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Chair

Mr. Andy Fillmore

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● (1535)

[*English*]

The Chair (Mr. Andy Fillmore (Halifax, Lib.)): Good afternoon, everyone. We'll come to order. Thank you all for being here.

Members, what I would like to do today is to spend the first hour with our witness Dr. Cornelia Wieman, a consultant psychiatrist who joining us by teleconference from Toronto for our first hour. We'll then move into our second topic, on web-based engagement. I'm going to keep 15 minutes at the end between 5:15 and 5:30 for some committee business, if that suits everyone.

I would like to start by acknowledging that we're meeting today on unceded Algonquin territory, for which we're very grateful. On a more personal note for us, this is where our committee held its first meeting, so it's nice to be back to our humble beginnings here today.

Without any further discussion, Dr. Wieman, I would like to welcome you and thank you very much for joining us today. I'm happy to offer you 10 minutes. We'll see how this works by video conference.

Dr. Wieman, thank you very much. You have the floor.

Dr. Cornelia Wieman (Consultant Psychiatrist, As an Individual): *Bonjour.* Good afternoon, everyone.

Thank you very much to the members of this committee for giving me the opportunity to share my experience with you.

I want to quickly introduce myself. You've already heard my name, Cornelia Wieman. I'm originally a member of the Little Grand Rapids First Nation in Manitoba. I'm also a survivor of the sixties scoop. In 1998, I finished my training in psychiatry, and at that time I was the first woman to become an aboriginal psychiatrist in Canada.

The discussion that I hope we're going to have today will be partly based on my experience and the areas I've worked in over the past 20 years or so in the areas of mental health and health generally.

I spent eight years working as a psychiatrist in a community-based mental health clinic on the Six Nations of the Grand River territory. Then I moved to Toronto and spent about seven years in research at the University of Toronto. I co-directed the indigenous health research development program at the University of Toronto, and also the national Network for Aboriginal Mental Health Research, based out of McGill University.

From 2001 to 2002, I was a member of the suicide prevention advisory group. This is one of the key things I want to present to you with this afternoon. This was a group of individuals representing Canada nationally. We examined the issue of first nations youth suicide very comprehensively and released a report entitled “Acting On What We Know: Preventing Youth Suicide in First Nations”.

If you haven't seen a copy of that report, I can send the clerk the link to the pdf. It was a joint project between Health Canada's first nations and Inuit health branch and the Assembly of First Nations.

Since that time, I've moved back into the clinical realm. This time I have had quite a bit of experience working with urban aboriginal populations, mainly in Toronto, providing mental health services through the YWCA Elm Centre, which is a housing first model. This means that they will take women who are homeless or vulnerably housed, 50 aboriginal women suffering from mental health and addictions, and 100 other women who are not aboriginal. I was part of a mental health support team that worked with those women to try to improve their mental health but also maintain their housing in that building.

I've been working at the Centre for Addiction and Mental Health in Toronto since March of 2013. As part of our programming here at CAMH, we have an aboriginal services program. We serve people with mental health and/or addictions. We offer in-patient residential substance abuse treatment, outpatient substance abuse treatment, and outpatient psychiatric care.

In January of this year, I took a position at McMaster University one day a week to work as a faculty adviser to the aboriginal students health sciences program. The major goal of that program is to increase the number of aboriginal health professionals gaining entry into and graduating from McMaster University, which is very relevant to some of the recommendations from Canada's Truth and Reconciliation Commission that I've also included in my handout.

I know I have to be brief. I will talk mainly about the recommendations that came out of the suicide prevention advisory group, which were grouped into four major areas.

The first area was called “Putting Forward an Evidence-Based Approach to Prevention” of suicide. That advocated for continued support for research initiatives around the country, both in aboriginal communities and in partnership with aboriginal communities and academic institutions, such as universities, to increase what we know about indigenous suicide and work on solutions.

I know that previously at this committee, you heard a presentation from Alain Beaudet, who is the president of the Canadian Institutes of Health Research, and the Institute of Aboriginal Peoples' Health, whose scientific director is Malcolm King. I won't go into too much detail, except to say that when we talk about evidence-based approaches, we don't just mean a western framework for doing research. This can also include community-based initiatives and de-colonized approaches to understanding suicide. A lot of the time, there's difficulty obtaining funding for suicide research that communities want to do because, for whatever reason, it doesn't meet the academic standard that's put forward in a western framework.

● (1540)

The second major area was entitled “Toward Effective, Integrated Health Care at the National, Provincial and Regional Levels”. I suppose this is the area where I have the most experience. We need to learn about the best practices and models for delivering exemplary health care to aboriginal communities. I had the great fortune of working in the Six Nations of the Grand River, which you may or may not know is the largest first nations community in the country. When I worked there, it had a population of 11,000 to 12,000 people living on reserve, and almost the same number living off reserve.

