HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Indigenous and Northern Affairs

INAN • NUMBER 028 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Monday, October 17, 2016

Chair

Mr. Andy Fillmore

Standing Committee on Indigenous and Northern Affairs

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● (1530)

[*English*]

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

This is the Standing Committee on Indigenous and Northern Affairs. We're continuing our study of suicide among indigenous peoples and communities.

We're meeting today on the historical land of the Algonquin people, for which we're very grateful.

We have two panels today. The first is the First Nations Health Managers Association, who are seated with us in the room, and the second is the Canadian Indigenous Nurses Association, who are joining us by teleconference.

We're happy to have you all here.

The way this works is that each organization has 10 minutes to present. I see in both cases we have two people from each organization. You can share that 10 minutes between you any way that you see fit. When you get to around nine minutes, I'm going to hold up a yellow card. It means we're nearing the end. Then when you're out of time, I'll hold up the red card. I'd ask you to please finish up at that point, and then we'll move into questions from committee members.

With that explanation, I would welcome Marion Crowe, executive director of the First Nations Health Managers Association, to take the floor.

Ms. Marion Crowe (Executive Director, First Nations Health Managers Association): Thank you.

As mentioned, my name is Marion Crowe. I'm a Cree woman from the Piapot First Nation in Saskatchewan, and I'm here in the capacity of the founding executive director of the First Nations Health Managers Association.

With me, of course, is Mr. Calvin Morrisseau, board executive member and Ontario representative of the First Nations Health Managers Association. Mr. Morrisseau works as the executive director of the Fort Frances Tribal Area Health Services.

As you indicated, Chair, we are on Algonquin territory, and we would like to acknowledge that territory on which this hearing is being held today. We also want to send our condolences to the families who are impacted by and grieving due to the very reason we're here.

Our thanks to the Standing Committee on Indigenous and Northern Affairs for the invitation to speak and to provide our testimony related to life promotion strategies. It really is a responsibility we carry with humility and pride.

The First Nations Health Managers Association, which I will refer to as FNHMA, was founded in September 2010. We're a national professional organization providing certification and professional development opportunities to health managers and directors who work in and with first nation communities from across Canada.

We have over 300 members and a network of approximately 1,200 first nation health leaders, representing grassroots health professionals who administer, advocate, and in some instances are clinicians practising health services in our communities. There are over 100 certified first nation health managers across Canada designated by our organization. We are a certification program that is built on core competencies that were created and led by grassroots health leaders.

Right now we're the only organization in Canada that has a curriculum built around relevant health services and practices, and a governance that is actually reflected in our communities and incorporates and respects culture as part of our competencies. This makes us unique as we celebrate and share our inherent knowledge while balancing and maintaining management principles.

We have brought with us today evidence that speaks to our subject matter expertise in first nation health service delivery, and it will be distributed. It's the textbook written by FNHMA, largely authored by our certified members from across Canada.

We are uniquely positioned to share the experiences of grassroots health managers on the ground in our communities. The issue that has brought us here today is suicide prevention. We usually don't speak from a deficit position, so we'll refer to it as life celebration, please. We bring forward four recommendations for consideration as a really small part of the larger strategy required to make inroads into this issue.

Before we get into our proposed solutions, in reviewing previous witness testimony, we know you have had 42 witnesses prior to us, and we feel obligated to note that Thunderbird Partnership Foundation is absent from the witness testimony. Thunderbird Partnership Foundation is an FNHMA partner, and they are committed to working with first nations and Inuit to further the capacity in communities to address substance abuse and addictions. We would implore the committee to consider their participation in this very important work.

As regards the very first recommendation we bring to the committee, we already know from previous testimony, research, and academic studies that we are facing an issue that is pervasive in our communities. We are specifically speaking to the testimony that has already been provided on the first nations mental wellness continuum framework. It identifies a continuum of services needed to promote mental wellness and provides advice on policy and program changes that will enhance first nation mental wellness outcomes. This framework enables us to adapt, optimize, and realign mental health wellness programs and services based on our own priorities.

The framework includes a number of elements that support the health system, including governance, research, workforce development, change and risk management, self-determination, and performance measurement. Health services integration among federal, provincial, and territorial programs is critical to its success. Discussing how to implement the framework in our communities is really important to us as an organization and it will be a highlight at our national annual conference this year. Our delegates are at the forefront of life celebration, and suicide prevention will be a very valuable resource when discussing the implementation of this framework.

● (1535)

We also refer to previous testimony that cites the urgent need to implement the Truth and Reconciliation Commission of Canada's 94 calls to action in order to redress the legacy of residential schools and advance the process of Canadian reconciliation, but you have heard that already.

Our second recommendation that we bring increases the efforts in certification and accreditation in our communities. These are key elements to FNHMA. We see in health services accreditation recommendations all the time around governance and capital. Investments need to be made in our communities on capital assets to even be able to reach health services accreditation, investments such as the repairing of our existing facilities, and also the creation of new treatment and quality health centres. Having certified health managers in our communities will contribute to increasing accreditation goals made by this very government, Health Canada's first nations and Inuit health branch.

Our third recommendation is around strengthening the existing networks that are already in place, such as FNHMA and the Canadian Indigenous Nurses Association, who are also here to testify today, and the other national indigenous organizations that are leading capacity building in our communities. We have to reinvest in them and redress the cuts that were made in 2011. This will increase the supports to our health professionals who are on the ground, who are leading, advocating, and creating partnerships to implement the health services integration in our communities that's required. Our existing national indigenous organizations require equitable support to continue the journey of capacity building.

● (1540)

Mr. Calvin Morrisseau (Board of Directors, Executive and Ontario Representative, First Nations Health Managers Association): Thank you, Marion.

