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Chair

Mr. Andy Fillmore

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● (1550)

[*English*]

The Chair (Mr. Andy Fillmore (Halifax, Lib.)): Good afternoon, everyone. We'll come to order.

First off, apologies for the late start. You may have heard that there were votes in the House and we were all held up there, but we'll get right under way.

Welcome, also, to the folks in the gallery. We're happy to have everyone here.

We are meeting today on traditional Algonquin land, for which we are grateful.

We have two panels today. For the first panel for the first half of the meeting we have appearing as individuals, Rod McCormick, professor and research chair at Thompson Rivers University, and Michael DeGagné.

Welcome to you both.

Although we're starting about 20 minutes late, we are compelled to finish at the usual time of 5:30, so we'll be having each panel for 50 minutes instead of 60 minutes. We'll share the 20-minute loss between the two panels that we have this afternoon. It just means there might be one or two fewer questions after, but you'll have your full allotment of time.

You may speak in whatever order you would like. You each will have the floor for 10 minutes, and I yield the floor to you.

Dr. Rod McCormick (Professor and Research Chair, Thompson Rivers University, As an Individual): Members of Parliament, observers, and colleagues, it's an honour to appear before your committee on the unceded territory of the Algonquin peoples. I would like to commend the dedication of the members of this committee and thank you for the important work you're doing on behalf of all my relations. *Niá : wen.*

My name is Dr. Rod McCormick. I'm a member of the Mohawk Nation, Kanienkehaka. I work as a full professor and B.C. government-endowed research chair in aboriginal health at Thompson Rivers University.

Before moving back to my partner's home on the Tk'emlúps te Secwepemc Indian reserve, I was a psychologist and counselling psychology professor at the University of British Columbia for 18 years. I've also been a psychotherapist and clinical consultant supervisor for the last 27 years.

Because of the limited time available, I'll confine my comments to two of the objectives of your study.

I'll start with the factors contributing to an elevated risk of suicide. I would like to focus on one method of assimilation and colonization used by Canada that was intended to separate indigenous peoples from primary sources of meaning and strength. I believe that this disconnection is one of the greatest factors contributing to the elevated risk.

A theoretical explanation can be found in logotherapy developed by Viktor Frankl, a Jewish psychiatrist who survived the extermination camps of Nazi Germany. Frankl found that individuals and cultures can survive if they have a strong reason for living. This can be found in sources of meaning such as spirituality, work, significant relationships, contributing to one's culture, and so on.

Through colonization, our experience has been one of disconnection from those sources of meaning. Disconnection from family was experienced as 120 years of residential schools that separated aboriginal children from their parents. For example, my children's *Kye7e*, or grandma, attended the Kamloops Indian Residential School from the age of 5 to 18.

There was a disconnection from communities. Communities were relocated to reserves and often relocated once again when the government chose to do so. Communities have also been split by various means such as forced replacement of traditional community leadership, with elections imposed by the former department of Indian affairs, and so on.

Disconnection from culture meant that cultural practices such as the potlatch and the sun dance ceremony were often banned or prohibited, and speaking one's language in residential school was punished.

There was a disconnection from spirituality. Every effort was made to replace traditional spirituality with Christianity.

Disconnection from the land resulted from the government's policy to relocate aboriginal peoples to urban settings when possible, to speed up assimilation.

I'll just mention a couple of other contributing factors. One that this panel has already heard about is that suicide has been normalized. The predominant community gathering for most communities has become the funeral. As one colleague said, we're becoming a culture of death. We've also become disempowered to the point where we are no longer "response-able," i.e., able to respond to crises.

Another point I'll mention is that the government still doesn't understand an indigenous world view. The government uses a mechanistic world view in dealing with indigenous peoples. The idea is that one can create change using drivers, levers, determinants, and so on.

Now, I'll talk about protective factors that help to reduce the vulnerability.

My research with indigenous peoples reveals that one of the paths to healing is reconnecting to those sources of meaning we've been disconnected from; reconnecting with family, community, culture, nature, the land, and spirituality. In addition to reconnection, a meta-analysis of my 25 years of research and practice regarding healing with indigenous peoples indicates that healing leads to one or more of the following: empowerment, cleansing, balance, discipline or responsibility, and of course connection and belonging.

Going back to that mechanistic world view example, I thought I should explain. One of our newspapers, the national indigenous newspaper *Windspeaker* wrote up a presentation I gave a few years ago in which I told Health Canada to stop pushing. We are pulled towards healing, not pushed. Causes push, reasons pull.

Another article titled, “Get out of the way, and let Aboriginal people get on with health,” states:

> McCormick was highly critical of Health Canada’s approach for strategic planning for Aboriginal long-term health planning and the department’s use of “mechanistic” language.
>
> Health Canada has been in the business of pushing. . . . We are instinctively pulled towards reason for living a good and healthy life and it’s not instinctive to be pushed. And I think when we’re pushed we tend to be resistant and that resistance can sometimes end up in self-destructive behavior.
>
> He believes that Health Canada has “to remove the barriers,” which he noted included such factors as lack of access, lack of culturally-appropriate programming, and short-term funding, and allow Aboriginal people to seek healing through traditional and cultural means.

● (1555)

I'll give you one example of my research and it was published in the *Routledge International Handbook of Clinical Suicide Research*, and that is a chapter in their own words, “a retrospective exploratory study of how to facilitate healing for suicidal indigenous youth”.

By means of interviewing 25 first nations participants who recovered from being suicidal, they provided examples of their own experiences in healing by describing what was done and what action was taken to facilitate healing for them. If we look at the categories that facilitate healing and recovery for suicidal first nations youth, in descending order of significance, I'll just read the top 10, as follows: self-esteem, self acceptance; obtaining help from others; changing thinking; connection with culture, tradition; responsibility to others; expressing emotions, and cleansing; future goals, and hope; spiritual connection; learning from others, role models; and connection to nature.

The study indicates that there is an abundance of potential healing resources that exist for indigenous youth who are suicidal. It also has the potential to reorient the way indigenous communities and practitioners view the nature and source of mental health services provided to them. In recognizing that the natural healing resources of youth themselves can be effective sources of healing, indigenous community leaders may feel empowered to start examining ways to utilize these methods of healing in addressing youth suicide in their communities.

Given that 13 of the 22 categories involve cultural and spiritual practices, the results of the study suggest that it is necessary to understand the belief systems and world views of indigenous cultures before applying theories and techniques of healing.

Among the other factors—just to finish up here—is the idea that we need to ask the real experts, as I did with this study. I believe communities must find out what works to prevent suicide by asking those who have recovered from being suicidal, because it's important to acknowledge the coping and healing resources that exist within the individual, the community, and the culture.

Obviously we could develop training programs to cover off those 22 categories that deal with positive self-esteem, self awareness, emotional literacy, cultural identity, communication skills; and life skills such as problem-solving, decision-making, values clarification, relationship skills, and stress management. I think another witness said that we have to ensure that our youth have the necessary skills to succeed.

I'd just like to touch on unresolved grief and trauma. We need programs such as those formerly offered by the Aboriginal Healing Foundation that can provide healing resources and programs to deal with unresolved grief and trauma.

As well, I don't believe the video conferencing capabilities, at least in B.C., are being utilized for mental health. There are some logistical safety issues regarding therapy but until they are worked out the facilities could be used to provide support, supervision, training, and consultation to community workers. A 24-hour consultation line, for instance, could be developed for workers such as community health nurses, who could consult and debrief with a senior mental health professional.

Concerning the use of ceremony, many indigenous communities have historically held community events and ceremonies that assist youth in reinforcing their personal and cultural identity and their connection to the community and culture, such as the naming ceremony.

The slow transformation in indigenous health research—wearing my other hat—is a good metaphor to use with regard to indigenous healing. In the beginning research was done on us—we were the guinea pigs—and then for us as we hired researchers for things like land claims, etc., and then with us as research ethnical guidelines required meaningful partnership.

Eventually research will be done by us. This transformation will require an investment in capacity-building.