I can't speak on behalf of the Six Nations community, but I do know that through the care that we delivered, our goal was always to try to provide services that would be equivalent to, or exceed, what someone would be able to obtain at a community mental health clinic in any urban or rural clinic, anywhere across the country. I believe we did that.

They have much more data on outcomes and things like that. I cannot speak to that because I don't work there anymore and they own their own data. I do know that, generally, people's outcomes were much better for being in contact with our service and being followed. We had lower rates of admission to hospital and lower rates of suicide than what you would expect when you look at first nation suicide rates across the country, which are generally thought to be two to four or five times the Canadian national average.

A major issue in mental health care is providing sustainable funding for mental health services and healing centres, on reserve, in rural areas, and in urban areas. Again, some of the recommendations from the Truth and Reconciliation Commission also speak to this.

For example, when you look at the budget for non-insured health benefits for the year 2013-14, the total expenditures for the entire budget were just over $1 billion. Pharmacare takes up 40.5% of that budget. There's a lot of money that's spent on pharmacare, as well as medical transportation to get people to and from their appointments. “Other health care” only accounts for 1.4% of that budget, which amounts to about $14.2 million. That other health care is deemed for short-term crisis intervention and mental health counselling benefits to address at-risk situations.

I know from checking the meeting schedule of this committee that you've already heard from the first nations and Inuit health branch. I believe you heard from Keith Conn around that.

There's been a long-standing issue of insufficient funding for both western-trained mental-health professionals, and traditional healing, which typically isn't reimbursed in the way that say, physicians, social workers, or psychologists are reimbursed. That, in itself, is an issue as well, because traditional healers spend a lot of time working with people in their communities, and a lot of the time, the work that they do is on a volunteer basis.

In its recommendations, the Truth and Reconciliation Commission also stressed the value of aboriginal traditional healing practices. Because I am aboriginal by background, I think I've had a natural tendency to be open to including traditional healing practices in the patients that I see, but other psychiatrists may not be.

That leads me into talking briefly about a health and human resources issue across the country. I checked the data from the Canadian Psychiatric Association. There are 4,770 psychiatrists across the country. I know of three other aboriginal psychiatrists who are practising in the country. There have been four of us for some time. I know of two aboriginal psychiatry residents who are in the process of completing their training, which brings us to a grand total of six. When you divide six by 4,770 you get 0.01%.

● (1545)

The reality is that virtually all psychiatric care across this country to aboriginal people is provided by non-aboriginal psychiatrists and other health professionals. I have questions about why we're training aboriginal family physicians, but why psychiatry, in and of itself, is seeming to be an unattractive specialty to attract aboriginal medical students to choose upon graduation.

In my work at McMaster in trying to recruit aboriginal students into the medical program, for example, we would really like to continue this pattern. Again, this is another major recommendation of the Truth and Reconciliation Commission. Because the majority of care is provided by non-aboriginal health professionals, there's a great need to train health professionals in cultural safety, so that they're providing culturally relevant care.

I'll end there and hope we have a really good discussion.

Thanks.

The Chair: Thanks so much, Dr. Wieman, for that. It's much appreciated.

We're going to move into a series of seven-minute questions from members. We'll use the same cards as we have just now.

The first question is from Michael McLeod, please.

Mr. Michael McLeod (Northwest Territories, Lib.): Thank you for the presentation. They were very interesting points. It sounded as if you had more to add, but timing became the challenge.

I really was interested to hear more about the traditional healers. We have the concern in a lot of communities that.... First of all, in most parts of the north, where I come from in the Northwest Territories, we don't have professional care at all. In most cases when we do, it's certainly not by aboriginal people. A lot of our communities have worked hard to try to engage our elders in working with youth or people who are in situations of crisis. It's been very difficult. First of all, they're not compensated properly, if at all. When they are compensated, our tax laws claw it back. They are really reluctant to accept any money, but at the same time, it's not fair for them to be doing a lot of this work on their own.

We heard from many organizations and people over the last while on what works well. I wanted you to expand a little bit on the role that aboriginal culture could play in developing positive identities. I've asked this question many times on the role that delivery agents, such as the friendship centres and aboriginal head start, could make in dealing with some of these issues that are challenging us socially.

● (1550)

Dr. Cornelia Wieman: Thank you.

