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Chair

Mr. Andy Fillmore

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● (1530)

[*English*]

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

Good afternoon. Welcome, everyone.

This is the House of Commons Standing Committee on Indigenous and Northern Affairs. We are today continuing our study of suicide among indigenous peoples in communities.

I'll just note to members that we're not broadcasting video today, but we are streaming audio.

Today we are hearing in the first hour from two individuals in the first panel. First is Dr. Amy Bombay, assistant professor in the Department of Psychiatry at a very august east coast institution called Dalhousie University, where I myself was once a faculty member. Joining her is Dr. John Haggarty, professor and chief of psychiatry at Northern Ontario School of Medicine.

Welcome to you both, and thank you for making time for us. We're very grateful.

I am happy to offer you each 10 minutes as we proceed.

Dr. Bombay, you have the floor.

Dr. Amy Bombay (Assistant Professor, Department of Psychiatry, As an Individual): Thank you so much for the opportunity to speak today. I'll be speaking mainly about the research I've been doing over the past 10 years looking at health inequities among indigenous peoples and at some of the pathways that contribute to the health inequities we see, particularly in relation to mental health.

Some of our research has focused on documenting the health inequities related to mental health. We really don't have a lot of data documenting these inequities across time, and so we don't really know, across different groups, how much worse or better this has become. From the data we have, we see that issues related to psychological distress, suicidal thoughts, and suicidal attempts are getting slightly worse over time and not necessarily getting better.

We compared non-indigenous peoples to first nations on and off reserve, Métis, and Inuit, and we see that first nations living on reserve present more than double the proportion of adults who are reporting suicidal thoughts. The rate is also higher in all of the other indigenous groups. We also note that within these groups, rates of suicide vary significantly across communities and across regions within Canada.

Some of our other research looks at documenting the long-term effects of certain collective traumas faced by indigenous peoples. Much of our work has looked at the long-term effects of Indian residential schools in relation to mental health outcomes.

Here I am showing you a graph representing the proportion of adults who report medium or high levels of psychological distress, based just on a self-reporting questionnaire. This is one of the few questionnaires that measure mental health across these different groups within national surveys that allow us to make some comparisons.

When we looked at this, we found that in the total Canadian population—which actually includes indigenous peoples, so that this number may be elevated a little—about one-third reported moderate or high levels of distress. We compared those findings with results for first nations adults living on reserve according to whether they or their families were affected by the Indian residential school system, and we found that all of those individuals who had a parent or at least one grandparent who attended, or who attended themselves, were at increased risk for psychological distress compared with first nations adults whose families were not affected. This is just to show that the schools affected not only those who attended but also their children and grandchildren.

We looked at that situation across a number of different studies, within both national representative samples and our own data, which we collected on and off reserve. Again we show that those who had at least one parent who went to residential school are at greater risk for reporting high levels of depressive symptoms. In the lower graph on this slide, we show that this was also the case for first nations youth living on reserve.

Already among youth aged 12 to 17 we see that these intergenerational effects of past collective traumas continue to put them at risk for these negative mental health outcomes.

Another goal of our research was to document and explore the pathways that contribute to this increased risk among those whose families have been affected by these major collective traumas. One of the major—and, I think, most intuitive—factors that contribute to this intergenerational trauma is the greater exposure to childhood adversities.

● (1535)

We found that those who had a parent who went to residential school were more likely to report a higher score when we were looking at cumulative exposure to various types of childhood neglect, various types of trauma, and various types of household dysfunction.

The greater risk for childhood adversities in turn put them at risk for experiencing more stress throughout their life. In the literature, this is referred to as a process called "stress proliferation", where early-life trauma and trauma faced by one's parents continue to put someone at risk for more stress and more trauma throughout their life.

In addition to adult traumas, we found that those affected by residential schools also perceive higher levels of discrimination. Our research in this and other work points to the real negative effects of racism and discrimination on mental health outcomes among indigenous peoples, and not only in general interpersonal day-to-day experiences. There's also a lot of research showing that experiencing racism within the service-provider context in the health care system and within other systems can have even double the negative effects.

Another one of our major findings was that these past collective effects can actually accumulate across generations, so really, if we do nothing to address these intergenerational cycles, we can expect that the effects are only going to get worse.

We did a comparison as shown. These are all first nations adults living on reserve, again from a representative sample, and we compared those whose families had not been affected by residential schools to those who had a parent or a grandparent who attended and to those with a parent and also a grandparent who attended, so two previous generations. We showed that with each additional generation of a family that attended residential school, there was an increased risk of negative mental health outcomes.

We also wanted to see if that effect seemed to transfer to other types of collective trauma. We focused on the residential school system because it was really the only kind of major collectively experienced trauma that we have data on, and we could look at the negative outcomes. The large removal of indigenous children into the foster care systems is another major collectively experienced phenomenon that today contributes to negative outcomes in the same way that the residential school system does.

We showed that the more generations there are in your family that went to residential school, the greater the risk you're at for being removed into foster care at some point in your life. When we looked at the pathways that accounted for these increased risks, we found a kind of sequential relationship, where having a parent who went to residential school put those children at risk of growing up in a household with low economic stability and living in poverty. In turn, that low economic stability put them at risk of just not having a generally stable household. Even if it wasn't about abuse, it was about providing a stable household, which these parents just really couldn't do because of their familial residential school history. In turn, those people were more at risk for being taken into foster care, again really demonstrating the intergenerational nature of all of these environmental and collectively experienced traumas.

Our research looking at this has also found that same effect among youth living on reserve in relation to suicidal ideation and suicidal attempts. What we found is really interesting. When we split the groups up into those aged 12 to 14 and those aged 15 to17, we found that this effect was particularly evident in the younger age group, those aged 12 to 14, which suggests to us the extreme importance of early intervention. When we looked at adults in terms of those who reported suicidal ideation in childhood and youth, it was these individuals who continued to have mental health problems throughout their lives. We know that's also the case in the mainstream population and in the mainstream literature. Those with early onset of any type of mental health disorders are at risk for chronic problems throughout their lives, which really emphasizes the importance of addressing these early on.

● (1540)

In addition to identifying the risk factors that put those affected by residential schools at greater risk, we were also really interested in looking at the protective factors that can protect, because not all of those affected by residential schools do have depressive symptoms or other health problems.

I wanted to share some quotes from subjects in some of our studies in which we have done some qualitative research, just to hear in their own words what has been protective for them. This is from someone whose parent went to residential school.

She said:

> I was ashamed growing up but I have since reclaimed my identity.... Now that I am on my own, I have more pride and I am learning to love my identity. I gave my son a traditional Ojibwe name and I vow to raise him to be proud of who he is.

In a lot of our research we constantly heard stories of cultural pride being a really important protective factor. When we looked at that in our quantitative data, we also found that cultural pride was really protective.

In this graph we looked at the negative effects of discrimination in relation to depressive symptoms among first nation adults, and we found a strong relationship. "In-group affect" is just the academic term for cultural pride. When we see those who have high in-group affect, so high pride, we see that those individuals are protected against the negative effects of discrimination. Their depressive symptoms don't shoot up when they perceive these high levels of discrimination. There's other evidence out there showing these protective effects of cultural pride and cultural engagement.

Our research has also really pointed to the importance of learning about historical trauma and learning about residential schools and learning about the foster care system, and how all of these things have affected indigenous peoples. I just want to share another quote on how continued learning about this is needed, because people are still just learning about how this has affected their families.

This person shared the following:

> I found out when I was 27 that my father attended residential school, my sister told me. My father has never spoken to me about it. I read his court statements without his knowledge... and this is where I learnt about the sexual, physical, emotional, and cultural abuse he endured. I was deeply saddened, but it gave me an understanding of why my father behaves the way he does. It helped me understand the cycle of abuse, because in turn he abused my mother and I. He learnt these behaviours in Residential School and could not cope so he turned to alcohol and so did I... but at the moment I am in treatment and dealing with these issues. I CAN break the cycle.

This is just a quick graph from, again, a representative sample of first nation adults. It points to the importance of traditional healers in dealing with mental health issues. Even though traditional healers are typically not part of the mainstream health system, about one in five adults still reports using traditional healers more often than other types of healers.

This graph shows the number of community projects aimed at healing as a result of the residential school system, and how, as the Aboriginal Healing Foundation was shut down, the availability of these services decreased over time. When we look at that compared to the proportion of adults affected by residential schools on reserve, we see that doesn't match up. We see that the proportion that has been affected themselves, either by attending or by having a parent or grandparent who attended, has not decreased since 2002, and that today our most recent data shows that more than half have been affected intergenerationally by residential schools.