The last thing I will just mention is that I am developing a centre called All My Relations.

● (1600)

It will be a new research and training centre to help indigenous communities to identify and, in many ways, reclaim traditional healing resources, such as the naming ceremony I mentioned. It is hoped that there will be a lateral exchange of these healing approaches between indigenous communities and training in the use of such approaches, if requested.

I'll stop at that.

Niá : wen.

Thank you.

The Chair: Thank you so much, Dr. McCormick, for that. It was very well-timed. I appreciate it.

Mr. DeGagné please, you have the floor for 10 minutes.

Mr. Michael DeGagné (President and Vice-Chancellor, Nipissing University, As an Individual): Thank you very much for the welcome to your territory and for your important work.

I'm here today to offer a few remarks and answer questions about, first of all, my work as the president of Nipissing University here in Ontario. I'm a first nations person from northwestern Ontario.

I'm going to speak specifically to 15 years of work at the Aboriginal Healing Foundation, which preceded my work at the university.

The Aboriginal Healing Foundation was a structural response to a very serious problem in first nations, so I think you can draw parallels and analogies to the work you're doing here. We were set up to address the legacy of physical and sexual abuse in residential schools, and we received an endowment from the federal government that provided us a number of advantages, not the least of which was that we were allowed to invest that endowment and stretch that money for what, at the end of the day, was 17 years.

We began in 1998. We did both funding and research. Led by a board of directors of 17 aboriginal citizens from across the country, we provided funding to 1,300 community projects that were residential-school specific. We were also responsible to monitor those projects, to ensure that money was used wisely, and that healing outcomes were achieved.

We supplemented that with $50 million in research over the course of the life of the foundation, in health, healing, reconciliation, a suicide project, etc., so I would say 30 pieces of research conducted across the country and, at the end of the day, publishing that research to ensure it had widespread use and uptake.

As a mechanism for addressing a very serious problem, like the one you're facing here, it had several strengths, not the least of which was that it had a national aboriginal board. It brought together perspectives from across the country. Secondly, we sustained funding from an endowment. You heard Dr. McCormick reference that, but non-short-term funding. I cannot say enough about the power of sustained funding, the idea that a project that is working in a small community that has very little else to sustain it, doesn't have to shut down for months at a time while funding applications weave their way through bureaucracies. Also, there's a consistency in the individuals who are working on these projects and a capacity to develop greater and greater skills as time goes on.

It doesn't sound like a long time, but some projects that were funded by the foundation were funded for up to 10 consecutive years, and the human resource capacity that was developed to address serious health issues in that time was quite remarkable.

Let me get into some of the community strengths. First, the foundation supported capacity for some and capacity development for others. It's an important distinction, and one that's actually very rare. Often what happens is capacity is developed or funding programs are developed that fund everyone equally, so that everyone is either equally happy or equally disappointed, depending on how you look at it. This formula funding that's rolled out often means that communities with a tremendous amount of capacity and capability are under-funded, and those that have very little in the way of capacity to deal with health are funded for something they have no ability to deliver. We see this happen across funding in the aboriginal community.

We focused on communities that had the capacity to deliver in-community programs. These programs were of their own design. They were a wide variety of counselling services, land-based programs, and elder-driven programs; it depended on what the community was prepared to offer.

Surprisingly, many communities found a way to blend traditional practices with western practices, so this was not a knee-jerk reaction to return to traditional means of delivering counselling services. You often found a blend. Communities used the tools that were available to them to best effect.

● (1605)

In terms of addressing suicide, I wanted to supplement Dr. McCormick's position on the historic transmission of trauma. The notion we are left with sometimes is that a lot of the suicide we see today had its genesis in the residential school programs many decades ago. This is a very difficult idea for us to get our heads around, the idea that something that could have happened decades ago might affect our behaviour today.

I think we have some interesting and robust evidence that's coming out of various places. Amy Bombay and her colleagues at Carleton University have shown how health outcomes for successive generations who did not attend residential schools, but are descended from aboriginal people who attended residential schools, are negatively affected by the fact that they come from a family of residential school survivors. I think this is something we really have to focus on.

Let me offer in the next minute or two a few notions of what I would recommend in terms of a national response to aboriginal suicide. First, however we find the mechanism, a sustained funding presence is absolutely critical. For those of you who have spent time discussing a variety of issues in the aboriginal community, you know the problems we have with funding applications. We see applications that begin at the beginning of a fiscal year. People often don't see money until halfway through. They have to rush to spend it in six months, and it reconvenes again at the end of the fiscal year when they apply again.

What you have is spasms of activity that are not consistent within the community. I cannot say enough about the importance of a sustained funding presence for programs that address suicide.

The second recommendation I would make is the review and use of existing consultations. There are some very rich consultations that have occurred across the country. The NAN territory has been consulted several times on the issue of aboriginal suicide. I know many of you have been active in that area as well. I don't know that we need more consultation on this. I think what we can do is take a good hard look at the consultation that's already gone on and review the directions that have been set already. There's great research and there are great consultations that already exist.

My third recommendation is that we tend toward community-developed programs, and in communities that have a track record of capacity in these areas. I recommend allowing the community to develop its own programs and then working with that community to offer sustained funding.

I would remiss if I didn't mention something about the importance of universities in all this. My concluding remark is that university-led programs that combine western and traditional counselling are emerging, and I think they hold real promise, especially for northern communities. Too often we see southern-trained or western-trained psychologists and psychiatrists who go into aboriginal communities; they have no intention of a sustained presence, and they leave not long after many wounds have been opened. What we're looking for is people who have been trained locally and can work locally in an ongoing way.

Those are my recommendations, and I very much appreciate the opportunity to address this group. Thank you.

● (1610)

The Chair: Thank you very much, Dr. DeGagné and Dr. McCormick, for your remarks. We're very grateful for those.

We'll move right into a round of seven-minute questions. Members will have seven minutes for both the question and the response and, as always, I'll try to urge members to get to the point of their question as soon as possible, so we can hear more from you.

The first question is from Mike Bossio, please.

Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.): To speak to that sustained, long-term, stable funding, from 1998 to 2014 you received $350 million in funding that you were able to expand through other means, I assume, to $536 million that went to 1,345 communities. Why did it end?

Dr. Michael DeGagné: The government at that time was under no obligation to continue it. It had been extended twice with small amounts of money. We originally received a $350-million endowment up front in the trust of our national board. It was discontinued because there was the sense, as was explained to us, that there was no sense that we would continue on indefinitely.

Mr. Mike Bossio: How many people did you have working for you? How many counsellors were there?

Dr. Michael DeGagné: We would have had hundreds of them in the 1,300 programs we funded over the course of that time. Many hundreds of people either arrived at community projects and worked for them or were trained on the job in community programs.

Mr. Mike Bossio: At the end of this, you had locally trained counsellors who could counsel individuals on healing practices for indigenous peoples in 1,345 different communities.

Dr. Michael DeGagné: Yes, sir.

Mr. Mike Bossio: Long-term, stable funding and self-government for indigenous peoples to allow them to establish their own priorities have been raised many times in this committee. Do you really see that they have to go hand in hand?

Dr. Michael DeGagné: Yes, I do. I think you have to have long-term, sustained funding to help people develop capacities to keep going, right?

The Aboriginal Healing Foundation was provided with an additional endowment. From that endowment, we funded all future operations and a $50-million research agenda based on interest alone.

If you have the right group and the right funding profile, you can provide funding and leave people alone to manage their own affairs and generate their own capital so they can sustain themselves and make a huge impact in the community.

Mr. Mike Bossio: Would you agree, Dr. McCormick?

Dr. Rod McCormick: Yes. It's a shame that you couldn't just operate it from the investments. I don't think government works that way.

Dr. Michael DeGagné: No.

Mr. Mike Bossio: [*Inaudible—Editor*] process, right?

Dr. Rod McCormick: Yes, there is set funding for five years, or whatever. I worked for some of those projects, some of the long-term ones, and saw tremendous capacity being developed, and then it was all gone, disbursed. The elders were trained to work with the healing programs. Without the continued funding, things fell apart.