Going back to the suicide prevention advisory group report, the fourth major area that I didn't get to was recommendations around strengthening youth identity, resilience, and participation in cultural activities. I've seen a couple of articles on that in the news over the last couple of weeks. I think in the western provinces there have been a couple of studies released that indicate that incorporating traditional and cultural activities into the daily life of a community is helpful for their mental health. Some of you may be familiar with the seminal work that's been presented by Michael Chandler and Christopher Lalonde in British Columbia that talks about lower rates of suicide in communities that have at least one facility dedicated to traditional and cultural practices.

The way I have always operated as a mental health professional is that I have been open to patients or clients participating in both areas if they wish. I would treat them as a psychiatrist, because I'm trained as a psychiatrist; but as a first nations person, I would also be open to sharing the care with a traditional healer. I understand some of the difficulties around traditional healing: engaging them, engaging the elders, and how they're compensated. It's still an issue that needs to be sorted out, and probably individually for each community. When I worked at Six Nations, there was also some controversy around who may call themselves a traditional healer. We relied on respected individuals in the community to point these folks out to us so we could establish a working relationship with them.

Understandably, some traditional healers were very hesitant about working with a western-trained psychiatrist. I think the point to learn is that these types of good collaborative working relationships take time to establish. The western medical model wants to move things quickly, and wants to see someone, assess a person, diagnose them, make a plan, and that's sort of it. I had to relearn a lot of my training when I finished and started working in a community on reserve to learn how to work at that community's pace. It ended up being fruitful in establishing that type of relationship.

Even though it requires effort and commitment on both parts, if there's mutual respect present, then I think it can do nothing but provide optimal care for aboriginal people living in a variety of communities, not just on reserve, but here in downtown Toronto as well. CAMH is progressive in the sense that we have two elders, two traditional healers, who are attached to the aboriginal services program here as well. Someone can see a western-trained psychiatrist, or a social worker, or a nurse, but they can also see a traditional healer for ceremony and counselling if they wish. I haven't visited the site over the last little while, but I believe they're putting a sweat lodge on the grounds of the Centre for Addiction and Mental Health, which would be terrific for the people undergoing the residential treatment.

I don't know if that answers your question. I think we need to appreciate that aboriginal people are asking for this as part of their mental health care. It's up to the health care providers to be open to that. There's a challenge, however. I know in Ontario—I can only speak for the Province of Ontario—without going into too much detail, Ontario's doctors are at odds with the provincial Minister of Health, and there's been a lot of chatter around—

● (1555)

Mr. Michael McLeod: Can I just interrupt you? The area I was hoping you would address is the facilities in communities. You mentioned that this is part of your recommendation, and I agree with that recommendation. Communities across the north—and I can only speak to the ones in the north and the isolated communities—in a lot of places don't have restaurants, don't have coffee shops, and don't have places where youth can gather. They don't have friendship centres. They don't have drop-in centres. We need a mechanism or an organization in communities that can deliver youth programs. I like the point that you're making.

I've also heard from the traditional healers, the people in the communities, and the elders that while they like working with youth, they also don't like mixing with people from other.... For example, one community said they don't want to be participating when there are hip hop dancers and all these other motivational types of influences.

The Chair: Mike, we're out of time.

Mr. Michael McLeod: Sorry, but thank you.

The Chair: The next question is from Cathy McLeod, please.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Acting on what we know, you talked about four. First was the evidence-based approach. The second was effective integrated care. The fourth is the strength in cultural identity.

Were the third and fourth talking about the resources and allocation, or did we miss the third?

Dr. Cornelia Wieman: We did miss the third. The first was research. The second was mental health services. The third I had to skip over, and it was about supporting community-driven approaches.

That can also be inclusive of traditional healing, but we're also talking about other types of activities, like on-the-land activities for youth, youth and elder pairings, community kitchens, and sports facilities, etc.

I know the committee has met with Jack Hicks who used to work up in Nunavut and now is at the University of Saskatchewan, but I recently heard of a small, anecdotal study that came from Nunavut where a community with very high rates of suicide didn't necessarily do anything too extreme in bringing in crisis teams or getting a psychiatrist to visit that community. The community built a skating rink, and the suicide rates in that community went down.

Sometimes I think the answer doesn't always have to be very complicated or, should we say, western and scientific, but sometimes it can be what the community asks for, and how they are supported in making use of it. That can lead to a decrease in the community in the level of distress and suicide. That's really encouraging.

Mrs. Cathy McLeod: Your last two are a primary prevention model, a public health model, and the others are more care models.

Dr. Cornelia Wieman: Yes.

Mrs. Cathy McLeod: I know I have experienced incredible frustration, but with the jurisdictional issues, when you're talking about integrated care, could you narrow down your particular recommendation about integrated care? I ask because I think it's an important area where sometimes things overlap: it's a little about Jordan's principle, but it's also a little about what the province is doing, what Health Canada is doing, what the health authorities are doing.