The Chair: Dr. Bombay, we're not going to get through all of your slides.

Dr. Amy Bombay: That's okay.

The Chair: Do you want to hit the conclusion, and then we can draw out during the questioning whatever we've missed?

Dr. Amy Bombay: For sure.

That was pretty much it. I just wanted to end by sharing this graph showing that we really need a holistic approach to dealing with these issues. That's going to be different in different communities. It needs to address youth, but also the community, and supporting children and youth into the future.

Thanks.

The Chair: Okay, thank you so much.

Dr. Haggarty, let's move right into your presentation. Thank you.

Dr. John Haggarty (Professor / Chief of Psychiatry, Northern Ontario School Medicine / St. Joseph's Care group, As an Individual): Good afternoon. It's a pleasure to have a chance to meet with you and to be invited to participate in the discussion that has been under way for many years and will continue for some time.

I come to you both as a clinician and as part of now more active health care planning in northwestern Ontario. My clinical work with first nations dates back to the late 1980s and the early 1990s in Labrador, and subsequently as a resident in psychiatry and a researcher in Baffin Island and later Nunavut.

I also now work as a clinician in a collaborative care mental health service model. This is a model of care that I will speak to a little later on in regard to bringing specialty care to primary care locations, which is where much of mental health service gets delivered.

I've been involved with research in the area of indigenous suicide since the early 1990s, and there are a couple of points I want to highlight from both the work I've been involved in and Amy's presentation. These include some challenges to the traditional ideas of suicide and suicidal behaviour in first nation and Inuit communities.

Something that complements what Amy said is that in one study we undertook, we found traditional language maintenance to have a protective effect. There was clearly a difference, as was already pointed out in the data, in that when a community is able to maintain traditional language at a higher rate, there appears to be a lower rate of suicidal ideation and attempts and behaviour.

The other thing that's a bit of a counter to what I'd call a mainstream suicide study is that the presence of common mental disorders explains only a small percentage of variation in suicidal behaviour. In a study I undertook, we looked at two communities in the far north, and we found that although there was a very high incidence of suicidal ideation, less than 20% of it could be explained by the presence of common mental disorders that we were also looking at, such as depression, anxiety, and alcohol abuse.

This is a subtle but important consideration. It means that there are probably other factors in communities that could account for suicidal behaviour. Amy has spoken of this, and I'm sure Dr. Kirmayer will speak of it later. This is important, because when it comes to delivering clinical services, as clinicians we certainly know that mental disorders are a part of the suicide picture, but we have to clearly bear in mind that the social determinants of mental health and the social determinants of health are critical to understanding it. Some of these have been touched on.

I want to emphasize, without getting into the details, the work of Chandler and Lalonde, who published a number of articles on cultural continuity, which has been touched on already. As well, the adverse childhood events study by Felitti is, I think, important. These are highlighted in a number of places and it would be worthwhile for this committee to have as good a grasp of these as possible.

Amy touched on a number of issues, one of which is how generations pass on these effects. I'm not sure, but there may be a few biologists in the room here. The study of epigenetics is increasingly showing that there are biological reasons as to why the trauma that happens to a grandfather or grandparents may be passed on genetically through methylation of the key genetic coding within our own cellular structure.

This is an important phenomenon that is gaining in understanding. It was very gratifying to go to Fort Frances and be asked to talk about passing on trauma, and to then go to a talk, at the American Psychiatric Association meeting, about how the genome project has allowed us to understand many aspects of this. This is important for us to grasp. It's early days, but there is some understanding of what has been touched on. It's very powerful.

I won't touch on the Nunavut suicide strategy or the Pikangikum coroner's report, but I think these are important to have a full grasp of, because the advice is all there, and many of us would be repeating what has come from very bright people preceding us.

In the last few minutes that Andy lets me speak, as a program planner, a chief of psychiatry, and someone who has been involved in the determination of service modelling, I want to touch something on.

● (1545)

I gave a presentation a couple of Fridays ago in Thunder Bay to the Ontario Psychiatric Outreach Program and shared the idea of how we can create specialty service access in places like the Pikangikum nursing station or Pond Inlet. As we evolve the technology of service delivery, I think there are really creative opportunities that are low-intensity and potentially low-cost that we are certainly trying to look at and optimize.

Part of this arises out of the Auditor General's report on nursing stations, which talks about the need for specialist access, not just by having someone fly in but by having someone who can be contacted or having on-site resources that can be developed. I proposed possibilities to increase those, and I'll touch on those in a minute.

The Sachigo Lake study of first aid skills is an example, in our region of northwestern Ontario, of how you can develop a specialized skill in an areas such as crisis assessment and then capacity-build. The issue is how to sustain it, how to deliver it, and how to ensure that the nurse practitioners and RNs in these communities have these skills. I think these are critical.

I have one final point on policy and resources before I move on to a model of care. I sit on the Ontario child and youth mental health funding review committee. I think you folks are placed where this can really have an impact. The social determinants of health are highly impacted by the ability of policy and funding to drive change and create what has been called “equity plus”. That term comes out of a book, and it describes the idea that we are not just looking for fairness or equality but we are looking at, probably for some time, an enhanced funding formula that will need to give consideration to distribution of resources. I really think the social determinants of health highlight the importance. It's not just about health care delivery; it's about improving job opportunities and addressing poverty and housing.

I'll close with a couple of comments and highlight a few key things. I've had the opportunity to try to steal from across the country and from outside of the country some of the best service-delivery models. The conceptual draft model I am now entertaining with our local health integration network includes a few conceptual ideas that build upon a stable primary care system. Any discussion about enhancing health care has to be built on a stable primary care system, whether that's family doctors, nurse practitioners, or good nurses with solid skills.

In primary care, I think we are underperforming in a lot of avenues: in the development of a basic understanding of crisis assessment, in the skills to deal with suicidal ideation and in the skills to deal with basic depression and anxiety. Things like the CBIS model, which is a cognitive behavioural therapy model out of British Columbia, and DBT, which is an enhanced cognitive behavioural therapy model, deserve some community and cultural adaptation. I have had discussions with Dr. Mushquash in Thunder Bay about this, and maybe you've heard about it as well.

The RACE model in British Columbia—rapid access to consultative expertise—offers a model of care across a number of specialties. Someone calls and says, “I need to talk to someone who is a primary care provider in two hours to two days. Who do I call, and how do I do that?” It's possible. It has worked in British Columbia.

With regard to access, we are moving into the health care system delivery model. It started out of a cardiology and a family practice unit in Vancouver that said, “Why can I live next door to specialists who are 200 feet away and I can't call anybody?” It's something that is translatable anywhere in Canada, no matter how rural and remote.

The Ottawa e-consultation model is another model that says, if a family doctor or nurse practitioner doesn't need to speak to someone in two hours to two days but could do so maybe in the next three to seven days. It is looking at province-wide implementation in Ontario, and I think it should be given some consideration. It has been strongly piloted, with somewhere around 6,000 consultations in the four years it's been running in Ottawa. It is being piloted in our area of northwestern Ontario, and I look forward to seeing that happen.

As a primary care provider, if I don't need to speak to a specialist, how can I get assistance for someone with common mental disorders such as depression and anxiety that is adaptable to settings such as nursing stations. The case consultation or the ECHO mental health model, which is coming out of the Centre for Addiction and Mental Health, is an additional model.

What you are hearing me describe is a progressive pyramid of innovations that add to what exists currently, which is, for someone who is in a crisis and needs to be in a crisis bed at a hospital, either a “Form 1” or an elective consultation.

● (1550)

We don't seem to have a lot in between. We have an adaptation of e-consultations, rapid assessment, and the ECHO mental health program, which is an intensive mental health training program that is available for any primary care provider. Last, there is case consultation, which we've integrated across a number of NP clinics that I've been working with. I'd be glad to further discuss this model of psychiatric access, which I'd like to see implemented, that optimizes a lot of service-delivery innovations.

The last thing I want to talk about is PCVC. Anyone with a computer, as long as it has a little camera on it, can link up anywhere in the country that has WiFi to access a specialist on an encrypted network. I think this allows turning down some of the steam on a nurse practitioner sitting in an outlying community that has no road access, who can say I'm not sure how to manage this but I can put the patient in front of you if you'd like to help. We have a chance of having that with the available technologies, which are an enhancement of the telepsychiatry model that currently exists.

I'll pause there. Sorry for going over.

