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Chair

Mr. Andy Fillmore

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● (1530)

[*English*]

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

Welcome, everyone. We're very grateful today as always to be meeting on unceded Algonquin territory.

I just want to take one minute for some housekeeping, and then we'll get right into the session with our guests.

First, I want to say welcome back to David Yurdiga who's been doing yeoman service in Fort McMurray for the past several weeks, helping his community there. David, well done. It's nice to have you here.

I'd like to introduce the committee to Grant McLaughlin, who is joining us right now as a clerk for a while. You'll be seeing his face around, and we welcome Grant as well.

With regard to the suicide study, if you still have witness names you'd like to add to that list, I'm reminding you of the June 15 deadline for additional witnesses so that the analysts can plan the logistics of that trip and that study.

Then finally, you may recall at our last meeting we talked about having each member indicate which of the communities we're visiting are mandatory for them and which would be nice to have.

Michelle Legault, as our clerk, has kindly prepared a little form. It's easy to fill in. You check boxes. I'm going to ask Michelle to pass that around. Perhaps you or the staff members that are with you might get that done while we are here today. That would be great, but if not, certainly if we could have that completed form back for Thursday's meeting this week, that would allow us to build a budget and proceed with the study.

Thank you very much for that. Let's go right in.

We're very happy to have some guests from Indigenous and Northern Affairs Canada. We welcome Paula Isaak, the assistant deputy minister, education and social development programs and partnerships; and Daniel Leclair, director general of the community infrastructure branch, regional operations. From Health Canada, Keith Conn is with us. He is the assistant deputy minister of regional operations. Dr. Tom Wong is here again, executive director, office of population and public health. From the Canadian Institutes of Health Research, we have Dr. Alain Beaudet, the president.

Welcome to you all.

Since we have this group for the full two hours, I wonder if we might give our speakers 15 minutes rather than the usual 10. Is there consent among the committee members for that?

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): There are bells at 5:15.

The Chair: Cathy McLeod reminds me there will be some bells at 5:15 for a vote at 5:30; perhaps we should stick with the 10 minutes, if you're able to stay.

Thanks and let's get right to it.

Who would like to start?

Dr. Tom Wong (Executive Director, Office of Population and Public Health, Department of Health): To begin, I would like to acknowledge that we are on the traditional territory of the Algonquin people. Thank you for gathering us here today and inviting us to speak on this very important issue of suicide in indigenous communities in Canada.

As a physician and as a father, I know the death of a child is heartbreaking. A death of a 10-year-old child by suicide compounds that heartbreak as the profound impacts spread across families and communities. The circumstances are tragic and difficult to comprehend. When we ask ourselves why, we must acknowledge the impacts of colonization, which continue to affect indigenous peoples today. The Truth and Reconciliation Commission has offered Canada the knowledge and recognition that policies of forced assimilation have assaulted and suppressed indigenous culture for as long as Canada has existed as a nation.

As a nation, we now have an opportunity to recognize that the introduction of the reserve era in the 19th century, the residential school experience in the 20th century, and the forced adoption policies of the sixties and the seventies are just examples of policy that led to eradication of culture, loss of language, erosion of traditional values, and the disintegration of traditional family structures. These impacts have been passed down through the generations and these effects are often referred to as intergenerational trauma and have led to the tragedies that we collectively face today.

Health Canada, through the first nations and Inuit health branch, recognizes the need to reset its relationship with indigenous partners, and through these relationships, support community-led, comprehensive, culturally founded, and culturally safe services that are integrated into a broader continuum of wellness programming.

● (1535)

[*Translation*]

My role and the work of the branch is guided by inclusive and participatory policy engagement approaches with first nations and Inuit organizations, as seen through several key frameworks developed in partnership with indigenous organizations.

[*English*]

In fulfilling the mandate to promote the health of indigenous peoples, I advocate for equitable programming to address social determinants of health, and to strengthen prevention, diagnosis, treatment, support, surveillance, and data for public health actions.

In Canada, the rates of indigenous suicide are much higher than the general population. The overall Canadian rate has declined, while in some aboriginal communities rates have continued to rise. In general, risk factors for suicide include depression, hopelessness, low self-esteem, substance use, suicide of a family member or friend, a history of physical or sexual abuse, family violence, intergenerational trauma, poor peer relationships, social isolation, poor performance in school, and unemployment, to name just a few.

Protective factors that contribute to resilience include family cohesion, good communication, feeling understood by one's family, involvement in family and community activities, indigenous language, cultural knowledge, activities with elders and traditional healers, community self-determination, good peer relations, and school successes.

Suicide is just one indicator of distress in communities. For every suicide there may be many more people suffering from depression, anxiety, and despair.

There are five key elements funded by Health Canada to support first nations and Inuit health: health promotion, health protection, primary care services, supplemental health benefits, and health infrastructure support. Health Canada spends $300 million a year in community-based programming and services guided by mental wellness frameworks. Through a variety of targeted programs, organizations and communities deliver mental health promotion, addictions and suicide prevention, crisis response services, treatment and aftercare, including prescription drug abuse and supports for eligible former students of Indian residential schools and their families.

Mental wellness teams are community-led teams that provide a comprehensive suite of culturally appropriate services, which include but are not limited to capacity-building, trauma-informed care, land-based activities, early intervention and screening, aftercare, and care coordination with provincial and territorial services. Each mental wellness team serves between two and 10 communities, depending on community size, location, and need. Health Canada has allocated funding to regions for 10 mental wellness teams. The B.C. First Nations Health Authority also funds a team in B.C. However, flexible funding allows regions to maximize the number and reach of teams to address regional needs.

The brighter futures, building healthy communities program, available to all first nations and Inuit communities, supports improved mental health, child development, parenting skills, healthy babies, injury prevention, and response to mental health crisis, depending on community needs.

The IRS resolution health support program provides cultural, paraprofessional, and professional supports to eligible former students, their families, and communities.

The national native alcohol and drug abuse program and the national youth solvent abuse program include funding for 43 first nations addiction treatment centres and community-based prevention programs that respond to substance abuse.

The national aboriginal youth suicide prevention strategy supports over 130 community-based suicide prevention projects in first nations and Inuit communities across Canada. Strategy funding was used to train over 800 community-based front-line workers to provide culturally appropriate information about suicide prevention. We have seen positive results.

For example, the Taiga Adventure Camp is a camp for girls aged 11 to 17 and is open to all 33 Northwest Territories communities. The goal of the camp is to increase self-esteem and promote healthy living, relationships, and mental wellness to protect against youth suicide. The camp uses outdoor skills development to provide leadership opportunities and develop confidence and respect for others. Outcomes have shown improvements in confidence, initiative, leadership, and optimism, an increased ability to address conflict, and improved knowledge of protective factors.

The department is also supporting the development of a web-based first nations “wise practices” resource that will allow communities to access and implement proven and promising youth suicide prevention strategies.

The Mental Health Commission of Canada has been provided with $1.2 million from FNIHB to support first nations and Inuit adaptation of its mental health first aid training.

Health Canada, the Assembly of First Nations, and community mental health leaders jointly developed a first nations mental wellness continuum framework, grounded in culture as its foundation.

● (1540)

[*Translation*]

Application of the framework is supported by an implementation team with members across regions and communities, as well as the department.