It was really bad timing. It was at the beginning of the Truth and Reconciliation Commission, so it didn't logically make any sense to take away the mental health programs and supports when they were starting this huge process to get people to talk about their past hurts and so on.

Mr. Mike Bossio: Do you think it is, from a self-government standpoint...? I know it's not one size fits all. I think that's become very clear in the testimony so far. Is it possible to do it reserve by reserve, or should it be, like the model we have now, done provincially, municipally, by county? Do we have a Mohawk nation —I have Mohawks in the Bay of Quinte in my riding—at the nation level provide a certain level of service, like the provinces would, and fund it to that degree, then at a local level have municipal, council-led reserves receive different funding?

● (1615)

Dr. Rod McCormick: Possibly. I think there were all kinds of variations under the Healing Foundation. Some were run by tribal councils quite effectively, others by just small communities. I think the idea is that the community has to feel empowered—as I said, response-able—to take on that responsibility. I was a fly-in psychologist for Health Canada for 10 years, and that certainly wasn't empowering, nor very effective, I have to confess, in terms of addressing mental health needs.

Mr. Mike Bossio: The Mohawks at Bay of Quinte have a number of youth counsellors. One is a close friend of mine. When there are youth he finds who are kind of heading toward trouble, he will have weekends when he takes them back to the land. He calls them "back to the land". They spend a weekend and camp out on the land and have a fire. All cellphones and electronic stuff are gone. It's just him and the youth. There might be a couple of them around the campfire just talking about what's bothering them, what's making them angry, or the issues they're struggling with.

I had the good fortune of going to Haida Gwaii and meeting with the Haida Gwaii Watchmen. Steven Nitah has come to our environment committee, and I've met with him and talked about the rangers. I've met with Valérie Courtois, who is leading the charge on the guardians front.

There is this whole notion of getting indigenous peoples back to the land. Do we need long-term stable funding to bring these types of long-term programs to indigenous peoples because of the positive benefits they provide?

Dr. Rod McCormick: Yes.

Dr. Michael DeGagné: I think, certainly, the proof is that when a community is left to its own devices, to design its own programs, that's often the road they take—the idea of going back to the land, and going back to traditions. I don't know if Dr. Kirmayer will be here, but he's talking more and more about the idea that the traditional supports for mental health involve going back to the land.

Mr. Mike Bossio: Thank you so much.

The Chair: Thank you for that.

The next question is from Cathy McLeod, please.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you to both of the witnesses.

I want to note that Dr. McCormick is from Thompson Rivers University, which we're both very proud of in the riding of Kamloops—Thompson—Cariboo.

I guess a whole number of things have piqued my interest. To some degree, in response to a crisis that's been very profound lately —I would say it's been a crisis forever—Health Canada created SWAT teams to go in, and what I'm hearing is that probably it won't be all that effective.

How is that going to help in terms of the response, from your knowledge and the research that you've done, versus what some other short-term crisis responses might be?

Dr. Rod McCormick: I would say you're right. Initially, to contain things is a good idea, but that SWAT team, or whatever, mental crisis team, is going to leave eventually, and that's not going to solve any problems. If there's a suicide, if there's fear of contagion and so on, it might contain that, but it's not a long-term solution.

I know the government has invested heavily just recently in the mental wellness teams, which hold more potential, if there are enough of them. But the idea there is you have a sustainable, community-based team that can provide this ongoing support. The difficulty is we have 600-and-some first nations alone, and then there are the Métis communities and Inuit communities, so one team is never going to have the local knowledge. At best, I think there were about a dozen that were based on already existing sorts of community projects that were pretty successful, based on the evaluation I read. But again, they struggled with human resources, with how to maintain those workers, some of whom didn't have much training; and once they had it they went off and found better jobs, full-time jobs. For others, burnout occurred.

Logistically, I just can't see bringing in outside people. No matter how many teams you have they're never going to have local knowledge because, at best, they're going to be representing 10 different communities, or trying to provide services to 10 or 20, whatever the math is. I just can't see how it's going to work. The needs from community to community vary so much.

● (1620)

Mrs. Cathy McLeod: I know there has been probably a lot of time and energy over a lot of years. From your research, are we having any impact on rates? For all the different programs and supports, have we done anything that's helping?

Dr. Rod McCormick: As far as—

Mrs. Cathy McLeod: In terms of rates....

Dr. Michael DeGagné: I don't know that we've had a tremendous impact. We're still talking about it significantly. If we look at the royal commission 20 years ago, we will see that we were talking then about the urgent need to train 10,000 new community-based health workers. We haven't achieved that yet.

It was an urgent need two decades ago, and the rates may have fallen in some parts of the country, but we still have a desperate need for locally trained people with local knowledge that will sustain a presence in communities.

Mrs. Cathy McLeod: You both represent or are related to universities. Certainly I know there's a large indigenous population at Thompson Rivers, and I would presume at Nipissing, and we also know that we have young people who are perhaps fragile and vulnerable. Do your universities have specific program support services that are proactively looking at this issue? Are they being effective?

Dr. Michael DeGagné: Universities are very good now at making sure that there are all sorts of programs and services available for incoming aboriginal students. This is something that we've developed over probably the last 10 or 15 years. We've got bridging programs and mental health supports. We have opportunities for students to arrive early and be acclimatized to the university, and then a lot of follow-up, full-time aboriginal support people usually housed in some sort of indigenous student centre.

So we do a good job at it now, but we have the advantage of knowing that there will be more students next year and we can sustain our presence year after year.

Dr. Rod McCormick: I think the best intervention has been peer support programs. I developed, I think, one of the first ones 20 years ago for indigenous post-secondary, and then UNBC took it on. They've been training people, and I think they even have an annual conference now. It's indigenous peer support that's university based.

For me, that was my outreach. That got me my business. If I was working as a university counsellor, my business came from the peer support students because they were trained to identify, not to provide therapy, but how to refer and who to refer to. People who would never come and see me would end up on my doorstep with the peer support person who brought them there to see me.

It was tremendous outreach, because students tend to talk to other students first. That same model could be used, and I've used it, actually, in a high school in Whitehorse. There were no completed suicides the three years that I ran that because it was specifically to address suicide prevention. I think that's a really underutilized resource, but the universities are picking it up.

Dr. Michael DeGagné: Yes, quite aggressively.

Mrs. Cathy McLeod: Thank you.

The Chair: Thanks, Cathy.

The next question is from Charlie Angus, please.

Mr. Charlie Angus (Timmins—James Bay, NDP): Thank you, Mr. Chair.

Thank you so much for this and your presence.

I want to say that every time I see on Facebook one of the students from Treaty No. 9 announcing they're going to university, that's a huge victory. That's the future. Certainly many are going to Nipissing. I want to thank you for that work.

Mr. McCormick, I'm sure it's the same in your area.

I'm interested in the issues of sustained funding. We had an example in the Attawapiskat housing crisis when the media came up for the first time to see the situation. They were shocked and outraged to find there was this beautiful healing centre. What were those people in Attawapiskat doing with that beautiful healing centre? There was lots of money to build a healing centre, and there was no money to run it, no money to staff it, no money to heat it. Both the feds and the province came, cut the ribbon, then left town, and we had a beautiful healing centre that sat there empty.

It's the March madness, where we go into schools that don't have math books and they'll suddenly have state-of-the-art gear and it's like, “How did you get that?” Indian Affairs called and said, “We have to spend the money within three weeks, buy something”.

My real deep concern out of this study is that Health Canada will announce, in response, that they're going to start a new program, and it'll be a carry on of this hamster wheel of programs.

How do we get to taking this money out of INAC and out of Health Canada and say, “ITK has a plan for suicide prevention, let ITK run it”, or “NAN territory has done the work, let them do it”, so we can start to do modelling that actually responds to the needs of communities as opposed to ticking the boxes for the bureaucracies here?

● (1625)

Dr. Michael DeGagné: One of the issues of creating the sustainable funding profiles is the idea of finding aboriginal organizations that will take this on, or creating those organizations.