● (1555)

The Chair: That's okay.

Thank you for that, Doctors Haggarty and Bombay.

We're going to move right into a round of seven-minute questions. That includes asking the question and answering it. I would urge the committee members to come to their point as quickly as possible so we can hear from you.

The first question is from Mike Bossio.

Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.): We got a lot of information from both of you.

I want to talk to some of the cultural imperatives that seem to be coming out of a lot of discussions on mental health and the impact those can have toward giving individuals pride and hope.

That speaks to a lot of what you spoke about, Amy.

I'd like to know the level of importance cultural heritage and cultural connection have in indicating that where it's strong, the suicide rate is here, and where it's not strong, the suicide rate is there. Are you seeing a correlation there in different studies?

Dr. Amy Bombay: Across the different studies, culture can be measured in a lot of different ways. Language is one measure. That's been shown to be protective in relation to suicide and in relation to educational outcomes and other outcomes. That said, not all communities have their language, yet they have other strengths. Different aspects of culture will be protective for different communities.

For example, in northwestern Ontario some of the communities are trying to go back to their culture, and they have their own ways of doing that in line with their own cultural traditions, whereas some other communities aren't keen to go back to their cultural traditions as they've held on to their Christian religions. Even though these communities are pretty close together, the same kind of cultural approach is not going to work in both of them.

Mr. Mike Bossio: Are you seeing a correlation between those that have made that connection and lower rates of suicide?

Dr. Amy Bombay: It's going to be different across different communities. In some communities, you're going to see the strong link between language and positive outcomes. In other communities, you might not see that. Other aspects of their culture might be protective. Typically, various aspects of culture do seem to be protective according to the empirical literature.

Mr. Mike Bossio: Some may be land-based, or some may be art-based, as is the case in Haida Gwaii.

Dr. Amy Bombay: Exactly. Some have to do with political involvement. Some have to do with collective activism. People can try to enhance their cultural pride in various ways.

Mr. Mike Bossio: Have you seen that cultural connection in a lot of communities? In a lot of cases, they also have more empowerment, or self-government, in that they have a model of longer-term, stable funding associated with that, so they establish their priorities.

Dr. Amy Bombay: That's right. I think that's another aspect of the Chandler and Lalonde studies. There's been some question as to what they were actually measuring in those studies. Some of them were measuring cultural factors. Some of the others were more about having systems in place in self-government and self-run policing and self-run firefighting. Those aspects are just as important if not more important and they also act as a source of pride for communities when they're running them themselves in their own way.

● (1600)

Mr. Mike Bossio: John, I don't know if you want to comment at all on any of those points.

Dr. John Haggarty: No, I think that Amy summarized it well. Again, that early work was by Lalonde, and I think it would certainly be worth understanding what the categories were.

In one study we did in northwestern Ontario, we actually took his findings and made a checklist to say, “Okay, in communities A, B, and C, which ones match?” and we did a comparison. His findings were consistent with what we found in our part of the world, in our communities, with regard to the ability of communities to be in distress or to show signs of distress.

Mr. Mike Bossio: You'd also talked about early onset to make sure that you bring in therapies or consultations very early on in the process. Can you give us some particular examples as to what that might look like?

Dr. Amy Bombay: I think that's going to look very different in different communities, and it will be based on what they feel is going to be protective.

That graph shows increased risk among 12- to 14-year-olds, but we also know from the epigenetic research that intervening at times such as when the mother is pregnant, is important. Taking a developmental life course perspective and trying to intervene at some of those key developmental stages is really important. That starts with the mother at preconception and continues. I think that education has to do with just working with a community to see what particular issues are affecting it and working with it to find the answers.

Mr. Mike Bossio: John, you proposed numerous models around the social determinants of health and mental health, such as RACE, PCVC, ECHO mental health, and the Ottawa e-consultation. Do you think it's imperative that a lot of those be driven by indigenous communities to establish an indigenous presence, or counsellors, or local representation to really be effective?

Dr. John Haggarty: I don't think there can be any success without it becoming embedded within the community environment that's there. I think there has to be flexibility and there has to be some invitation to participate, but like anything that's been successful...no community that I've ever visited has said, “We're going to start totally from scratch, and we have no interest in dialogue and what works elsewhere”. Often it's “Talk to us about what you've done and what's worked, and find a way to make sure that it has cultural sensitivity and respect, and we'll make it our own or adapt it as we need to.”

Mr. Mike Bossio: And so—

The Chair: We will now move to Cathy McLeod.

Go ahead, please.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, both, for some great presentations here today.

One area we haven't had a conversation about is pharmaceuticals, appropriate use, and appropriate access. We have a different issue with collective trauma, and I think it was Dr. Haggarty who talked a bit about the incidence and about being less connected with normal psychiatric issues.

Do you have anything to say about that, and is there access to appropriate best practice for...?

Dr. John Haggarty: I'm not sure if I'll answer that question correctly, or if I understand it right. There can be a tendency for distress to mean depression and that means using an anti-depressant. We sometimes placate these issues by thinking that if we can get the newest anti-depressant, even though it's more costly....

My recent travels to Haiti reminded me that you don't need the sophisticated best stuff. What you need is a good understanding of the circumstances of the situation.

I can't comment on the rates of prescribing in these communities. What I can say is that this is where primary care.... A psychiatrist on a distant line will have a different experience seeing someone in Sioux Lookout or Thunder Bay than will a nurse practitioner in the community who understands the context. I think it's important to not confuse clinical phenomena with complex social issues that are not prescribed away.

If someone's life circumstances aren't changing, why would I expect an anti-depressant to be helpful, let alone treatments. When there are such powerful challenges to someone living a healthy life, such as poverty, homelessness, and a lack of housing, it's not uncommon for me to tell a clinician that these things have to change in order for any medication to fix this.

● (1605)

Mrs. Cathy McLeod: So you have no sense of either over or under in terms of what would be best practice.

Dr. John Haggarty: I can say that until we get a grasp of the roots of what's going on, the tendency would be for there to be higher rates of distress. Amy spoke to Dr. Kirmayer, as I did in my studies, which I didn't comment on. There will be a tendency to prescribe more readily, but there is no solution through prescribing in this situation.

Mrs. Cathy McLeod: I appreciate that.

Go ahead, Dr. Bombay.

Dr. Amy Bombay: I've been working with the friendship centre in Halifax, and it has approached me with this exact problem. The number one issue for the people they're working with is mental health, and typically they are prescribed something, which is funded through NIHB, whereas psychologist visits are typically not funded. They are now, actually, through NIHB, but no one seems to know about that. In Halifax I looked into it, and there are two psychologists on the NIHB list who indigenous people can go to, but no one seems to know about them or is being connected to them appropriately. I think that's because a lot of mainstream providers don't even know that exists.

Mrs. Cathy McLeod: I understand from the psychologists association that Health Canada has decertified a lot of capable providers, indigenous and non-indigenous master's-trained counsellors. So you are aware of that issue.

Dr. Amy Bombay: Yes, that's what we've been hearing anecdotally from people. I haven't talked directly with NIHB about it yet.

Mrs. Cathy McLeod: That's a really big issue when you have a problem with health care providers, and the move by Health Canada to decertify has all of a sudden created a much bigger problem of, as I say, capable people who could be doing the job.

You talked about a strong primary care system. In your experience, do most of the communities have the appropriate level of broadband to actually deliver that connectivity? Also, in our rural northern remote communities, I'm not thinking that we're actually starting from a strong, stable primary health care base.

Do you have a few comments?

Dr. John Haggarty: Both of those things are true. Do all communities have great broadband? No. Is it getting better as each year passes? I think it is improving and I think that'll be a challenge. Again, the farther north you go, the more those challenges exist. There are places in which it can be successfully done, but it's not disseminated through all of the north. I do know that the OTN in Ontario has really made an attempt to improve that. I don't think it's there yet in every community to the depth that you would get down the street from here. I think there is some work to be done. It's not disseminated broadly.

Your second question...

Mrs. Cathy McLeod: I was talking about starting from a primary care base that will.... It's all packaged.

Dr. John Haggarty: Yes, is it stable. I think was your question.

As we often hear in the media, there are sometimes waves of exodus of stable clinicians, nurses with experience who may exit the pressure and the scope of practice for RNs, as it's changed with nurse practitioners. I think it's made us hopeful to know that the NPs have more autonomy, but getting NPs to be stable in communities is often a struggle, as you go farther north. I certainly notice where I work in Thunder Bay that having NP-led clinics with really no physician on site—except when I'm there doing my clinics with my nurses—really creates more accessibility for those who are often the most underserved in our communities and that the NP-led clinic offers some hope. The greater autonomy for those clinicians, I think, offers a really positive stability.