[*English*]

FNIHB is also supporting ITK in their work to develop Inuit mental wellness teamwork and an Inuit suicide prevention strategy. Both the strategy and the framework are anticipated to be finalized later on in 2016.

The Chair: You have one minute remaining, Dr. Wong.

Dr. Tom Wong: Other federal programs and departments, including but not limited to INAC, Public Health Agency of Canada, CIHR, Public Safety, and Justice provide programs and services to first nations that address indigenous social determinants of health, and they are important partners in this effort.

Health Canada is working with partners on their approach based on mental wellness frameworks that amalgamate mental wellness programming and seek additional resources to address gaps. Additional resources are required to expand core services and services that help indigenous people, and any new federal funding will support the long-term goal of transfer to communities, alignment, and integration with provincial services. Promising practices of community healing relate to culture and identity, and are community-based, community-paced, and community-led initiatives with strength-based and holistic approaches that blend western and indigenous therapeutic approaches with strong community relationships.

While important progress has been made, it is clear that more needs to be done. The levels of health inequity between indigenous Canadians and the rest of Canada are unacceptable. Health Canada will continue to work with first nations and Inuit to advance areas of mutual priority. Efforts to support first nations and Inuit in their aim to influence, manage, and control health programs and services that affect them continue to be fundamental for improving health outcomes and access to needed health services and programming.

In addition, Health Canada will participate in a whole-of-government approach to address the recommendations of the Truth and Reconciliation Commission, but this is not something we do alone. Reconciliation is the work of Canada as a whole. I ask you to join us in the efforts of reconciliation and ensure that all children in Canada have access to nutritious food, safe housing, quality education, clean water, and finally, access to a robust and responsive health system.

Mr. Chair, I'm glad we had the opportunity to present here today on this very important issue. My colleagues and I would be pleased to respond to the committee's questions at the end of all the opening remarks. Thank you.

● (1545)

The Chair: Thank you very much for those remarks.

Let's move right along to the next speaker, Dr. Beaudet.

Dr. Alain Beaudet (President, Canadian Institutes of Health Research): Thank you, Mr. Chair.

First I would like to thank the committee as well for inviting me to discuss this critical issue of suicide prevention in first nations, Inuit, and Métis communities. As president of the Canadian Institutes of Health Research, or CIHR, I appreciate the opportunity to share with your committee the vital role that research is playing to address this tragedy.

As you may be aware, CIHR is the Government of Canada's granting agency responsible for supporting health research in universities, hospitals, research centres, and communities across Canada. CIHR's commitment to address the disproportionate health burden faced by indigenous people in Canada is steadfast. This is why we have made the health and wellness of indigenous communities and families one of four research priorities in our most recent five-year strategic plan.

When it comes to suicide, science has a critical role to play in helping us understand the root causes of this most complex and sensitive issue, and in developing evidence-based solutions for preventing it. The causes behind the unacceptably high incidence of suicide among indigenous people and how to design and evaluate interventions aimed at promoting mental wellness are at the heart of our research efforts.

[*Translation*]

It is important to understand that the research funded by CIHR on the topic of suicide and mental health covers a vast range of the health sciences, from basic to applied. It ranges from studies on the biological basis of depression to investigations of the cultural, social, and environmental risk factors linked to suicide ideation.

It includes, for example, research on the effects of the environment on genetic disposition to mental health disorders, research on intergenerational health impacts of residential schools, studies linking suicide to variance in exposure to daylight in the north, and the psychosocial impacts of housing conditions.

The research is happening at all levels, for it is critical to understand the etiology and the risk factors underpinning these high suicide rates if we want to be in a position to meaningfully address and prevent them. Indeed, research on suicide is not only meant to improve our understanding of the problem, but it is also meant to help develop evidence-informed interventions and programs, in other words, to translate knowledge into practice.

Appropriate interventions can be successful, as demonstrated by Quebec's preventative efforts, which led to a more than 50% reduction in suicide rates among its youth; this reduction was even more pronounced among young men.

It is imperative that research be leveraged in a similar way to help address suicide in first nations, Inuit, and Métis communities. We are talking about two very different sets of research questions and approaches here. The first, referred to as intervention or comparative effectiveness research, is about developing and testing the efficiency of interventions under tightly controlled conditions. The second, referred to as implementation research and delivery science, or IRDS, is about implementing and scaling up successful interventions in the real world. What works, for whom, and in which circumstances? How can successful prevention strategies be adapted and scaled up for different communities and settings?

Implementation science needs that research to be embedded into care and adapted to socioeconomic and cultural contexts to maximize efficiency and impact.

[*English*]

Implementation science and delivery research is a relatively new area of health research that we have embraced at CIHR to address a number of global health issues, including indigenous people's health. Thus, through a major strategic research initiative called “Pathways to Health Equity for Aboriginal Peoples”, we have supported a series of implementation science projects aimed at improving mental wellness and reducing the incidence of suicide in indigenous communities.

For instance, a project led by Dr. Claire Crooks from the Centre for Addiction and Mental Health in Toronto, took the mental health first aid program and adapted it to first nations communities across Canada. This original program had been demonstrated to increase individual skills and knowledge about how to respond in a mental health crisis.

● (1550)

It is currently used across Canada; however, previous evaluation studies found a critical need to culturally adapt the program to first nations communities. Using a combination of interviews, focus groups, implementation tracking, and surveys, the research studied the implementation of the adapted program in several first nations communities and confirmed its effectiveness.

Another example of the CIHR-funded research aimed at implementing research into practice is ACCESS open minds, a groundbreaking, national research network focused on youth mental health. Through this network, supported in partnership with the Graham Boeckh Foundation, researchers are taking existing mental health practices and treatments and making them age-appropriate for diverse youth populations. Through testing and evaluation of these tailored youth interventions at 12 sites across the country, including five that are working with indigenous communities, this network will help identify effective approaches for assessing and treating Canadian youth with mental illnesses.

A common feature of these two research initiatives is that they both involve multiple research sites and allow for learning across communities and between jurisdictions. Crossing jurisdictional boundaries also means developing international collaborations to address suicide prevention. The issue of indigenous suicide is not unique to Canada. Indigenous populations in other countries such as the U.S., Denmark, Sweden, and Australia are facing similar challenges.

While some of the causes and manifestations of suicide differ across countries, as they do across Canada's first nations, Inuit, and Métis communities, there are also important points of commonality and overlap. This shared problem presents an opportunity for joint research efforts and the sharing of best practices across borders. This is why since 2013 we've been involved in international research efforts to address suicide prevention in northern indigenous communities through the Arctic Council. Under the Canadian chairmanship of this international forum during 2013-15, CIHR spearheaded a research initiative involving researchers and community members from across four Arctic countries to identify promising practices in suicide prevention. These efforts culminated in an Arctic symposium in Iqaluit, held in March 2015, where researchers shared best practices in suicide prevention. The symposium was hosted jointly by the CIHR, the Government of Nunavut, and international partners.

As a second phase of this work, we are now partnering with a U.S. organization, the National Institutes of Health, in a follow-up project to further address suicide in Arctic regions. Through this follow-up initiative, called the RISING SUN, partners from across the Arctic states are coming together to identify common metrics to track suicidal behaviours, as well as key correlates and outcomes, so as to facilitate data sharing, evaluation, and interpretation of interventions for suicide prevention.

