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The Honourable MaryAnn Mihychuk

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● (0845)

[*English*]

The Chair (Hon. MaryAnn Mihychuk (Kildonan—St. Paul, Lib.)): I call the meeting to order.

Good morning. I hope everyone is well. We're going to begin our meeting of the INAN committee. We have two presenters in our first hour. I call you up to the table.

The way the committee works is we'll give you 10 minutes each to do your presentation, and then after that there are a series of questions from committee members. When you're ready, one of you will begin. You've tossed a coin for whoever starts, and we'll get going.

Mr. Del Graff (Child and Youth Advocate, Office of the Child and Youth Advocate Alberta): I guess I'm elected to start.

The Chair: Oh, very nice. Good. Del, welcome.

Del Graff, child and youth advocate from the Office of the Child and Youth Advocate, Alberta, welcome to our committee.

Mr. Del Graff: Good morning, Madam Chairperson and the committee.

I would like to say I appreciate the opportunity to talk with you about suicide among indigenous peoples and communities.

My name is Del Graff. I'm the child and youth advocate for the province of Alberta. I'm of Cree, Métis, and German ancestry, and I've been married to a woman who's Métis from northern Alberta for 30 years. We have raised three children and we have two wonderful grandchildren. I'm very honoured to have the opportunity to speak with you today.

I would also like to acknowledge that the land on which we gather is the traditional unceded territory of the Algonquin Anishinaabe people.

As an independent office of the Alberta legislature, we provide direct services to vulnerable people throughout the province. Our advocacy efforts focus on children and youth in the child welfare and youth justice systems.

I also have the authority to review the deaths and serious injuries of young people receiving child welfare services or who had received services within two years of their death.

Unfortunately, what I have observed in this role is extremely unsettling. Since I took on this responsibility in 2012, my office has received 40 reports of young people who have died by suicide or been seriously injured after attempting suicide. Twenty-six of those young people were indigenous.

I'll be referring to two reports that my office has released in the last year. Both reports can be found at our website under "Publications".

In 2016, I released a report called "Voices for Change: Aboriginal Child Welfare in Alberta", a special report on aboriginal child welfare in Alberta. We talked to indigenous young people, elders, parents, caregivers, and professionals about their experience in child welfare. They also talked to us about what they think would make it better. I raise this here because the report provides a snapshot of what has happened in Alberta.

When we looked at the overrepresentation of indigenous people, this is what we found. About 10% of the young people in Alberta are of indigenous ancestry, yet they account for almost 70% of the young people in government care. Of those who are involved with child welfare but not in care, 38% are indigenous young people. Of those who are in temporary care, 54% are indigenous young people. By the time they reach permanent care, three out of every four young people are indigenous. What that means is that the more intrusive government is, the more disproportionate the numbers are.

In Alberta on a per-1,000 basis, for every 1,000 non-indigenous children, three will be involved with child welfare. For every 1,000 Métis children, 18 will be involved with child welfare. For every 1,000 first nations children in Alberta, 94 will be involved with child welfare. What that means is Métis children are six times more likely to have child welfare involvement than their non-indigenous peers, and first nations children are more than 30 times more likely to have child welfare involvement than their non-indigenous peers.

This has to be considered unacceptable by anybody's standards.

In April 2016, we released a report called "Toward a Better Tomorrow: Addressing the Challenge of Aboriginal Youth Suicide". In that report, we talk about the experiences of seven indigenous young people who died by suicide over an 18-month period from 2013 to 2014. The deaths of these seven youth put a face on these tragic circumstances.

Two of these young people were brothers aged 15 and 18 who died within four months of each other. I'm using pseudonyms, as our legislation prevents me from identifying youth who are receiving designated provincial services. The names are most often chosen by family members. Fifteen-year- old Sage was a shy boy who dreamed of becoming a famous violin player or a rap artist, while his 18-year-old brother Cedar was outspoken and the protector of his younger siblings. They grew up in a home where they were exposed to family violence, addictions, and neglect. Their mom was a single parent.

Because of these concerns, child welfare services became involved with their family shortly after Cedar was born, and support services were provided in the family home. The boys were taken into government care when Cedar was three years old and Sage was six months old. Over time, there were efforts to return the boys to their mother's care, but, sadly, they were unable to stay with her. The boys moved into foster care and group homes, but they yearned to be returned to their mother.

By the time Cedar and Sage reached adolescence, they were both using drugs and alcohol and had stopped attending school. Sage was a very sad child, and he expressed that he did not know why. He died by suicide when he was 15 years old. Just four months later, 18-year-old Cedar also died by suicide. Both boys' manner of suicide was the same, and they both died in their mother's home.

● (0850)

I had the privilege of meeting the mother of these two young men, and she feels that Cedar ended his life because he felt he was to blame for Sage's death. Her grief is beyond words. She's very worried about her remaining children, who have told her that they've contemplated suicide.

The community where this family lives has been tremendously impacted by suicide, and this is not unlike other communities in Alberta or across Canada. The other five indigenous young people whose experiences we describe in our report came from different communities. Some lived in cities, some on reserve, some off reserve, and some in small towns. There were three girls and four boys, ranging in age from 14 to 18 years old. Some grew up in government care, while some were primarily raised by parents or relatives.

What did they have in common? It was family disruption and the legacy of residential schools; early childhood trauma from exposure to family violence, neglect, or abuse; and parents or caregivers who had addictions or mental health problems. Many experienced the death of a family member by suicide.

My report identified three areas where we think action should be taken for improvement.

First, we must pursue community-led strategies to address indigenous youth suicide. We cannot apply a one-size-fits-all approach to this issue. Each community is unique and has different circumstances and conditions. As a result, it's imperative that each community develop local strategies and solutions that are community led. I believe that government is best positioned to provide resources and to use its policies and financial levers to support community-led strategies.

Second, it is important that we address indigenous youth suicide holistically. What does this mean? It means that we need to demonstrate an understanding that youth at risk for suicide must be assisted physically, mentally, emotionally, and spiritually. It means that communities need to engage families, community leaders, service providers, and key professionals to collaborate in the development and implementation of their community-led strategies. It means that those strategies should include efforts and responses across a continuum of suicide, including prevention, intervention, and aftercare.

Finally, our report calls for building and supporting protective factors for young people. When we talk about protective factors, we're specifically referring to conditions that promote the social, physical, emotional, psychological, and spiritual health and well-being of children. We know with certainty that investing in protective factors greatly enhances a child's healthy development and prevents suicide. For example, a strong connection for indigenous youth with their traditions and culture can enhance their sense of belonging, of identity, of purpose and meaning for their lives, which will act as protective factors for them. Protective factors can be found at the individual, relational, social, and community levels. Individual protective factors like good physical and mental health, good coping skills, along with relational factors such as having positive role models and strong and healthy relationships with extended families and elders can make a huge difference.

Hope comes from protective factors. Dr. Chris Lalonde, who's a professor of psychology at the University of Victoria, was an expert committee member on our report. He speaks about resilience and protective factors in his work. He points out that there are a number of healthy indigenous communities across Canada that have very low concerns related to suicide. He suggests groups can look at the protective factors in those communities to see what's working well.

If you take those protective factors and work with communities to implement them, you'll likely see positive change. Risks can never be fully eliminated, but young people can be empowered with the skills they need to successfully navigate and cope with risks they encounter. Having this resiliency can help young people from turning to suicide.

It's my sincere hope that my presence here today moves governments, communities, and community leaders to act on the issues related to indigenous youth suicide. Further, I hope that as we move forward, we will find ways for young people to build on and celebrate their strengths, and that when they face adversity, they do so with a clear sense of who they are and where they come from, a sense that they are surrounded by people who love and support them and that they feel a sense of belonging to a healthy and caring community. That is what I think we all want.

I was told a long time ago that when you are really struggling with challenges in life, you need to go where you're loved. Every young person in this country needs to know where they can go for the love, comfort, and support that they need.

Thank you very much, Madam Chair, and I'll be happy to answer any questions once the other presenters finish.

● (0855)

The Chair: *Meegwetch.*

I want to apologize to the committee and to the guests. I normally point out that we're very grateful to be on the unceded territory of the Algonquin people. It's especially important as we've begun the process of truth and reconciliation. I wish to point out my apology on that.

Now, thank you for those insightful comments.

We're going to hear now from First Nations Child and Family Caring Society of Canada. I welcome the executive director, Cindy Blackstock.

Dr. Cindy Blackstock (Executive Director, First Nations Child and Family Caring Society of Canada): Good morning. I too recognize the unceded territories of the Algonquin people.

My name is Cindy Blackstock. I'm the executive director of the Caring Society. I am also a professor at McGill University.

Faced with the tragic headlines of repeated deaths of first nations children and young people across the country, too often Canada's historical reflex has been to cite what it has done and to promise to do better. We say that first nations children and young people should be patient with the government, that we should all be patient while progress is done.

The word “patience” means to suffer without complaint, and I think this country is far better than asking children to suffer without complaint.