The Chair: The next question is from Charlie Angus.

Go ahead, please.

Mr. Charlie Angus (Timmins—James Bay, NDP): I want to thank you both for these incredible reports that you brought forward.

Professor Bombay, when I look at the factors that you've identified—the residential schools, the intergenerational effects, the sixties scoop, the issues of early intervention—I see you've drawn a map of my riding. Would you be able to say that it would be possible, from this kind of evidence and research, to map out where the high-risk areas and high-risk communities could be found? Is that something that would be a fairly straightforward thing for a researcher to do?

● (1610)

Dr. Amy Bombay: Yes. I think right now not a lot of reliable data exists across Canada. The data I was showing was from the First Nations Regional Health Survey, so it's just a sample of first nations communities. It could definitely give you an indication of what regions are maybe more at risk. At the same time, for example, in Chandler and Lalonde's work, when they look at individual communities in the same province, those rates vary wildly. For example, I can't report on individual community-level data on that because of the rules around OCAP.

Mr. Charlie Angus: Yes, but I mean generally, if you're looking at risk factors, there are predictive elements you can see.

Dr. Amy Bombay: That's right, for sure. If you had more funding for research, and funding for communities to measure the things they want to measure, I think that would be very helpful.

Mr. Charlie Angus: Dr. Haggarty, I find it fascinating when we talk about the biological or genetic effects of passing on trauma. These are things we hear in our communities all the time. Having scientific support is really fascinating.

I always felt, when we dealt with suicides in our region that there was this notion of it being a contagion. I see that the World Health Organization talks about suicide as a contagion, and if it's not addressed, especially in young people, clusters form.

From your work in Thunder Bay, would you say that in the northern communities the cluster effects from the shockwave of a suicide create the contagion? Is the outcome predictable if there is no intervention?

Dr. John Haggarty: Clusters are a phenomenon. Clusters are unique. They link with what Amy has touched on and others have commented on, which has to do with a sense of self. If my sense of self is built around pride and a connection with my grandparents, and if I know who I am, then as a 14-year-old or 16-year-old, I'm going to be influenced by my peers but I'm not going to be life-dependent on them.

I would say that individuals who may not have that stability and may be disconnected from the language of grandparents make themselves more vulnerable. At least that's some of the rationale.

Why are there clusters? Why would a 14-year-old lead to three other 14-year-olds ending up in hospital or actually dying? In a sense, that vulnerable sense of self has occurred with this loss of cultural continuity.

Without getting into more details—clusters are a whole talk in themselves—I certainly think it's a factor. As you address some of the issues Amy has touched on, which Laurence Kirmayer will comment on, you'll see that building cultural stability is going to be important to reverse the likelihood of the impact.

Mr. Charlie Angus: Here's the thing. We had a horrific suicide crisis in Attawapiskat in March or April. At the same time there were six states of emergency declared across Canada in communities that were completely overwhelmed and could not deal with the self-destructive behaviour of their youth. Yet every time it happens, it seems to me that at the government level there's shock; there's surprise. They tweet out that it's a tragedy.

To me, a tragedy is someone getting hit by a car while they're walking home. Something that's predictable, something that's preventable is not a tragedy to me. That's something else; it's a form of negligence.

I mention that because I was in Saskatchewan talking to people about the latest suicide crisis, and we were getting the same level of response—the shock, the surprise. Now we're going to send in an emergency team and we might have them for 30 days.

I was talking to front-line workers who had been doing the programming of suicide prevention. They are not working up in La Ronge because their funding is gone. They get hired on these short-term projects.

I look at the projects funded by the Aboriginal Healing Foundation, and I see the dramatic drop-off from 2009 down to 2012. From that point on, in my region we had 700-plus suicide attempts, and nothing was done.

I'd like to ask you about this idea of sending in an emergency team. The minister, God love her, sent out a tweet the other night, saying, “Hey kids, there's a 24-hour hotline,” as opposed to supporting the people who could actually do the preventative work.

Do you see that there's a connection between these suicide clusters and suicide effects, and the fact that there is no proactive programming in many of the high-risk regions where we could have predicted this would happen?

● (1615)

Dr. Amy Bombay: Yes, absolutely. We just looked at the data. We showed psychological stress over time, but it's the same with ideation and attempts. They haven't changed. You have to wonder whether, if the Aboriginal Healing Foundation had continued, that would have changed at all.

We also know, based on the Aboriginal Healing Foundation reports, that even at their peak—I think they had the most community projects going in 2003—the service providers who were interviewed said they still weren't getting to the people who needed the most healing. There was still so much healing left to do in these communities. The fact that a model that was really working closed down really didn't make much sense.

Mr. Charlie Angus: Thank you.

I want to go back to the issue of the Healing Foundation. St. Anne's Indian Residential School was in our region, and the intergenerational effects are still horrific. The grandparents still need counselling as it winds down. We have unfinished business still affecting the families.

Edmund Metatawabin, a St. Anne's survivor, said that there was a direct highway from what happened at St. Anne's to the suicides we're currently seeing all across Mushkegowuk territory. What do you say about the issues of this intergenerational trauma? If we're still not healing the grandparents and the parents, what about the effect on the children?

The Chair: Answer very briefly, if you could. We're out of time.

Dr. Amy Bombay: I think that it's really clear. I have a graph in there showing the proportion of youth affected. So many youth reporting don't even know if their families.... Some families haven't even spoken about it. Still some communities aren't speaking about it. So many communities are not even close to being finished healing.

The Chair: The next questioner is Mike McLeod.

Go ahead, please.

Mr. Michael McLeod (Northwest Territories, Lib.): Thank you for your presentation. It was very informative.

I see a lot of interesting graphs and I see a lot of things that we really should make note of across the country.

I come from the Northwest Territories and we have issues in the north, not only in the Northwest Territories, but right across the north, and we have huge issues with suicide. There are so many things that you talked about that we've identified. We can add to those the economy, the lack of housing, and all of these other factors that are causing the issue to grow. When you said today that the situation is getting worse with suicidal thoughts, that really concerns me even more, even though that was something that we acknowledged.

We have had programs up to now. For the most part, they were really being cut and some of them were done away with: the friendship centre program and the aboriginal Head Start program, programs that were organized and run, for the most part, by aboriginals. In the Northwest Territories, we had the Healing Drum Society, which was part of the programs funded by the Healing Foundation.

You talked a little about the friendship centre in Halifax and I'm wondering if those programs had any effect. Were they helping the situation at all? We know that they weren't dealing with all the issues and they didn't have all the resources, but were they playing a role through what they did and the programs they delivered?

Dr. Amy Bombay: I'm working with the friendship centre in Halifax, as an example. I've been working with them only recently and trying to get more mental health supports, because they say that is what they need, and that's the one thing they can't get any funding for. They really don't have any mental health programs, even though that is the main thing they want.

I think where there is a lot of evaluation is with respect to the programs from the Aboriginal Healing Foundation. Their program evaluations did show that these community-driven approaches were very effective, and that they were reaching people who they had not previously seen, who had not gone to them for help. This culturally appropriate approach did reach some of those people who I think would otherwise never have gone for help. So they really do meet the unique needs of some communities, and there is evidence to support that, for sure.

● (1620)

Dr. John Haggarty: I can add to that, Mr. McLeod.

I'd like to point out two things. The Anishnawbe Mushkiki clinic was a place where people felt invited because of their cultural identification. And it's usually the opposite: “Don't bother coming here if you smell or if your clothes are old”, and so people don't feel welcome. This is actually just down the road from where I work, and where Don's office is, and I think it really creates an environment that says, “We're here to engage with you, and your cultural identity matters.”

The other place is in Fort Frances, at the tribal councillors' group where I visit. They had to overcome things like wanting to have a sweat lodge in their backyard, being able to do smudging and other traditional things, and they said, “We're asserting ourselves here. We're in the town but we're also doing traditional practices”, and I really felt that, again, it was an invitation to say, “If that's what you'd like to engage with, we're running it every week. This is when we do these ceremonies.”

I think it has been a really important part for the individuals who access it, who are interested in traditions. It's important for those of us with non-traditional interests as well. We need to learn that. I'm thinking of the residents, medical students, and trainees in social work. This really matters. If we don't start having these things as visible and really existing..., then we won't be able to even understand what these mean. They'll all end up being just a museum experience. I felt Fort Frances was exemplary. There's a sweat lodge on CAMH's campus, at the medical school in Thunder Bay, and in Sudbury, I believe. I think we're starting to change and to be more welcoming of those.