CIHR will soon be launching another major international research program on global mental health through the Global Alliance for Chronic Diseases or GACD, an international consortium of health research funders that Canada currently chairs. This program, with a combined international investment of over $60 million, will fund research into the prevention and management of mental disorders, with a focus on interventions in low- and middle-income countries, as well as vulnerable populations in high-income countries, including Canada's indigenous populations. Once again, through this opportunity, the CIHR will be able to leverage knowledge from international contexts that are relevant for Canada and will provide tools to tackle the issue of suicide in our communities.

[*Translation*]

These are just a few national and international examples of how CIHR is supporting research to address wellness and suicide prevention in indigenous communities. Through the science and applied research initiatives I described, CIHR is committed to continue supporting research to identify ways to promote resilience and positive mental health among indigenous peoples and to ensuring that research evidence is brought to bear on policy-making through knowledge translation.

In this regard, CIHR will look forward to continue working with Health Canada and other federal, provincial, and territorial partners to help inform policies and programs related to indigenous health.

● (1555)

Before closing, I would like to take a moment to underscore that all of the CIHR research projects in this area are designed and carried out in close collaboration with indigenous communities. Our ultimate objective over the long term is to develop and support a cadre of indigenous researchers as they are best positioned to understand from the inside the cultural determinants of mental wellness.

This is why strengthening research capacity within our indigenous population is at the heart of the CIHR agenda.

[*English*]

Finally, please allow me to acknowledge that research is only part of the solution to this very complex and challenging issue, but it is an important one for identifying the most effective path to achieving wellness.

Mr. Chair, thank you again for this opportunity to share our work with you in this critical area. I look forward to your questions.

Thank you.

The Chair: Thanks very much, Dr. Beaudet.

The next speaker is Paula Isaak.

Thank you.

Ms. Paula Isaak (Assistant Deputy Minister, Education and Social Development Programs and Partnerships, Department of Indian Affairs and Northern Development): Good afternoon, Mr. Chairman and members of the committee.

I'd like to thank the committee for this invitation and would also like to acknowledge that we are gathered on traditional Algonquin territory. This is an important study, and I want to offer INAC's full support as it evolves.

As my colleagues have noted, suicide is often the tragic consequence of a complex array of factors.

[*Translation*]

That includes mental health issues such as depression, substance abuse, social and family factors, poor performance in school, and bullying or relationship issues.

[*English*]

One of the contributing factors to high suicide rates among first nations and Inuit, including youth, is inadequate basic supports. These can include a lack of income supports, education opportunities, adequate housing, or health and social services. These factors of instability have direct repercussions on the decline of mental health in indigenous communities, and each element is part of a continuum that is vital to providing a sense of hope, to wanting to go on in life, and to seeing oneself contributing in society.

[*Translation*]

I understand that, among other aspects, the committee will be studying these risk factors broadly, as well as protective factors that promote well-being and help reduce vulnerability.

This broad approach is helpful because so many players are involved in ensuring that those basic needs for indigenous communities are met.

[*English*]

For my part, I'll frame my remarks around those elements today, in order to best provide context on INAC's roles and programs. INAC, as you know, is a focal point at the federal level for indigenous issues. We are one of 34 federal departments responsible for meeting the Government of Canada's obligations and commitments to first nations, Inuit, and Métis.

● (1600)

[*Translation*]

INAC provides financial support to first nations communities to deliver services on reserve. This includes education, housing, and social support to indigenous peoples.

[*English*]

Our social programs aim to assist first nation individuals and communities to become more self-sufficient, and promote strategies to reduce the risk factors that negatively affect the health and well-being of communities.

Embedded in many of these programs is funding for prevention. It supports indigenous families and communities in taking steps to avoid situations of crisis, and in achieving improved outcomes whether they be in the care of children or generally in the support for greater participation in the labour market.

[*Translation*]

The department flows funds to first nation bands, organizations, and, in some cases, provincial service providers who provide on-reserve residents with individual and family social services that aim to offer culturally appropriate programming to meet the needs of those individuals and families.

[*English*]

INAC also provides funding for a suite of elementary and secondary programming through core funding and complementary targeted request- and proposal-based education programs that seek to focus on specific aspects of education support and success.

INAC's elementary and secondary education program funding is part of a broader strategy of investment in first nations children and youth. In addition to supporting elementary and secondary education, INAC also provides support to first nation and Inuit students to attend post-secondary institutions. Health Canada and the Public Health Agency of Canada provide early childhood programs such as the aboriginal head start program, which helps promote school readiness among aboriginal children. Employment and Social Development Canada has labour market programs tailored specifically to aboriginal Canadians, including the first nations job fund and the aboriginal skills and employment training strategy. Departments are increasingly looking for ways to enhance co-operation.

In all cases, the programs are intended to be community-driven.

[*Translation*]

These types of programs go a long way toward promoting stronger, healthier communities, and toward reducing vulnerability and improving mental well-being.

[*English*]

The fundamental challenge that's before all of us is improving the foundations upon which indigenous communities can thrive. When those basic needs are not met, it is a tragic reality that crises and emergencies can occur. In those cases, as the committee knows, both our minister and departmental officials engage quickly with local leaders to discuss how best to give immediate and long-term help.

Certainly this outreach informs our ongoing efforts on how to proceed to meet the Government of Canada's commitment to working on a nation-to-nation basis and improving health and social outcomes in first nation communities, identifying program supports for required services, and strengthening the resilience among children and families on reserve.

[*Translation*]

In all cases, collaboration between all partners is key in working toward ensuring the continuum is working—that basic needs are in place to not only address crises when they occur, but more importantly prevent them from happening in the first place.

[*English*]

As part of historic budget 2016's $8.4 billion in investments, the department is on track to providing first nation recipients with the first round of investments. Much of this early budget funding is earmarked for addressing basic needs. As that moves forward, INAC remains committed to delivering on the government's promise of a new fiscal relationship with first nations to provide sufficient, predictable, and sustained funding for first nations communities.

I can also report that the Minister of Indigenous and Northern Affairs Canada continues to work with cabinet colleagues on several early key initiatives, as outlined in their respective mandate letters.

● (1605)

[*Translation*]

This includes elementary and secondary education, the first nation and Inuit youth employment strategy, and post-secondary education.

[*English*]

Our department's work also contributes to meeting the Government of Canada's commitment in addressing the Canadian Human Rights Tribunal's order to reform the first nations child and family services program. We are also moving with all partners toward meaningful engagement with regard to informing options for program reform.

Recently departmental officials also joined the minister in announcing full support for the United Nations Declaration on the Rights of Indigenous Peoples. One of the principles of that declaration reads, “Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health.”

[*Translation*]

The department is committed to working in collaboration with partners to ensure those gaps between indigenous and non-indigenous people are closed, and to help first nations, Inuit, and Métis people improve wellness.

[*English*]

On one front, the department and minister spent the months from December to February engaging with survivors, families, and loved ones, indigenous organizations and governments, and provinces, territories, and experts on the design of an inquiry into missing and murdered indigenous women and girls. We expect that this inquiry will also shed more light on many of the conditions that lead, tragically, to suicide in some communities.

I will also highlight that the minister is working with the Minister of Families, Children and Social Development to launch consultations with provinces and territories and indigenous peoples on a national early learning child care framework. This is a first step towards delivering affordable, suitable, high-quality, flexible, and fully inclusive child care.