The aboriginal community has little in the way of civil society. Most of the services we access are accessed through some sort of political body. If you go to a typical first nations community, you will find—and you know this, I'm sure, from other presentations—that most of the employment will be from the band itself. It's not unusual to have as many as one in 10 people run for public office whenever there's an election. You have everything, including businesses, journalists, and programs, all embedded within the band government.

It's one way to manage things, but there's nowhere that's non-political for aboriginal people to turn to for services and supports just like the rest of Canadians. We can go down to the Cancer Society if our parent has cancer, and then we can access information. We know it's not a government service. It's there for the support of cancer and cancer survivors.

What we need to do is regenerate what was decimated around the same time as the Aboriginal Healing Foundation closed. Most of the national aboriginal organizations that were non-political, such as the National Aboriginal Health Organization, the First Nations Statistical Institute, and all of these types of organizations were managed by and governed by aboriginal people, but they were for direct service provision to aboriginal communities, and they were apolitical. They were all done away with at the same time and often within a few months. It represents a strata of aboriginal society that was gone virtually overnight.

If we were to re-establish some type of program where aboriginal people can govern their own services, and which did not have to have the blessing of political bodies...certainly there would be liaison, but not everything in the world is run through our MPs, and not every health service is run through our MPPs.

Can you imagine a system where I had to go to my MPP in order to make sure I got adequate health service? It makes very little sense, but that is the world that is faced by most aboriginal citizens.

Mr. Charlie Angus: Mr. McCormick, I want to talk to you about the historic transmission of trauma and what you have seen.

As I have seen in our communities with St. Anne's Residential School, Edmund Metatawabin says there's a direct road from that trauma to the children killing themselves today. You can see the physical trauma in the faces of survivors. You start to identify where the heavy trauma was just from the physicalities, and that's intergenerational.

The steps of trying to get people out on the land and the steps of trying to break that cycle have been really difficult, but it's deeply embedded now as intergenerational.

From your experience, how do we start to find the alternatives and the healing paths that are community driven and not outside driven?

Dr. Rod McCormick: I think there have to be the resources there. If you're going on a healing journey, then you have to gather your medicines. Whatever those resources are, whether they're traditional or a mixture of some western psychology and some traditional healers, there has to be a safe place for it, as well.

You can't have people coming in and offering these weekend workshops to rescue your inner child, and let's all talk about our abuse, and then leave. That's often because there's so little money within communities. With $20,000 for mental health, what are we going to do with that? We can't hire a counsellor, so let's get one of these people with their road shows to come in and open us all up.

I would say that what you see that's transmitted intergenerationally are ways of coping that don't work very well. One of them is disassociating. Your mom went to residential school for 15 years, and she didn't learn to identify and express emotions in a good way. Well, your kids aren't going to either. You need to be able to break that, but you also need to do it in a safe place. There have to be enough resources for it, as well as the safety that it's not going to be discontinued when the government feels like discontinuing it. Ownership of it is needed.

I can't stress the safety enough. I think that's one of the things the Healing Foundation has tried to ensure: that the safety was there.

There are so many things I can say to answer your question, but I'm out of time.

● (1630)

The Chair: I'm afraid we're out of time there, Charlie. Thank you for the question and response.

My apologies for the limitations of the time. We have time for one more question with this panel, and it's from Don Rusnak.

Mr. Don Rusnak (Thunder Bay—Rainy River, Lib.): Thank you, Mr. Chair.

I worked for a time in northern Manitoba, and we dealt with the Aboriginal Healing Foundation through many of the community programs that existed at that time. The work of the foundation and the organizations that were dealing with the foundation was amazing. I am curious to know if you have numbers from communities in terms of the successes in what they were doing. Would that information exist, or has it all disappeared with the foundation going by the wayside?

Dr. Michael DeGagné: We transferred our resources to Algoma University in Sault Ste. Marie, so we have a number of research resources there, but all of the outcomes from those 1,300-odd community projects are also archived, so we have access to that. Strangely enough, we've never had a Ph.D. student come up to us and say, “Can I access all of these data? This would be fantastic.” We also have published resources that are...that legacy is continued on through the Legacy of Hope Foundation. We're trying to make those available.

Mr. Don Rusnak: I was going to suggest that the analyst grab some of the data from, at least, some of the projects throughout the years that the foundation did the good work that I saw on the ground. I was immensely upset when the previous government cut funding to that foundation because it did such good work.

I'm going to go off on a tangent and agree with my colleague from the NDP in saying that, yes, there are good things that could be done through organizations such as the Aboriginal Healing Foundation. It doesn't always have to come from government. Oftentimes when the federal government does something or one of its departments does something in terms of health, it's well meant but done in stringent boxes. It's not done with the flexibility that's needed in a lot of our first nations communities. And I say our first nations communities because I'm Ontario's only first nations member of Parliament. So I'm well aware of the problems in our communities and in the communities of Hunter Tootoo who is sitting here today. The communities experience amazing rates of suicides and other problems. Michael McLeod from the Northwest Territories just had a rash of suicides over the last couple of weeks in his communities.

I've said this a number of times at this committee: I don't want my successors 10, 20, 100 years from now sitting at another committee studying indigenous youth suicide. We need to do something now, and I believe that the Aboriginal Healing Foundation was doing was amazing work because I saw the work. But again, it's a two-part stage. In my mind, at least, and in the minds of a lot of the people I've talked to, we don't want to create this industry just on the misery in indigenous communities. We want to end that misery somewhere. I know that's what the foundation did so well. They were doing programs built within the communities that were finally putting a stop to the feelings of despair and the problems that lead to other problems in the community and cost all of society so much.

I see it in my community of Thunder Bay where we have a lot of people coming from the north who aren't adjusting well to the city of Thunder Bay. We have colonialist attitudes among institutions. We see it with an investigation of the Thunder Bay police force right now. I really don't want to see this continuing, and the work that the foundation did was a starting point but not an ending point.

Other than restarting an organization like the Aboriginal Healing Foundation, do you have any recommendations on how to help to at least start to end these crises?

● (1635)

Dr. Michael DeGagné: I think the work of Michael Chandler and Lalonde, in B.C., has probably come to this committee already. If not, it will.

It's the notion that any community that develops more and more self-efficacy or self-government, has its own agreements, has its own police force, all the way up to true self-governance.... The higher you get on that sort of scale, the more resilient you become, and the youth in that community become more resilient to suicide.

The idea, then, is that if we can't create structures—and that's fine—then what we can do is make sure that we act within at least a policy framework. That means, if we're going to act, we have to engender more empowerment. We have to engender more authority for people over their own lives. That's even if it's small things, small agreements, or opportunities for youth to meet and speak peer to peer and support each other. As long as it's supportive of empowerment, I think anything we do will be better than what we're doing.

Dr. Rod McCormick: I would add that in terms of empowerment, I don't know that necessarily governance...when I look at the experience of the Nisga'a in B.C., one of the first, at the Government of Nunavut....

I think it was Natan Obed who said that governance in Greenland and in Canada hasn't necessarily lowered our suicide rates. If what is reproduced in terms of governance is similar to the old government, people get pretty disappointed and disillusioned when they had high expectations. That's one variable.

We still have to deal with a lot of unresolved grief and unresolved trauma, and I think that we need to address that. What's being offered currently by FNIH just isn't doing it. It hasn't worked.

The Chair: Fifteen seconds.

Mr. Don Rusnak: Thank you for your time coming here and presenting on this important subject for us. I appreciate it.

Dr. Rod McCormick: Thank you.

The Chair: That brings us to a close, Dr. DeGagné and Dr. McCormick.

Thank you very much for your testimony. It will be reflected in the record and ultimately in the report, which we hope will be completed some time early in the new year. We'll look forward to sharing it when it's ready to be shared.

Thanks again for your time.

Dr. Rod McCormick: Thank you.

The Chair: We'll have a brief suspension while we switch to the next panel.

Thank you.

● (1635)

(Pause)

● (1640)

The Chair: Okay, we're back.