Our fourth recommendation is investing in the capacity of our front-line workers to further contribute to strengthening our health service delivery. This transfer of health services to first nation control, as demonstrated in the B.C. tripartite agreement, is pivotal in enabling communities to decide where to invest their own health resources and self-determine.

I wish to note here that one of the four pillars in the creation of the tripartite agreement was solely focused around health directors, underpinning the importance of their role in delivering health services. This, in conjunction with having a certified workforce place, will contribute to achieving these solutions.

In addition to these potential four solutions, we can take a small step in moving forward with having meaningful foundations that contribute to indigenous life promotions and quality health systems.

Ms. Marion Crowe: A very specific example that we wanted to bring to the committee around this is demonstrated in the 2015 budget where the Government of Canada renewed the aboriginal health human resources initiative, AHHRI, but with a reduced ongoing budget of $4.5 million nationally. The renewed AHHRI funds are intended to support capacity building and to increase the number of aboriginal people entering into health careers.

This program is delivered through two streams. One is scholarships and bursaries that are provided to aboriginal students pursuing health careers, such as nurses and doctors, but these aren't the folks who are necessarily going back into our communities. The other stream is training and certification for community-based workers, including first nation health director or health manager positions. While this current investment is being made, the second stream is the only existing program for our community-based workers who are on the ground to apply to.

Three million dollars of the $4.5 million goes to scholarships and bursaries, a vehicle through Indspire, and the remaining $1.5 million nationally is split among the Health Canada first nations and Inuit health regional offices. This amount is insufficient to meet the current professional development and certification needs in our community.

A specific component of the mental wellness continuum framework underpins the need for capacity and that will play a key role in ensuring the continuum of mental wellness programs and services that are relevant, effective, and meet our community needs.

Mr. Calvin Morrisseau: We are well positioned to establish being leaders in the first nations health service and professional development. The First Nations Health Managers Association is an organization that has an existing knowledge circle that collects, promotes, and shares meeting practices to assist in strengthening the capacity of our members at a local level.

We are committed to being a part of the solution, and we can be a valuable partner in strategies moving forward. We are the credentials made for and by first nations. Our members are front-line workers and subject matter experts in first nations health service delivery.

We give you heartfelt thanks for your time today, and it's been an honour and a privilege to be called upon to be witness to this discussion, because it really impacts the current and future lives of our nation.

The Chair: Thank you very much, Ms. Crowe and Mr. Morrisseau, for your presentations. They are very much appreciated.

Ms. Marion Crowe: *Hai, hai, merci.*

The Chair: We'll move right into the presentation from the Canadian Indigenous Nurses Association. From that organization, we have Dr. Lisa Bourque Bearskin, president, and Lindsay Jones, who is an indigenous nursing student.

Welcome to you both. I'm happy to give the floor to you for 10 minutes to share between yourselves either way.

Dr. Lisa Bourque Bearskin (President, Canadian Indigenous Nurses Association): Thank you very much. *Tansi*. Hello. *Bonjour.*

[*Witness speaks in Cree*]

I want to thank the chair and the committee for this invitation to present on behalf of the Canadian Indigenous Nurses Association and to support the families who have lost loved ones.

I'd like to begin by honouring the traditional territory of the Algonquin people, as you've mentioned.

I am from Beaver Lake Cree Nation in Treaty 6 in northern Alberta, and as you mentioned, I am the president of the Canadian Indigenous Nurses Association. I have worked in health care service delivery my entire life, as a nurse. I am now an associate professor at the school of nursing at Thompson Rivers University. Today I have Lindsay Jones with me. She is one of our CINA nursing members and a student here at Thompson Rivers who is studying community health within indigenous communities.

Beyond the symbolic ritual of place, this acknowledgement signals the urgent challenges we face in the era of reconciliation. The struggle for human rights and equitable health care for our indigenous children and youth is a collective and vitally important undertaking, so I come to you today as a survivor. I am reminded of what our elders and traditional knowledge holders continue to tell us. As we continue to reflect on our own philosophy, the spirit of wellness and the struggle for self-determination, we have to know who we are and where we come from, while walking in the footsteps of those who have moved on to the spirit world at the same time of creating footprints for those who come after them.

It is clear that the health of indigenous youth is intimately related to the history of colonization and residential schools, removal of the child from their home and their culture. We know the statistics are grim and that one of the most difficult things to face in life is the reality that somebody close to you has committed suicide. This harsh aspect of life is all too real for first nations, Inuit and Métis families. What we know is that indigenous youth suicide is the most significant public health issue facing our societies.

Our brief presentation today will address how the Canadian Indigenous Nurses Association, CINA, can contribute to addressing the crisis by offering three recommendations for the committee's consideration. These recommendations address the sustainable funding, about which you've heard extensively, to improve access to high-quality culturally responsive and integrated health service delivery by increasing the number of indigenous nurses working with individuals across lifespans, across the nation, and across our northern communities, specifically where the elevated risk of suicide is at alarming levels.

You've heard about the productive factors. You've heard about the risks. We stand united in support of our other indigenous-led organizations and researchers who have undertaken extensive inquiries into this topic.

Our first recommendation is to advocate for sustainable funding for CINA as a national leader on behalf of our front-line nurses and the communities they serve. Firmly rooted in this recommendation is the belief that the Canadian Indigenous Nurses Association can significantly contribute to the overall wellness of our indigenous youth by supporting and fostering the human potential, in creating community capacity to deal with the issues at the local level with front-line workers.

Most do not realize that CINA is the longest standing professional indigenous health organization in the history of Canada. It is a non-profit voluntarily run organization that is governed by 12 indigenous nurses whose vision is to be recognized as a bio-expert advancing the health of indigenous communities, with an end view to improving first nations Inuit, Métis peoples health and well-being.