The issue linking the inequalities that first nations children experience in health care and the deaths of these children is not a new story in Canada. In 1907, 110 years ago, Dr. Peter Henderson Bryce, Canada's chief medical health officer, raised the concern about the inequitable health services provided to first nations children in residential schools and their preventable deaths from tuberculosis. A leading medical doctor at the time, president of the American Public Health Association and founder of the Canadian Public Health Association, Dr. Bryce said that medical science knew how to save these children, who he stated were dying at a rate of 24% a year or 48% over three years. He believed it would have cost Canada $10,000 to $15,000, but the Canadian government said it was too expensive and that it would take one step at a time. The children continued to die.

In 1908, one of the leading lawyers of the time and co-founder of Blakes law firm, Samuel Hume Blake, said in response that if Canada failed to obviate these preventable causes of death, it would bring itself “into unpleasant nearness with manslaughter”. People of that period found Canada's failure to respond to the health inequities faced by first nations children to be immoral and possibly illegal.

There are a number of reports that span the decades, pointing out to the federal government the inequalities experienced by first nations children. The deaths and indeed the harms done to first nations children are too numerous to recount in this short period of time, but I will take your attention to 1946, when the Canadian Welfare Council and the Canadian Association of Social Workers did a joint presentation noting the inequities in services to the Royal Commission on Aboriginal Peoples in 1996; to the report by Dr. Patrick Johnston in 1983; and, of course, to the numerous reports done jointly with the Department of Indian Affairs in 2000 and 2005.

January 26 of last year provided a new moment of hope for this country. It ended a 10-year legal battle filed by the Caring Society and the Assembly of First Nations on Canada's inequitable treatment of first nations children in child welfare and its failure to implement something called Jordan's principle.

Jordan's principle is to ensure that first nations children receive equitable access across a whole range of public services on the same terms as other children, without delay. It was filed in 2007. The Canadian government fought it tooth and nail, but the tribunal substantiated the complaint and—relevant to this matter—cited significant evidence before it in the hearings that Canada was aware that mental health services were desperately required by first nations children due to the multi-generational impacts of residential schools. In Ontario specifically it was required by the Ontario Child and Family Services Act, yet federal officials testifying before the tribunal confirmed that yes, they were aware of that statutory provision, but no, Canada did not fund those services.

No, Canada does not fund those services, and kids were dying. The tribunal orders make specific mention of this in numerous paragraphs of the decision handed down on January 26, substantiating the racial discrimination by the Government of Canada and ordering Canada to immediately cease its discriminatory action. Specifically, it says paragraph 392:

> ...the application of the *1965 Agreement* in Ontario also results in denials of services and adverse effects for First Nations children and families. For instance, ...the agreement has not been updated for quite some time, it does not account for changes...over the years to provincial legislation for such things as mental health and other prevention services. This is further compounded by a lack of coordination amongst federal programs in dealing with health and social services that affect children and families in need, despite those types of programs being synchronized under [the provincial child welfare act in Ontario].

● (0900)

Canada did nothing to respond to that particular section of the order. In fact the tribunal, in its April non-compliance order against Canada, cites the failure of it to immediately provide mental health services again. In July we get this announcement from the federal government that they're providing up to $382 million for Jordan's principle. It was a breath of relief for those of us who hoped that those poor kids in Ontario would finally get the mental health services they require, not only in Ontario but across the country, but that did not happen.

In September the tribunal makes another non-compliance order and specifically mentions Canada's failure to provide mental health services and asks for further details. It recognizes the $382 million announcement and the further announcement of $60 million on mental health, but it doesn't know what it means for children. They said those are nice numbers to hear in the air, but what does it mean for children and Canada's compliance with this order? All of that remains unclear.

Canada starts to clarify that on October 31, 2016, when it finally says that INAC is working with the Province of Ontario and first nations to discuss the provision of mental health services.

I want to make it clear here that the tribunal did not order Canada to discuss how to provide mental health services; it ordered it to immediately provide those mental health services. That's Canada's own document of October 31, 2016.

In January of 2016 we get a legal submission from the Government of Canada. We find out how much they've spent of the $382 million, and it turns out they've spent $5 million of that. That's 1.3% of that allotted money, and 91% of the claims are in Manitoba and in Saskatchewan, leaving only 9% for the remaining jurisdictions.

There are further non-compliance orders against Canada. We have cross-examined Canada's witnesses, and those transcripts will be made available publicly. When that evidence comes out, I think it would be well worthwhile for everyone who is on this committee to read it very carefully.

I want to back up and look at the consequences. Remember Blake's statement that Canada brings itself into “unpleasant nearness with manslaughter”. We like to think we learn from residential schools. I'm not sure that we always have. While Canada was failing to comply with the order, Wapekeka first nation sends an urgent mental health proposal to Health Canada dated July of 2016, right after the first non-compliance order handed down by the tribunal. It makes a plea for the immediate provision of mental health services, citing a suicide pact among the girls. Canada doesn't reply for some months. Then says it will discuss the provision of mental health services.

On January 10, 2017, Chantel Fox dies by suicide at the age of 12. Two days earlier, Jolynn Winter, 12 years old, died. We don't know if those little girls would have died had Canada implemented the order, but I think we can all agree around this table that it would have given them a fighting chance.

It's inexcusable to me that we can offer any justification for Canada's non-compliance. People have said to me that we can't afford to implement the entire order, to which I ask, what are first nations children losing to? The Canadian government is spending half a billion dollars on the birthday party. You're renovating Parliament. Is that more important than any of these kids?

Racial discrimination and inequity have been known to this country for many decades and years. Equity for first nations children need not be done a teaspoon at a time. A great nation and a great people and great leaders don't make excuses for inequality. They move with dispatch, because children's lives are on the line, and as Dr. Michael Kirlew, the physician at Sioux Lookout in charge of Wapekeka, says, these deaths are preventable.

● (0905)

You can talk about codifying this as a personal problem for first nations or for the kids or for what you're going to do for services, but as the World Health Organization has said, “social injustice...is killing on a grand scale”, and the one thing you can do in this committee is ensure that the federal government fully complies with that Canadian human rights order and with Jordan's principle.

The Chair: Thank you very much to both presenters. It was very informative and passionate. I'm sure our members will have a lot of questions.

The first questioner is MP Rémi Massé.

[*Translation*]

Mr. Rémi Massé (Avignon—La Mitis—Matane—Matapédia, Lib.): Thank you, Madam Chair.

I want to thank Mr. Graff and Ms. Blackstock for participating in the committee's work. It's very much appreciated.

We've heard many people speak about the major crisis plaguing aboriginal youth. We must find prevention solutions, and ways to heal and ensure this type of crisis doesn't continue.

My first questions are for Mr. Graff.

In your presentation, you spoke about three possible intervention areas, and one involves pursuing a community-led strategy.

Can you elaborate on this?

[*English*]

Mr. Del Graff: Thank you very much for the question.

When we looked at the issue of community-led strategies in Alberta, where we found some encouragement was in the strategy to address homelessness. There was enough of a framework and enough resources to have some kind of goalpost, but there was also enough flexibility so that each community could deal with its own concerns related to homelessness.

That's also within the context of having suicide prevention strategies at a larger level, both provincially and nationally. Alberta does not have a suicide prevention strategy that then provides a frame for that kind of approach with communities. In many ways, the most important thing is to get both a national strategy and a provincial strategy, because that enables communities to then lever the resources and address the concerns that are quite community-specific.

In my remarks, I also included the importance of having a range of groups involved, including community leaders, families, etc. It is absolutely critical that there be a broad level of involvement in those strategies, or else they will not be effective.

● (0910)

Mr. Rémi Massé: Do you have any best practices examples of this specific strategy that have worked in some communities? Do you have some concrete examples of things that seem to have worked and provided some solutions?

Mr. Del Graff: I don't have any specific ones at the moment, but I can certainly find them. One of the things I can say is that the work of Chris Lalonde has elevated some of those communities to become examples of where suicide concerns are at a very low level, and it is because these communities have had approaches that deal with those protective factors so that young people have been enabled to have the resilience they need when they face adversity.

Mr. Rémi Massé: You caught my attention with your entire speech, but especially when you talked about protective factors. Help me to understand a bit more what you mean by those protective factors.

Mr. Del Graff: I can describe them as knowing who I am; knowing where I'm from; knowing what my values are, because they were instilled in me through generations and through extended family and my community; being a valued member of the community, having both rights and responsibilities; feeling embedded in a place that is healthy and that helps me when those adversities show themselves.

Those are factors that protect me when difficulties arise. I know what to do. I have resources. I have internal resources, but I also have support resources around me.

That is what I am talking about when I'm referring to protective factors.

[*Translation*]

Mr. Rémi Massé: Ms. Blackstock, over the course of its work, the committee has heard many times that the coordination of health services among the various levels of government is particularly complicated and that this could great gaps in health services delivery. You referred to this issue.

As part of a solutions-oriented approach, what measures would improve the coordination of services?