Mr. Michael McLeod: I want to ask about the comment you made on stable primary care systems. In the Northwest Territories we're quite challenged with having the facilities, the services, the experts located in the north. We spend a huge part of our budget on travel—millions of dollars—and we have for the most part only locums who come as doctors and nurses; there are virtually no specialists. We used to have five hospitals in the Northwest Territories. We're down to three—two hospitals have been downgraded. And we have poor Internet service.

The Government of the Northwest Territories has been looking at how to deal with this situation and how to deal with the number of issues around addictions. They've been talking about remote and on-land programs and mobile services. Many people think that's better than nothing, but in your opinion, does it work? Is it consistent enough? Is it something that can work—having people come in for periods, holding courses, and going on the land?

Dr. John Haggarty: Is the question whether it's valuable to do these cultural-based approaches to connecting to things such as the land, or are you trying to connect it with primary care?

Mr. Michael McLeod: It's bringing in the experts, the mental health workers and going out, whether into the community or on the land. These things are intermittent and few and far between. Do they really work?

Dr. John Haggarty: They work in this way. The issue is termed capacity building, supporting local individuals. When I did my first several-week study in Pond Inlet, the question was who the local leaders were on the mental health front. They might have been high school-educated. That didn't matter so much; what mattered was that they were the leaders. They were the ones who were asking the good questions, such as you folks are asking, saying, help me to understand this epigenetic stuff. There was no lack of interest.

I think you can have someone fly in as an expert, but at the end of the day I want my expertise to be theirs. It depends on the nature of that relationship; that matters most. If I just go in and run a clinic, I've done my job but I've not really helped to build up the local resources. To me, that's the critical thing.

The Chair: Thank you.

That's the end of the seven-minute questions. We have time for just one question in the five-minute round, from Arnold Viersen.

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

Thank you to our guests for being here today.

My question is for Dr. John Haggarty.

You mentioned systems such as RACE and ECHO. Have you done any work on putting those all together? You talked about a pyramid shape. Do you have anything that you can submit to us in terms of what that is?

● (1625)

Dr. John Haggarty: I do.

Mr. Arnold Viersen: Are there any gaps in that pyramid?

Dr. John Haggarty: It was constructed to ensure that from the point at which I'm calling somebody for sure because a person has to be on a Form 1—they're suicidal and they might harm themselves or someone else—to the point of that being elective, I've tried to make a patch as to whether I call somebody in two hours or have somebody see them in two to seven days. The model tries to fill in as many of those options as possible, all the way down to a case review once a month. I do have this conceptually and I will be sharing it with Michelle after I'm—

Mr. Arnold Viersen: Okay. Is this an idea, or is it in place, or is it a patchwork across the country?

Dr. John Haggarty: It's a composite. No one place has taken all of these together. In Ontario, Ottawa will take on the e-consultation; B.C. has.... They each have between four and seven years to implement those two initiatives, and the case reviews have been in place for some time.

ECHO is an Arizona- or New Mexico-based model for their rural and outlying areas. Each of these initiatives has been trial-run for close to a decade, and so there's not a composite of those things. We've learned to try to steal as many good ideas from elsewhere as possible.

Some of these we're already doing, but as a formalized structure at a government level, no, this has not been all put together in one place.

Mr. Arnold Viersen: One thing we run into all the time is that some things are provincial and some are federal, and sometimes even the friendship centre is doing a big chunk of it. Is your pyramid able to move among those different jurisdictions?

Dr. John Haggarty: No, it's not, and that is one of our struggles. When you go to Meno Ya Win in Sioux Lookout, it's almost half-and-half federal and provincial. I don't make those distinctions myself. I confront the federal funding challenges, such as wanting to use a long-acting injectable anti-psychotic for an individual schizophrenic who is first nations, which I can't get because of funding issues.

No, this model does not give consideration to those.

Mr. Arnold Viersen: Does it run into hurdles because of that?

Dr. John Haggarty: I would anticipate that it would, yes, but I think there are ways around that. We can make it work by co-operating in between the lines. I think that will have to happen.

Mr. Arnold Viersen: For sure. I wish I had it in front of me so I could have a look at it. That's particularly what I was interested in hearing some more about.

I'm currently working on a similar process when it comes to human trafficking: who to phone first. That's one of the things. In Alberta it's called “211”. For any health or human services you need, you call 211. It branches out from there.

Is that something we could incorporate within your pyramid, or is it specifically for suicide prevention?

Dr. John Haggarty: No. It was meant to be for a primary care provider who needs access to what we call “stepping up” to a specialist opinion. Let's say I need to speak to a psychologist or psychiatrist or brain surgeon about their patient who's now returned to my community. I can't wait seven days or thirty days to have them fly back to—

Mr. Arnold Viersen: So at the bottom base it's more a professional than a family member or something like that. Is that correct?

Dr. John Haggarty: Correct.

Mr. Arnold Viersen: Okay. Interesting.

Do you know of any work that's being done on the one layer before the bottom of your pyramid? How do we get family members tied in, or just even get them to a professional or something like that?

Dr. John Haggarty: I sense you're talking about peer- and family-based issues.

Mr. Arnold Viersen: Yes.

Dr. John Haggarty: It takes a lot of subtlety. It's really community-based. It's really how well people feel invited as family or peers to engage with health care services. It's now starting to be a part of the structure of health care delivery models—i.e., where is the advice-giving from those who are users of this service model?

I'd say it's not a formal part of most structures, and it's certainly not a part of the service-delivery model concept that I've put forward, but making it work is an important background issue.

Mr. Arnold Viersen: Thank you.

Dr. John Haggarty: I'll leave a copy of this.

Mr. Arnold Viersen: The clerk, Michelle, should have one as well.

The Chair: Thank you.

That ends the panel discussion for now.

Dr. Bombay and Dr. Haggarty, thank you very much for making the trip to come and see us. From your testimony, the depth of your experience is clear. It's of great assistance to us in our work. Thank you very much.

We'll take a short suspension.

● (1630)

(Pause)

● (1630)

The Chair: We'll continue the meeting with our next panel.

The next witness is Dr. Laurence Kirmayer, professor and director at the division of social and transcultural psychiatry at McGill University. He's also director of the culture and mental health research unit at the Institute of Community and Family Psychiatry at the Jewish General Hospital. He is joining us by teleconference from Montreal.

Welcome, Dr. Kirmayer. It's very kind of you to join us today. We are very happy to offer you the floor for 10 minutes to make your presentation. After that we'll move into a round of questions from committee members, if that sounds good to you.

Dr. Laurence Kirmayer (Professor and Director, Division of Social and Transcultural Psychiatry, McGill University, Director, Culture and Mental Health Research Unit, Institute of Community and Family Psychiatry, Jewish General Hospital, As an Individual): Thank you very much, Mr. Chair.

It's a privilege for me to be able to speak with you. I regret I can't be there in person, and I thank you for your patience with telecommunications. I had the opportunity to listen to the last 20 or 25 minutes or so of my colleagues' presentation, so I'll try to build a little on that in my own remarks.

With regard to my own background and the perspective that I bring to this, the program I direct at McGill is focused on issues of culture and mental health. It's primarily concerned with putting the social and cultural dimensions into our thinking about mental health problems. I also direct the national Network for Aboriginal Mental Health Research, which was funded by CIHR to build capacity across Canada to do research in ways that respond to the needs of communities, in terms of both the protocols and the actual topics of concern.

My own research was driven by my experience as a clinician working in northern Quebec and Nunavut, going back to the late eighties, during which time I encountered many young people making suicide attempts. Despite efforts on the part of myself and many people in the communities, over time the problem has continued in many places, and indeed has been exacerbated by a variety of factors.

My own research over 25 years or so now, with many colleagues, has been aimed at trying to understand what is distinctive about indigenous mental health issues, and suicide in particular, with a view to developing meaningful interventions.

I'll say a few words about what's distinctive. I apologize, again. I know this presentation is coming at the end of a long string of experts you have heard, who have given you, I hope, a very vivid picture. Most of what I'm going to say, I'm sure is already very familiar to you. Hopefully, I can address specific issues with you in the questions afterward.

What's distinctive about the situation of indigenous people in Canada is, first of all, the shared history of colonization and of the state apparatus that specifically targeted people's cultures and ways of life, and, in so doing, unravelled some of the fabric of community for people in ways that are still echoing down the generations.