Our organization began as a political support to Monique Bégin when she started to take this on back in the early 1970s. CINA members are the doorway to the indigenous communities and delivers its core strength from its membership base.

Currently there are approximately 9,000 indigenous nurses in Canada, which represents a huge untapped and underestimated resource. CINA holds real potential to expand its work as nurse members.

Our CINA nurses continue to bring their unique and diverse languages, understandings of culture and healing traditions to their practice. Their roles as stewards of indigenous nursing knowledge informs the ongoing development of local, regional, and national indigenous health policy and service programs around the country.

● (1545)

CINA believes that addressing youth suicide can be achieved by putting the health of its youth back into the trusted hands of its families, communities, nations and nurses. This includes indigenous leadership by promoting the development of practice of indigenous health nursing that is grounded in indigenous knowledge and the expertise that our members hold.

In advancing our mission, CINA engages in activities related to recruitment, retention, member support, and consultation. For the past five decades, CINA has traversed this ever-changing environment.

What we are experiencing is an urgent call for action on reconciliation, decolonization, and incorporation of traditional approaches to health and wellness. We need to apply the metaphor "culture is medicine".

Unlike any other national aboriginal organization, CINA receives no core funding. Equity funding is an important discussion that has not been explored fully to date. We support Dr. Cindy Blackstock's human rights fight for equity funding for indigenous children. It is currently needed, and we stand strongly beside her.

The greatest potential that CINA has is its ability to deliver primary health care by investing and supporting nurses who work in each of the 655 different communities across the country. What we do know from the Auditor General's report is that one in 45 nurses is adequately trained to work in these northern communities.

As a result of growing requests, we have been working on a collaborative indigenous partnership framework, which I can discuss later, but it really establishes how we are better prepared and situated to work with non-indigenous communities and partners.

Our second recommendation is to support the implementation, as you've heard about...the mental health framework stemmed from the collaborative work together. CINA was a major contributor to that work, and we stand by that report. It really addresses the six continuums of care: community development, early identification, secondary risk, active treatment, specialized treatment, and facilitation of care. That is where nursing is often underestimated. We have the skills, the abilities, and the capabilities to foster that.

Our third recommendation is to support the reorientation of health services to focus on health care closer to home, health care that supports capacity building and health, economic, and environmental sustainability by giving children and youth the skills and capabilities to cope with the impact of intergenerational trauma from dislocation and displacement from their families, so they are much better able to handle that systemic violence that continues to impact the health and well-being of our communities. There is ample evidence to show the point that systemic issues continue to contribute to these inequities.

CINA has been able to develop some much-needed training. We propose that the federal investment in indigenous health and education be used to support the new health accord, which calls for the reorientation of health services. This training can help reduce racism and discrimination, which is found to have a significant impact on people's health. A study with which I am closely involved is examining rural access to health care. It has revealed that people living in these rural settings are even further marginalized by bias-informed care.

With the evidence, it is clear that we need to put in a whole-of-government approach that supports the people and puts the power back in their hands, and while there are new and promising partnership models, such as the First Nations Health Authority here in British Columbia, there is a lot to be done for a comprehensive, holistic approach as services continue to be siloed.

Now I'd like to give Lindsay an opportunity to discuss health care closer to home.

● (1550)

Ms. Lindsay Jones (Indigenous Nursing Student, Canadian Indigenous Nurses Association): Hi. I'm Lindsay Jones. I'm Nlaka'pamux from Kamloops, B.C. I'm a fourth-year nursing student attending TRU. I'm also a member of CINA.

I have three recommendations in response to the suicide epidemic among indigenous people in our communities.

Nursing understands that when working with such a marginalized and vulnerable population, it is salient to work on professional development with regard to building capacities within the communities. Nursing is more than psychomotor skills. It is a relational practice to work in culturally safe ways to build bridges to close the equity gaps.

Research shows that retaining highly trained and effective health care workers is important in providing quality, accessible health care to people living in rural areas. There also needs to be support systems in place for nurses providing care within these communities. Nurses know a community's strengths and how to build them, understanding that solutions come from within the community.

In the Truth and Reconciliation Commission of Canada, call to action number eight states:

> We call upon the federal government to eliminate the discrepancy in federal education funding for First Nations children being educated on reserves and those First Nations children being educated off reserves.

While the social determinants of the health movement has helped to shift some of the blame off the individuals to political and economic systems, the focus is still on what is under-provided in the community and how those deficiencies negatively affect children and families.

My last recommendation is to build on the idea of health care closer to home. As a foster parent, I believe that instead of removing children from their families and their culture, we as a country and as health care providers need to start fostering the families in the traditional, appropriate ways.

Research has found that adolescents may also be less at risk for suicide if they experience the neurophysiological benefits of connectedness, like believing in one of the values for care for and able to better regulate their emotions through social affiliation and attachment with caring adults.

Starting at the grassroots, nursing can support families to empower their children to build confidence and nurture their opinions so they have a voice and develop coping skills, fostering the families to provide an environment where children thrive, instead of removing these children instead of going from foster home to foster home, which only perpetuates the ongoing issue.

Thank you for this opportunity.

● (1555)

Dr. Lisa Bourque Bearskin: In summary, we want to advocate for nurses to be perfectly situated on the front lines to provide immediate intervention, to teach about protective factors that stem from our own limited experiences.

I want to leave two words with the committee, *kiyam ahkameyimo*, which means enough has been said and that we must never give up. These actions are about resiliency and the internal power we each have to eliminate these escalating crises we face as Canadians.

We look forward to taking any questions from you.

Thank you very much for this opportunity.

The Chair: Thank you so much for that. Thank you very much, Ms. Jones.

We're going to move right into questions now. We have until 4:40. I think you might be in a different time zone, so we have 45 minutes for questions and answers.