[*English*]

Dr. Cindy Blackstock: I think Jordan's principle is the answer, and that's what the House of Commons passed unanimously in 2007. It simply says that where there is a gap, the government of first contact pays for the service and then works out the jurisdictional issues later. As we know with mental health services in Ontario, this is statutory and confirmed by the department going back a number of years. It's a very simple solution.

Keep in mind that when people say that it sounds complex, it's actually not complex, because Canada has worked out arrangements with the provinces and territories to ensure that every other child in this country is not exposed to the level of risk that first nations children are exposed to.

Mr. Rémi Massé: More specifically, do you think there are specific difficulties with Health Canada in the First Nations and Inuit Health Branch in terms of coordinating efforts to help prevent and resolve, which is a big word? Do you think there is a specific issue with one section of Health Canada, which is the First Nations and Inuit Health Branch? Are there any best practices that we can implement? Is there something there that we need to look at particularly?

Dr. Cindy Blackstock: I would recommend that there be an internal review both of INAC and First Nations and Inuit Health Branch in terms of an independent evaluation of their capacity to be able to implement the orders and respond to the many good solutions that have been put forward to them for improvements throughout the years.

One of the examples I would say is if we look at things like the CHRT order, where there was clear direction by the panel on how to resolve these issues, and yet Canada and the First Nations and Inuit Health Branch has not moved to resolve those matters, even when it was as easy as approving a mental health proposal from Wapekeka First Nation. I think that needs to be done internally in government to better prepare those departments to comply with the orders and take advantage of the good solutions that will come from this committee and that have come from past committees.

● (0915)

The Chair: Thank you.

That concludes your round of questioning.

We'll moving on to MP Cathy McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

Thank you to both of the speakers today for their passion and presentations.

I think it was November 1 when the NDP put forward a motion, which was unanimous in Parliament, about the injection of $155 million. Sometimes you hear lots of numbers thrown out in terms of what's happening. Has that $155 million wound its way through the system to help children on the ground?

Dr. Cindy Blackstock: My information, based on the analysis of INAC submissions and of its public statements, is that nothing has been provided of that $155 million since the motion has been passed in the House of Commons.

Mrs. Cathy McLeod: That was a very specific motion. It was supported by the Liberals, and it was immediate. The word was “immediate”, so that certainly is a huge concern in terms of that piece not being followed through.

Did the tribunal indicate how that money could flow and how it would immediately support first nations children?

Dr. Cindy Blackstock: The tribunal lays out in its orders very specific measures for the rectifying of the inequalities that it sees as most urgent. Included among those is the provision of mental health services and ensuring that the Department of Indian Affairs is funding on a basis of need.

The department, I should say, can fund on the basis of need immediately in one way, and that is to provide actual costs for the prevention services and for the array of other services that first nations children need. They have it within their existing authorities. They do it already for maintenance and for many arrangements for which the provinces are service providers. They have simply not done it, despite calls by first nations to do it in this case.

Mrs. Cathy McLeod: In British Columbia, of course, we have the First Nations Health Authority. Have they managed to be more agile, nimble, and responsive in terms of mental health?

Dr. Cindy Blackstock: I have not seen any kind of evaluations in terms of its application for children specifically. I will say that on-the-ground reports are that they're providing more culturally based services, but it's important to recall that they don't provide child welfare services and—

Mrs. Cathy McLeod: But they would be responsible for mental health.

Dr. Cindy Blackstock: Yes, but that's within the restrictive envelope of whatever the federal government would provide in terms of their funding arrangement.

Mrs. Cathy McLeod: I'm a former health care worker and certainly was involved with a lot of rural and remote services throughout British Columbia. Mental health can be a huge challenge both on and off reserve. The actual mental health services prevention communities, I think, are in a very good position to move prevention services forward.

Are there any creative ways? I know it's a huge challenge to get appropriate mental health services into rural and remote areas, period. Do you have any thoughts on that?

Dr. Cindy Blackstock: Yes. I would say that Wapekeka provides us a good example of a community in a remote area that was doing great work in preventing suicides, but that funding program was cut by Health Canada, and then we saw the resurgence of those risks, and that was their call for funding. There are examples out there of remote first nations that have developed culturally based plans of care that Del was talking about, and implemented them.

The other piece is that I think we have failed as a country to take advantage of the technology available. Why don't we have adequate telemental health services for children and young people? Often when we do provide mental health services, they're short term and acute, and they don't account for the longer-term needs of children or for the specific developmental and cultural needs of first nations, Métis, and Inuit children. That needs to change.

Mrs. Cathy McLeod: You bring up a good point, because I thought it was certainly something we should be taking advantage of.

I believe we did have a witness who talked about the telehealth services for mental health. They were concerned in terms of how effective it would be in supporting communities and children in communities. They expressed concerns. Do you have any thinking there? Are there examples of children who are receiving good, appropriate mental health services through telehealth?

Dr. Cindy Blackstock: I don't know if children are receiving good and appropriate services through telemental health, because my experience in talking to youth in northern communities is that it's not available to them.

I don't see that as the exclusive approach, but I think it's one approach, and it's certainly better than what's going on in many communities right now, which is that there is no support for children and young people in mental health services. When there is mental health provision, it's often geared to adults and not addressed specifically to the unique development of children, and I would include brain development.

● (0920)

Mrs. Cathy McLeod: Is there a little time still?

The Chair: We have a minute and a half.

Mrs. Cathy McLeod: Good grief.

Mr. Graff, is there analysis out there? Certainly we've had some very difficult and compelling testimony, and often it's been suicides of loving children in very loving families.

You talked about children who are in care in Alberta. Has there been any sort of analysis in terms of...?

I would presume that they would be at higher risk, but I don't know if that's accurate in terms of what you found, because they wouldn't have those protective factors or the place to go when loved. Can you make any comment? Is there analysis done?

Mr. Del Graff: I can make a couple of comments about that.

Certainly young people who come to the attention of child welfare authorities usually do so because they're at higher risk than the general population. Some of those risks have nothing to do with the circumstances of those children, other than that they don't have adequate care. The issues surround neglect, substance abuse-related neglect, exposure to parental violence, and those kinds of issues. There can be a host of reasons that they have an elevated level of trauma in their histories, and certainly that is something that comes to the fore.

When we look at child welfare, we're just looking at a population that has been identified. There's a whole wealth of young people who have those issues, who aren't identified through child welfare, and they're an important group as well.

The other thing I'd say is that in the isolated and remote communities that I've been to, one of the things we can overlook is the strengths that those communities have. If you go to Fox Lake, Alberta, a fly-in community primarily, you'll find that almost everybody in that community speaks their mother language fluently. That is something you don't see in other places, but it gives some sense of collective community when you can see three-, four-, and five-year-olds speaking their language and doing it in a way that is part of their everyday lives.

That's just one example of a strength that some of those communities have that we can overlook quite easily.

The Chair: Thank you very much.

Moving on, the next round of questions is coming from MP Romeo Saganash.

Mr. Romeo Saganash (Abitibi—Baie-James—Nunavik—Eeyou, NDP): *Meegwetch*, Madam Chair.

I thank both of our witnesses this morning. In my view, any child and youth advocate deserves the highest of respect. Thanks to both of you for your work.

I have a couple of questions, but I don't think I'll be able to ask them in the short period of time I have.

First of all, Cindy, I think you talked about patience. In my experience over 35 years in this business, a lot of people have always talked about the complexity of the issues that we face as indigenous peoples. That's one side of it, but however complex and difficult issues are, if there is no political will to work on them or to resolve them, then we're not moving ahead. Thank you for that.

Here's one of the questions that I would like to ask you. I commend you for the work that you've been doing over the years for children. I think Canada owes you a lot. On behalf of Canada, I want to say “thank you” to you this morning.

One of the things that always bothered me in this discussion is the fact that for a very long time, and in fact for the last 150 years since Confederation, indigenous rights have been viewed as constitutional rights, rarely as human rights. Everybody endorses the UN Declaration on the Rights of Indigenous Peoples. Also, the present government said that they would implement all 94 of the Truth and Reconciliation Commission's calls to action. I'd like you to speak to that aspect of these kids having human rights: the human right to clean water, the human right to a roof over our heads, and the human right to be who we are as indigenous peoples and indigenous kids.

I'd like you to address that, because it's never been talked about in that sense. Then I want to come back to the Human Rights Tribunal decision and orders, but first of all, it's about human rights.

● (0925)

Dr. Cindy Blackstock: Just two days ago, I was on Parliament Hill with 700 children. Children understand that these kids have human rights. They understand that they are little kids just like them. In fact, one of the poems that one of the non-aboriginal kids wrote out reads:

> Roses are red,
> Violets are blue,
> Indigenous kids
> are children too.

In the 90,000 documents that I read in the lead-up to the tribunal —these are federal government documents—I can see them referencing these children as “people” in maybe less than a dozen documents; they were a “program”, a “file”, or an abstraction, something that “we're making progress on”. Even when it got to the minutia of a four-year-old little girl who needed breathing equipment so she wouldn't suffocate, it was about the authorities the government had to respond to it. It wasn't about a four-year-old trying to breathe.