What's also a common dilemma across these communities is their very geographic locations, their cultures and contexts, which pose challenges for the delivery of conventional mental health services. Finally, what's distinctive, looking more specifically at mental health, is the fact that suicide in these communities occurs primarily among young people, starting from early teens into young adulthood, and it often occurs in clusters. I think all of these are reflections of a particular social dynamic, a particular social context.

In addition to the conventional psychiatric or psychological or mental health approach, which tends to focus on individual characteristics and individual vulnerability, all of that kind of knowledge is certainly pertinent to understanding why one person rather than another in any particular community is vulnerable. However, given the high levels across whole communities and whole cohorts of young people, we have to look at the broader factors. Those are primarily social and structural factors. They include what I've already mentioned and what the work of many speakers, including Amy Bombay, speaks to, which is this history of suppression of culture and of forced assimilation and the disruption to parenting that resulted, in terms of the kinds of early parenting experiences that young people have in the community.

Then, in addition to those transgenerational forces, there are ongoing structural problems related to poverty, to relative poverty, not just to the absolute constraints of infrastructure, but to young people's sense of their own possibilities or disadvantage. There are also the problems of housing and crowding, infrastructure, and limited educational and vocational opportunities. Added to that mix is exposure to high rates of interpersonal violence, childhood abuse, and domestic abuse, resulting from trauma-related problems.

● (1635)

Finally, in the larger society, there is a dilemma of what we could call the “misrecognition” of indigenous people in terms of their histories, their autonomy, and their identities, and, along with that in many places, elements of racism and discrimination that really hit people very hard.

All of these issues need to be looked at to try to explain why certain communities, many indigenous communities, and young people in particular are affected. Also, in a sense, we have to put together the conventional body of knowledge in mental health around individual vulnerability, which most of our interventions are oriented toward, with a broader social perspective that understands these historical and contemporary forces that are really raising the vulnerability of a whole population.

We've also been involved in research, working with different first nations and Inuit communities around questions of resilience, because although rates of suicide are high in many communities, of course there are many communities and many families and individuals who are doing well, despite common adversities. There again, we assume that much of what's been learned about resilience in the general psychological literature is pertinent, but in our research, we try to look at what might be specific to indigenous communities in terms of aspects of resilience.

Very roughly, four broad themes came out of that work.

One was the notion of identity as being tied to place, tied to the land, and tied to the environment, and the sense in which one can have a self that is deeply related to the environment. That applies in particular for communities in remote and rural areas, where people are still very much surrounded by a living environment that they feel emotionally connected to.

The second distinctive source of resilience—I mention these because if we are looking at vulnerability factors, we also have to look at where the solutions might lie—has to with the recuperation of tradition, language, and spirituality, all of those sources of positive identity that we each draw from to have a sense of who we are and where we come from and a sense of pride in our background. Since that was an explicit target of the state policies that I've mentioned, such as residential schools and other policies, the strengthening and reinvigoration of indigenous traditions is recognized as important in many communities.

The third has to do with the oral transmission of knowledge, the idea that one trusted source of knowledge—the most basic, perhaps —comes from other people, and it comes in the form of stories that are rooted in tradition and convey a sense of collective knowledge that can then be a source of personal strength and problem-solving ability.

Finally, the thing that was raised by a number of communities we worked with was the notion of political activism. Given the history of disempowerment and the conflicts people have faced, the ability to engage actively in some way in taking control of local institutions —as was shown in the work of Michael Chandler and Chris Lalonde —and being able to feel a sense of empowerment and a collective voice is a very important issue, and for young people as well.

We've been interested in how these kinds of observations, which come from communities themselves, can be translated into effective intervention. Part of the challenge is that suicide itself, although it's an urgent problem and demands its own focus, is in a sense part of a larger array of interwoven issues related to mental health and well-being, so it probably requires a multipronged approach, in which some responses are targeted to the acute vulnerability to suicide, and others have to do with following up on people who are recognized as being at risk and providing them with appropriate resources that can prevent the escalation of their problem. Ultimately, they would have to do with long-term prevention, beginning with very young children and with parents before they have children, working through infancy and early childhood, and helping to strengthen resilience.

● (1640)

The Chair: You have just one minute remaining, Dr. Kirmayer.

Dr. Laurence Kirmayer: I direct a CIHR-funded Pathways to Health Equity suicide prevention implementation research team for first nations communities. We've been involved in recent years in working with first nations communities to develop mental health promotion strategies that are rooted in local culture and that can blend conventional mental health ideas about family well-being and youth resilience with a framework that is grounded in local culture and identity.

I think the take-home message for me is that it's not either-or. People need access to adequate basic mental health services, particularly in times of crisis and particularly for those who are most vulnerable, and also, the community as a whole can benefit from mental health promotion strategies that blend good ideas about improving family well-being, community well-being, and individual health with a strengthening of local culture and identity.

Thank you very much.

The Chair: Thank you very much for that, Dr. Kirmayer.

We'll move right into questions from committee members. I'll just let everyone know that we're going to be carrying on until 5:15 in this panel, at which time we'll switch to committee business.

The first question for you, Dr. Kirmayer, comes from Mike Bossio.

Mr. Mike Bossio: Thank you very much, Doctor, for being here today and for an outstanding presentation and the information you provided.

This hits at a lot of what I've been talking about throughout this study—the questions around re-establishing cultural heritage and the pride that goes with that, as well as self-governance and long-term stable funding. Would you agree that this connection to cultural heritage, whether through language, art, or the land, is imperative in dealing with the long-term nature of the suicide crisis that we've been dealing with?

● (1645)

Dr. Laurence Kirmayer: Well, thank you, Mr. Chair.

I think it is essential but it needs to be flexible, because in most communities there really are a range of perspectives. There are people who are sorely missing a sense of connection to their historical traditions and who want to recuperate them. There are people who are oriented in other ways. There are people in some communities who strongly identify with various forms of contemporary Christianity. There are other kinds of emerging forms of identity. So, as in any community in Canada, young people need a range of options and need to be able to find strength within any of those. It certainly is true, though, that the community as a whole has experienced, in a way that few other communities have, a kind of undermining of its collective identity. That can be strengthened and supported with benefit to everyone, even those for whom that will not be at the centre of how they construct their new identify as a young person. Maybe they want to be a scientist or a business person or some other kind of person in larger society.

Mr. Mike Bossio: Okay. Thank you so much, Doctor.

Very quickly, because I want to share my time with my fellow member Hunter Tootoo, and just feeding off of that, once again I guess it's imperative that the communities be the ones to establish the priorities. Therefore, the long-term stable funding needs to be there to support those priorities. Would you agree with that?

Dr. Laurence Kirmayer: Yes, I agree with that absolutely. Again, that speaks to the notion that the dilemma is in the sense of a loss of control, and that filters from the adults who are sort of mandated to exert control down to young people looking ahead to what their life might be like. I think re-establishing that in a meaningful way is going to be helpful to communities.

Mr. Mike Bossio: Thank you, Doctor, and I will now pass my time over to Hunter Tootoo.

Hon. Hunter Tootoo (Nunavut, Ind.): Thank you, Mr. Chair.

Thank you, Mike.

Thank you for the presentation. I have just one question I can think of.

You talked about a multipronged approach and the importance of long-term prevention and basic health services. If you've worked in northern Quebec and in Makivik, you've seen first-hand the challenges with being able to deliver those services there. How important do you feel it is to be able to have and provide those services, and to be able to help address this crisis in those communities? What are some of the barriers or obstacles you see to being able to deliver those services in those more rural and remote areas?

Dr. Laurence Kirmayer: Thank you, Mr. Chair.

I mentioned a multipronged approach partly representing different time frames. When individuals are in acute crisis, they need support and intervention at that time, and that requires particular resources. That raises right away one of the dilemmas in small remote communities, which is that our models of crisis intervention, for example, are generally based on a large urban environment where helping professionals are not directly related to the people who are involved. That's how people are trained, and that's how the various kinds of interventions are configured. It's very different in small communities, where it's likely that somebody who is affected is closely related to the people who are ostensibly offering help. That has both strengths and limitations. The strength is obviously that there is, or can be, a strong emotional bond and a deep understanding of the individual's predicament. The limitation is that it can be overwhelming for the care providers. They may feel that their actions are very constrained because of their relations with other people, and so on. It's part of why I say I think it's important to have both inside sources of help and support from outside, when a community is facing particularly challenging and severe acute problems.