This second panel today is composed of three witnesses, and we're offering 10 minutes to each of them.

The first witness is Gwen Healey, who's going to be joining us strictly by teleconference, no video today.

Dr. Gwen Healey (Executive and Scientific Director, Qaujigiartiit Health Research Centre): Thank you to the chair for the invitation to address the committee today.

I'm Dr. Gwen Healey, and I was born and raised in Iqaluit, Nunavut. It's in this community that I continue to live and work. I'm the executive and scientific director of the Qaujigiartiit Health Research Centre. I co-founded Qaujigiartiit in 2006 with the late Andrew Tagak, Sr. I am also an assistant professor of human sciences at the Northern Ontario School of Medicine. My formal training is in epidemiology and public health.

Our centre is an independent, non-profit community research centre. We exist to answer the health questions of our communities. This may take the form of community-based research, territorial and systems-level research, or circumpolar international projects across the Arctic. We develop evidence-based interventions, conduct surveys, collect narratives, and explore community-identified health questions. We are contributing to scholarship and academia by sharing our evidence nationally and internationally, and by developing and sharing health research approaches that are developed from an Inuit epistemology.

Health research studies are usually developed from a deficit-based model. There is an issue, a medicine or treatment is created and applied, and then presumably an individual gets better. However, this is not the only way to examine a topic. This method often treats contextual information as confounding or biased. Occasionally it is ignored altogether. However, sometimes the contextual information can be the essence of the issue.

We know that the context of Nunavut's suicide crisis is extremely important but rarely openly discussed. There is a marked difference between Canada and Nunavut when it comes to such social determinants of health as poverty, housing, and education. From the Nunavut portion of the Inuit health survey, we know that 11% of adult respondents were verbally abused as children; 31% of adults reported experiencing severe physical abuse in childhood; 52% of women and 22% of men reported experiencing severe sexual abuse in childhood; 43% reported feeling depressed some or little of the time, and 9% all or most of the time; feelings of depression were more commonly reported among women and youth; 48% of respondents reported having thought seriously about suicide; and 29% of respondents reported a non-fatal suicide attempt in their lives.

These are heartbreaking statistics, and the context of this information is extremely important. Nunavut settlement history is relatively new compared with other indigenous communities in Canada. The federal settlement program, the tuberculosis outbreak, the dog slaughter, and the residential school system events all occurred in roughly the same time period, in the 1950s and 1960s.

At this time, families were severed, children were taken away from their parents, and a complex series of events unfolded that had an immediate and long-lasting impact on Inuit society. What is particularly damaging about this series of events is the fact that Inuit society is relational, founded on a system of kinship relations. These relations form the basis of a unique attachment philosophy. When parents were separated from their children during the settlement and separation events, the development of family attachments was disrupted, threatening the foundation of Inuit kinship society, ways of knowing, language, transfer of skills, and knowledge about wellness and what one needs to be well. It severed the very threads that wove the fabric of many families together.

The deficits are important to understand, but so are the strengths. Rather than a purely deficit-based model, at Qaujigiartiit we often apply a strengths-based model to our work. We know that we have certain strengths in our communities and our way of life. We know that certain aspects of our lives are very good as a result of celebrating and building on these strengths. How can we help others to tap into their strengths and ensure that our communities are well, now and for future generations?

Between 2006 and 2008, we held a series of public engagement sessions across Nunavut to identify health priorities from the perspective of community members. Mental health and wellness of our communities was the most important priority. Our board focused on the mental health and wellness of children and youth in particular after these consultations. At that time, we knew there was a dearth of programs or supports for children or youth or their parents in Nunavut. We knew what our strengths were. Our relationship with the land, our connections and relationships with each other, our willingness and readiness to help each other, our arts and music and stories, our absolute undying love for our children—all are our collective strengths and core societal values.

From this place, we set out to design a program to help young people realize these strengths in themselves. Our belief was that from this position, we could, as a community, contribute to the building of such strengths in our youth to help them be well, especially if their home environment included trauma or neglect, or if for any other reason they were not learning about these strengths at home.

● (1645)

Through this pathway, we believe we can prevent death by suicide. This program would be something that any community member could deliver if they also saw these strengths in themselves. We worked with elders, youth, parents, youth workers, and community members from across Nunavut to develop the content for the program that one of the parents named Makimautiksat, which means “building a foundation within oneself.” The program was designed to take place on the land and in the community. We spent the next four years piloting and evaluating the program in Nunavut.

The model for Makimautiksat comes from Inuit perspectives on what it means for a young person to be well, as well as the western scientific literature. For example, we know from neuroscience literature that in an adolescent's developing brain, a very important time to develop coping skills is between the ages of nine and twelve years. By focusing on this age group, there is a greater likelihood of retention; hopefully, these skills can be retained during tough life events and transitions that lie ahead in the teen and early adulthood years.

The model for Makimautiksat is developed around eight core concepts or foundational pillars. We envision them as rocks in a tent ring, which provides the stabilization for a tent or qammaq. The first concept is the strengthening of coping skills. The second is *Inuuqatigiitiarniq*, which is being respectful of others and building healthy and supportive relationships. The third is *Timiga*, my body, promoting awareness of the body, movement and nutrition. The fourth is *Sananiq*, which is crafting and exploring creativity. The fifth is *Nunalivut*, which is our community, and is about fostering personal and community wellness. *Saqqatujuq*is the sixth concept, which is the distant horizon and it's about self-discovery and future planning. The seventh is understanding informed choices, substance use and peer pressure. The eight concept is *Avatittinik Kamatsiarniq*, stewards of the land and connecting knowledge and skills with experience on the land.

From our research findings, as we evaluated the program, we found that activities fostered physical, mental, emotional, and spiritual wellness and supported a holistic perspective among youth. Campers reported feeling more happy, cheerful, and energetic, with a decrease in feeling sad or miserable, and felt more comfortable expressing themselves. Lessons that they were glad to have learned included being physically active, to have respect for themselves, the importance of going on the land to Inuit culture and values, self-empowerment skills, and healthy relationships.

Six months after the program, one youth was reported saying, “I am smart”, and others reported feelings of confidence in their ability to complete tasks, like going to school on time, and were more aware of problems that they now had control over. They reported realizing that they were capable of helping others and offering advice.

Facilitators felt youth were more confident after attending Makimautiksat and that the land component was vital for skill building and for revitalizing the importance of stewardship for the land among youth. Parents also described that their children had more confidence.

After the conclusion of the funding we had received to develop Makimautiksat, we tried for two years to find more funding to sustain ongoing delivery and expansion. We submitted a number of proposals, to the territorial government in particular, and nothing came through, so the project stagnated. This year, we have received six months of funding from the Government of Nunavut, to train new facilitators and support the delivery of Makimautiksat as an after-school program, which will culminate in a land camp in the late winter and early spring. We continue to struggle to find opportunities for sustainability and scale-up.

Inuit societal values and pathways to wellness are key to moving forward. Rebuilding and strengthening the relational aspects of society, fostering the relationships between youth, their families, their communities, the land and the spirit world and the ancestors, will take time but is essential. We are thinking about the seven generations to come.

Seven people in my life have died by suicide. This issue affects all of us. I have young children, and when I look at them I think it's unacceptable that our children should have to grieve the way we grieve for the loss of our peers, our loved ones, and our fellow community members. Our generation must do something about this. It's imperative that we act. I believe we know many of the pathways forward, and what we need are sustained support, leadership, and opportunities to act on them.

Thank you for your time. That's the end of my statement.

● (1650)

The Chair: Thank you very much for that, Dr. Healey; we very much appreciate it.

We're going to move right on to the next statements and then we'll come back and do questions all at once, so I hope you're able to stay on the line with us.

The next witness is Jakob Gearheard, the executive director of Ilisaqsivik.

Please have the floor for 10 minutes.

Mr. Jakob Gearheard (Executive Director, Ilisaqsivik Society): Ladies and gentlemen of the committee, on behalf of Ilisaqsivik's board of directors and staff, thank you for this invitation to appear before you today for this important discussion. My name is Jakob Gearheard, and I'm executive director of Ilisaqsivik Society.