I think we have to unhinge ourselves from the abstraction. I think it's too comfortable to say that it's a program or a file. Chantel Fox and Jolynn Winter and their families don't have that ability, and I don't think we should allow ourselves to do anything less than to imagine that these are our own children, and to call ourselves up to doing everything possible, everything imaginable.

Even that which we think we can't do, we must do, because governments do a lot of complex things. They brought in 40,000 refugees, and I'm very supportive of that. They fight wars and they sign international trade agreements. They're able to do that. I have full confidence that they're able to operate on the solutions that are already on the table and, in fact, the legal rulings that are already on the table. They just need to do it.

Mr. Romeo Saganash: Thank you.

Obviously, since the decision of the Canadian Human Rights Tribunal and the two subsequent orders to comply have not been met to date, that's clear contempt of court on the part of the government. It's contempt of Parliament as well, because that motion we presented was unanimously accepted by Parliament. The motion expresses the will of Parliament. There's clear contempt of Parliament there too.

If we had the ability to do something tomorrow morning, what would you suggest we do?

Dr. Cindy Blackstock: You can do it today. The government could immediately comply with all the orders that are very specifically mapped out in that tribunal decision. There is no reason for further discussion.

When Canadians are found to be in breach of the law, we don't ask them to discuss how they're going to comply. You have to comply with these orders. If I failed to comply with three legal orders, I would be in prison at the moment, as a citizen. The Canadian government is setting a very dangerous precedent here of saying, “We'll accept the decision. We won't appeal it, but we're not going to comply with it.” What does that mean for every other respondent who's found responsible for discriminating against human beings of any diversity in this country—that you just have to accept the order, but not comply with it? That's a dangerous precedent, not only for first nations children but for all equity-seeking groups in the country.

I would hope Canada wants to set a better example. It must comply immediately. That's what it's been ordered to do.

The Chair: You have 20 seconds left.

Mr. Romeo Saganash: I want to ask about the protective factors. I know language and culture are important. The Prime Minister had other suggestions in that respect, but that's his opinion. Can you provide any specific examples of how we can achieve those?

● (0930)

Mr. Del Graff: I can certainly identify what happens in some communities now in terms of cultural events that bring people back.

There's been a large migration in our province of indigenous people moving from rural and remote communities to urban communities, but because there are identified areas of celebration for particular first nations communities, those people will come back. They refer to it as coming home. They go home for that ceremony or that event. That helps them to be connected to their community, even though they may live in an urban centre. It's certainly one example that happens frequently.

The Chair: We're going to move on to questioning from MP Don Rusnak.

Mr. Don Rusnak (Thunder Bay—Rainy River, Lib.): Thank you both for coming to the committee this morning.

I know this is a very difficult subject. One life lost is far too many. I know we on the government side want to do everything we can to make sure that the government is responding correctly and with the utmost urgency to the crises that are faced in indigenous communities.

I, as an indigenous person, faced a lot of challenges in this country growing up. I would say I still face challenges in this country. We can't be divided on this. We need to be united and give real solutions to government. Having said that, I know there have been tribunal decisions, and the government has committed money and announced money in response to these decisions.

I want to ask first, Ms. Blackstock, where does that money go if Health Canada or INAC releases that money immediately, and how does that happen?

Dr. Cindy Blackstock: The tribunal has already put out where the money needs to go. I'd also just draw your attention, member, to significant research that's already been done on child welfare and Jordan's principle dating back now, in my early involvement, to 1997. We could actually show you down to the last penny pretty much where we could spend these monies.

I'd also like to point out that budget 2016 was actually drafted in the fall of 2015, before the tribunal even ruled, and there's been no adjustment to budget 2016 since the tribunal ruled. We need to press the refresh button, look at what's needed, and provide the resources with dispatch so that these children are not going yet another day without the services.

Mr. Don Rusnak: You mentioned that 91% of the $5 million went to, I think, Saskatchewan and Manitoba communities.

Dr. Cindy Blackstock: Yes.

Mr. Don Rusnak: Of $5 million, if that were to be expanded in terms of Wapekeka and its ask from Health Canada—and I don't know what the ask was specifically—but if it received the the money and if other communities have been asking for funds for their prevention strategies, would that eat up the amounts that Health Canada and INAC have?

Dr. Cindy Blackstock: I think it would exceed them.

Health Canada and INAC have been using a very narrow definition of Jordan's principle. It was up on Health Canada and INAC's website even as recently as last week, and it said that the only children eligible to apply to that fund were children with short-term critical illnesses and disabilities, so if I'm the parent of a child with mental health issues, that is a “do not apply” sign right on the INAC website.

We have seen that Wapekeka, for example, wanted $376,000. That's how much it would have cost to save those children's lives. My recommendation to the government is that you fund at actual costs immediately across all government services to ensure that first nations children are not denied services available to every other child, and that can be done very quickly.

Mr. Don Rusnak: Where would that money go? You said the tribunal has ordered very specifically where the money should go. I know from my time at Grand Council Treaty No. 3 that a lot of first nations organizations ask for money to do certain things, a lot of very good things. I know a certain amount has been promised by the Ontario government and Health Canada in Ontario, and not all of that money has flowed. I have heard from my connections within first nations communities that there's a battle between some indigenous organizations over that money, and that has delayed some of that money.

Is there any truth to that?

● (0935)

Dr. Cindy Blackstock: You asked where it went. In the tribunal's evidence at tabs 78 and 302, which I would be pleased to provide to the committee later, these are actually federal officials identifying the gaps in services that existed as of 2012 and that continue to exist. Health Canada and INAC have still not addressed those gaps.

They're about things like children's mental health, ensuring that there is addictions treatment on par with what other children get, occupational therapy, and the breathing equipment we talked about so that children don't suffocate. Those things have already been identified within the record, and I provided them very recently again to Health Canada and INAC with a request that they move immediately to provide funding for those gaps already identified by their own officials at the highest levels in the department.

Mr. Don Rusnak: One of the things we heard on Tuesday from two chiefs testifying before this committee was that there are not only short-term problems that need to be addressed but also long-term issues. I've used this expression before and I've been attacked for it, but the chief said the same thing on Tuesday, and that was that we've become beggars in our land. For the long-term solution, we should have a share of the resource revenue of this land to make sure that as indigenous people and indigenous communities and indigenous governments, we don't have to go to some other source to pay for what we should have ourselves, and that we have our own resources to be able to do what we need to do as communities and to thrive as a people in this country.

There's the short term, always going to departments and asking for funding to do what we know we need to do in our communities, but there's also the long term.

Mr. Graff, do you see a road to long-term solutions to this issue?

The Chair: We have only about 30 seconds.

Mr. Del Graff: Change the relationship. Change the relationship so it's not the “dominion over” relationship that has always existed between government and first nations people. That's something that is, to my mind, a very obvious shift that could be made that could lead to what you're describing as an outcome.

Mr. Don Rusnak: Thank you.

The Chair: Thank you.

Sorry. You always seem to be getting the short end, but you have become very good at that.

We now move to MP David Yurdiga.

Mr. David Yurdiga (Fort McMurray—Cold Lake, CPC): Thank you, Madam Chair. I'd like to thank Cindy Blackstock and Del Graff for joining us this morning.

This is a very important issue for us. I've been working very closely with the native friendship centres in my riding. They do amazing work. They provide all types of services including counselling to urban indigenous people who do not have access to first nations programming.

What role do you believe the native friendship centres should have in helping the indigenous youth in our urban centres?

I'd like a response from both of you.

Mr. Del Graff: Certainly in Alberta the friendship centres are active in communities in providing options for young people to have activities and for their families to gather. In many communities, when there's a tragedy and there are wakes, for example, they take place in the friendship centres, so they play an integral role in the communities.

One of the things we know in our province is that migration from remote and rural communities to more urban communities has to also include an elevated level of support in those urban communities. That's a key role in which the friendship centres can be quite effective, but they need the resources to do that.

In a place like Edmonton, where there has been a huge increase in terms of the indigenous people migrating to the city, there hasn't been a corresponding increase in the supports to groups like the friendship centres.

Dr. Cindy Blackstock: I'd also point out that the friendship centres indeed do a lot of important work. I echo the issue about the lack of resources, but I think it needs to be broader than that. Certainly there are first nations that want to provide services to their members in urban communities. They have been asking for that for many years. It's certainly something that's practical and that could be done. I would echo that it would go a long way to providing culturally based specific services along the lines of those protective factors of culture specific to different first nations, Métis, and Inuit groups.

● (0940)

Mr. David Yurdiga: We heard from many witnesses about the importance of indigenous control over health services. What types of support are needed to ensure that indigenous communities have the capacity to design and deliver health services?