The first question is coming from Gary Anandasangaree, please.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): Thank you very much for your presentations this afternoon.

I'd like to pick up on the concept of health care closer to home. I know many of the challenges stem from the fact that there are very few health care providers in the communities. Earlier, you alluded to people who are studying in the health field are not going back to work in the communities. Often they're lured into the major centres because there may be better facilities and better conditions.

What do we need to do to make sure that we're able to get health care providers into the local communities, make sure that they're there for a longer period of time, and that they're part of the community, as opposed to those who are there on locums or who fly in and out for a shorter period of time?

The Chair: Who would like to take it?

Please go ahead, Doctor.

Dr. Lisa Bourque Bearskin: I think the evidence is very clear that when you're looking specifically at indigenous nurses who have been trained, you'll see the retention is higher for them to stay in their communities. Our indigenous nurses are staying and working within their own communities.

We need to create better support systems for them. Particularly in our rural and northern areas there is very limited support in terms of training. They can't leave the community to extend their training or professional development because they have no one to replace them. We need to build a pipeline or pathway to indigenous careers so that we're attracting students into health careers at grades 3 and 4. What I found out in a survey that I did with children is that by the time they're in grades 3 and 4, they're actually being deferred away from a health science background because the belief is that you're setting them up for success by encouraging them to go into education or social work. It creates this huge gap of interest for going into any kind of health career or health science programs. Even when you look at the education available to first nations kids on reserve, you see they don't even have an opportunity to have those courses at a higher level so that they are prepared to go right into a university.

I think it's very complex, but the evidence is really clear that if you support indigenous people to go into health careers at a very early age, they will stay, and they are staying in their communities providing a great service, but they are burning out at fast rates because of the lack of support for them.

● (1600)

Mr. Gary Anandasangaree: Doctor, in relation to nurses, I think you mentioned there are about 9,000 indigenous nurses. What is the ratio for doctors who are of indigenous background, and what do we need to do to increase those numbers in order that they, too, can contribute to the whole overall health care, particularly the concept of health care closer to home?

Dr. Lisa Bourque Bearskin: Yes, that's a really good question. I can't speak for the Indigenous Physicians Association as to what their numbers are, but I know nursing has definitely had growing numbers.

I know when the recruitment and retention strategies are out in the community, there is a focus on medical training. I'm often advocating that we need more support in terms of advocating for nurses training.

Right now that 9,000 is underestimated, but that number only represents the number of nurses working within our province. Those do not actually include numbers of nurses who are working in first nations communities, because that data came from the family survey which was off reserve, so that's a gross underestimate of that.

In terms of national standards, if you look at how many patients registered nurses are able to have first contact with as opposed to indigenous physicians.... I work a lot with communities and I hear all the time that they need doctors, and I say that actually, no, they don't need doctors. Yes, we need doctors, but nurses can really help support the whole focus of care. Not everybody needs to go to a doctor because of a temperature or some investigation. A registered nurse, adequately prepared, can actually streamline some of the priorities faster. We can get appropriate care faster to the people who need it most if you implement a nurse pathway program starting right from health careers, to LPNs, to registered nurses, to degrees in community health, and to nurse practitioners. Nurse practitioners are a really underutilized group of nurses who have amazing skills.

We have one in Maskwacis in Alberta, and I know there is one who splits her time between Paul Band and Alexander. They've actually shown that they've been able to reduce...and improve the efficiency and satisfaction with clients' heath care contacts.

Mr. Gary Anandasangaree: This question is for both of our guests today.

You mentioned the challenges with funding for these services. What are the specific challenges that you see with respect to increasing the pool of health care practitioners, including nurses and doctors?

Also, what other impediments do you see in terms of health care as a whole when people need a specialist or they need to go to a dentist, and so on? Maybe you could touch on that.

Ms. Marion Crowe: I'd like to address the question, Chair.

The Chair: Go ahead, Ms. Crowe.

Ms. Marion Crowe: Thank you, Chair, and thank you for the question.

The question is, from our perspective, how do we see supporting paraprofessionals and professionals in our first nation communities? I think it's, at the very beginning, looking at actually having positions that are recognized within our funding agreements to communities around health coordination and health supports, supporting the physicians, so it's really about dollars being recognized in the funding agreement. Some communities don't have a health coordination amount, so we would say that a defined scope of practice within our health directors and the communities should be offered.

One of the other things is once you have that health director who is trained and certified, wage parity becomes an issue as well in retaining those quality professionals in our communities.

The Chair: Okay. I think we're out of time unless, Mr. Morrisseau, you wanted to squeeze in a very short remark.

Mr. Calvin Morrisseau: I was just going to say that as far as retaining doctors is concerned, I think there's an issue, especially in the area I come from, in accessing the ability to even entertain bringing doctors into our area. We use nurse practitioners to a great degree; however, within our first nations there is a real discrepancy in terms of having doctors available to us.

It's not just a matter of funding. There's a system out there that recruits doctors, but we're not part of that recruiting system. We have to be part of that recruiting system if things are going to change.

● (1605)

The Chair: Okay. Thanks very much.

The next question will be from Arnold Viersen, please.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you to our guests for being here today.

Ms. Crowe, you mentioned earlier the acronym AHHRI.

Ms. Marion Crowe: Yes, that's the aboriginal health human resources initiative.

Mr. Arnold Viersen: Okay, and you're saying that would be one clear way we could make a difference, to change perhaps the percentages of the two streams of the funding on that. Would that be a correct assessment of your recommendation?

Ms. Marion Crowe: Thank you for that question. I think that's one very specific and concrete way we could look at developing the competencies within community-based workers. There are two streams that are identified, and that's one, supporting scholarships and bursaries to people who are going into health professions, such as nurses and doctors.