Ilisaqsivik was established in 1997 by community members in Clyde River, a community of about a thousand people on the northeast coast of Baffin island. Ilisaqsivik was founded because the community was not happy with the existing mental health and social services and other wellness-related programs that were provided by the government. These services were not culturally relevant, they were not provided in Inuktitut, and they did not reflect Inuit values. In many instances throughout Nunavut this is still the case today.

Ilisaqsivik is a true grassroots, community-based Inuit organization. It is a Canadian registered charity and a Nunavut registered society. At Ilisaqsivik our mission is to encourage and support community wellness by providing safe spaces, resources, and programming that empower families and individuals to find healing and develop their strengths.

Ilisaqsivik was started by just a few people, but it has grown until today and strengthened over the years. Today we are the largest employer in our community, with more than 50 people in part-time and full-time positions. We are also the first employer for many community members. We offer employment training in many types of job skills.

In addition to our wellness centre, we operate the Ittaq heritage and research centre, which also houses a digital media centre. Last year we opened a hotel whose profits go to support Ilisaqsivik, one of the few examples of social entrepreneurship in Nunavut.

This last point is important, and I want to highlight it here. Ilisaqsivik has branched into social entrepreneurship because it needs to find ways to mitigate a serious funding struggle. Despite winning national awards for our work—including from the prime minister of Canada—and being held as a positive example of quality care closer to home by different government and Inuit organizations, nobody has stepped up to ensure our financial security. We survive project to project and year to year. We are always at risk of not securing the resources we need. So, while I tell you about the successes of our organization over the next few minutes—successes thanks to the dedication and hard work of our board and our staff and our community—you must understand that our funding security is a critical issue. We are constantly addressing an ongoing risk to our existence.

To fulfill our mission of supporting community wellness, we provide a wide range of programs. Last year we offered more than 80 programs. Our programs support all of our community members from pregnant women to children, teens, families, and elders. We provide programs related to education, culture, language, nutrition, land skills, health, wellness, and more. I cannot mention all of our programs as it would take too much time. But just to give you a few examples, we offer pre-school parents and tots, prenatal nutrition, land-based healing, cultural and hunting programs, youth drop-in, parenting programs, diabetes prevention, Inuktitut literacy, etc.

Land-based programs are the most important and successful programs we offer. We offer a variety of land-based programs including elder-youth camps and hunter training programs for youth. Local youth regularly have the opportunity to learn to hunt, fish, and practise on-the-land skills through our programming. They share their catch with the community. These programs contribute to food security by providing fresh meat to households and also passing knowledge and experience on to the next generation of hunters. Just last month, we held a three-week-long summer land program whereby more than 50 community members camped on the land and participated in facilitated cultural and healing activities. Our land programs are held in all seasons, for all ages, and everyone is welcome.

There is one other key area of Ilisaqsivik's services that I would like to highlight for you today, and it is our counselling services. One of our key achievements is providing culturally relevant counselling and counsellor training grounded in Inuit values and knowledge and provided in Inuktitut, for Inuit and by Inuit.

● (1655)

All across Nunavut, Inuit struggle to access appropriate mental health counselling and social services. In most cases the mental health services available to Inuit are from fly-in, southern-based counsellors and social workers who have minimal to no knowledge and experience with Inuit culture, do not speak Inuktitut, and do not understand the historical and cultural context of where they are working.

Inuit have always had counsellors who were recognized as trusted and respected people who had life experience, to whom others could talk when they needed to talk. These recognized people are in all of our communities. At Ilisaqsivik we decided that we needed to organize and empower these community-based counsellors. Our local counsellors wanted more training, but there were no training programs available to them. All available training was in English, based on southern-style counselling and based on southern approaches and values, so we built our own counsellors' training and mentorship program at Ilisaqsivik called Our Life's Journey.

The program started in 2007, and since then we have grown tremendously in our counsellor training. We offer a one-year program that has five modules to be completed. The program offers counselling and addictions training to people working in the health and social service fields in Inuit communities. The training is based on Inuit knowledge and values combined with useful approaches from many other sources, and it is delivered in Inuktitut. Training Inuit is our priority, but we also make exceptions for other front-line non-Inuit workers. We are inclusive. We want to collaborate with our mental health professionals, but we only provide training in Inuktitut and in the Inuit way.

Since 2007 over 110 people have participated in our training. The age of participants has ranged from 20 to 83 years old. To date, we have had participants from all 13 Qikiqtani communities, and also from several communities in the Kivalliq and Kitikmeot regions. In 2016 our counsellor training program became accredited by the Indigenous Certification Board of Canada, and as of now we have 38 graduates who have completed our full program.

The result of our counsellor training program is a network of professional counsellors with specialized Inuit-appropriate training available to clients in Inuktitut. Ilisaqsivik counsellors know the language. They know the culture and they know what clients need.

At Ilisaqsivik, as part of this program, we have a mobile trauma team. In the past, if there were a traumatic event in a community, southern-based workers would be flown in. Now communities are calling Ilisaqsivik to send assistance. We are responding with trained counsellors across Baffin. We can quickly send people to communities and to families to help in their own language, counsellors who understand the context, the culture, and the people they're helping. Based on our experience, we feel strongly that there should be mandatory training for any caregiver working in Nunavut, training that educates them about Inuit culture and history, but that is only the beginning.

The Government of Nunavut should hire more graduates from the Inuit counsellors and mentorship program and put these people in positions to help Inuit communities and families. They should also invest in programs like this to train more Inuit counsellors and caregivers and provide more culturally relevant services.

We are proud of our work at Ilisaqsivik and we wish more communities could have centres like Ilisaqsivik. In Nunavut, Ilisaqsivik is very unique. It is run by Inuit for Inuit and it is truly community based. We are exceptionally strong even though we struggle with funding and recognition for Inuit ways.

I am grateful for the opportunity to share experiences with this committee and truly believe that the only way to build stronger, more resilient, and healthier communities is by all of us working together, listening to and respecting one another.

Thank you.

● (1700)

The Chair: Thanks so much, Jakob. It is much appreciated.

We are pleased to welcome now Dr. Margo Greenwood from the National Collaborating Centre for Aboriginal Health.

You have 10 minutes, please.

Dr. Margo Greenwood (Academic Leader, National Collaborating Centre for Aboriginal Health): Good afternoon. I'd like to begin by thanking the organizers and the committee for inviting me. It's a real privilege to be here. As you can probably tell, it's the first time I've been here, so I'll do my best.

I actually prepared some slides for you but then quickly realized that you don't have those here. I'm going to do my best to talk from them. If I sound a little disconnected, please forgive me.

I'm a Cree, from Treaty 6 area, in central Alberta, but I've lived most of my life in northern British Columbia, in Prince George. That's where the National Collaborating Centre for Aboriginal Health is located, at the University of Northern British Columbia, in Prince George. Most of my adult life has been in the north. My children were born and raised in the north, not the far north as Jake and Gwen talked about it, but in the northern part of the province.

The National Collaborating Centre is a knowledge translation centre. I've prepared for you today five slides that contain key elements or points taken from the literature. Mike, Rod, Jake, and Gwen have already spoken to a number of the points I have, so I'm affirming them as I present this to you.

I'd like to start by really looking at the principles of some of the best practices that we're hearing about. What underlying elements are common to them? I have heard many of them already.

One of the first ones we think and talk about is that any practice, program, or policy needs to be anchored in indigenous knowledge and the right to self-determination. I heard people talking about self-governance, but self-determination is not the same as self-governance. I think that's an important distinction. I think one leads to the other. It's really important that we have the right to determine our own health and well-being and the right to determine our children's health and well-being in this country.

Another element with regard to practice or policy is that they are rooted in the land, in their indigenous cultures, in their languages, in their values, and in their beliefs. We've heard examples of that already today.