Dr. Cindy Blackstock: I would say that two key emerging themes have come up in the reports I've read on children's mental health and children's health over the years. Number one is that there needs to be an expansive framing by the federal government of the range of jurisdictional models the federal government will fund for the provision of health services. Right now, it's often just restricted to providing services according to provincial and territorial statutes. I think that needs to change.

The second, of course, is adequate funding of those services. As the tribunal pointed out, it is not dollar for dollar what a non-aboriginal child receives. Because of the multi-generational impacts, we can expect to have to invest more.

I'd like to point this committee to an important report called “The International Handbook of Suicide Prevention”. It talks about the vital importance of building systemic and societal equity into any national or local suicide strategy. The evidence linking inequality with a preponderance of suicide, both on and off reserve, is overwhelming. It needs to be a critical element in the development of a youth suicide strategy.

Mr. David Yurdiga: Thank you, Ms. Blackstock.

How much time do I have?

The Chair: You have another minute.

Mr. David Yurdiga: Thank you.

Mr. Graff, go ahead.

Mr. Del Graff: Certainly one of the shifts that need to be made, in my view, with respect to health services is a level of self-determination that can enable a broader perspective of health services, a more integrated approach.

In my earlier comment, when I was making reference to a holistic approach, the way that funding is provided program by program does not enable that. Groups have to take a piecemeal type of approach. I believe that being able to step back from that and asking how we can create an integrated, holistic way of dealing with the health and well-being of our communities is really what's important and what needs to be put in place on a go-forward basis.

That would be much more effective than the piecemeal approaches that now are just meant to plug the leaks in a boat that might be sinking.

The Chair: Thank you.

We'll now move to the last question, and that goes to MP Anandasangaree.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): Thank you, Madam Chair. I'll be splitting my time with our colleague from Nunavut.

Thank you both for being here.

I want to take this opportunity, Ms. Blackstock, to congratulate you in advance for the human rights award that will be bestowed on you next week by the Law Society of Upper Canada.

I want to probe one issue, and that's the issue of child sexual abuse. I'm wondering if both of you could comment on its relation to suicide, teen suicide particularly.

Dr. Cindy Blackstock: We know from the research that any sexual abuse experience for children predisposes children to a wide array of harms.

When it comes to looking at the national incidence of what we know to be reported cases of sexual abuse among children—I want to underscore “reported”, because we have no measures for unreported cases with either the non-aboriginal population or first nations—there is a slight overrepresentation of first nations children, but not significantly so.

One of the pieces that came forward in tribunal evidence was that where sexual abuse occurs, it absolutely needs to be dealt with and addressed, but adequate resources for child and family service agencies, for both prevention and response, are key to that. That's one of the reasons we brought the case and why we were so happy that the tribunal ordered immediate prevention services and response services so that first nations agencies could elevate their response to children and to families who have experienced sexual exploitation or sexual abuse.

Mr. Del Graff: Perhaps the only thing I can add is that in my experience, when there are incidents of sexual abuse, the levels of trauma on not just the individuals involved but also the whole family system, and in fact in the community, are so substantial that they cannot be ignored. The behaviour that comes out of trying to cope with that level of trauma is very difficult. In many cases that's where we do see those impacts of suicide.

● (0945)

The Chair: We adjourn in about a minute, so I'm going to turn it over to MP Hunter Tootoo.

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

Thank you, Gary, and welcome to both of you. I'll try to be quick.

My colleague Romeo talked about political will. I think that will is there. We have the Prime Minister who is genuine about it now, as well as Ministers Bennett and Philpott. In my experience of almost 16 years in public life, which is half of Romeo's experience, I have always found the bureaucracy is great at spending all their time and energy telling you why you can't do something. They'll give you 100 reasons you can't do something, and I always used to tell them, “Give me 10 reasons why we should.”

You mentioned a review at INAC and the First Nations and Inuit Health Branch. Do you feel that's part of the problem in moving some of these issues forward? There seems to be political will, but there has been 150 years of treating people as programs and numbers.

Dr. Cindy Blackstock: Yes, I do think there needs to be a recalibration and an exploration of those two departments to better prepare for the implementation of the TRC.

I would also note, though, with the greatest of respect, that the minister recently said she is very proud of the work her department is doing on the Canadian Human Rights Tribunal case. I don't feel that type of messaging is a clear signal to the bureaucracy that it needs to reform and implement those good visions that the Prime Minister and the minister have set forward.

Mr. Del Graff: I would add that there is an extreme need to address the apathy that exists in this country regarding indigenous children and families. One of the ways that Cindy has been quite effective has been to try to raise the awareness of Canadians to these issues. We need to do an awful lot more of that for there to be actual change, so I think it's absolutely critical that we address that apathy.

The Chair: Thank you so much.

We're going to suspend because we have the second hour of additional presenters. They're going to be presenting by video conference, so it will take us a couple of minutes to set up.

To the presenters, *meegwetch*. Thank you very much for coming and sharing your thoughts with us. We appreciate it.

● (0945)

(Pause)

● (0950)

The Chair: I am sorry for the delay. We were having some technical difficulties.

I will ask members to specify the person to whom their question is directed, because otherwise it can be a little confusing when we are on video conference.

I want to welcome everybody who is participating in this meeting. The committee is on unceded Algonquin territory here in Ottawa. As we are in the early stages of truth and reconciliation, we always make a point of recognizing our first nations peoples that welcomed the rest of us to this beautiful country.

We have with us the Mamawetan Churchill River Health Region, and in their delegation we have David Watts, Denise Legebokoff, and Dr. James Irvine. We also have Dr. Alika Lafontaine, who is with the Indigenous Health Alliance with.

Is that correct? Everyone is good.

We're going to open it up to the Churchill River Health Region.

● (0955)

Dr. James Irvine (Medical Health Officer, Mamawetan Churchill River Health Region): Good morning. I'm James Irvine. I'm the medical health officer for three northern health authorities in Saskatchewan, roughly the northern half of the province. David Watts and Denise Legebokoff work with Mamawetan Churchill River Health Region. We're on Treaty 6 territory here in northern Saskatchewan. Thank you very much for the opportunity to present to you.

The northern half of Saskatchewan has roughly 40,000 people. It has some of the highest proportions of indigenous people in Canada, with about 87% being self-identified as indigenous and about 49% of those living on reserve. We have 12 first nations living in multiple communities, all of which have had health transfers, and we work in partnership with them.

Northern Saskatchewan faces, like many other northern or mid-northern areas, challenges related to social determinants. We've provided information on some of those determinants, such as the income levels and poverty.

Fifty per cent of the individuals in northern Saskatchewan live on 20% of the average income of the average Canadian. Crowding in northern Saskatchewan on average is more than six times that of crowding within other Canadian homes. All of those things are indicators that show the challenges related to some of the social determinants of health.

With regard to the longer-term incidence of suicides in northern Saskatchewan, since about the mid-1970s we've had rates two to three times the crude rates in Saskatchewan. On average across the north, with about 40,000 people, we have about 12 suicide deaths a year. Youth account for most of these deaths. This slid shows that across Canada, the highest group at risk of suicide are the middle-aged or elders, whereas in northern communities and many indigenous communities the rates are highest within youth. For data up until 2014, for males and females combined, in northern Saskatchewan the suicide rate for youths age 15 to 24 is almost seven times greater than the Canadian average.

Hospitalizations for self-harm tend to be greater among females. In the last 10 years, suicide deaths have been higher in males, while in the French version, you see that females have a higher rate of hospitalization for self-harm.

We've just experienced a cluster of suicides in the north that was somewhat different from what we had in the past. These suicides were predominantly young girls under the age of 15. There was a cluster. We've experienced clusters in the past, with one community experiencing this and then several years later there was another community. That tends to be the pattern. We've noticed over the last few years that those clusters have spread geographically, and it's thought that part of this may be because of social media.

Six deaths occurring within about a two-week period has had a tremendous impact, and that impact was sustained in the following several months, with fairly serious attempts and serious ideations. We've provided a graph showing the significant effect on emergency departments and other mental health teams.

We've also provided a breakdown of this last cluster of attempts and ideation following these deaths. It's hard to comprehend that girls between the ages of 12 and 14 would find themselves in this situation. I would be happy to respond to questions about this later.

● (1000)

Generally across the north, we've had the issue of suicides for decades, and this will continue unless really long-term supports and strategies are enhanced and sustained.

These events have been occurring on and off reserve, in Métis communities, and in first nation communities. In general, communities work closely together, and we do well at times of crisis, pulling together and responding and getting support from provincial and federal governments. It's really the longer, sustained, culturally based preventive strategies that need to be strengthened and resourced.

We also talk about the many faces of the issue. Suicide is one. Others are self-harm, assaults, injury, unresolved grief, previous trauma, bullying, substance abuse, and addictions. Social issues of poverty, intergenerational trauma, and cultural ties and loss are also important.

We also looked at risk factors. As you're very well aware, there are the individual factors and social factors, as well as community culture and continuity. In our circumstances, we find that it tends to be much more involved with the social and community and cultural perspectives and that it's often not an individual issue. It ends up being much more of a community issue, and it's often in clusters.