A key component of combatting this ongoing tragedy is working in partnership with indigenous communities to promote and ensure that indigenous peoples have a secure personal cultural identity. This is a key issue for the minister and department. I am sure my colleagues at Health Canada will attest to the evidence that shows that a stronger sense of identity and self-sufficiency can in fact lead to reduced rates of suicide in indigenous communities.

[*Translation*]

As I and my colleagues have noted, to truly improve the situation for indigenous peoples, we must focus squarely on improving the socioeconomic conditions they face.

[*English*]

We will continue to reach out to provinces, territories, indigenous leadership, and others to find concrete solutions and look at long-term needs in mental health, child welfare, education, infrastructure, and employment in indigenous communities. I look forward to the advice, support, and dedication of this committee as we move the yardstick forward together on these issues.

I will be happy to answer any questions at the end.

Thank you very much.

The Chair: Thank you very much, Ms. Isaak.

To all the speakers, I think you've been through this before, so you will know that we now go to a round of seven-minute questions. I'll continue to use the yellow and red cards, sometimes for the responder and sometimes for the questioner.

I would just invite all the members to try to come to their questions with as little preamble as possible.

Jumping right in, we'll begin with Don Rusnak, please.

Mr. Don Rusnak (Thunder Bay—Rainy River, Lib.): I'll be as brief as possible.

We know this is an absolutely complex issue, and there are many layers and ideas for solutions. I look at this as a short-term problem where we're reacting to the immediate crises that are absolutely horrible in these communities. That will form one of my questions.

Ultimately we're going to have to look at long-term solutions to make sure the first nations communities and the indigenous populations aren't facing these horrible issues. I'm familiar with them because of my work. For the benefit of committee members who've heard me talk many times, I've worked with first nations organizations. Over the years I've worked in first nations communities in different capacities and with different governments.

I have one question for INAC and one for Health Canada. What have you come up with in terms of immediate solutions and immediate programs to deal with the immediate crises? Are you working ad hoc, or are there crisis teams on standby? We know the problems are entrenched in the communities. We need that immediate response to the crises to make sure the communities get the support they need right away. Is there a plan in place?

The first question will go to Health Canada.

Dr. Tom Wong: Thank you very much for the question.

Yes, crisis needs to be dealt with in the context of needing to deal with the long-term issues. Regarding the immediate crisis, there are a number of things already in place. I spoke about the small number of mental wellness teams across Canada that have been mobilized and can be mobilized to help deal with emergencies. Within that context it has to be working together at the invitation of the first nations communities and also in collaboration with the involved province. Most recently, with Attawapiskat, there was an invitation by the province and the invitation from the community to assist. It's a collaborative effort.

The reason why I mentioned the number is small is so you can do the math. Canada is a big country. Ten mental wellness teams are a good start, but we need more to do a better job.

As far as what to do in emergencies, before dealing with emergencies one should think about whether there is a way to prevent emergencies. Some of those elements are social determinants of health, reconciliation around Indian residential schools, and the TRC recommendations. All those things need to be in place.

I will turn to my colleague, Paula, regarding some of the social determinants of health work her department has been actively working on with the communities.

● (1610)

Ms. Paula Isaak: As Dr. Wong was talking about, the long-term solution is around ensuring those basic underpinnings are solid. That means ensuring education supports, labour market supports, and income supports are there to prevent these from happening in the future. Those are long-term solutions that need to be done with the communities, jointly and collectively. There is not one strategy for all communities writ large, but there are strategies that need to be developed with those communities.

That's the commitment our department has with our Health Canada partners. Health Canada is there at the front lines when some of these crises happen, but we're right there with our Health Canada partners working with the communities to see what key underpinnings need to be strengthened.

Mr. Don Rusnak: Immediately, is INAC working with these crisis teams through their contacts within the communities to make sure they're localized? This is probably a two-part question. What are the outcomes or successes of these crisis teams going in? What has been the reception in the community, and what's been the result?

Dr. Tom Wong: INAC and Health Canada work hand in glove with some of the activities in response to a crisis. For example, with a crisis we know there are some long-term issues that need to be addressed, but there are some short-term approaches that can be quickly instituted. For example, when we hear from youth that there's a need for more books, better schools, a place to play sports, and programs to actually link up with elders, some of those activities and some of the linkages do not need to wait two, three, or four years. Those are some of the things, like building a centre, that can be done very quickly.

Those are some of the practical linkages and activities that we at Health Canada have been working with communities to try to facilitate. To me nothing is as important as linking a youth who sees no hope, no meaning in life, and is disconnected from their culture to a connection with the elders and with their culture.

Mr. Don Rusnak: I'm going to cut you off there because I want to ask a question of my friend Dr. Alain Beaudet from the CIHR. I see I have one minute left.

Targeted research funding and suicide prevention to build research capacity at the community level, build partnerships with communities.... How many community-based research projects and suicide prevention research projects were funded, and what are the outcomes of those funded projects?

Dr. Alain Beaudet: We've been funding a number of communities. I can't pull open the exact number, because different projects will fund different numbers of communities. We've been funding particularly through major strategic initiatives and implementation science, as I said, which actually aims at integrating research and care.

We not only implement an intervention but ensure that the intervention as it is being implemented has a research protocol built into it so that you can actually analyze the results and determine if the intervention is effective, and if it's not, how you can correct the course to improve it.

We've done that with multiple communities and particularly in the ACCESS open minds project, and the advantage of it is that we then bring the researchers and the network together so that we can compare notes on the effects of the interventions on the various communities.

I think what I could best do to illustrate the impact is perhaps to read you an email that I received from the chief of the Eskasoni First Nation. He writes, “As Chief of Eskasoni First Nation, I have been on board with being involved with the jointly funded CIHR/Graham Boeckh Foundation ACCESS Open Minds initiative since day one! With more than half of Eskasoni’s population being under the age of 25, I, and my fellow council members, are excited that ACCESS Open Minds will build upon our current model of mental health/addictions care and make our services even better. We believe that this enhanced model—which includes and blends case management/care facilitation, 24/7 online, in person, and toll free crisis intervention, peer support/lived experience, sports, recreation, and Aboriginal cultural and traditional teachings with Western therapeutic interventions, therapies, and practices—can be implemented successfully by others throughout Canada.”

● (1615)

The Chair: Thank you, Dr. Beaudet.

Now, Mr. Rusnak.

Mr. Don Rusnak: My friend, Jaime Batiste, who's from Eskasoni, will actually be here this week meeting with me and Phil Fontaine.

The Chair: Thank you.

Next is Cathy McLeod, please.

Mrs. Cathy McLeod: Thank you.

Thank you to the witnesses.

This is a quick question. We know that the rate is horrific; it's unacceptable. In the period between 1980 to 2016 has the suicide rate decreased at all in indigenous communities?

Dr. Tom Wong: The question is a complex one. The reason is that surveillance or information gathering is very specific to each community. Therefore, the statistics for Canada as a country and specifically for first nations on reserve nationally do not come on a day-to-day basis. They only come when periodic surveys are done.

Mrs. Cathy McLeod: I thought that could be a quick sort of.... Is your sense, then, that we are making any headway on this issue, or are the rates as horrific as always? Just a quick answer....