There's no substitute for local support, for a safe place to go, for somebody who can be with individuals who are in crisis and who can offer a kind of warmth of human connection and understanding of their predicament, and solidarity, and intervene to protect them in different ways.

But there's also a need for people who have an ability to stand back from the situation and offer help and support from a position of not being entangled in whatever local conflicts are at that moment affecting the young person, for example.

This is one central issue in terms of training community mental health workers in crisis intervention, whether it's coming through the nursing station, a community worker, a self-help organization, a church, or other organizations within communities. It's one dilemma, and I think here again is an example of how it would be important to use perhaps e-health and other strategies to support people from a distance to do the work that only they can do up close because of their intimate knowledge.

This speaks to an equally important issue in terms of the intermediate range of intervention. When we think of intermediate intervention in this context, we're talking about identifying people—youth in particular—who may be at high risk for repeated suicide attempts or ultimately for death by suicide. They may need more intensive intervention, something along the lines of an extensive re-engagement, with connection in social networks, with some form of focused cognitive therapy, dialectical behaviour therapy, particular forms of intervention that help people who are having lots of recurrent and intense suicidal feelings and ideation, to help them deal with it more effectively. That is a fairly skilled kind of intervention, which again probably needs to be provided through some kind of pairing of local people and someone available perhaps outside the community.

Finally on the largest scale and the longest time frame, the hope is that we can really prevent more people from getting into the kind of predicament of contemplating suicide, and that is through prevention programs. Those I think are very clearly things that can be provided primarily by the community with help from outside the community in terms of programming.

● (1650)

The Chair: Thank you very much, Dr. Kirmayer.

The next question is from David Yurdiga.

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

I'd like to thank Dr. Kirmayer for participating in our suicide study. It's a study that's been going on for some time, and everything we've heard so far points to the healing process. We have heard testimony on suicide, poverty, incarceration, and a variety of other issues since the committee started looking at the indigenous issues in isolated communities and communities around Canada. We must not only keep looking at issues but also start looking into the proposed solutions the TRC report put forward.

Mr. Chair, I would like to apologize to the doctor. With my remaining allotted time, due to the importance of the TRC report, I want to resume debate on my motion and have it voted on. My motion reads as follows:

> That, pursuant to Standing Order 108(2), the Committee study the progress of the Government of Canada's promise to implement the Calls to Action of the Truth and Reconciliation Commission of Canada, including the resources that have been both expended and earmarked, as well as implications of implementing the Calls to Action; that the witness list include, but not be limited to, the Minister of Indigenous and Northern Affairs, the Minister of Justice, the Minister of Health, the Minister of Heritage, the Minister of Sport, and the Minister of Immigration, Refugees and Citizenship; government officials from Indigenous and Northern Affairs Canada, the Department of Justice, Health Canada, Heritage Canada, Immigration, Refugees and Citizenship Canada; and that the Committee report its findings to the House no later than June 1, 2017.

The Chair: Thanks a lot, David.

By way of explanation to Dr. Kirmayer, Mr. Yurdiga is using the rules of the committee, as he's permitted to do, to insert some debate on a previous motion that's been before us. If we get through this promptly, we'll come back to you. Please do stand by, and we ask for your patience. Thank you.

Is there any discussion on the motion?

I have Gary and Arnold, and then Charlie.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): Mr. Chair, I believe we have a lot of time for committee business toward the end of the session. I think it's disrespectful to interrupt a very eminent speaker today who is giving us very valuable information. I would respectfully ask that we defer this to the discussion that's scheduled for 5:15.

The Chair: Gary, David's within his rights to ask this, so the question is really to him, if he's willing to do that.

Mr. David Yurdiga: It won't take long. I request that we vote on this, if possible.

● (1655)

The Chair: Okay.

Arnold.

Mr. Arnold Viersen: Thank you, Mr. Chair.

I would highly recommend that our entire committee support this motion. We've heard time and time again that the TRC recommendations are important for this government to get under way. We want to make sure that's happening. I think it would be highly advantageous for us to take up a study on the TRC recommendations and how they're being implemented. I'd recommend we support this motion.

The Chair: Okay. Thanks.

Charlie, and then Mark

Mr. Charlie Angus: Thank you, Chair.

I want to thank Dr. Kirmayer for his excellent presentation. There's certainly much I'd love to discuss with him.

My colleague has brought forward the issue of the motion on truth and reconciliation. It is very pertinent because of the issue of the youth; what is going to be done with the youth today was one of the key findings, in the truth and reconciliation calls to action. We had a promise from the Prime Minister to bring forward every recommendation, and to implement it. I was there when the Prime Minister gave his word to the survivors that this would be done. This is a promise that runs bigger than an election promise. This is about a solemn promise that's made by a nation, through its parliament, through its Prime Minister.

I have to say on the record that of all the days I was in Parliament, I was proudest on the day the previous Prime Minister made that historic apology. That was a moment when Canada said we would make this right, and we still haven't made it right. We've seen this past week that the incredible work of Gord Downie and the Wenjack family has touched Canadians. We, as a nation, want reconciliation. We're expecting our officials to move on reconciliation. We expect this Prime Minister to follow through. I believe this is a recommendation to study this. This is not a partisan issue. This is about how we, through the Parliament of Canada, follow through on the promise that was made, that the Prime Minister speaking on behalf of all us and all Canadians, made.

If we are not going to look at the issue of truth and reconciliation and implementation of it, that would send me a very clear signal that this was just another promise to be broken, just another ploy. That would send a very negative message. We have to make sure that this nation-to-nation relationship is one of respect. It is perfectly reasonable for our committee to study it. Where else would we study it if not at our committee? We can be asking the ministers where they're going. This is not a confrontation. We are all in this as the Parliament of Canada, as the people of Canada. We want to know that path forward.

I thank my honourable colleague for his leadership on this and for bringing this forward. I certainly think that a vote is very important on this.

The Chair: Mr. Strahl.

Mr. Mark Strahl (Chilliwack—Hope, CPC): Thank you, Mr. Chair and members of the committee. This is no longer my permanent assignment, but I spent more than two years as the parliamentary secretary on this committee. I know the good work and the general collegiality that existed then and that I've heard exists here now.

I too, like Charlie, remember the Liberal Party of Canada quite quickly—before the full report was even released—saying that they accepted all of the recommendations without fail, every single one of them, and that they would implement them. That was part of their solemn promise to indigenous Canadians and to all Canadians.

I think quite frankly that having Mr. Yurdiga bring this forward is a step forward. You're talking today about suicide among indigenous peoples and communities. We can trace much of the current state of affairs, particularly on reserve, back to the dark chapter of Canadian history that involves the residential schools. This is a multi-generational issue that continues to manifest itself today.

I would say that, rather than this being an insult to the professor, this is actually extremely important and extremely germane to the study we are embarking on today, because this is a promise that was made.

It has been now nearly two years. We need to have a progress update. We need to have measurables. We need to move past words to action. All of the good words, and they are good words, about making things better for indigenous communities are only that, if they're not followed up on with significant action.

That's where we want to focus as Conservative members on this committee. As members of the official opposition, we want a report. It's just to get that update.

Concerning the fact that there's committee business, what the public or the witness might not know is that it occurs in an in camera discussion; it's not in public. If this motion is moved in private and it doesn't come out the other end, well, Canadians will know what happened to this motion, I think, seeing the unanimous support for the motion on this side of the table.

We want this to be debated in public. We want it to be debated, because we think it's the right thing to do, to get that progress update and see it done in a respectful way. There's no torqued-up language in this; no one's looking to embarrass anyone. We just want to get tangible, meaningful discussions to take place, we want to have those discussions in public, and we want this vote to take place in public, which is why Mr. Yurdiga moved it now. I salute him for it and I'll be supporting it.

● (1700)

The Chair: Gary.

Mr. Gary Anandasangaree: Mr. Chair, I would like to move that the committee proceed to another order of business.

Mr. Mark Strahl: There's already a motion on the floor.

Mr. Charlie Angus: There's already a motion on the floor.

The Chair: Are you moving to adjourn debate?

Mr. Gary Anandasangaree: Yes. Well, I'm moving to proceed to another order of business, because we have witnesses here. I think it's disrespectful to have them waiting.

The Chair: I think Mr. Anandasangaree is moving a dilatory motion to adjourn debate, to move on from this topic, which is his prerogative.

Mr. Mark Strahl: I would like a recorded vote.

The Chair: This will be a recorded vote.