It's the same with the sense of protective factors. There's the sense of community cohesion, family cohesion, family communication, social supports, engagement in things like schools and sports, but there's also a lot of evidence in British Columbia and Alaska, and anecdotally around the country, that it's the community engagement in maintaining cultural continuity that's so important for that self-identity.

In general, we've put together a couple of recommendations that you see before you, but really, one of the areas is that big area of prevention and looking at those social determinants: poverty reduction, housing, early childhood intervention, indigenous language and cultural identity, and intergenerational knowledge sharing, and really learning what's working in other indigenous communities through rigorous evaluation, along with culturally based early childhood development, supporting parents, enhancing coping skills, and strengthening and supporting communities to strengthen the family and cultural identity.

In the area of more clinical connections, there is working together between the biomedical and indigenous systems, enhancing training of mental health workers and mental health professionals, increasing the availability of team approaches and multidisciplinary teams, and coordinating across jurisdictions. We have several first nation health authorities and several regional health authorities provincially, and it's so important to be working together there, as well as with social services, the RCMP, and education.

Then there's working closely and supporting indigenous approaches to wellness.

There are a couple of things as well that we've learned recently. One is the importance of having suicide cluster response plans, and having the surge capacity to deal with that. Learning to use some common assessment tools and training across jurisdictions have been found to be valuable as well. We also support the development of quality data systems for surveillance, very much led or incorporated with first nation and Métis collaboration.

Thank you very much, and we'll be happy to respond to questions.

● (1005)

The Chair: Thank you, I appreciate that.

Now we're moving on to the Indigenous Health Alliance, with Dr. Alika Lafontaine.

Dr. Alika Lafontaine (Collaborative Team Lead, Indigenous Health Alliance): Thank you very much for inviting me here today. Thank you for the comments that were just shared, and for the acknowledgement that it is unceded Algonquin territory on which these meetings are being held.

My name is Alika Lafontaine. I'm an Ojibwa-Cree anesthesiologist, currently practising in northern Alberta, Treaty 8 territory. I am the immediate past president of the Indigenous Physicians Association of Canada and I currently work with the Indigenous Health Alliance, which is a collaborative approach to health transformation, currently led by more than 150 first nations from the territories of Manitoba Keewatinowi Okimakanak, the Federation of Saskatchewan Indian Nations, and the Nishnawbe Aski Nation.

As I have reflected on the unique contribution that the IHA could provide to these hearings, I believe that connecting the suicide crisis with the current health system we exist in as indigenous peoples would likely have the greatest utility.

In these hearings, you've heard a lot of testimony about a broken system. I'd like to suggest that, based on what community has taught me over the past several years that I've been involved in this project, the system is actually not broken. It does exactly what it is designed to do, but it will never be able to respond appropriately to a suicide crisis in our communities, or any other crisis, until we transform our health system.

In order to understand what the status quo is, I would like to share a very brief story. It's a story about a system we're all trapped in, not because we can't change, but because we choose not to change. As with any story, there are three truths that I would like to suggest you accept.

The first is that our communities are in perpetual crisis, and that crisis is worsening. You can see from the suicide crisis that suicides have become suicide pacts, and suicide epidemics are now becoming pandemics. This is happening in real time in the Nishnawbe Aski Nation, the Manitoba Keewatinowi Okimakanak, and the Federation of Saskatchewan Indian Nations.

Our indigenous systems were originally designed for colonial outcomes. That's the second truth. Colonial outcomes mean that the rights of indigenous peoples to land and resources are eventually extinguished.

The third truth I suggest you accept is that indigenous people are at a place where we need to change. We have no option but to create a different type of system because of the morbidity and mortality affecting our communities.

We'll begin our story in what I'll call a crisis.

If you look at the crises that happened in La Loche, Attawapiskat, Cross Lake, or any of the other communities that have been affected by suicide and mental health crises across the country, you will see that these crises usually lead to a meeting.

I remember the meeting that happened in La Loche. The Prime Minister attended, along with several ministers. The provincial government was represented. The meeting was supposed to lead to solutions, and those solutions were supposed to lead to an expected impact, which was a decrease in the suicide crisis.

In a review of La Loche and the amount of federal government spending that has happened there over the past 12 years, we've seen from our data that over $500 million has been spent in that small community of about 4,000. The question we have asked ourselves is why that didn't have an effect. Where did all the money go?

From both federal and provincial levels, $650 million was allocated to Nishnawbe Aski Nation since it declared its suicide crisis last February. Why has there not been the expected impact?

I would like to suggest that what communities think is happening —crisis meetings, solutions, and impact—is not really what's happening. This is simply what our communities are led to believe. Between the crises and the meetings, there are side conversations that occur between governments at provincial and federal levels, as well as with outside agencies that suggest they can assist with the crisis.

These side conversations occurring between the meetings and the solutions lead to a pre-allocation of funding.

It's interesting that of the $650 million that was allocated to the Nishnawbe Aski Nation, most of it was spent before it ever actually made its way into the community.

As an example of how this was spent, for the crisis teams, the federal government assigned specific suicide task forces that came into the community at a cost of about $2 million for three months. Once that pre-allocation of funding dried up, those crisis teams disappeared.

Between the solutions and the impact, outside agencies are almost always tasked with providing the solutions for our community issues.

● (1010)

While communities are stuck in the middle of a cycle—remember, we look at crisis, meetings, solutions, and impact—there is an outside circle that's happening at the same time, where we have side conversations, pre-allocation of funds, and outside agencies providing all of the care that is required to solve our crises. What this leads to is a lack of accountability within our communities and to our communities, a lack of resource allocation that goes directly to our communities, and a lack of responsibility and no role in implementation when it comes to solving our crises.

The guaranteed outcomes of this system, which I'm going to call the status quo, are worsening crisis and escalation by indigenous people in the form of political pressure, media, litigation, and civil unrest. The current system of government response has grown to recognize these outcomes and respond in kind. By keeping indigenous peoples within the cycle of crisis, meetings, solutions, and impact, the systems we work in are able to utilize their resources to de-escalate indigenous people through meetings, round tables, MOUs, and joint action tables. However, most of these activities have very little impact on the community crisis.

For example, although there is a joint action table with the Nishnawbe Aski Nation that has been established for more than a year, there are minimal, if any, real resources that have been established on the ground. The joint action table, from our point of view, is simply a mechanism to de-escalate indigenous peoples' move towards political pressure, media, litigation, and civil unrest.

That's not to say that any of these things are desirable. No community wants to move here, but this is where we are forced to move with the status quo. Quite literally, there are insufficient resources left to prevent the worsening crisis, because the attention is instead spent on de-escalating the indigenous peoples' response.

If we compare this to crises that have happened historically, we see that the response of the mainstream system was much different. After we recognized the prevalence of iatric injury to patients—that's physician and health care provider injury to patients—in the late nineties, a quality crisis led to the creation of health quality councils across the country. When we look at the SARS crisis, we see that the effect it had was the creation of the Public Health Agency of Canada. The crises in safety that we had in the mainstream system led to new rules for regulatory and accreditation bodies.

If we want to get out of the suicide crisis, we need to recognize that we need to write a different story, like the one I just shared, and we have to acknowledge our shared truths that our communities are in perpetual crisis, whether or not we receive media coverage; that our system is designed to produce the outcomes of worsening crisis and escalation by communities in order to get a response; and that we must change what we are doing. We need to re-task our bureaucracies from doing the job of incremental change to broad system transformation. It has been said in the past that the electric light bulb was not the result of incremental improvement of the candle.

In the Indigenous Health Alliance, we take on this task wholeheartedly in trying to address the indigenous health system, and we observe that this task is taken on wholeheartedly in the mainstream medical system. Patient-centred care is a complete transformation of the physician-patient relationship. You're talking about a national pharmacare program, which would reconstruct the way every patient in this country accesses drugs. We are not a country of incremental health system improvement; we are a country of health system transformation.

Indigenous communities are trapped in a system where worsening crisis and escalation are inevitable outcomes. Last week, representatives from more than 150 first nations presented their plan for health transformation of the indigenous health system to the ministers of indigenous affairs and health. It's in order to address the crisis in our communities, which includes suicide and mental health.

The IHA will continue on regardless of the role of the government, but our first nation leadership has been told that the bureaucracy only has the tools for incremental improvement of the existing colonial system. To be very straightforward, bureaucracy has no tools, no process, and no plan for health transformation, and that's what we need to move ourselves out of these crises.

A question I am often asked by communities is how severe a crisis must get and how high escalation must proceed before investment in health transformation finally happens and we work our way out of the status quo. My only answer to them right now is, “I guess we'll have to see.”

Thank you.

● (1015)

The Chair: Thank you very much. These are very powerful presentations. I appreciate your time and effort.

We'll now move to the questioning period from MPs here in Ottawa. Our first MP is Michael McLeod.