Dr. Tom Wong: Unfortunately, there are some communities where we are actually seeing increases in suicide. However, there are some communities that are not experiencing any suicide or are experiencing a decrease in suicide.

Mrs. Cathy McLeod: Thank you.

We have a myriad of programs, and I am glad to see that CIHR is starting to really focus, because I think that is going to be critical. Aboriginal head start has been around forever, as well as the NNADAP program. Programs have been around, and if they are not working, I think we need to start to refocus support. Obviously, the biggest issue is the upstream.

Again, hopefully my next question is a quick one. In the headlines this morning, in the *Ottawa Citizen*, was a young indigenous person who was clearly having challenges. The doctor was so horrified that she felt she had to speak out. You talked about the mandate of working with the provinces and territories. When those sorts of things happen, do you ever take an incident like this and give that doctor a call to say, what the heck is going on? Do you have a system in place with the provinces where you can use a case study like that to improve things? Did you pick up the phone, or did anyone in your department pick up the phone? Apparently, it sounded very horrific in terms of a local case.

Dr. Tom Wong: Yes. In a situation like that, what our department does is liaise with the province and have discussions about that. That particular example is something that can be of major concern to all Canadians, if all the facts that are described in the newspapers are there. The reason is that we need to think about the circumstances where an aboriginal youth who is very scared ends up in a facility. What is the most welcoming way to help this youth? Of course, we don't know the circumstances, and we don't want to comment on the individual circumstance.

Mrs. Cathy McLeod: I understand that.

I know, as well as many, that not everything reported has all the facts. Is there a system in place where you can immediately take action?

● (1620)

Dr. Tom Wong: Yes.

Mr. Keith Conn (Assistant Deputy Minister, Regional Operations, Department of Health): I will try to support my colleague. It's Keith Conn.

To answer your question, yes, the phone is picked up. I am not sure about this particular case, but for example, when there are disturbing prescription patterns for an individual client—we do have a tracking system—there is a call from our head office to that prescriber or pharmacist. We work closely with the various provinces and territories. I wouldn't say a hotline, but we have a direct line to senior officials to say that we have an issue, for example, “This person is in Toronto, they are stranded, and they are going through a crisis. How do we work co-operatively together?” We have navigators as well, who are out in the field working for first nation communities to champion or to help clients who are in a distressing situation that could be leading to some high-risk situation. Yes, we pick up the phone. We call pharmacists, doctors, or our connections within various ministries of health to resolve the issue.

Mrs. Cathy McLeod: My next question is for Dr. Beaudet.

You alluded briefly to two things. You said that you share best practices at the Arctic Council meetings. Is there a public document that could be ultimately tabled?

Dr. Alain Beaudet: There are several documents, and we will be happy.... The report of the project, the outcome of the project during the two years of Canada's chairmanship is out, and we will certainly be happy to send this report to you.

As I said, we are pursuing now.... It is great that under the chairmanship of the United States, they have decided to maintain the project and build on it. We saw what the gaps were from our first study. One of the problems we realized was that.... We all started with wanting not only to look at the interventions that had been successful in Canada, but also to learn from interventions that had been successful in Greenland, Alaska, northern Sweden, and northern Norway, where, as you know, there are also extremely high suicide rates among aboriginal youth.

We realized that we had a difficulty in actually comparing the studies because of the lack of standardized metrics. It is one thing to measure suicide rates, but there are all sorts of other metrics in the interim that could inform whether an intervention is successful or not, and whether we are actually changing the mental health core. This is what we are doing now. Canada will be hosting a major end-of-term symposium on this case in Iqaluit.

Mrs. Cathy McLeod: They have me down to my last minute. You talked about a very successful Quebec project, their preventative initiative, with a 50% reduction in suicide rates. If that could be tabled—

Dr. Alain Beaudet: Absolutely. It's been a major program launched in Quebec for preventing suicide. The results have been amazing, actually. As you know, Quebec had, among the provinces, the highest rate of suicide among youth. The effect of a systematic approach to prevention has massively decreased the rate of suicide among youth. We'll be happy to send you this information.

The Chair: Thank you for that.

The next question is from Charlie Angus, please.

Mr. Charlie Angus (Timmins—James Bay, NDP): Thank you very much for participating in what I think could be a very important study, with all our members of Parliament trying to deal with some of these issues. I hope we will see you again as more evidence comes forward.

Certainly, the issue of suicide is very complicated, but in some ways it's also very simple, in that the agencies, the adults, the institutions whose job it is to protect children are failing them. That's what we need to look at.

I bring forward the case of 14-year-old Azraya Kokopenace, who died a horrific death in Lake of the Woods. She was involved with child welfare. She was involved with police. She was brought to a hospital, walked out of that hospital in the middle of the night, and her body was found two days later. The family is asking for an inquest. I don't want to deal with the individual case, but what was raised in that tragedy was that she tried to get mental health services and mental health services were not available. In fact, in Queen's Park today, in calling for the inquest, MPP Sarah Campbell said, “To be clear, these services don't exist.”

Do you keep records, statistics, of the number of requests for mental health services for youth at risk? Do you keep records of how many are denied? Do you have records of what the delay rate for treatment is?

● (1625)

Dr. Tom Wong: Thank you very much for the question.

Yes, indeed, we are very concerned about the state of mental health services in Canada in general. This is both on reserve and off reserve for indigenous people and for non-indigenous people as well. Specifically, in remote and isolated areas, there's a particular challenge.

Yes, to answer the question, our department does have records of people requesting mental health services, and the department does actually provide those services by contracting with professionals to provide those services, both in person as well as through telehealth arrangements.

Mr. Charlie Angus: Thank you. I only have seven minutes, that's why I'm being curt here.

In our communities that I represent, I hear all the time that people are denied service, or they wait so long the young people go to ground and we've lost young people. Would you share those statistics with us so that we have a sense of what the delay rates are, because if we're being told that mental health services simply do not exist in parts of the country, then what else can we expect but that these young people are going to fall through the cracks? Would we be able to get those statistics?

Dr. Tom Wong: Yes, we'd be happy to provide those statistics. It is really important to us that anybody who wants and needs mental health services actually gets those services, because they want those services to get help.

Mr. Charlie Angus: Thank you. That's excellent.

You'd said that we have 10 mental health wellness teams in the country and you say they represent between two and 10 communities that they service. There are 634 first nations, so that's between about 3% and maximum 20%. The AFN said we need 80. Have you costed out what it will take to get us to have a full complement of mental health wellness teams?

Dr. Tom Wong: If we wanted to look at a utopian situation, yes, we want to go up to—

Mr. Charlie Angus: It's not utopian. This is about making sure that every community has a mental health wellness team so their kids aren't killing themselves. You say you have 10. They say they need 80, so have you costed out what it would take to get us there?

Dr. Tom Wong: Right now, we are actually doing the calculation on how much that would cost, yes, and we would very much like to expand those mental health wellness team services.

Mr. Charlie Angus: That would be great.

Dr. Tom Wong: Those mental health wellness team services are not just providing the services when there's a crisis, but they also to try to prevent the crisis from occurring. Then when a crisis happens they help the community deal with the crisis and mobilize other teams into the community.

Mr. Charlie Angus: We're 70 short, so could we get the numbers on what it would take to get us there?

I notice on the mental wellness continuum that only $350,000 was allocated. We asked Health Canada about this the last time they were here. How much would you need to get the full implementation of the mental health wellness continuum framework?

