we can do that help fix the situation in the very short term. However, the larger issue, the upstream public health investments that Canadians have talked about in a very nuanced way for other public health issues, must happen in relation to our communities. The environment of risk for suicide specifically, as it is created through a person's life and then as it is created in a societal sense, needs to be addressed.

There are often people in our communities who question why a particular individual died. Usually they start off the conversation by saying that the person came from a loving home and they graduated from high school. Often we don't get to the next part of the conversation, which is that the person was in a society that has risk factors for suicide. No matter who you are, no matter what individual situation you have, you are connecting with risk. Even the idea that exposure to suicide is actually a risk factor for suicide needs to be better understood and appreciated in the way we look at this issue within our communities.

● (1645)

The Chair: Thank you.

We have to keep moving along. Perhaps Mr. Hicks can slide in a response during other questions.

We are now into the five-minute round of questions. Time is moving quickly, so I would invite members to try to come to their question as quickly as they can, without too much preamble.

The next five-minute question is from Harold Albrecht, please.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Thank you.

Thank you very much to both of you for being here. The incredible grasp you have on this is very humbling for me, I'll tell you.

I had the opportunity to look through the outline of the "Resiliency Within" paper you've done. I certainly applaud many of the initiatives here. I could go through the eight chapters and list many of them. I think it's a great program.

In regard to this, has there been any consultation with the Public Health Agency of Canada in the development of the federal framework for suicide prevention, which is to be implemented sometime later this year? The Public Health Agency of Canada was charged with the responsibility of implementing Bill C-300, the federal framework. I'm wondering what kind of collaboration happened between the Government of Canada and the Government of Nunavut in terms of developing your program.

Certainly I wouldn't want to imply that the framework should supersede or even be over it. In fact, that's one of the reasons we chose the word "framework" rather than "strategy". We wanted something that was available to be contextualized in different communities across Canada, but I think there should have been, and I'm hoping there was, some degree of consultation with the Inuit community.

Mr. Natan Obed: I'll speak specifically for Inuit Tapiriit Kanatami. We have been engaged in those discussions with the Public Health Agency—

Mr. Harold Albrecht: You have been.

Mr. Natan Obed: —but all the way through those discussions, we have advocated for an Inuit-specific approach that the Public Health Agency and Health Canada can also adopt, in partnership with us, to work on suicide prevention. The ways in which risk is distributed in our communities are so different from the Canadian population that it demands a very Inuit-specific approach.

Mr. Harold Albrecht: Yes. I couldn't agree more. I'm not implying that the framework should in any way supersede what you're doing there. Again, I applaud what you've done here.

I find this paper you handed out to be very helpful. You have cultural continuity, community cohesion, family strength, and so on as protective factors. One thing that may be missing, or maybe we simply haven't stated, is an area I'm very passionate about, and that is the spiritual component of who we are as humans. I know there has been a lot of research done on that.

You may be familiar with this book on clinical research for suicide prevention. One of the comments the author makes as it relates specifically to indigenous communities was, I thought, very insightful. I'll quickly read it: “Similarly, actively participating in spiritual practices on a regular basis was found to buffer against suicide.” He's specifically speaking to indigenous youth suicide in Canada in this regard.

I'm wondering what aspect of the spiritual community, whether it's the indigenous faith community or other faith communities.... You mentioned the faith communities in your opening remarks, which I was pleased to hear. In terms of prevention, intervention, and even postvention, could you comment on what responsibility the faith community has in that regard?

That's for either one of you.

● (1650)

Mr. Jack Hicks: In our work in Nunavut, we recognize that the people who deal with the phone calls at two o'clock in the morning, be it a mental health crisis or a suicide or mentions of suicide, are often members of the faith community. They are just solid people, and they exist in every community.

One of our goals was to ask those people what training they would like. There are issues around how seriously the fly-in health workers treat those people. I mean, they don't claim to be social workers or nurses, but they are really solid community residents. Certainly in Nunavut I value those people tremendously. When we do our work, they're quite often the first people we talk to in the communities. The working group has always had a representative rotating among the different faiths.

There's no question that a strong spiritual grounding in any society is a protective factor, but not everybody has that.