Mr. Michael McLeod (Northwest Territories, Lib.): I want to start by thanking both presenters here today. I appreciate all the work you've done on this issue and the attention you bring to this very serious issue we're experiencing in our communities.

I chair the northern caucus, and this is an issue that is very challenging for us to address. As we look across Canada at what the different provinces are doing with some success, it's mostly for the non-indigenous population. It's a great concern that this seems to be escalating only in the aboriginal communities. Quebec has done some good work for the general population, but not with the aboriginal population, and that seems to be happening right through Canada.

In the north we don't have the same level of attention as the rest of the population seems to get. Of the hundreds of millions of dollars of funding announced for indigenous people, none of it goes to the north, and that's really shocking. This is only money for reserves. We don't have any treatment centres in the north. We don't have any programs for trauma, yet a good part of our aboriginal population went through residential schools and are experiencing lots of difficulties surviving in this new world we live in.

I tried to calculate how many people are committing suicide in the north, and we don't have all the information, but in the Yukon, Northwest Territories, and Nunavut, we are averaging about one suicide every eight days. Every weekend we have a suicide. Most of the people committing suicide are male. We have more attempts by the female population, but the people who are succeeding are male. That points out the seriousness of the situation. Since we embarked on our suicide study, over 50 people have committed suicide in the northern territories, so solutions are needed.

We know that we don't have the same quality of life. We've heard that from many witnesses who presented to us. We don't have the Canadian standards that everybody else enjoys. We live in crowded homes. Housing is a real challenge. We have people in some territories who are living in boxes or sleeping on couches, and some are just wandering around, which is escalating the crime and violence in our communities.

We also have a small population getting high school diplomas. Our education is a challenge, and as for food, I think everybody has seen what's being reported in the media.

The reality is that money is being invested where the media is paying attention, and that's not bringing it into the Northwest Territories, Nunavut, or the Yukon.

I want to ask a couple of things. First, what are your top three recommendations to deal with this issue across Canada?

● (1020)

The Chair: Can you direct your question to somebody specific?

Mr. Michael McLeod: Dr. Lafontaine, maybe you could start.

Dr. Alika Lafontaine: I'm sorry to hear those stats. I'll say that first. As you said, I've known that the crises in the north, the far north, were obviously very severe, but even those numbers are worse than the studies that I've read.

Bill Tholl, president of HealthCareCAN, who has overhauled the health regions in Canada, of which I believe Yukon and Northwest Territories are members, said that the biggest problem in health delivery is a consolidation of accountability, resource allocation, and responsibility to the proper levels.

When you look at our status quo and the cycles that I mentioned, particularly looking at the side conversations that happen with government, which really is the largest funding agency in Canada for health, and the pre-allocation that happens to these outside agencies that are then supposed to go in and fix our problems as indigenous peoples, you see that the challenge we have in health is ensuring that those three things—accountability, resource allocation, and responsibility—are consolidated under the communities that have the issues.

We talk about this federal-provincial split in funding; in reality, the provinces and territories receive a per capita allocation for indigenous peoples. They are funded to provide care to indigenous peoples.

Though I appreciate the arguments from health ministers from our provinces that indigenous peoples tend to present with more advanced disease, sickness, or other things—yes, absolutely, that's shown in the research studies for all the reasons that you mentioned here, including things like food security, etc.—but before the money even gets to our communities, it's already spent. For every Health Canada program, they immediately take off 6%. That goes to government to allocate the money. Then there's another 15% or 20% that gets taken off the top to ensure that Health Canada is properly staffed to deal with our issues. If that money just went directly to our communities and there was infrastructure in place to ensure that it was properly monitored, and if there was follow-through on measurement, which doesn't even happen now with most of the programs that get administered in our communities, I believe you would see a big change.

That's what happens in the mainstream system. In the mainstream system, the health system does not sit there and take off a big chunk before the money and resources make their way to the communities that need the help. That's why the mainstream health system works: it's because there's an infrastructure there to ensure that accountability, resource allocations, and responsibility are consolidated at the proper levels. Is it as good as it could be? Absolutely not, but it's definitely a lot better than what's happening in our communities.

I think, from a broad system level, if we want to impact where resources flow and, more importantly, achieve the outcomes that we all want.... I know both government and indigenous communities are not happy with the results that we're getting right now with current levels of funding, despite being quite large in some areas. We have to look at accountability, which is who you answer to; we have to look at resource allocation, which is whose pocket the money goes into; and then we have to look at responsibility, at who is responsible for implementation. If we take those into our communities, we'll start seeing an impact.

The Chair: Thank you very much.

The questioning now moves over to MP Arnold Viersen.

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

Thank you to our guests for being here as well.

My questioning is for Dr. Alika Lafontaine, who has really given us a large overview of the system dealing with situations and individuals. I really appreciate your testimony today.

I just want to step back a bit from that and address some of the things that you've said in the past to other committees. I know that you're from northern Alberta, Treaty 8 territory. You do significant work in my riding. Last year you gave remarks to the Special Joint Committee on Physician-Assisted Dying and you stated, “In a system where everyone is already dying, the effects of creating a literal program where patients intentionally die within the medical system will further disengage and disenfranchise indigenous patients and families.”

Obviously, the government didn't heed your warning. Bill C-14 was adopted, and now we have a system in place. Do you still have concerns with this impact?

● (1025)

Dr. Alika Lafontaine: I think the perspective of not fixing the existing system and just piling on new programs leads to unintended results. We have no data with regard to medically assisted dying or the impact that it's had.

I do know that if there are no systems in place to support better mental health and to address the suicide crisis, a perpetual crisis inevitably results in worse and worse outcomes. This is true for any group, any demographic. If the SARS crisis in Ontario had continued without proper response, the entire medical system would have eventually crumbled and fallen apart, and that's what you're finding in most of our communities.

I still stand by that statement, but as I said, there is no data to show what's been happening, except for anecdotal data, and I believe that things are getting worse.

Mr. Arnold Viersen: A number of the witnesses we've spoken with previously have indicated there may be a link between sexual abuse and suicide. Has your organization found anything like that as well?

The Chair: Who are you directing your question to?

Mr. Arnold Viersen: It's for Alika Lafontaine.

Dr. Alika Lafontaine: In discussions with the three territorial organizations that we work with, sexual abuse is flagged as a major reason that these things occur. On the issue of sexual abuse in particular and the way we approach indigenous health in general is that we latch onto a core reason and then just paint it with a broad brush across all of our communities.

Sexual abuse is not a problem in every community within the Nishnawbe Aski Nation, and it's the same with FSIN and MKO. I'm sure our colleagues from La Ronge could comment on this with more specificity, but sexual abuse definitely has been flagged as a major issue, absolutely.

Mr. Arnold Viersen: Would our other guests have any opinions on that?

Dr. James Irvine: There is certainly a wide variation between communities, and sexual abuse is one aspect. I think another way of looking at it is adverse childhood events in general, where multiple factors may be involved. Some may be the result of unhealed intergenerational trauma, things like witnessing violence within the home, separation within the family, and other challenges that may be faced within poor living circumstances.

I'll let David comment about the most recent event within the north.

I think the other part of it is supporting Dr. Lafontaine's talk about system change within health. I think often communities would look at health much more broadly than what we see in the traditional or conventional medical model. They would very much recognize the importance of community and the importance of healing and the importance of education and employment in offering real hope for our youth.

Do you wish to make a comment?

Mr. David Watts (Executive Director, Integrated Health, Mamawetan Churchill River Health Region): I completely agree that it's generations of untreated trauma. In the latest suicide cluster that we dealt with, we went into the school and we assessed every grade 7, 8, and 9 child there. The levels of untreated trauma in these youth is just immense,

We were able to do that because we had so much provincial support coming up. As we've mentioned several times, that soon goes when the crisis is deemed over, and then we're back to normal resources.

We feel terrible that we know there's so much need in our communities, but we're not able to actually deal with it because we don't have the resources to do so.

I completely agree with Dr. Lafontaine's saying that so much money is allocated at these times of crisis, but in reality nothing comes to us, and we are the ones who are dealing with the negative outcomes. I completely agree with that statement.

● (1030)

Mr. Arnold Viersen: The previous witnesses talked about there having to be a balance between the physical health of individuals, mental health of individuals, and spiritual health of individuals.

I guess my definition of spiritual health is the reason for life and why we are here and these kinds of questions. Do you think that the spiritual aspect is a big component of the health and the current.... I know, Alika, you were saying we need to redesign the system. Is there a spiritual aspect we need to incorporate?

The Chair: We have about 30 to 40 seconds.

Dr. Alika Lafontaine: Absolutely. I think if you're looking at the literal situation of these kids, you have a kid who gets sexually abused in a crowded house, right? They have nowhere to go after they get impacted by the sexual abuse.

We also have a food insecurity crisis that's happening, which leads to an additional triggering by whoever is doing the abuse, so the abuse gets propagated because of the environment they live in.

It's difficult to have any self-worth or feel that life has any meaning when you live in that sort of environment. Absolutely, I think transformation includes all of those aspects.