However, the one we focus on and that's available to a health director, for example, is if they wanted professional development or to achieve certification. They would be applying to the second stream of that funding that's now available, through the community-based worker. It's community-based workers, when you look at the program compendium: diabetes workers, all those unregulated allied health workers who are competing for those funds. Right now, that's $1.5 million spread out throughout the country through the FNIHB, first nations and Inuit health branch, regional offices.

Mr. Arnold Viersen: I liked how you said we're talking about life promotion strategies, and I'll stick with that.

You talk about a Thunderbird strategy. This is the first I've heard of this. Perhaps you could lay that out for us and maybe point us in the direction in which to go looking.

Ms. Marion Crowe: Sure.

The Thunderbird Partnership Foundation was formerly known as the National Native Addictions Partnership Foundation, so it has a long history in Canada in being a leader in addiction services. That's primarily funded through community-based worker training dollars out of Health Canada. They have that long-standing history, and as I was saying, they would be key in having this discussion, because they advocate for mental health services as part of their mandate.

The piece around supporting the framework is actually one that's not unfamiliar to this committee. That's the first nations mental wellness continuum framework, and I know you've heard that in testimony from Chief Day, as well as a number of other witnesses, such as CINA.

Mr. Arnold Viersen: Dr. Bourque Bearskin or Ms. Jones, you mentioned something about dealing with children who are taken out of their parental care and placed in foster care. Could you elaborate on that and perhaps give us an example of where you've seen something that has worked, rather than the traditional methods?

Ms. Lindsay Jones: Yes, I would like to speak to this.

There have been a couple of scenarios where a child has been taken out of the home.

I really believe that we need to start helping families build their cultural competencies back up within their homes and in the communities instead of removing them from the home. We're just giving them back and forth, over and over again.

Dr. Lisa Bourque Bearskin: You're right.

Ms. Lindsay Jones: If we can, just start at the grassroots. There have been situations where if we know of a young female who's pregnant, then we start at that stage to teach her how to look after the baby once it's here, its proper needs, and the roles and responsibilities within the families, instead of just instantly taking the child away. I think that it is a huge step in the right direction by starting right at the grassroots.

● (1610)

Dr. Lisa Bourque Bearskin: Just to speak a bit more to that, in my own community of Beaver Lake, what our community is starting to do is that whenever we do any kind of health programming, we have a relationship with the child welfare people. The families that are left in the community, when the child's been apprehended, they'll bring the child so that they can support that family unit. That has been shown to be very effective to help this transition back home.

I totally agree with the message that Lindsay was providing. We need to support children so they stay in their homes. We need to reorient services to build capacity within the home, as opposed to spending millions and millions of dollars shipping families out across the country. We need to focus on building the family as opposed to just breaking down the family dynamics.

I think there are some good examples across the country where that is starting to give us some good indication. If you look at Bella Bella, and you probably heard about that, the youth are really reoriented back to the land, and the communities, and the family units. Evidence is clear on supporting family units.

I have to speak to my own survivorship. I think about how, when I was removed from my community of Beaver Lake and brought all the way over here to B.C., one thing that always kept me grounded, and striving, and having those aspirations, was that those foster homes always supported my getting to know who my family was. I think that link was really a key attribute to the success. You see that in my other siblings, who were all apprehended, and they weren't in families that did support their transition back to their family. You could see the clear differences in my immediate family on how they were affected by that removal system.

Mr. Arnold Viersen: Thank you.

The Chair: Thank you.

The next question is from Georgina Jolibois, please.

Ms. Georgina Jolibois (Desnethé—Missinippi—Churchill River, NDP): Thank you for the terrific presentations. I have those similar discussions in my riding. I come from northern Saskatchewan. I'm the MP for Desnethé—Missinippi—Churchill River riding.

Recently in my riding we had three completed suicides by kids who were between 12 and 14. I have had these discussions with other physicians, aboriginal physicians, and nurses in the riding about the need for cultural relevance for those children who are removed from families and communities.

How far do we need to go to push this idea about making the real change at the core? Our youth are hurting. Our families are hurting. We know that, day in and day out. For culturally relevant physicians, and nurses in every province and in my province, we struggle. The province struggles with adapting this very concept about cultural appropriateness.

Nationally, how can we ensure that we push this and continue to do the work, so that at the grassroots level we have community-based, culturally relevant approaches?

Dr. Lisa Bourque Bearskin: I would like to speak to that, please, Mr. Chair.

One of the recommendations that I've made right from the beginning.... I believe so firmly in this organization. The Canadian Indigenous Nurses Association is part of the solution. We are at the front line. We see these kids in immunization clinics. We see them in home visits.

We don't have a lot of support. We're focused on treatment right now under the current.... My own personal philosophy is that we are too focused on treatment. Our community health nurses are focused in that area, which leaves us health promotion. We need to put nurses back in the school system. We need to put nurses back in the community. I think the funding cuts....

I want to tell you a story about a little girl—her name is Cassey—whom I met in Yukon. This is very striking to me. As I said, I acknowledge that I am a survivor. Our family is working on a lot of healing. When I was in the community in Whitehorse a couple of weeks ago, there was a little girl no more than nine years old. She was out playing. It was late. I was scolding her. I was telling her to go home and I asked where her mom was. I was trying to be that community advocate. She turned around, really foul-mouthed, and let me know where to go. I thought, oh my God, she's only eight or nine years old. I was upset about this.

I was talking to my brother and sister-in-law in the house about this. How do we help this girl? We were talking about boundaries, family dynamics, and everything. Then my brother said to me, “Sis, I don't know why you're getting all worked up. Would you want to go in there if you knew that five of her immediate family members committed suicide in that home in the last five years?” Now she has her single mom, with this child growing up. No wonder. It really affected me.