There is the concept of holism. We talk a lot about that. That is a concept anchored in, I dare say, indigenous spirituality. It's very deeply rooted in the understanding—as it is in other cultures as well—of the interconnectedness of all beings and the understanding that we are connected to the land. I think that's really important. We often hear about holism especially when we're talking about children's development. We often hear about the developmental domains: the physical, the social, emotional, cognitive, spiritual, and cultural. We also talk about these within the context of family and community. These don't happen independently; they're interrelated and they are situated within the context of family and community. I'm going to talk more about that a little bit later.

I have heard lots of the presenters talk about programs and practices that are locally initiated, owned, and accountable. I think that's a really important word—accountability. I don't mean accountability just to funders, but accountability to the people we serve, to ourselves, and to our communities. I think those are really important concepts in that they are determined by community. What that looks like is determined by them.

Many of these best practices are seen to be population-based. We're not just talking about individuals. I think I've made that point.

● (1705)

The other point that came out in the literature is strengths based. I think that's really important, in any issue.

How do we build on the existing strengths that we have? We have strengths that we probably haven't even tapped into yet. How do we bring those together?

This is—

The Chair: Dr. Greenwood, I just want to check in with you and let you know that we're at just over half the time. I'm getting some signals from you that you maybe have more to get through.

Dr. Margo Greenwood: I'll get going, because I can talk on and on.

These are probably some really important points, but I think strengths based is a really important piece. When we're talking about cultures and about knowledge, we're talking about different systems of knowledge. How do we draw from those systems, in partnerships, in collaborations, to realize the kinds of things we need to do to move forward together to address a lot of these social challenges that we're facing?

The literature also talks about protective factors, ensuring individual identity and personal skills, engagement of youth in the strategies that are being developed for them or with them—it should be with them—and really thinking about intersectoral collaborations, so that it doesn't just sit in health or in education, that there are multiple players here. There needs to be intersectoral solutions.

I'm going to skip some, because I probably have three minutes left now.

I'm going to talk about my last slide. I have a number of others in here. One I will say is on some of the protective factors. I think Rod and Mike mentioned about the seminal work of Chandler and Lalonde. They looked at communities that were more self-determining, and that indeed those communities had insignificant, if any, rates of youth suicide. That's a seminal piece of work in this country, in my opinion, and there are many others.

I want to go right to my last slide. I wish you could see it. It's a graphic. You'll maybe be able to see it in your mind. In the centre, there are nested circles. In the centre, we have “Restoring and Revitalizing Individuals and Families”, so that there's the healing. All of the programs we heard about are absolutely essential to the healing of individuals and families. Those constitute the community.

Sitting within that, though.... That circle is nested within systems and structures. Those systems and structures need to be enabling those direct services to individuals and families. They need to be enabling those to happen. If we have a lack of funding, or we have a policy that won't allow certain things, then we're not enabling those good practices that the community will develop. I think that's really important.

I see those as the enablers of all of this. Being in a lot of these discussions, I don't hear us talk about that. It's hard. It's not easy to make those changes. However, if we're going to see these practices at the community level—and we've heard about sustainability and all of that—we need to be looking at and moving simultaneously, at multiple levels, to ensure that what's happening at that one-on-one level will be successful.

I'm going to stop there. I made it through two slides.

Thank you very much.

● (1710)

The Chair: Thank you very much for that.

I will let you know that we do have one or two copies of your slides here, and your notes. We will duplicate them and distribute them to the committee.

Dr. Margo Greenwood: There's a larger document that goes with that.

The Chair: We have that as well. We'll distribute both.

Thank you, Gwen, Jakob, and Margo.

Jakob, I want to mention that we had hoped to see you in Iqaluit two weeks ago at our public hearing, but understand that the flights didn't allow it. We're very grateful that you were able to fly in today.

Mr. Jakob Gearheard: Thank you.

It would have been even better because then it wouldn't have been me; it would have been our chair and one of our councillors.

Sorry, I apologize that it had to be me this time.

The Chair: That's okay. We're happy to have you. I can tell you, just about every other guest that we had at our panel mentioned your work, so it's great to have you.

Thank you all.

We're going to move right into questions. We have time for a few questions. They're for seven minutes.

The first question is from Don Rusnak, please.

Mr. Don Rusnak: Thank you for your presentation. We probably do have the technology to get it up on the board, but we didn't today. I apologize for that.

We're hearing over and over again of the problem with funds to do the work, the great work, I'm hearing, that you guys are doing in the community. I'll ask you a question that comes from the analysts, because it was exactly what I was thinking in terms of testimony that was heard at the public hearing in Iqaluit. A witness noted that the federal program funding criteria were too narrow for some Inuit-specific initiatives. When program funding did arrive, partway through the fiscal year, it left only 20 weeks to deliver the program. A representative from Leave Out Violence Nova Scotia stated that she does not apply for federal funding, as the funding arrives too late in the year and only provides very short-term funding. To my understanding, they can do very little with it. They'll either have to return it or, in this case, she doesn't apply for it. It was recommended that funding be extended for multi-year initiatives.

First, how responsive have federal program criteria been to your community-based initiatives, right now and in the past, and what would be your recommendation for the future?

Mr. Jakob Gearheard: I would start by saying that, first of all, the federal government doesn't need to own the short-term funding problem. It's across the board. It's with all funders, or a lot of the funders—territorial funders, even non-governmental funders. There's this tendency to fund short term.

Funders always want to fund the new project, something that's never been done before. They often don't want to fund this ongoing project that we've been doing for 10 years and works. They want to fund a new part of that. That's another part of that problem.

We love federal funding. We apply for it all the time. We receive federal funding. We're funded right now by Health Canada. We're one of the Indian residential school programs. We represent Baffin Island for that program. That funding partially funds the counsellor training program that I'm talking about. It's awesome. I wish it were for more than one year at a time. We have to apply for it every year. Every year they say they don't know if we'll get it next year: maybe we'll get it next year. They'll tell us later if we're going to get it once we get the application in.

It makes my job really difficult. Instead of figuring out how we're going to make our program better, I'm scrambling around trying to figure out if we'll be funded next year. Our counsellors also have a really difficult time. They're asking me all time if they're working here next year or if they need to start looking for another job. It makes it so.... But I won't go down that rabbit hole.

In terms of the criteria being too narrow, I can't think of a specific example of when that stopped us. I think we may have a higher capacity in our organization to write proposals, so I would only be able to speak for our organization on that. I think sometimes it might be too narrow. Sometimes it might be too bureaucratic to get through that. Sometimes we have to hire consultants to help us walk through the application process.

● (1715)

Mr. Don Rusnak: Gwen, in terms of funding coming from funders, can you identify any problem for us so that hopefully at the federal level we can make a recommendation to government to fix that? As well, are there positives that you see? I don't know if you heard the previous presentation from the other two gentlemen who were talking about the Aboriginal Healing Foundation. Would an organization like that, with perhaps not as rigorous funding models or categories, be beneficial to organizations like yours?

Dr. Gwen Healey: Our organization has the same challenge as Ilisaqsivik. We are also only project-based funded. We don't have core funding, although we try continuously to find it. We also rely on proposal driven funding. We also love federal funding. We've been fortunate in being able to apply for it and to receive multi-year funding through the Public Health Agency, but it's usually through a research or innovation focused initiative.

Makimautiksat is a good example of this where we received a five-year grant to develop, pilot, and implement the program. Unfortunately, when we finished that, and we had this wonderful program, it was impossible to try and find the funding to fund the program delivery now that the innovation part has been concluded. That part has been a challenge, as well as trying to navigate the different streams of funding through Health Canada and the Public Health Agency. We were shimmied between different departments, and then it ended up just being no one's responsibility to help us find the right pathway. That was a challenge at our end.

When we do get that multi-year funding, then it's perfect, and it's great, and it works well in being able to work with the different departments. All of that is very smooth. We do appreciate that.

When it comes to the question of narrow criteria, I don't think I can comment on that. In my experience, the criteria have been broad enough to capture a wide variety of proposals, and in our experience we haven't had that problem necessarily.

● (1720)

The Chair: Thanks, Dr. Healey, we're just out of time there.