Where did you go with that one?

Dr. Cornelia Wieman: It's still an unresolved issue. When I worked on reserve in the province of Ontario my time was paid through the Ministry of Health, i.e., provincially, but the program I worked for was federally funded because it was a mental health program on reserve. Furthermore, the medications that patients received were funded through non-insured health benefits, which again is a national pharmacare program for first nations and Inuit across the country.

It seemed there were always different silos of funding for different aspects of the services for people, and it became very unwieldy to provide services in that manner. It would probably be too much detail today to get into some of the difficulties with the non-insured health benefits program from a practical point of view, but suffice it to say, they exist.

That makes it very hard to deliver care from a practitioner's point of view when you're trying to advocate for your patients, as there are different kinds of ways that things have to get done, because some fall under provincial jurisdiction and some under federal jurisdiction.

In the urban setting, it's not so much of an issue, except that some people may still have coverage for their medications through non-insured health benefits.

● (1600)

Mrs. Cathy McLeod: The pharmaceutical approach doesn't work well at all. Can you give us a sense of the lie of the land with significant depression. Where's the latest research?

Dr. Cornelia Wieman: I believe strongly, from my 18 years of being a psychiatrist, that there is a role for medications to play for every Canadian with a mental health issue, if necessary, and that includes aboriginal people. I don't think aboriginal people with severe depression who require medication should suffer because they don't have, for example, access to medications in certain circumstances. But I do believe that other non-medication forms of help and assistance should also be available to them.

Medications in many cases are required, but I think one of the issues I had—and this was with the non-insured health benefits program—is that there are different layers. I would often have to try the older versions of medications that, according to the clinical practice guidelines, were out of date, and I would have to have a patient fail on those older medications before they received funding for newer medications that were available on the market. I guess that's a feature of pharmacare programs that serve people on social assistance, people on provincial disability programs, and those receiving support from the first nations and Inuit health branch. It did disturb me when I was working with people—

The Chair: You have one minute left.

Dr. Cornelia Wieman: —when I felt they weren't able to access the same level of care, the same up-to-date level of care, that my patients in downtown Toronto had access to.

Mrs. Cathy McLeod: I have time for one more quick question. You talked about the de-colonized approaches. Can you maybe describe those a little better?

Dr. Cornelia Wieman: De-colonize, in my understanding, just means not coming from the lens of a western medical model. If somebody in a community decides that they would like to evaluate stories of mental health healing or recovery from trauma, I would say that it would be a meaningful study and a meaningful piece of research for that community to do. Unfortunately, that type of research often doesn't get funded, particularly from pots of money that are governed by western medical model frameworks. It makes it very difficult to determine who's doing the research, who it is for, what its purpose is, and what its value is going to be.

The Chair: We're out of time there.

The next questions are from Charlie Angus, please.

Mr. Charlie Angus (Timmins—James Bay, NDP): Thank you, Dr. Wieman, for this excellent presentation.

I want to start on the issue of the non-insured health benefits. You were saying that you are expected to give out-of-date medication to people, and the medications had to fail before they would be upgraded. That sounds to me like a very disturbing interference in the doctor-patient relationship, and we've had evidence of other medical practices that the non-insured health benefits branch has interfered with.

What would you recommend to end this, because it would seem to me discriminatory?

Dr. Cornelia Wieman: I felt that it was. For a number of years, I sat on the first nations and Inuit health branch's non-insured health benefits drug utilization evaluation advisory committee—it's a mouthful. I think the major factor that limits the pharmacare program is money. That's the bottom line, but I think when we're talking about treating people in acute levels of distress, if they, for example, have not had any clinical benefit on the first-line treatment, which is usually a certain type of SSRI anti-depressant.... I remember when I practised on reserve that they would have to have, for example, two trials of a medication in that class before we were allowed to apply to have a different class of medications.

It seemed to me very unfair and not up to the standard of care that's recommended according to the guidelines of care that I have to adhere to as a licensed health professional in the province of Ontario.

● (1605)

Mr. Charlie Angus: Thank you for that.

I represent a Treaty 9 region, which has been ground zero of the suicide crisis. We lost a young woman in Moose Factory on Sunday night.

What I've been told time and time again is that requests to have treatment have been overruled as unnecessary because young people have to be medevaced out, or there is nobody to medevac them out to, or there's no healing centre, and the only option then is to let child welfare know, so the young people go to ground because they would actually be taken and put into foster care, which is a social disaster if we're trying to alleviate a suicide crisis.

Has that been your experience in terms of what's happening in isolated regions?