When you talk about our priority, that's huge. We have eight- and nine-year-olds seeing this on a daily basis in some of our communities. If we don't step up now, this.... Suicide is a symptom of colonization, of a fractured system. I think it's an emergency state, as you've all said, which is why you are looking into this work.

I think about Cassey being eight years old not wanting to go into that home and rebelling. I can't say that as an adult I'd want to go back in there, but where else can she go?

● (1615)

Ms. Georgina Jolibois: Thank you.

Mr. Calvin Morrisseau: I want to address this question a little bit from my experience. I've been doing this for more than 30 years.

I guess one of the things important to know is that you can't fix a system or a community that's broken without investing in the community. I think a lot of people believe that if we take children out of the community, it's going to benefit that community. I think what needs to happen, from my own personal experience, is that we need to invest in those communities.

One of the things I've noticed is that when a crisis happens, everybody is ready with a crisis team to go into the communities and deal with the crisis, but once the crisis is over, everybody leaves. I think there's a real disconnect there.

I think you need to really look at making long-term plans for the children and for the people in the community. I've known suicides to happen with the very young as well as with the very old, so it's not just one specific age group that's affected. It's the whole community sometimes that is suffering from the impacts of what occurred over the course of the last 500 years with our people.

I think it would be an immature thought that there could be one quick fix. There have to be massive investments into these communities. We have to go in there and talk with the children. We have to talk with the adults, the parents. We have to talk with the elders. We have to bring people together and start a discourse on how we're going to do this.

To me, this is the thing that's been lacking in a lot of the situations. A crisis team comes in. The crisis is over for a little bit, and then everything goes back to normal. Then another one pops up somewhere else, and the crisis team goes over there. There has to be some long-term planning for this.

The other part to this is that we rely on health directors in the communities, for the most part, to do this—and I'm hoping to speak more about that health director role later on. The health director is only one person in a larger system that's out there. I think that, if we really look to address the long-term needs of the communities in terms of what their social, recreational, and health activities are, then you'll begin to see some changes in terms of how people are acting out.

We have to give people hope. Without hope, these are the things that occur within our communities, and they're occurring far too often. That means we're not doing a very good job of providing that hope across the board. I think we should all be ashamed of ourselves for not doing that.

The Chair: Thank you.

The next question is from Don Rusnak, please.

Mr. Don Rusnak (Thunder Bay—Rainy River, Lib.): Thank you all for your presentations today. I'm sure the analysts will take what you said and get the information in our report.

What hit home for me was what Dr. Bearskin was saying about taking the child out of the community and not having that family connection, that cultural connection. We see that far too often. We're getting into child welfare agencies and what they've been doing over many years. I don't know the exact stat, but I've heard over and over that there are more children in care today than ever during the residential school situation in our country. That's deplorable, in my view.

I want to hear more from Mr. Morrisseau regarding the health director role in the community. I don't understand the role. Is it for an individual community? Is it for a number of communities? Can you explain exactly what that role is?

● (1620)

Mr. Calvin Morrisseau: Thank you very much, Don, for the question. I'll do my best to answer it.

I can speak for our area. My understanding is that a health director is the one who's responsible for the health and well-being of the people in a community. There are a couple of things you need to know about that role of health director.

First of all, it's not a role that is paid for by the Government of Canada. Many first nations have to try to pool their money together to create that role.

It was originally put in place, I think, for reporting mechanisms. Somebody had to be responsible for reporting back to the government. But over the course of time, as our people began to find out about the horrendous discrepancies in our health outcomes compared to those of other people, the task of improving those health outcomes for our people began to fall to the health director. So when anything happens in the community, we look to the health director for guidance in how to deal with it.

One of the things with health directors is that there is very little support out there for them. They're kind of like a beacon out there doing the job all by themselves, and when things happen, when things go wrong, everybody looks to the health director to see what happened, and yet, the first nations and Inuit health branch has pulled back training for health directors and for health people across the board. The CHR, community health representative, training is almost non-existent now, and we see this across the board. Our people are left to try to find training wherever they can get it, whatever way they can get it. Thank God for people like Marion who has a program that's set up so that health directors can access it.

The problem then becomes where the health director gets the resources to improve his or her own set of skills. You have to understand that things are different from what they were 30 years ago. The complexities of the health determinants that affect our people are a lot different. We see chronic illnesses that come into our communities. We see mental health issues. It's no longer just alcoholism. It's alcoholism with bipolar, alcoholism with prescription drug abuse, and all of these things that are left at the doorstep of the health director, who is supposed to deal with all of these things. Then when we don't provide any training or any help for the health directors, we ask them what they're doing.

That's the situation we see in first nations. I was a health director. I spent most of my days dealing with crises, the daily crises that go on in my community. I had no time to look at what I could do in terms of planning, so that my people could get healthier. These are the situations that occur within many first nations, and until those inequities are addressed, we'll continue to flounder in terms of our own health outcomes. We'll see our young people dying at a greater rate than other people. We'll see all of these things that are occurring, and you don't have to look very far to see the horrid health outcomes that our people are facing. We have one person out there who is charged with trying to change this, and we provide no support to that person.

● (1625)

Mr. Don Rusnak: In your area, which is on the western part of my riding, as I understand it, the area that you cover is a number of first nations.

This question is for Marion.

Is it typical that health directors cover a wider area, a bunch of first nations, or do individual communities have individual health directors who are seemingly the on-the-ground experts in terms of the health needs, including the mental health needs of the communities?

Ms. Marion Crowe: Thank you for the question. I appreciate that.

In relation to our organization, we look at the health director position in terms of the community. Depending on whose stats you use, there are 630 to 650 communities across Canada. The first nations and Inuit health branch identified that there are potentially 500 health directors across Canada. Those are health directors in communities. Then you have health directors who are in charge of tribal health services. Then you take it to the PTO level, with the provincial and territorial organizations. Health director is a very key role in terms of the community individually, and that one person who employs doctors, nurses, and all the paraprofessionals. Then take it to the tribal council, and they could be looking at providing services to a number of communities in the surrounding region. That includes treatment centres as well. Treatment centre directors as well belong in terms of health director management.