Dr. Tom Wong: The implementation of the first nations mental wellness continuum framework is much more than the $350,000 because everything that was done up to the point when the framework was developed, was compatible with—

Mr. Charlie Angus: But without your framework, there's only $350,000.

Dr. Tom Wong: Yes, but the $350,000 was purely the first tiny step to do the pilot studies.

Mr. Charlie Angus: What will it take to fully implement?

Dr. Tom Wong: It would have to increase to two or three times the amount that is currently in the budget. We have $300 million a year.

Mr. Charlie Angus: I want to go back to the story of the young woman from Lake of the Woods because the other element was child welfare. Canada has been found guilty of systemic discrimination in the Jordan's principle case.

Paragraph 458 of the Canadian Human Rights Tribunal cited that the 1965 agreement in Ontario is discriminatory and ordered in paragraph 474 that INAC "cease the discriminatory practice", yet I haven't heard that there's been any change to the 1965 agreement to bring the government in compliance with the Human Rights Tribunal. Will that be happening this year?

Ms. Paula Isaak: Yes, absolutely, the 1965 agreement does need to be changed. It needs to be changed in partnership. We can't change it unilaterally. The first step was an increased investment in Ontario for child welfare, recognizing that the 1965 agreement is the framework in which child welfare is delivered. We've just started those discussions and will definitely continue those discussions over this year to come to a—

● (1630)

Mr. Charlie Angus: Will that include mental health?

Ms. Paula Isaak: It will depend on the needs that come out of those discussions. Then we'll bring in our partners as necessary, whether that's Health Canada or others, to look at that.

Mr. Charlie Angus: Thank you very much.

The Chair: Thank you.

The next question is from Michael McLeod, please.

Mr. Michael McLeod (Northwest Territories, Lib.): Thank you, Mr. Chair, and thank you to the presenters. This is a very serious, very important issue that's been around for a long time. I've sat in many meetings, many conferences where we've heard study after study, conferences after conferences, symposiums, all looking at this issue. We've heard today that 34 departments are involved in dealing with the conditions that aboriginal people are facing in the social and economic area.

Yet in my riding in the last 15 years, we've seen an increase in suicides. We're up to 123. You add Nunavut to that, there's another 500, well over 600 suicides in the last 15 years while we've been studying this.

Since this committee started this undertaking, I've had two suicides in my riding. This is a short period. It's a serious issue. I don't see who is taking ownership of it. I heard you talk and this department talks and another department is talking, but where is the strategy? Where is the combined effort to work together? Who is leading the strategy and where's the action plan?

Why aren't we involving aboriginal organizations in this? I work closely with aboriginal governments. I talk to them every day. I don't see aboriginal governments being included, except to be consulted when there's a study. There is no strategy for the friendship centres to be used. The aboriginal head start is sitting in hell. Why are they in hell? They're an aboriginal program. There is no strategy for aboriginal head start to do anything anymore, yet some of the solutions involve languages, education. That's not being inclusive.

Explain to me how we're moving forward in a unified position to deal with this issue.

Dr. Tom Wong: I'll start with a response, and then my colleagues at INAC perhaps can chime in as well.

Indeed, actually, we do have a number of frameworks and strategies. Those are limited in scope at the moment. For example, we have the national aboriginal youth suicide prevention strategy. That strategy is limited in scope because it only deals with prevention: primary prevention, secondary prevention, and tertiary prevention.

As you said, there are many upstream items that are not covered, such as, education, culture, etc. All of those need to be built onto this pre-existing national aboriginal youth suicide prevention strategy in order to make it a comprehensive strategy, because one cannot go with a health-only approach. One needs to deal with all of the other socio-cultural factors, housing, etc. For that, we are absolutely very interested in working with any sectors who are interested.

On the issue of working with indigenous organizations, we've been working very closely with the AFN, as well as with ITK. We worked with the AFN on co-developing the framework for the first nations suicide prevention and continuum framework. For the Inuit, we work with ITK to assist them in developing their suicide prevention strategy, as well as the mental wellness continuum framework.

We have regular meetings with those organizations, those national organizations, learning from them and offering any assistance we can to them so that together we can actually help address this very complex problem. We have been hearing from our AFN and ITK partners that they are very interested—

● (1635)

Mr. Michael McLeod: I'm going to interrupt you because you're not answering my question. My question is, who is the lead on developing a suicide strategy with all the different departments involved? Maybe you could answer that.

Dr. Tom Wong: For the strategy part, for the health part, Health Canada would be the lead, and we would invite other partners to join us.

Of course, this is from a government perspective. Everything has to be led by the communities, by the indigenous communities, and we are there to facilitate their work. Of course, because of issues of social determinants of health, we need the support of all federal departments, such as INAC.

Mr. Michael McLeod: I'll just cut you off again.

Mr. Chairman, I'm not hearing the answer, but we know that the highest suicide rates are amongst aboriginal people. Usually they're male. Usually they're in isolated communities. Usually they're in communities that are economically depressed.

If there were three things that you could do immediately to try to alleviate the situation, what would they be?

Dr. Tom Wong: The first thing would be the reconciliation regarding the Indian residential schools and all the intergenerational trauma. That's extremely important. Two, it's to bring hope, meaning, purpose, and belonging to the youth, the children, and the parents. For that, we need to have the social determinants of health. We need to bring the culture back to the youth. We need to reinvigorate the importance of self-esteem and the culture, and lastly —

Mr. Michael McLeod: Okay. I have one last question. Where is that plan? I'm hearing you say a lot of nice things, and I've heard all of you say good things. Where is that plan and when can we expect it?

Dr. Tom Wong: The plan is already in existence, with the AFN having worked with us to co-develop the first nations mental wellness continuum framework. All of those elements are there. We are going through the next step, to actually implement elements of that plan, together with the communities and together with INAC and other departments.

Mr. Michael McLeod: The AFN doesn't represent most of the communities in my riding, so....

The Chair: Thank you, Dr. Wong.

We now move to a round of five-minute questions.

The first question will come from Arnold Viersen, please.

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

I thank our guests for being here today. I really appreciate your time.

Suicide and suicide attempts come from a number of devastating situations. A recent study by the Canadian Medical Association found a strong association between child abuse and suicidal ideation or suicide attempts. I'm wondering if, from your research, any of your departments have shown similar associations between indigenous youth and child abuse, and then suicide attempts.

We'll hear from the Ministry of Health first.

Dr. Tom Wong: There's a strong association between abuse, violence, and suicide.

Mr. Arnold Viersen: I see that one of the programs you have listed is the family violence prevention program. I was wondering if you could elaborate on what that program entails?

Ms. Paula Isaak: Yes, that's one of the programs the department offers.

It has a couple of components. Its primarily focused on supporting a network of 41 shelters on reserves across the country, as well there are some programming dollars that communities are offered with respect to creating prevention programs around preventing family violence. It has two components. One is supporting shelters, and one is supporting some programming on a proposal basis.

Mr. Arnold Viersen: When it comes to suicide prevention strategies that are delivered through the national aboriginal youth suicide prevention strategy, do these suicide prevention programs include preventing child abuse?

You're saying these are programs that are driven by the communities that are applying for that family violence prevention program. Are there any suicide prevention parts that come into that national family violence prevention program?