Dr. Cornelia Wieman: Yes, I would agree with you. I think one of the major issues I have is that I have gone up to Sioux Lookout a couple of times for trips and have seen adolescents being flown out of the communities from the Sioux Lookout zone to come to see me in a clinic. Some of them have never been seen by a psychiatrist before, or if they have, they have not been reassessed for the last two to four years. They are grossly underserved compared to someone, for example, whom I now see at CAMH on a weekly basis, or even on a monthly basis. There are people who were started on medications years ago and their dosage has never been adjusted—or even changed if it's not effective. That's a huge frustration.

When I was talking about the lack of mental health resources, we have some psychiatrists in the country who are willing to provide services to these communities, and they should be congratulated, but we need so many more. We can also take advantage of technology, like telepsychiatry. I used to work in telepsychiatry at the Centre for Addiction and Mental Health. It's a big commitment for a psychiatrist to travel regularly up to a community, but there are some who do.

I think psychiatry programs—this is maybe another national initiative—really need to look at having a separate stream, perhaps similar to specializing in child and adolescent psychiatry, or similar to being a geriatric psychiatrist, or of being a remote or rural psychiatrist, or even an aboriginal stream of training people to work in communities and to travel to these communities if possible. I recognize the difficulty. I've done it myself. I used to be a fly-in psychiatrist. It takes a terrible toll on you personally and on your family. However, I'll say strongly that it is shameful the level of care that people receive in our communities, by and large.

Mr. Charlie Angus: Thank you for that.

We had an extraordinary group of young people from Treaty 9 at our meeting yesterday and they said they don't have mental health workers in many of the communities. Randall Crowe, an extraordinary young 26-year-old at Deer Lake, is one of the only mental health workers. He has received no training. He's been doing it since he was 19.

I want to focus on that because when we talk about the suicide crisis in places like Neskantaga, Fort Hope, Pikangikum, and Attawapiskat, it's always described in terms of dollars, that if we put in this amount of money or hire one more worker, that will make the crisis go away. I never hear it framed in that way when we deal with suicide in non-aboriginal communities. In their regard, it's seen as a public health issue and everybody rallies and the resources will be there.

Do you think there's a particular frame that's discriminatory in how governments respond to a crisis when it's indigenous youth, as opposed to non-indigenous youth?

Dr. Cornelia Wieman: I would agree with that. We talk about fostering youth identity and resilience in some of our recommendations, because I think that as the aboriginal youth suicide gets talked about as a phenomenon across the country—and yes, definitely, there are crisis spots—the youth start to believe they are only youth in crisis. They don't understand that they can be good students, good musicians, or whatever. I think there are some organizations across the country that are trying to do that. For example, there's the Indspire Foundation. I sat on its board of directors for something like six or seven years. They do a tremendous amount.

I've always had the idea, but never carried it out, of trying to promote the individuals who have been the recipients of the health career scholarships, trying to portray more positive role models for the young people so they can see that it's possible. Whenever I have visited remote communities, I have kids running up to me saying "Oh my gosh, I didn't even know people could be a doctor, that I could even be a doctor." Young people are not going to see themselves doing something if they can't even imagine themselves doing it. I think that's a part of mental health care that's not about writing a prescription, but something that can be very meaningful and helpful to people's overall mental health and their health holistically.

● (1610)

Mr. Charlie Angus: Thank you very much.

The Chair: Thank you both for that.

The next question is from Rémi Massé, please.

[*Translation*]

Mr. Rémi Massé (Avignon—La Mitis—Matane—Matapédia, Lib.): Good afternoon, Dr. Wieman.

I am very pleased that you are able to share your expertise with us today. You directed my attention to several important points, one in particular. You pointed out that almost all of the specialists and mental health interveners were not from the first nations, aside from six of them.

What would you recommend to specialists and others who intervene in the communities so that they can work more effectively?

You said that as opposed to what is normally done, it is important to work at the speed of aboriginal communities. I wonder if you could make some other suggestions that would help those who intervene with the affected communities.

[*English*]

Dr. Cornelia Wieman: To start, one of the major issues in working with people in communities is trust. There have been decades upon decades of mistrust between indigenous people and all types of other folks in this country of Canada, but specifically involving health providers.

This is my area of expertise. People may have had previous poor experiences with health care providers when they felt their needs weren't listened to, or they may have been as far out on the spectrum as being overtly mistreated by health care providers. One only has to look at the example of Brian Sinclair, the man who came to the emergency department at the Winnipeg Health Sciences Centre. He was an aboriginal man. He sat in the emergency room for 34 hours and died without even being seen. Trust is a major issue.