Mr. Harold Albrecht: I'm not implying that it's the magic solution. I wasn't implying that. I just I think it's unfortunate if, as mental health care workers or political people, we leave one tool out of the tool box. It's not the only tool, but it's one of many that I think we should be utilizing.

Do I have any time left?

The Chair: You have 10 seconds.

Mr. Harold Albrecht: Okay, 10 seconds will be great.

Mr. Hicks, could you identify whether your ASIST training is the same as safeTALK training? Is that the same thing?

Mr. Jack Hicks: SafeTALK is from the same organization. It doesn't teach intervention skills. They have a suite of programs.

Mr. Harold Albrecht: It's about observation.

Mr. Jack Hicks: The idea is teach you something about suicidal behaviour, and, in the event that you notice something, you know who the ASIST-trained people you can connect with are.

Mr. Harold Albrecht: Thank you. Thanks for your patience.

Mr. Jack Hicks: It was developed in Canada, in Alberta, I would point out.

The Chair: Very good.

Mike Bossio, go ahead, please.

Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.): Thank you both for being here.

Jack, your work is renowned, and we appreciate it.

Natan, you are once again coming to this committee. You really do have a tremendous handle on your community, and I commend you for that.

Mr. Rusnak was talking about self-determination and self-government. Is the funding formula that exists for Nunavut and Inuit communities the same as that in other contribution agreements and grant-type programs?

Mr. Natan Obed: There's a wide variety of ways in which health care funding and mental health funding flow to Inuit communities. The first nations and Inuit health branch has contribution agreements, sometimes with Inuit-specific providers and sometimes with governments. There is the overarching transfer for the Government of Nunavut. Then within provinces, the Province of Quebec and the Province of Newfoundland and Labrador interact with our Inuit regions for funding for health care.

Mr. Mike Bossio: You're saying there's a hodgepodge of different funding. Depending on what the program is or what the project is, there is an overarching fund. I guess what I'm getting at is that these funds are typically geared for a very specific area, and there's not a lot of control as to what can happen to that money beyond that area. Is that correct?

Mr. Natan Obed: Yes. In many of the Public Health Agency and Health Canada first nations and Inuit health branch programs, there are very specific terms and conditions around the types of services that can be provided and who provides those services.

Mr. Mike Bossio: Okay.

We've done studies on suicide and studies on health. We've done many different studies out there. Has a study actually ever been done —and maybe Jack can help with this—on the funding required to bring about social equality?

Mr. Jack Hicks: Our experience in Nunavut is that a strategy without a budget doesn't accomplish very much. Hopefully that's going to be rectified very soon. We're told that it is. That's basically the story.

Quebec put public money into a coordinated strategy to fund a range of activities. When the WHO recommends that every country have a national strategy, it means an adequately resourced strategy, which costs some money. I don't like to view it in these terms, but I really think suicide prevention pays for itself. Suicide costs government a lot of money—a lot of money.

● (1655)

Mr. Mike Bossio: Part of what you're getting at is what I'm leading to next.

I've been to Mistissini in Quebec, up into the north with the Cree people a couple of times, and I was there in the mid-eighties. There was a very different scenario when I was there in the mid-2000s, in 2005. I couldn't believe the transformation that had occurred within that community and within that society. It was as a result of the $10 billion that they had received from the Quebec government for the hydro dam project. They had a lot more self-determination and self-government over the types of services.

It was a beautiful community. You could see that it gave them pride in their community. It was incredible. I think that's part of this puzzle here: we have to figure out how we get the funding levels that are required to get that social equality to get pride back into the community and to get hope back into the community for the future for our youth. The expectations we set for our youth today are very high, but having no hope of achieving any of those expectations leads down a very dark path. Would you agree with that?

Mr. Jack Hicks: May I suggest you need to go one step more upstream? Adverse childhood experience—that's what the global literature speaks to. When Nunavut was created in 1999, there were seven Head Start programs; 16 years later, there are seven Head Start programs. After all these years of high rates of child suicide, why does every child in Nunavut not have access to a Head Start program? The communities that have them love them, and the federal government's own research says they're brilliant.

Mr. Mike Bossio: I'm sorry to cut you off, Jack, but I have one more point I'd like to make.