● (1640)

Ms. Paula Isaak: I would say typically they're not designed toward suicide, but I expect the benefits of a number of those prevention programs might be ones that would also benefit prevention of a variety of types of violence, or potential violence toward oneself, or suicide prevention potentially.

Mr. Arnold Viersen: Mr. Chair, I spent a little time recently pulling together a bunch of statistics. What was interesting was that I initially thought—as my colleague across the way, Mr. McLeod—there were generally economic reasons why there were such high rates of suicide.

I pulled a bunch of numbers. Going on purely the province or territory they're on, Nunavut has the highest rate of suicide but it also has the highest weekly average income, which seems counter-intuitive to me. If the weekly average income is high, you would expect lower rates of suicide. It also has the most police officers, but it still continues to have the highest rate of suicide. It also has the highest rate of sexual violence. It was interesting to see those correlations.

Correlation never predicts causation. Is it because we have too many police officers that we're causing suicide? Is it the sexual assault rate that's causing suicide? Or is it that these people are making more money that's causing suicide? It didn't seem to make any sense to me.

I was wondering, have those correlations been carried out at all—and this would be for Alain—and is there some causation with specifically income, sexual assault, and the suicide rate?

Dr. Alain Beaudet: Yes, they have. They're complex, but they all are part of the determinants of mental wellness.

Mr. Arnold Viersen: Is there some study that you could table that has those?

Dr. Alain Beaudet: We can send you some articles, absolutely.

The Chair: Thank you.

Next question is from Gary Anandasangaree.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): Thank you, Mr. Chair.

I want to thank all of you for joining us today.

I want to distinguish between the short-term solution and a longer-term solution. I want to leave the longer term out and just talk about the short term, recognizing that a number of social determinants in health will have a significant impact on the longer term, as well as the TRC and a lot of the things Dr. Wong outlined.

In terms of the short term, and let's say a year or a two-year timeline, do we have a dashboard? Is there somebody with a dashboard or a screen where we can see, of the 600 communities that INAC serves, these 30 have a high likelihood of suicide, or they're highly susceptible to suicide, or there's an increased risk in a certain period of time, the second group has a lower risk, and the third group has effectively no risk?

Are there any metrics of that sort that are available, which somebody's looking at continuously and deploying resources accordingly?

Dr. Tom Wong: Yes, we do have a dashboard precisely to look at that. To us, it's really an issue of equity. You start by addressing the areas where there are lots of needs first, and then with time, you start going to the second tier and the third tier. The short answer is yes.

Mr. Gary Anandasangaree: With respect to that first tier, what kinds of supports are being offered proactively? Given the limitations that exist right now, what supports do you provide? How do you bring the provinces in? How do you bring the different agencies in to ensure that they are supported—let's say the top 30 communities or the top-tier communities—in that timeline that we're talking about?

Dr. Tom Wong: For those in the top-tier, high-need communities, we are working with partners, the communities, first nations communities, Inuit communities as well as with universities, hospitals, professionals, and professional groups to try to see how we can find ways to expedite services as well as to maximize the use of telemedicine in order to provide those mental health services.

In addition, we also work with our partners, other government departments as well as provinces and territories where appropriate, to find ways to address some of the other issues that are beyond health. We want to bring in other partners to look at recreation, traditional activities, how to reinvigorate the language and culture, and so on.

● (1645)

Mr. Gary Anandasangaree: For that top tier, are those numbers static or do they move around?

Dr. Tom Wong: Unfortunately that top tier is not static. It's dynamic and it changes with time. Therefore, our response is also dynamic.

Mr. Gary Anandasangaree: What are your greatest challenges in re-evaluating and fulfilling those needs as they arise?

Dr. Tom Wong: Resources.

Mr. Gary Anandasangaree: What kinds of resources?

Dr. Tom Wong: Both human resources at every single level as well as financial resources.

Mr. Gary Anandasangaree: How do we start addressing the human resources? I know that for financial resources there is a commitment right now from our government for $8.4 billion over the next five years. It will go to some of these things, but really, a lot of it is for infrastructure. How do we address the resource deficit? I'm assuming it's professionals, doctors, psychiatrists, nurse practitioners, and so on. How do we address that in the short term? Are there locums? Are the medical associations involved? Are there nurses associations involved in supporting this right now?

Dr. Tom Wong: On the professional resources front, we are in discussion with medical schools, professional organizations, and nursing schools, in order to see whether there are ways that professionals can be mobilized to offer services, whether regularly or periodically, through a collaboration with the communities. We are trying to facilitate that, working of course with provinces and territories.

Already, we have a number of institutions very interested in trying to work in that capacity. Some of the medical schools and nursing schools have training programs as well. We also facilitate the encouragement of training more nurses and doctors, in order for them to eventually work in those remote and isolated areas on reserves.

The Chair: Thank you, Dr. Wong.

The next question is from David Yurdiga, please.

Mr. David Yurdiga (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair. I'd like to thank the witnesses for being here today and presenting. It's very informative.

Some first nations experience virtually no suicides in their communities, while others experience three, four, or seven times the national average. What are the factors that contribute to the higher suicide rates? Is there a magic thing when you compare communities to communities?

I open up the question to any of the witnesses.

Dr. Tom Wong: If I understand your question correctly, you're interested in looking at the factors that determine why one community has a high risk for suicide, and another, a low risk for suicide. Is that correct?

Mr. David Yurdiga: That's correct. You have two communities in proximity, and you have one that has a substantially lower suicide rate. Then you go 100 kilometres and that other one has a high suicide rate. Geographically, they're in the same region but the suicide rates are much different.

Dr. Tom Wong: Chandler and Lalonde have done a remarkable study looking at that exact question. To sum up, what they found is that there is a list of factors that are important, but the most important factor is that services and governance have to be determined and controlled by the community, including mental wellness services, other health services, education services, police services, etc. They found that was very important in reducing the rate of suicide and increasing mental wellness.

It gives the control and the leadership to the community, for the community. Other people can assist, such as governments, but they are there to support. The leadership and the control needs to be by the community and for the community. This is in addition to all the social determinants of health that Paul and I spoke about earlier, as well as the reconciliation part.

● (1650)

Mr. David Yurdiga: What I found in my riding is that one community is very active in other communities, whether it's sports, hockey…. It seems that the one that's very aggressive as far as being a participant with other communities, they have role models. The community rallies behind their teams. Have you found that in other regions?

Dr. Tom Wong: Yes, indeed. Having recreational activities, sports activities where there is a network to promote the youth, gives them a vision, a purpose in life, that's very helpful.

How can you live in a community where there's absolutely nothing to do? There are no sports. When you look to your left, look to your right, you see the suicide of your friends. There's no future. When there's a vibrant community where the leadership controls the education services, the recreational services, and the health services, it gives the young people a goal in life. They participate in those activities. They excel in life, and they see role models that they can emulate. Those are some of the key factors for success in those communities.

Mr. David Yurdiga: Many indigenous people on reserves have difficulty finding good long-term jobs. Having a job for one month here and two months there is not really a job. Have there been any studies that correlate employment and suicide? Are there any studies out there that say that's one of the contributing factors?

Dr. Tom Wong: Yes, there is a correlation between those.

Mr. David Yurdiga: What are some of the interjurisdictional challenges that affect access to health services by first nations and Inuit individuals?