For the folks I worked with on the reserve, it took a lot of time. It took months of my working in that community for people to come forward and feel comfortable in coming to see me because, even though I'm first nations myself, I was presented to the community as "This is going to be our psychiatrist who is working in the community", and people have a lot of hesitancy about psychiatry. It resonates some of the trauma they may have experienced through the sixties scoop, through being in child protective services, or through the legacy of residential schools, in that psychiatrists have the special ability to involuntarily hospitalize people if necessary, or treat them against their will in very extreme cases, as you know. So because there is that quite vast difference in power, it takes a lot of time and a certain temperament to be able to sit there and be patient and allow the patient to trust you. You have to gain that trust not only through your words but through your actions.

On non-aboriginal health care professionals, for example, I have seen colleagues especially when I was at McMaster University, where there is a psychiatrist whose name is Gary Chaimowitz, who has provided psychiatric services to communities on the west coast of James Bay for something like 20 years. He goes regularly. He is committed to those communities, and the communities know that, so there is trust that has developed.

I'm not saying it has to take 20 years, but psychiatrists who might visit a community are probably not going to function that well in that community if they expect to see 30 people in one day and just get people in a revolving door, every five minutes, and hand them prescriptions. It takes patience.

● (1615)

[*Translation*]

Mr. Rémi Massé: You say it takes time to establish a bond of trust. How can we accelerate the establishment of that bond of trust? In certain communities there are crisis situations and interventions have to happen.

What would be some potential solutions to accelerate the establishment of a bond of trust so that we may intervene more quickly?

[*English*]

Dr. Cornelia Wieman: First of all, I'll just preface by saying that clinical skills cannot necessarily be taught entirely. A lot of it has to do with the clinicians' personality style and whether they seem approachable and friendly. It sounds perhaps like a silly thing, but it's actually quite important. Initially, to establish a quick rapport, especially in crisis situations, the patients, or clients, or community members need to feel that they are going to be heard, that their distress is going to be heard, but also that their ideas about potential solutions are going to be heard.

I have heard time and time again stories of people saying they were depressed and wanted to maybe try a medication but wanted to see a traditional healer, and when they mentioned that to the doctor, he said it was "either my way or the highway", and they were sent out the door. In a crisis situation, being open to what community members or patients are saying to you about what they think might be helpful for them is a really good point to stress and work with.

The Chair: One minute, please.

[*Translation*]

Mr. Rémi Massé: I have one last question.

Given that a large number of specialists may be required to intervene in the communities, in the meantime, what could you recommend to the communities in the more remote areas to help them prevent suicide?

I would like to know, for instance, what lessons learned could help the communities where adequate mental health support cannot provide benefits quickly.

[*English*]

Dr. Cornelia Wieman: I think a really good example came out of the recent suicide crisis in Attawapiskat, where the youth got together as a group. They essentially had a focus group and came up with what they thought would be helpful for them and their community, such as having a place to gather, or play pool, or whatever. The point is the youth themselves came up with those solutions, and in many cases that's a concept that health providers are not familiar with, because we like to say what we think would be best for the patient, and it may not match with what the patient sees would be helpful for them. I think that's really the crux of it. It's trying to collaborate together to come up with solutions, both for individuals and specific communities.

The Chair: We're going to move on now to a round of five-minute questions, and the first question will be from David Yurdiga, please.

Mr. David Yurdiga (Fort McMurray—Cold Lake, CPC): Dr. Wieman, thank you for participating in our study today. It's a very important study and we all want to resolve this, but it's not an easy subject to talk about because there are a lot of challenges and a lot of heartache.

My first question, or maybe it's a clarification, is about traditional healing. We heard a lot about traditional healing today. What does that entail? What does that actually mean? What's traditional healing?

● (1620)

Dr. Cornelia Wieman: First of all, I'll say I am not a traditional healer myself, but I am open to working with traditional healers. There are different kinds of traditional healers. There are some who do ceremonies, for example. In my culture, in the Anishinaabe culture, there may be ceremonies around smudging; ceremonies that you may or may not have participated in the past, where they pass around the conch shell and you smudge yourself with the smoke. There are other ceremonies like the sweat lodge, which is a cleansing, purifying ceremony, which I won't go into in detail. And there are many other ceremonies that I don't even know that much about myself.

Then there are traditional healers who may offer traditional medicines that are probably mostly herbal in nature. Again, as a psychiatrist, I have to be careful. When I've worked with traditional healers, I'm not opposed to my patients taking traditional medicines per se, but I do monitor people very carefully because sometimes people also want to take a prescription medication. The first principle is the safety of the patients, so we want to monitor them to make sure they're not having any traditional medicine and prescription medicine interactions.

Traditional healing can be the medicines, as I said; ceremonies; and traditional counselling. That may be from an elder, it may be from people whom we call cultural resources, so people who know the stories, etc. It's actually very broad. You'll find some people who really specialize only in the medicines, and some traditional healers who work only with ceremony.