The Chair: We're out of time on that one. Thank you very much for that.

We're moving now to five-minute questions. I'll invite both members and witnesses to try to come to the point quickly so we can fit as many points in as we possibly can.

The first five-minute question comes from Cathy McLeod, please.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): I'd like to welcome some Kamloops colleagues at the table. Of course, we had Dr. McCormick not so long ago. We've certainly been very well represented in this study.

I'll start by picking up on the nursing issues. The nurses can be a key player, absolutely, as one of the types of care providers who tend to be in the communities and not flying in and out.

I'll date myself. I went to my 33rd nursing reunion two weeks ago. The dean of nursing was proudly saying people now need 90% to get into our programs. I think we all looked at each other in shock, for one thing, and said that you don't need 90% to be a good nurse. For young girls and boys from indigenous communities who want a career in nursing, have we swept some of the barriers out of the way? Ninety per cent is ridiculous, to be quite frank.

The Chair: Did you have anybody in mind, Cathy?

Mrs. Cathy McLeod: Dr. Lisa.

Dr. Lisa Bourque Bearskin: Great, Cathy. Yes, I'm very new to Thompson Rivers. I was very excited to come to the university here. They recruited me here very aggressively because of their program on indigenous health research.

When I look at health careers across the board, yes, you're absolutely right. I totally agree with you. Those whom we're targeting at 90%, sometimes book smart does not translate into a really good, awesome bedside nurse.

One of the things I advocate for is this pathway to health careers, starting them in grade 3 and 4, teaching them that medical terminology, levelling it up so by the time they get to grade 7 they have a little more knowledge. They do the anatomy and physiology. There's a really good way to strengthen that so we could create a pipeline from high school into a health career position. They do health career for 27 weeks. They work and take care of their families. They go back, and they do the LPN for two years. Then we create the pipeline further and extend it into the registered nursing program and the baccalaureate program.

Right now, as you know, Thompson Rivers has committed to developing the first indigenous master's program in the country. It will have a specific focus on indigenous nursing leadership. I think that's really telling. As I mentioned earlier, our indigenous nursing pool is a really untapped resource. You have an expertise here to fill a gap. We know they are the most trusted health professionals in our community. Our communities see that too. We are at the bedside, in the alleys, in the back of cars. We have that relationship with our youth. We have to start building that bridge strongly, looking at equity seats and equity funding.

I know TRU has an aboriginal health careers program here. Circulating in some of the communities here was interesting. I asked students how come we don't have more aboriginal students. They believe they are not smart enough. I talked to three or four adults in the last two weeks, trying to encourage them to go into an LPN program. They are mature students, and I always use my own life example.

I was a single parent with four kids, and I went through every health career program from the time I was 18, and I just finished my Ph.D. in 2014. I was able to be a better health care provider with the school because I was able to navigate around my classes. I ended up being at home for my children more so than if I were committed to doing a 12-hour shift.

That for me is a dream, and I think a lot of kids come with life experience already. They know how to get their grannies to the doctors, how to interact with the emergency services. They know all about emergency by the time they are 12 years old. They are already navigating the system and the health care system at a very young age. I think we can draw on those strengths.

● (1630)

Mrs. Cathy McLeod: Thank you.

I was only 30 years old. I better correct that for the record.

The Chair: Cathy, I'm so sorry. You're out of time. It was a five-minute question, and we're over five.

Mr. Arnold Viersen: Five minutes is short.

The Chair: Yes, they go fast.

Mrs. Cathy McLeod: Thank you.

The Chair: The next question is from Mike Bossio, please.

Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.): Thank you all so much for being here today. We really appreciate the discussion.

There are 9,000 nurses in the Canadian Indigenous Nurses Association. I assume all 9,000 are indigenous.

Dr. Lisa Bourque Bearskin: We do not have 9,000 members as part of our organization. We have under 200.

Mr. Mike Bossio: I'm sorry. I thought I had heard that number somewhere.

Dr. Lisa Bourque Bearskin: We have the potential to reach 9,000 nurses.

Mr. Mike Bossio: Okay. If you were to fully staff all indigenous communities, do you estimate it would take 9,000 nurses to do so? Is that where the 9,000 number comes from?

Dr. Lisa Bourque Bearskin: The 9,000 is a number that was collected through the 2011 community health survey where it was self-reported whether or not they were registered nurses. A question on that survey asked if you were aboriginal and a registered nurse. That's where the number comes from. I'm saying there's that potential for us to reach those numbers.

One of the historical things about CINA is people see us as a home base where they are able to be supported by other indigenous nurses with that same mindset.

Yes, we only have 200, and we have no public funding, no core funding to keep us. We're all registered nurses working full time, working off the sides of our desks to do this voluntarily.

Mr. Mike Bossio: Thank you.

Marion, maybe you could help with this. Do we have an idea as to how many nurses there are in indigenous communities today and what percentage of those nurses are indigenous?

Ms. Marion Crowe: Thank you for that question, but I would go respectfully to my colleague, Lisa, to answer the question about how many indigenous nurses are required across Canada.

Lisa.

Dr. Lisa Bourque Bearskin: If you're just looking at the first nations communities, in each of the communities, to be truly effective, as Marion suggested, it depends on the size. If we have 655 indigenous first nations communities, then you need to at least create a support system to do that work, so three to four nurses in each of those communities. The needs are huge for what we can do and what we need for the system. If you have the numbers that we were—

● (1635)

Mr. Mike Bossio: Sorry, I apologize for cutting you off, but I don't want to run out of my five minutes. Do we know how many nurses we have today supporting indigenous communities?