Mr. Charlie Angus: I'm sorry, I just want to get this clear. It has been put forward that we vote on this motion on the TRC, and I'm certainly willing to vote in support of it. I'm not quite sure what my colleague is doing. Is it that he does not want us to be able to debate this publicly? Is he opposing the motion? Could he explain, because I understand the Conservatives are going to support studying the TRC. I'm certainly going to be voting to study the TRC recommendations.

I'm not quite sure what he's bringing forward at this time; from what he says and what you say I'm not quite sure. Is he saying he wants to bring forward—?

The Chair: Charlie, I'm sorry; you don't have the floor at the moment.

Mr. Charlie Angus: Well, actually I do have the floor. I'm asking for clarification. Mr. Chair, with all due respect, you are our chair. I'm asking for clarification here, so I did have the floor.

The Chair: Mr. Anandasangaree is putting a dilatory motion on the floor to adjourn debate on the topic of Mr. Yurdiga's motion, as is his prerogative, as it was Mr. Yurdiga's prerogative to raise the motion again today.

So there is a call for a vote, and we've been asked for a recorded vote.

I'm going to ask again that all those in favour of—

Mr. Mark Strahl: I'm sorry, what is the motion?

The Chair: Do you mean the motion as read by David Yurdiga a few moments ago?

Mr. Mark Strahl: I mean the new one.

The Chair: I'm sorry; I beg your pardon.

Could you repeat your motion please, Gary?

Mr. Gary Anandasangaree: The motion is "That the committee proceed to another order of business."

Mr. Charlie Angus: The question is what is the business that we are moving to?

Mr. Gary Anandasangaree: We do have a witness here, and I think we need to finish.

The Chair: You will proceed with a recorded vote then?

The Clerk of the Committee (Ms. Michelle Legault): Yes.

The Chair: Thanks for the clarification.

All in favour of moving to another order of business?

(Motion agreed to: yeas 5; nays 4)

The Chair: With that, we'll return to Dr. Kirmayer's testimony.

You have a minute left on your time for a question to Dr. Kirmayer if you would like, David.

Mr. David Yurdiga: Thank you very much.

We do hear a lot of issues about isolation. How is technology changing that? Is there a movement forward that's making it better, such that psychiatrists and psychologists can actually have face time with either their counterparts or individuals seeking counselling?

● (1705)

Dr. Laurence Kirmayer: Thank you, Mr. Chair.

Thank you, honourable member.

I think there is good evidence that the Internet and telecommunications can be used to have meaningful engagement with people to offer them support, to do psychotherapy and a variety of things. It's particularly the case for young people, who are already often heavily engaged in various forms of social media, and telecommunications, and are perhaps more comfortable with it. That said, there's no substitute for a physical presence, both on the part of somebody who wants to know the realities of the community and in terms of the physicality, the presence of someone who is there for you. Again, the ideal scenario involves some combination. It's much easier, for example, to provide support to someone over the Internet when you've met them at least once in person and you're reinstating or building on that existing relationship.

There is good evidence now that a whole variety of mental health interventions can be provided at a long distance and that they're more acceptable than some people would have thought, reflecting the comfort that many people are developing with these kinds of communications.

The Chair: Thank you, Doctor.

The next question is from Charlie Angus.

Mr. Charlie Angus: Thank you, Mr. Chair.

Thank you, Doctor, for this discussion.

I was fascinated by your talk on the disruption of parenting. It's something that I don't know if we've looked at all that much in this. We see the broken child welfare system. We see the huge effects that have been raised through Cindy Blackstock's work. If you look at statistics, we also see that it appears consistently that rather than support being provided to a family at home, when it comes to an indigenous family, the child will be taken out. If it's a non-native family, the supports will be put in place to support the family. We have this perpetuation of broken families from the sixties scoop right up through today.

What do you think that effect is, in terms of destabilizing young people and its effect in terms of suicide?

Dr. Laurence Kirmayer: I think you're pointing to a very important issue that occurs at multiple levels. There's no doubt that, because generations of people experienced institutional environments in the residential schools, they had very poor models for parenting in many of those environments. Parenting is something that, at least in part, needs to be learned; it's not innate. You need to acquire positive models. If your model is from a rigid and at times violent environment, then that will be the model—to some degree—that you're taking on board. That has affected whole cohorts of people, so the effect goes beyond individual families to affect whole communities.

Indeed, in our mental health promotion intervention in some first nations communities in the last few years, parents have been very keen to have parenting groups to talk together and to share experience, ideas, and approaches to the dilemmas they are experiencing with their kids.

There's an added wrinkle to this, which is that the nature of many communities is fundamentally different from what it would have been 100 years ago. In the sense of the scale of the community, for example, many northern peoples lived in small, nomadic groups, and the kind of parenting that works very well in that environment does not fit perfectly in an environment of 500, 600, or 1,000 people in a community. Different approaches are needed. People are in the midst of recalibrating their parenting processes. Taking children out of the communities and not reinforcing and helping people to build appropriate parenting in context contributes to a sense of destabilization and vulnerability in the communities.

It's a missed opportunity to help people reconnect with both traditional notions of parenting and those aspects that need to be adjusted creatively in order to deal with the modern environment, the Internet, and the other possibilities that our youth are facing in the larger communities.

Mr. Charlie Angus: Thank you.

I want to add another element to this. I was in one of the communities just before a huge suicide wave hit. They were trying to stabilize a youngster, but there were no mental health services available, and they couldn't get her flown out. It was told to me by people on the ground that when a young person is identified as being at risk of self-harm, there's the duty to report. Then, if the only tool you have is a hammer, the hammer is applied. The hammer is child welfare, so the child is taken and put into protective care, which makes all the young people go to ground, so tracking youth at risk becomes very, very difficult. If the only tool we have in the community is the child welfare system, it has an obvious negative effect.

I'd like your thoughts on whether we could put other proactive and preventive strategies in place so that the youth don't go to ground. What effect would that have in terms of breaking up these clusters of suicide before they form?

● (1710)

Dr. Laurence Kirmayer: You're absolutely right. I had an experience many years ago, in Inukjuak, in northern Quebec. It was during a period when the community had set up a kind of safe house or crisis centre for young people who were suicidal, where they could go, and where they could have a local elder or older person in the community who was solid and reliable be with them 24-7. It was possible not only to give them some support there but to bring in the family and talk to the family and try to defuse the crisis in some way. Therefore, there is potential to do much more good and, moreover, to have a positive intervention that would have a spillover or ripple-outward effect in the community, as opposed to simply taking the child out of the community.

You're right that our existing child welfare mechanisms are relatively crude. They're based on trying to intervene in what's viewed as a life-threatening situation, but they don't allow those gradations of intervention that could be more constructive. I think there's a very important opportunity to think that through more effectively.

Mr. Charlie Angus: There is, I guess, a perception in the non-indigenous community that the children are being taken out because they're at risk of violence or abuse. However, we were dealing with a case of a young woman who was in treatment for potential suicide. Her children had been taken away from her because she had no place to live, and unless she could find a place to live, they would not give her children back. These children were in a non-native community 1,000 kilometres away. She had no way to get her children back because we had no housing. In this situation, she is on the suicide watch, but these factors mean it is well beyond her ability or her family's ability to actually keep their family together. Again, we have really crude tools here, but they're actually incredibly effective at destroying lives.

Dr. Laurence Kirmayer: You have given an extraordinarily important example, not only because of how painful and how urgent the situation is, but also because it points to two blind spots in our way of thinking about these problems.

One is that a social structural problem, like a lack of housing, can have a profound effect on how people cope with situations. When the mental health system encounters that, it still tends to interpret it in terms of individual vulnerability and individual characteristics because those are the tools we have. There's a shift away from keeping the focus on the thing that needs to be changed structurally.

Equally, this becomes a problem in terms of social interventions. I think you're right when you say that the larger Canadian society—not only professionals but society as a whole—doesn't often have a very good picture of the real constraints and the tradeoffs in a small or remote community. These stories need to be brought forward so that people understand the kind of catch-22 that's built into the system and that demands a more flexible and appropriate response.

Mr. Charlie Angus: Thank you very much.

The Chair: I'm afraid we're now out of time for the panel discussion.

I want to thank you, Dr. Kirmayer, on behalf of all the committee members, for your well-considered and thoughtful testimony. It will be a wonderful help to us as we carry on.

Dr. Laurence Kirmayer: Thank you. It was a privilege to take part.

The Chair: We're not going to suspend. I think we'll move right into committee business. We'll go in camera at this point.

[*Proceedings continue in camera*]

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