Mr. David Yurdiga: I am curious if by incorporating traditional healing within the western mental health services, you have you noticed a decrease in suicides. Is there a difference from before, using traditional healing versus western medicine, or is it a combination of both?

Dr. Cornelia Wieman: I'm not sure if that type of particular study has been done, but I do know from the large surveys that take place every three-to-five years, called the regional health surveys, that the vast majority of first nations across the country want to see traditional healing practices as part of their health care, including their mental health care. We as health professionals have to respond to that. We have to acknowledge that and try our best to be accommodating of that. I think that's the other major piece. Health professionals who are being trained in western academic institutions —meaning nurses, midwives, physiotherapists, occupational therapists, physicians, and psychiatrists—need to know that this is quite possibly going to be part of the person's treatment plan, and be open to that. I don't really know how much of that is being addressed in medical training across the country.

The Chair: You have one minute left, please.

Mr. David Yurdiga: What are the qualifying factors to become a traditional healer? Obviously, you want somebody who has some background. Are there criteria that you guys follow to incorporate a traditional healer within your programs?

Dr. Cornelia Wieman: Again, I can say, as I'm not a traditional healer, so it would never be my place to say what the criteria would be for a traditional healer. I know, generally, that it's either passed down in families. Someone's grandmother or mother might have been one, and the person may be drawn towards traditional healing.

When I worked on a reserve community, we relied very heavily on respected elders in the community to tell us who they thought would be good, traditional healers for us to work with. I mention this because in some communities there are people who are calling themselves traditional healers but don't necessarily have the respect and backup of their communities.

The Chair: We're out of time.

The next question is from Gary Anandasangaree, please.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): Dr. Wieman, in an article for the Canadian Psychiatry Association in 2007, you mentioned that it would be desirable to have 60 aboriginal physicians by 2020. You indicated today that there will be six, meaning four presently and two in the pipeline now as residents. Is it safe to say that we won't meet that target and, if not, what are the strategies that we need to employ to make sure we have those numbers? Is that number even adequate at this point?

● (1625)

Dr. Cornelia Wieman: I think from the point of view of aboriginal people who are trained as psychiatrists, we are almost non-existent. We're one-thousandth of 1% of the number of psychiatrists in Canada. So we're not going to meet any goal anytime soon, but it is an important question. We are graduating across the country a fair number of aboriginal individuals in medicine. We do much better in the western provinces, with British Columbia, Alberta, Saskatchewan, and Manitoba doing a much better job in that respect than the rest of Canada.

We do pretty well in Ontario to a certain extent—better than we did in the past—but by and large, graduates of medical school choose to specialize in family medicine. I'm always curious as to why people don't choose psychiatry, because the mental health needs of our communities are so great. I don't think there has ever been a study done on this. I'd like to do a survey of graduates and find out why it is that they don't pick psychiatry as a choice. It may have something to do with the fact that many aboriginal medical school attendees are mature students with families and family medicine training can be completed in two years following medical school, whereas psychiatry residency takes five years.

I don't know if that's part of it, and I also don't know if, again, it's because of that dynamic where as psychiatrists we can do things that are involuntary. We can hospitalize people against their will. We fill out form 1 certificates to hold people against their will. I don't know whether or not there's a reluctance to engage in that kind of health care where you have that kind of power, so to speak, over your patients and that it seems kind of paternalistic, or whatever it is.

What I would very much like to see as a solution, however, is psychiatry training programs across the country having a sub-specialty in rural and remote mental health care, including delivering services to first nations, Inuit, and Métis communities across this country. I think that may go a long way to attracting some aboriginal graduates of medical school into that form of training, but it also would train a cadre, so to speak, of psychiatrists who upon finishing their residency training would be willing to work in these communities and provide services where they're so desperately needed.

Mr. Gary Anandasangaree: With respect to the urban indigenous population, do you believe that the current services available in places like Toronto and major cities are adequate and, if not, what additional services would be desirable?

Dr. Cornelia Wieman: I would say that the need in many cases outweighs the supports that are available. I myself don't work at the aboriginal mental health centre in downtown Toronto, which is called Anishnawbe Health Toronto, but they have a mental health program there. I think people would probably say—

The Chair: You have one minute.

Dr. Cornelia Wieman: —that there are always more people seeking health care than the number of providers available to provide it. I know that at Anishnawbe Health Toronto, for example, the practitioners or psychiatrists who provide consultation services to Anishnawbe Health, again, are not of aboriginal ancestry, but people probably have fairly long waiting lists for assessments.