Dr. Lisa Bourque Bearskin: No. That's one of the issues that CINA would like to entertain. We want to do an official count of how many indigenous nurses there are across Canada. That's never been discussed. If we went through our provincial bodies, we still wouldn't even know, because it's not a requirement of voluntary self-identify.

Mr. Mike Bossio: Right now, one of the questions—

Dr. Lisa Bourque Bearskin: That's the gap that we need—

Mr. Mike Bossio: Okay.

One of the questions earlier was around nurse training and the funding for that. Is there dedicated funding today for training for indigenous nurses?

Dr. Lisa Bourque Bearskin: There is funding available through Indspire. They do offer health career training, and that's a national one.

Each of the provinces targets some small bursaries to support indigenous nurses.

Mr. Mike Bossio: Okay.

Dr. Lisa Bourque Bearskin: The Canadian Nurses Foundation this year launched a big initiative hoping to hit the $1-million mark to support indigenous nurses.

Mr. Mike Bossio: The only type of funding that is there for indigenous nurses is the same funding that's available for any post-secondary students of indigenous background today.

Dr. Lisa Bourque Bearskin: Right.

Mr. Mike Bossio: Okay, so there is no dedicated funding.

We don't know how many nurses are out there. We don't know how many nurses are needed. We don't know what percentage of those nurses are indigenous.

Are there any schools around health care training in indigenous communities?

Dr. Lisa Bourque Bearskin: No, there's not. That's the vision of CINA we'd like to develop. We talked with Jane Philpott last week about creating a 10-year plan looking at creating indigenous nursing areas of excellence in each of the four directions of our country. If we had one in the north, one in the south, one in the east, and one in the west, we could really do some great work around supporting, recruiting, and retaining indigenous nurses across the country.

Mr. Mike Bossio: Okay, I'm out of time, I'm afraid.

The Chair: We've come down to our final question, and it's from David Yurdiga, please.

Mr. David Yurdiga (Fort McMurray—Cold Lake, CPC): I'd like to thank the witnesses for presenting today and taking our questions.

I'd like to mention that Beaver Lake is within my riding, and my wife's family is from Beaver Lake, so it's nice to see you here, Dr. Lisa.

We spend a lot of time and capital recruiting health care professionals, but what is being done to retain these individuals, especially in the remote communities?

Dr. Lisa Bourque Bearskin: It's very frustrating, because I get weekly calls, as the president, from indigenous nurses in these communities who are burnt out, stressed out, and have no support. One nurse was in her community for three weeks providing 24-7 care. There's no way we're going to be able to retain that nurse. She's going to be burnt out. There's a huge lack of community support. I think that was made clear by the Auditor General, who found that one in 45 nurses is prepared to work in the communities and in their scope of practice. It's hugely telling to me that we have not developed a very functioning health care system.

Ms. Lindsay Jones: I'd like to add to that.

At TRU campus, we have an indigenous nurse health committee, and one of our practicum placements is in Hazelton. I think the way that Thompson River University is starting to branch out and have placements in more indigenous rural communities is an excellent start.

Mr. David Yurdiga: Thank you.

May I hear from Marion Crowe, please?

Ms. Marion Crowe: Thank you.

In further quantifying that, we need to have the supports in place to retain our indigenous health professionals, not just at the national level and the regional level, but at the community level as well. Organizations like CINA, like IPAC, the Indigenous Physicians Association, and like FNHMA are providing the network to keep those people in place in our communities. Without that, I've heard health directors all across Canada say, “I wish you would have been in place 10 years ago.” We're six years young, our organization. We need to support the professional associations. As Lisa mentioned, we're two organizations right now that are unfunded.

● (1640)

Mr. David Yurdiga: If we had funding, what could be done to retain these health professionals? What do you envision that would make a big difference?

Ms. Marion Crowe: I think Lisa will have a lot of thoughts on this, too.

The number of projects are endless that we could look at to help retain our supports. There are a number of projects that we've put forward to the Government of Canada around a hotline of some sort, as you would see in crisis intervention. If I were a health director and I had a question about how to report, who can I call as an actual support to me to address the health inequities in my community, I think that's one thing, and it's a role that national organizations have.

It goes back to being equitable. There are national organizations that are supported, core funded, actually, and you're looking at two of the front-line health services delivery organizations that have nothing.

Mr. David Yurdiga: We hear about a lot of people going into these rural communities and leaving. I'm looking at the educational aspect of things. When a youth goes into the nursing profession, is there traditional spiritual healing incorporated in the post-secondary institution?

Ms. Marion Crowe: Is that question for me?

Mr. David Yurdiga: Yes.

Ms. Marion Crowe: I can't speak to nursing, but I can speak to the education and certification criteria as set out by this professional association. The training that is provided through the organization of FNHMA is relevant around incorporating the culture of how people practise in our communities. That's why we exist. We did an environmental scan across Canada and said that yes, tons of universities deliver business administration, health services administration, but there is nobody in Canada who is able to develop a curriculum that speaks to the governance of our communities and also speaks to all the jurisdictional issues that our communities represent, while respecting western medicine and incorporating our traditional knowledge. We celebrate and share in that.

The Chair: We're out of time, I'm afraid. We're out of time for the two panels as well, with that final question.

I would like to thank all of our witnesses for coming today: Marion Crowe and Calvin Morrisseau from the First Nations Health Managers Association; and Dr. Lisa Bourque Bearskin and Lindsay Jones from the Canadian Indigenous Nurses Association. Thank you so much for your heartfelt and thoughtful testimony today. It will certainly help us out a great deal in the work that lies ahead.

We will just suspend for a few minutes before we go in camera.

[*Proceedings continue in camera*]