We're in crisis situations right now. From the health standpoint, when you're in a crisis situation—an outbreak, for example—you need to attack it with a lot of resources, get it under control, and then put in place long-term resources to maintain a certain level. Would you agree that's part of what's missing here today? If we have a crisis there from a mental health standpoint or from an addictions standpoint or an abuse standpoint, we need to attack it with resources very specifically within the community.

Mr. Jack Hicks: We attack it in partnership, yes, and there is absolutely no reason we can't start investing in the well-being of children at the same time. There's no reason.

The Chair: Thank you.

The next question is from Arnold Viersen, please.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you, Mr. Chair.

Thank you, Natan and Jack, for being here. I appreciated your presentation today. It's been informative.

I don't have a lot of questions for you today. I think your presentations have been amazing. I've been reading this piece of paper right here, particularly on the risk factors. That's probably the number one thing, if we can mitigate the risk factors.

We've worked really hard on the protective factors for a while, specifically mental health. Every time there is a suicide crisis, there's a call for mental health workers. That's entirely a Band-Aid solution. We need to get past that. There is a culture of suicide, and we have to work to change that culture a little bit.

Natan, can you just explain or broaden that out a little bit for me? Is that the correct terminology to be used, "culture" of suicide? I have no experience with what you're talking about. It's foreign to me. Perhaps you could just broaden that out a little in terms of communities suffering from suicide.

I read here about family strength, and to me that seems obvious, but when you write it on a piece of paper, it's suddenly, "Oh yes, we have to worry about family strength." How does that work, and how does community cohesion play into it? When I look at my own life, those things exist in my own life, and I can't see a reality without them.

Could you speak to that a little bit?

Mr. Natan Obed: Thanks.

We say that suicide is "normalized" in our communities. We say it that way because, as I said in my opening statement, everyone is affected. Everyone, from a very young age, understands very graphic details about it, how it happens and how a person is affected. The life courses of people are altered. The life courses of whole families and whole communities are altered by suicide in a way that envelops all of us.

That's just something that does not happen in most of Canada. It may happen in specific families, or perhaps there's a high-profile death by suicide, but it is not an environment that children grow up in and understand as just a part of how their community functions or does not function.

The root of this, stemming from the 1970s, when the rate of suicide increased, and the dysfunction in many cases in our communities, passed down from generation to generation, all play into that factor of why we are the way we are today. Families were being broken up because people didn't have mental health services. People couldn't heal from the things that tore them apart, whether it was physical or sexual abuse as children or whether it was that they were in residential school from the time they were five to the time they were 18. Many different things that happened in our society over a short period of time led to people not being able to deal with the things that we all take for granted.

Love of your partner, love of your children, love of your family, the ability to overcome difficult situations in life—these are all things that need to be created when there is a vacuum in an individual. That is the reason there is hope for us. You can build resilience. You can build coping mechanisms. You can heal from things that you've gone through.

What we have been saying is that we have not been given those opportunities. We don't have the mechanisms to do that. We've been asking for them for generations now, and we still don't have them.

● (1700)

Mr. Arnold Viersen: That's my 18 seconds.

The Chair: You're done.

Mr. Arnold Viersen: I swear it's shorter for me. It always seems that way.

Thanks so much.

The Chair: Thank you both. I apologize.

The next question is from Gary Anandasangaree.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): Thank you, Jack and Natan, for being here.

Natan, welcome back.

I want to probe a couple of statements you made earlier with respect to the execution of the strategy.

From what I understand, ITK is the lead on the strategy, but in terms of execution, will it be through different agencies or will it be through governments? How do you envision this rolling out once you make the announcement on July 27?

Mr. Natan Obed: In many ways the communication with all Inuit and with all Canadians about why suicide presents itself the way it does and what we all need to do to prevent suicide is one of the key parts of this initiative. As I said earlier, we don't have that unification yet. I believe that we need to have that unification in order to all push in the right direction to prevent suicide.

Our strategy imagines different concepts. Some will be our advocacy to government. Some will be our network of suicide prevention strategies, from the community level to the regional levels to the national level, that all work together to provide supports for Inuit wherever they may be. Some are going to be specific actions that ITK can take to adopt programs or facilitate the creation of different resources that can apprise Inuit regions or Inuit communities.