Mr. Arnold Viersen: Thank you.

The Chair: Thank you.

I'm going to suspend for a minute. We have a couple of business items that we need to take care of at the end of the meeting. We only have 15 minutes left of our allocated time.

Is it the will of the committee to extend beyond the time or keep...? No, it's a hard stop, so we'll continue with the regular process, and where it ends, it ends?

Some hon. members: Agreed.

The Chair: All right. That's very good.

The next question goes to MP Romeo Saganash.

Mr. Romeo Saganash: Thank you, Madam Chair.

Thank you to our witnesses today for their contribution to this committee.

Dr. Lafontaine, you spoke about transformation, and for once somebody's on the same page as me on these kinds of things. I've always felt that I'm in the status quo process myself, being part of this committee. I know this committee will provide a decent report to government. As for what will happen after that, your guess is as good as mine, but it's been like that for 150 years, since Confederation. This government has not even bothered to comply with an order of the Canadian Human Right Tribunal, so what about a report from a committee?

I heard you very clearly with respect to the kind of transformation this country needs with respect to all the issues we're dealing with. It's not just suicide. There are interrelated and interlinked aspects to this crisis, including housing and everything else.

You spoke about the perpetual aspect of what we're dealing with, the colonial outcomes, and how the system needs to change. If you had to the reins of this country for a day, where would you start?

Dr. Alika Lafontaine: I think the first place you need to start is that people need to believe our stories. I think what often happens is these crises happen, and then they make their way out of the news, and the overall impression is the crisis must have been fixed. Well, the crisis is still happening.

The second is that the bureaucracy needs to recognize that the system is producing the very outcomes they don't like. Our bureaucrats are skilled at what they do, which is maintaining the status quo, and that's what they're tasked to do. They have to acknowledge that these crises are creating the very situations that they don't want to respond to. It's increasing their workload, it's making things more complex, and it's leading to escalation, which both the political and bureaucratic side don't want. They don't want our communities going to the media, thinking about litigation or political action or bringing in non-governmental groups.

The solution to all our problems is through transformation, but until we all start to believe the same story, there won't be any change. If I were the head of the country for a day, I'd call together all my MPs, as well as the MPs of the opposition parties, and agree on the story that's happening. Once we understand that, I think we can finally have change.

● (1035)

Mr. Romeo Saganash: Is the Indian Act part of the problem?

Dr. Alika Lafontaine: I think it definitely is. That is the status quo that needs to be changed, but part of it is understanding the context of the story.

Mr. Romeo Saganash: Thank you.

The next question will be for Mamawetan, which is a similar word in my part of the world.

There's a lot of talk about putting a national suicide prevention program in place. Other witnesses who testified before us would prefer locally led programs for suicide prevention. What kind of balance should we try to achieve between those two, and how would a national suicide prevention program help what you're doing in your part of the world?

Mr. David Watts: I think the key is coordination. We can be asked to run a suicide prevention program, and then the bands could be running their own different prevention programs. We need to run one program together and we need to work as one team. It needs to be all-inclusive, and we all need to be coming up with the same things. It needs to come from the grassroots. I can go onto a reserve and start preaching to people about doing this and that, but I don't live in those circumstances, so they won't hear me.

Some of the conditions on our reserves are like the third world, and they're only highlighted at times of crisis. People only actually recognize what's going on; then as soon as it's out of sight, it's out of mind. It needs to be one coordinated approach from all the different groups and it needs to come from the grassroots.

Dr. James Irvine: I think you're so correct regarding the importance of balance. Many communities have their own unique strengths and approaches that are valuable, so how do you incorporate the independent approaches and yet still have the capacity for working together through coordinated action? Often communities and individuals are moving back and forth, so the challenges of maximizing what we have for resources and the individual capacities and the strengths of communities is so important. That's where that national template of approach is important, with the allowance of individual community and regional collaboration and coordination.

Mr. Romeo Saganash: Dr. Lafontaine, do you have any comments?

Dr. Alika Lafontaine: I think that communities will collaborate when they have the capacity. If low staffing levels, lack of funding, or being overwhelmed by crises prevent communities from having the capacity to reach out to other communities and actually understand what they're doing, that's the reason communities turn inward. This is what I said before. It's accountability and a regional allocation responsibility, but it's not communities being uninterested and not wanting to be involved with each other. Our communities will collaborate with each other if they are properly resourced.

The Chair: Thank you. There's eight seconds.

All right, we're moving on to MP Mike Bossio.

Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.): Thank you, Madam Chair, and thank you so much, guests, for your testimony. It really links to a lot of testimony we've heard around the need for long-term stable funding that goes to the communities. With that funding, the communities are able to have community-driven priorities, rather than INAC or paternalistically driven priorities.

I think everyone would agree that a transformation needs to occur. I certainly know that's what our Prime Minister has communicated and that's what our government is trying to work towards. I guess the difficulty we've heard from a lot of the witness statements is the multi-faceted nature of the problem. Yes, we're studying the suicide crisis, but how has this been derived? It's multi-generational to trauma, residential schools, etc. However, within the communities themselves, whether it's cultural awareness, health, mental health, education, housing, food, employment, skills training and development, where would you start? I know you have to approach these problems in a multi-faceted way, but if the money was getting to the communities—and I'll direct this first to Dr. Lafontaine—where would you start to spend that money that you think would have the greatest impact and evolve towards this transformation?

● (1040)

Dr. Alika Lafontaine: We provided a costed program to both ministers last week. That was developed with the three territories. There was a desire by the bureaucracy to have that funding all pooled into a single pool. The reality is that with the way the territories work, they need their own independent pot.

If you're looking at the different slices that need to get funded, you'll see that there's the AFN, which is kind of our national body, and the territorial organizations, such as Nishnawbe Aski Nation, and then there are the tribal councils and the first nations. That funding has to be split.

Within our own health system, we have different areas that get funding: health quality councils, ministries of health, and the health regions that provide the care at the hospitals and the clinics, etc. That type of allocated funding needs to happen as well within our communities. Our communities have to work through a process of transformation to find out what levels should do what. What's important is that the communities decide what happens.

Our territorial organizations have a strong role in coordination between communities. Our communities themselves may have more of a role in clinics and direct primary care. Our tribal councils may be coordinated through regional hospitals or other types of regional programs. We already have a map for how this works, and that's the mainstream health care system. It's just that we don't apply the map in our communities.

The funding we tabled with the ministers is specific to the transformation model. That will take a period of time—not a very long period of time, but it will take time. If that gets properly funded, the answers to those questions will come out, but they will not come out with the crisis we currently have and the crisis response.

Mr. Mike Bossio: I would invite you to present that report on the transformation to the committee, if you could, which we could then embed as part of our study. If you have the ability and authority to do so, that would be invited.

It has been identified as well in much of the testimony that one of the biggest challenges in terms of this being community-driven and community-led is community employment and the lack of human resources to deliver these programs within the communities themselves. You spoke about the Nishnawbe nation and others, etc., that would be involved in helping to deliver this. Can you speak to some of the human resources aspects and the challenges around that? Also, can you even expand upon that? As part of your report, what do you see as the key challenge in delivering on this?

Dr. Alika Lafontaine: It relates specifically to Nishnawbe Aski Nation. The cost of the proposal looks at hiring 43 staff personnel to move the process of transformation forward. Linking that to economic development, health is big business, honestly. It's the way small communities in Saskatchewan and Alberta have maintained local economies: through hospitals and local clinics. You will have economic development as you build that staffing capacity, because those people live in communities and put that money back into the communities.

Mr. Mike Bossio: Is the staff there? That's the concern. It's about trying to attract these health care individuals, and for mental health care in particular. Across the country we have a huge issue around mental health and the delivery of services around mental health, and there are the added challenges of recruiting them to the north as well. Is that a reality that you see as well? Do you see any solutions to that?

Dr. Alika Lafontaine: Right now when funding comes to our communities in any of these territories, you get a back-loading of funding. You get very little funding at the beginning of the year, and then suddenly before March 31, you get told that you have three, four, or five times more funding than you had at the beginning of the year.

If you have health transformation and you're able to stabilize that funding equitably throughout the year, and that money actually goes to our communities and there's infrastructure in place to ensure that it's properly spent and allocated, you will find that people will migrate to our communities. We won't have a problem with recruitment. It's in changing the status quo.... The problem is not the fact that it's remote; it's the fact that you don't know if you're going to get paid next month because there is no funding in place until January.

● (1045)

The Chair: That's a very good place to end.

I want to thank you very much for participating in the video conference from La Ronge to.... I don't even know where you are. Is it Grande Prairie?

Dr. Alika Lafontaine: Yes, Grande Prairie.

The Chair: Thank you to the west for doing this. We appreciate it very much.

Meegwetch.

To the committee, I want to confirm that we will be back next week at 8:45, the regular time for our committee, and also that the minister has agreed to come before our committee on February 23 in relation to the supplementary estimates.

Thank you very much. The meeting is adjourned.