It gets complicated as well in urban settings, where, for example, if you have young people in crisis, there are often a multitude of other community and social service agencies involved: for example, the schools, the CAS—Children's Aid Society—or child protective services. Police are sometimes involved. The cases are very complicated, so that limits the number of people you can see per day.

As psychiatrists, we can't just.... As I said, the revolving door of seeing people every five minutes just does not work with aboriginal people.

● (1630)

The Chair: Thank you for that.

We have time for one final question, Dr. Wieman.

It is from Arnold Viersen, please.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you, Dr. Wieman, for being here today.

I have two questions. My first one I don't think will take too long to answer.

There are always several issues that come into play when we are dealing with people who are attempting or have committed suicide. If you had to rank the issues, where would you place child abuse or sexual assault in the early years of someone's life? How would that play into suicide in general, or suicide attempts throughout the lifetime of an individual who has experienced one of those two situations?

Dr. Cornelia Wieman: I think it is definitely a significant factor for some people who are at risk of suicide, but more importantly for aboriginal people, I think it is not just one trauma. It is a series of traumas that occur over a young person's lifetime.

They may have been sexually assaulted by a family member, an extended family member, a neighbour, or another community member, but they are also contending with so many more traumas. They may be dealing with parents or grandparents who attended residential school; they may be witness to domestic violence; they may be struggling with substance abuse, which we haven't really touched on but which is another critical factor; they may be totally disconnected from the educational system and school.

It is not just that they have an experience of being sexually abused as a child. It is the fact that they have experienced trauma after trauma, death of relatives, death of friends. It is not unusual to take a history from someone and find out that over the last five years they have lost 10 friends or family members. It is just that severe.

All those things combine to place people at increased risk of suicide.

Mr. Arnold Viersen: We talk a lot here about culture, cultural appropriateness, and things like that. One of the things I would like you to expand on a little is that, through things like the sixties scoop and the residential schools, big swaths of culture have been lost. It is fairly easy to reinstate, for example, clothing or food. Even language, though difficult, is something fairly tangible we can deal with. Some of the other things are much more difficult to deal with—say, how society is organized, what the meaning of life is, and these kinds of issues. A culture generally has those answers, and to some degree, we need to reinstate that.

You will probably run out the rest of the time, two minutes, responding to this. How does the federal government go about renewing, say, those answers to “Why are we here?” or reinstate those parts of the culture that are not so tangible?

Dr. Cornelia Wieman: I think you've touched on another important factor for suicide, which is that we know that kids, young people, are at lower risk of suicide if they have what we call forward thinking, so they can see themselves at some point in the future doing something. Whether that's being a mother, a father, a student, an employee, they have to be able to see themselves at least at some point in the future, and then we know they have something to hold on to.

The challenge that we face—and I'll be the first to admit that there is no easy set of solutions to this—is how to help and support indigenous young people across this country to develop a sense of identity for themselves that is consistent with their tradition, their culture, and their values, but also functional in contemporary times. Do you know what I mean?

For example, I am about to turn 52 years old. I'm a child of the sixties scoop, and I can honestly tell you that I did not feel strong in my identity until I was probably in my mid-twenties to mid-thirties. It took that long for me to feel comfortable in both, such that I could be a strong first nations woman and yet be a psychiatrist and function in a very difficult job and be who I am in my life, a wife, a mother, whatever.

That's the challenge, and I don't necessarily think there is an easy answer, but I think one way to go about it that I touched on briefly is to invest much more heavily in sharing stories of resilience with our young people. All of the resilience literature, whether it has to do with indigenous people or not, says that if somebody has at least one strong person in their life that they can relate to and they have a good relationship with, or they share a story with, that, in and of itself, can foster resiliency.

We need to hear stories like my own, and I don't mean that in an arrogant way at all. If you talk to indigenous people across the country who are recognized as achievers, no one will tell you a story that it was just smooth sailing, that they were just born and they went on to greatness without a hitch. That is not the case at all. I think everyone has a very complicated and rich story of struggle, and yet ultimate achievement. If we shared these types of stories with our young people, I think they could relate to pieces of themselves, see themselves in that, see possibilities for themselves in the future, and ultimately it would result in them flourishing as contributing, valuable members of Canadian society.

● (1635)

The Chair: It's a great note to wind up on, Dr. Wieman.

On behalf of the committee, I'd like to thank you for your well-considered remarks today. They're going to be of tremendous help to us as we carry on this very difficult study of indigenous suicide.

Thank you for being with us.

Dr. Cornelia Wieman: Thank you very much for having me.

Chi-miigwech.

The Chair: We'll suspend for a short period while we change up and come back in about a minute and a half.

Thank you.

[*Proceedings continue in camera*]