Dr. Gwen Healey: Thanks, okay.

The Chair: The next question—and we only have time for two more questions I'm afraid—is from David Yurdiga.

Mr. David Yurdiga (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair, and I'd like to thank Dr. Healey, Jakob, and Margo for joining us here today. Your input is very valuable, and it will be an important part of our report.

One of the concerns we heard in our committee trip to northern Quebec and Nunavut was the cost and turnover of mental health professionals. What challenges do the youth experience with this constant turnover? I'd like to hear from all the witnesses, if possible.

Mr. Jakob Gearheard: I'll start.

It's a huge challenge. Somebody comes into the community, and it takes them.... They might come in on a contract that's six weeks long, or they might come in on a contract that's two weeks long. They fly in. They spend most of their time trying to figure out where they are. Flying into a community on Baffin Island is not like driving down the road. It's really different. There are all kinds of trauma you're going to see and hear about because you're in a small community. There is a lot of trauma. We have mental health workers who leave. They fly in, they get traumatized, and they leave.

If you're a client—and this happens all the time—people will come over to our office and they'll complain about the mental health worker who just flew in. They'll say things like, “I went in there and I had to spend the first 30 minutes explaining to them Inuit history, and about residential schools, and what is the dog slaughter, and how all this stuff is impacted. I even had to tell him why it's super expensive to live up here. I couldn't speak Inuktitut to him, and the mental health worker wanted to bring in a translator, or he is related to me, or he's my ex-boyfriend.”

It's a small community. There are 1,000 people. If you're a fly-in mental health worker it's tough, and it's not fair for the clients. I would go as far as to say that it's not ethical for a mental health worker to fly in and pretend they're counselling when they don't speak the language, or when they are not sure of the capacity of their interpreter, or how the interpreter is even related to the situation they're talking about. They don't know enough about the community to know the basic history.

I've had clients say they felt like they should have been paid to provide the mental health worker with an orientation to the north, and they didn't feel like they got anything out of it.

Then what happens is that the mental health worker leaves. They're there for six weeks, and you finally you get to trust them and you're working on a plan. Maybe you're going to go for residential treatment somewhere or something, and then someone else comes in and you start all over.

The Chair: Gwen.

Dr. Gwen Healey: I was just going to add that I agree completely with what Jake said. It's unethical to consider four- to six-week contract counsellors as providing a service, because they aren't, and they're coming in without any orientation. That is a significant challenge in the system as it currently exists.

The other piece I would add is that it's also at the management level; it's not just on the front line. It's also higher up in the department or in the division. The entire complement of the mental health unit here in Iqaluit changed over in the last six months, and they're all new people, so it's just this constant rebuilding of connections and relationships and explaining what's happening. It's a challenge for sure.

Dr. Margo Greenwood: I can just add a very small anecdote from northern British Columbia. We don't live in the far north, but we certainly have challenges with turnover.

I totally agree with what Jake and Gwen have said about the challenge of practitioners coming in who don't know the context of what they're stepping into. One of the things we've done is we have small groups of communities across the upper two-thirds of British Columbia. They're almost like in traditional groupings. We engage with them, as the Northern Health authority. I also work with them. One of the questions we ask them as we prepare for these folks coming into community is, “If I was a new health practitioner coming to your community, what would you want me to know?”

Northern Health has supported them in developing resources, and we have all kinds of resources now: DVDs, elders speaking, and all kinds of teaching materials to start to mitigate some of that in-and-out stuff and give them some background before they actually get there.

● (1725)

Mr. David Yurdiga: Thank you.

What types of resources do we require to ensure that we have a longer-term solution? We're looking at two, three, six weeks, and it's not working. So what can we do to get someone to commit to the community for a longer period than six months? Is there anything that could be done, or is this a reality we have to deal with?

The Chair: Briefly, if you can. We have just one minute remaining, I'm afraid.

Mr. Jakob Gearheard: First, support counsellor training programs, like the one I described that we're running that will train community members to be counsellors. Then you don't have to worry about flying anyone in and out.

Second, if we are flying people in, and there are reasons to fly people in, connect them to local counsellors and be colleagues. Be equal, be peers, don't treat them like “I have a Ph.D. and whatever, therefore I'm on a higher level”. No, everyone is a counsellor and needs to work together. That way, if that counsellor comes and leaves, the one who is a fly-in, fly-out, there are still people in the community who have a relationship with that person who is flying in and out, and they can continue to work with clients.

Mr. David Yurdiga: Thank you.

The Chair: We're out of time there.

The final question is from Charlie Angus, please.

Mr. Charlie Angus: This has been absolutely fascinating. I'm not going to repeat the questions that have really laid out what it's like on the ground. We've heard it very clearly.

Ms. Greenwood, I was really struck by your comments about the effects where you have communities that are self-determining. The very first time I flew into Kashechewan, a woman came up to me and asked, “How would you like to raise your child in a prisoner of war camp?” I looked around, and suddenly I saw it in a different light.

I mention that because Allan Teramura, the president of the Royal Architectural Institute of Canada, called me. He wanted to come to Kashechewan because his mother was raised in a Japanese prisoner of war camp. She had seen a picture of Kashechewan and said, “That's where I grew up”.

We toured Kashechewan, and what he pointed out as an architecture specialist was that there was absolutely nothing in the community that allows the community to make its own decisions. This is a holding camp that was designed as a holding camp. When they signed Treaty 9, they put everybody in holding camps. Everything, from the architecture, to the community layout, to the decisions, and to the education, is decided by bureaucrats in Ottawa. Businesses that try to get off the ground are decided by bureaucrats in Ottawa.

So you have communities that have no ability for the leaders and adults to take control. It's all on the whim of someone, at someone's desk someplace. That sense of hopelessness is something we don't often think about.

Then you add the trauma of the residential schools, the trauma of the poverty, and the black mould in the houses, but there's the overall psychological damage of treating these communities as though they're holding camps.

I would like to ask what you meant in terms of the idea of communities having good health outcomes and the ability to be self-determining.

Dr. Margo Greenwood: When I think about that, I think about that from multiple levels. I think there are some things that happen at the individual level. I think there are things that happen at the community level.

I can't help thinking about an article in *Maclean's* on September 18 that talked about Bella Bella, youth suicide in Bella Bella. The fellow's name was Jorgensen and he came from Ontario and he went to Bella Bella, which is a northern community in British Columbia. He went there to try to try to make sure that students were going to school, young people were going to school, but it turned into much more than that. It turned into the young people going with him out on the land, having a reconnection to the land and the identity, and then it started to spread to the families. Then it started to spread to economic development. It's a really great article if you can get it. It's online too.

I see hope there. I see that it didn't take a huge big piece, but it took someone to recognize a small piece and grow it. And when I read stories like that, I'm hopeful.

One of the other things that we've put a lot of energy into is the arts. Sometimes when you look at architecture and sometimes when words don't convey what needs to be said, the arts do. I've seen a number of programs around youth suicide and child development that focus on the land but they also focus on the arts. How do you transform your reality? It may be local artists who do that, who take some of those dismal scenes and change them. I think it's things like that, and supporting the kinds of programs that Jake has been talking about. I think that's what gives us hope, and you're right, we can fall into a pit where there is no hope, and that is the question. How do we get it back? How do we find the pathways out of that?

I don't think there's a singular path, but I think I would believe in the community because there was health there and there will be health again. And that's what I mean by strengths and finding those strengths, and the avenues that are innovative are not just government-funded programs, because the community will know that. Then they'll use those pieces to build, and I think it's incumbent on us to put the structures and the systems in place that enable that kind of revitalization.

● (1730)

Mr. Charlie Angus: Thank you.

The Chair: That brings us to the end then of the meeting today. I want to thank Gwen, and Jakob, and Margo, and all the witnesses in fact who preceded you as well, for the thoughtfulness and richness of your remarks. That's going to be a great help to our path forward here.

Thank you so much.

Dr. Margo Greenwood: Thank you.

The Chair: I have a motion to adjourn.

We're adjourned. Thank you.