In many cases we are in the middle, facilitating change, advocating for change, and working with communities and Inuit regions to ensure those things are possible and that we imagine them in the same way and that we approach them together.

At the centre, we are going to play a lead role in that advocacy work but also in filling in the key gaps in knowledge. The idea that we don't have ethnic identifiers in any of our jurisdictions except for Nunavut, and the idea that in the creation of our own strategy in 2016 we had to hire outside help to work directly with coroners' offices to get Inuit-specific suicide data that just does not exist, because the data that does exist is community-structured data, not Inuit-specific data on the national level.... We need to create those changes to ensure that we have an understanding of how our communities are affected and an understanding of what works, and we need to create an evaluative process over time to ensure that anything we are doing and doing together is having a positive effect. If it is not having a positive effect, then we need to adapt it to ensure that we see a difference in the population over time.

This, of course, isn't a three- to five-year thing; this is a generational push, but we can understand how we're doing along the way.

● (1705)

Mr. Gary Anandasangaree: In terms of the government's involvement through both Health Canada and indigenous affairs, what do you see their roles being in supporting the strategy, keeping in mind that there is a longer-term nation-to-nation relationship that needs to be developed? In the absence of that relationship right now, how do you see them supporting your work?

Mr. Natan Obed: First and foremost, I would like a change in the way government respects Inuit in how it articulates this issue.

There are questions every day in the media and there are statements made on a very regular basis about suicide prevention and how it will happen for indigenous Canadians. For the Inuit component, we need to work on those together. We need to have shared perspectives on moving forward. It is the only respectful way to address this issue.

Specific interventions and investments are going to be necessary from different federal departments. Also, the time that departments need to take to understand those issues in an Inuit-specific context can't be overlooked either. Many federal departments still function as though all indigenous people live on reserve or as if the obligations or the realities are the same for Inuit as they are for other indigenous Canadians.

We have a long way to go, but I imagine a reality in which we can work together to find investments that make the most sense and that change the reality in the way we all want it to change.

The Chair: Thanks.

We can just squeeze in a final three-minute question from Georgina Jolibois, please.

Ms. Georgina Jolibois: When you speak about the true partnership, the nation-to-nation relationship, from your perspective, and from the youth, the families, the elders, and the leaders, how does that look?

Mr. Natan Obed: The renewed Inuit-to-crown partnership—that's the term we as Inuit have used—starts with a respect for Inuit land claim agreements and the Inuit governance structures that have been created under land claim agreements.

In our four regions, we have different governance models, but they are all based on these comprehensive land claim agreements with the crown. Our populations are all invested in those agreements. In many ways, the shared future that we imagined when we signed those agreements still has yet to come. As Inuit leadership and the federal government and jurisdictions in which Inuit reside move in this path together, it has to come with that shared sense of partnership.

That can be seen through the Government of Canada working with our leadership to create this change, and not going beyond it in cases where it can, and just having relationships with public governments in jurisdictions in which Inuit reside, or with Inuit organizations or community-based organizations that are not the representatives of Inuit. That is a way in which everyone can feel as though there is this new change.

Within the Inuit democracy, if you will, we have youth organizations and we have women's organizations. We are structured in such a way that our voice can be utilized in a very specific response to specific questions. Seeing all that function is an ongoing challenge for us, because we don't have the historical connections to success. We haven't been recognized in the same way that perhaps other indigenous representation groups have, and our land claim agreements have not been implemented in the way in which many Inuit have felt that they need to be, so we look forward to this shared path moving forward.

● (1710)

The Chair: Would you like to make a comment?

Mr. Mike Bossio: Just as in the past, so many questions are asked here that it's impossible to get a real answer out. I would just invite both of you, if you have any further comments that you'd like to add, to please send them in to the clerk and we can get them on the record, especially some of the stuff.... I was trying to lead toward Quebec and why they are successful. Anything you can add there would be greatly appreciated.

The Chair: Mr. Obed, Mr. Hicks, thank you both very much for this compelling, rich testimony. It will be extremely helpful as the work of the committee proceeds. Thank you very much for your time today.

We'll just suspend for two minutes and then come back in camera for committee business.

Thank you.

[*Proceedings continue in camera*]

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