Dr. Tom Wong: The isolation of the communities, and for many of them, the lack of social infrastructure, the lack of access to the Internet—all these things are so important. There is also poverty and all the social determinants of health, the lack of recreation, and the lack of linkages to the elders and their tradition.

The Chair: The last five minutes go to Mr. Bossio.

Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.): I thank you very much for joining us here today on this very important subject.

Many times we've talked about strategies and frameworks and consultation. Is the consultation to establish strategies and frameworks on mental health and suicide and social determinants just happening at the AFN level, or is it going right down to the reserve level?

Dr. Tom Wong: It's happening beyond the AFN level. For Inuit, it's more than just ITK. It goes down to the community level with different first nations and Inuit groups.

Mr. Mike Bossio: Do you know what percentage of different reserves you've actually consulted with, of the 634 reserves across the territories?

Dr. Tom Wong: I don't have that number off the top of my head, but it's been a large percentage of that over time.

Mr. Mike Bossio: Okay. I know the CIHR have been doing the same. You've been doing a lot of studies. I assume you're also going right down to the reserve level. It sounded as though that's what you do.

Dr. Alain Beaudet: Absolutely.

We are working at the community level. For instance, the ACCESS program, which is the major program on mental health in indigenous populations, which I talked about, has been working on the ground with communities. I mentioned the Eskasoni First Nation. That's also at the Sturgeon Lake First Nation, and Ulukhaktok in the Inuvialuit settlement region.

● (1655)

Mr. Mike Bossio: Okay.

Dr. Alain Beaudet: I could go on and on.

We've also set up partners for engagement and knowledge exchange in the community to help us get the research evidence and the research results into the community to work more closely with them and to learn how to actually work more closely with the community.

Of course, for me, as I mentioned, a key element is to think of the future, through education to support young indigenous researchers. Their number is growing.

Mr. Mike Bossio: Actually, that's where I'm going to get to.

CIHR and Health Canada are working hand in glove on this in these different communities, rolling out this research, identifying the hot spots, etc.

Dr. Alain Beaudet: We are working collaboratively not only with FNIHB and Health Canada but also with the Public Health Agency of Canada on these various issues, absolutely. We're in the same portfolio.

Mr. Mike Bossio: What percentage of the people working in these specific areas with indigenous people are of indigenous background?

Dr. Alain Beaudet: Not enough.

Mr. Mike Bossio: What percentage would you say, if you had to throw a percentage out there?

Dr. Alain Beaudet: I don't have the numbers right now, but I can tell you, however, that in the area of aboriginal people's health—and I'm not talking only mental health, since as you know there is also a huge cross-correlation between other disorders and suicide—the number of people doing research on indigenous people's health in 2000 when CIHR was created was 37. The number of researchers working on indigenous people's health issues right now is 1,174.

Mr. Mike Bossio: That's great.

Dr. Alain Beaudet: The number of indigenous researchers has also increased, but not by enough.

One of the problems we are facing is, again, a problem of self-reliance, of support, of mentoring, of maintaining the cultural identity, and of maintaining the contact with elders, so that they have role models in the research community, but they also need to keep role models in their own community as well.

Mr. Mike Bossio: Okay.

Sorry, but we're really running out of time here.

Dr. Alain Beaudet: We've developed a program to support that.

Mr. Mike Bossio: That's where I'm going as well. I know the challenges exist out there to try to get more and more indigenous people into these roles. How long does it take to train somebody to be a mental health support individual within the community?

Dr. Alain Beaudet: You have to start education early on. You have to decrease the dropout rates in high school. You have to bring them to university and once they're there, you have to build their self-reliance, their self-confidence....

Mr. Mike Bossio: I'm just looking, from a post-secondary standpoint, at whether it is a four-year program, eight years, or a Ph. D.

Dr. Alain Beaudet: We're starting to get them in some projects while they're in high school.

Mr. Mike Bossio: Good.

I'm out of time.

The Chair: Sorry, Mr. Bossio.

We're moving to a three-minute question now from Charlie Angus, please.

Mr. Charlie Angus: Thank you very much.

I was looking at the Pikangikum coroner's recommendations from the horrific suicide crisis of 2006 to 2009. There were 100 recommendations. We will be having the Thunder Bay inquest recommendations. We've had the TRC recommendations.

Can AANDC tell us, in a case like that, how many recommendations are followed up on?

Ms. Paula Isaak: We're currently working right now to implement the calls to action of the TRC. That process has started.

Mr. Charlie Angus: But in the case of Pikangikum...?

Ms. Paula Isaak: I can't tell you off the top of my head, so I'd have to get back to you.

Mr. Charlie Angus: One of the key recommendations from Dr. Bert Lauwers, who did the Pikangikum report—and it strikes me as something to be learned in Attawapiskat—was to establish a steering committee with health professionals, law enforcement, and government in the community so that we could actually move forward. That doesn't seem to have taken place. It seems to have been a bit ad hoc. But a coherent steering committee.... This is what we're hearing in Attawapiskat as well with the youth, about giving them something.

We see that there are partners stepping up. In Pikangikum, Project Journey with the OPP is doing incredible work with young people. When Mr. Conn and I walked into Attawapiskat we were met by the Canadian Rangers, who were on the ground. We have an enormous amount of goodwill. We have an enormous amount of expertise in providing services, but in some of these communities we need a framework. We need to have, especially in troubled communities of crisis, the federal government or the provincial partner playing a role to support the efforts of organizations that want to help.

Mr. Conn, the clock is ticking on the EMAT team in Attawapiskat. People in our community have seen this movie before, where once all the attention is gone, one by one so are all the workers, and we're back to square one. What's the post 30-day plan with EMAT and making sure that we can get the best out of all these organizations that want to help?

● (1700)

Mr. Keith Conn: Thank you for the question.

The EMAT team along with some of the federal resources—we have a senior executive from Health Canada as well as representatives from the North East LHIN, Local Health Integration Network—have been working with the community itself. The EMAT has been doing some knowledge transfer and training within the community, including for the health director and other staff, to develop a transition plan so that as the EMAT dissipates, there will be a plan in place in terms of medium-term supports, coordination.

They've been doing some community mapping of all the agencies, the workers that are in place on a continual basis but also what is going to be augmented shortly between the collaboration and input of the North East LHIN and the WAHA hospital, so those are being solidified. We're going to have some discussion hopefully with the chief on Thursday. I think there's a reasonable plan. It's been a lot of hard work, but I think there's some light.

Mr. Charlie Angus: Is it applicable to other...? I mean, it seems to me we're always reinventing the wheel in the middle of—

The Chair: Charlie, I'm afraid we're out of time, but your name is coming back up again.

We're moving through the list. We're going to start again with seven-minute questions, and the first one comes from Rémi Massé.

[*Translation*]

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

I'd like to thank the witnesses for contributing to this important exercise of trying to shed light on the causes of high suicide rates and potential solutions to prevent them.

My first question is for Dr. Beaudet. Our colleague, Cathy McLeod, touched on this earlier, but unfortunately, we ran out of time.

I'd like you to speak at greater length about the solutions Quebec put in place, solutions you described as successful. They, in fact, led to a 50% reduction in the youth suicide rate. Please take your time because I think it's important we hear what those solutions are.

Dr. Alain Beaudet: I can give you some details on that. It's a program-based government approach that relies on structured prevention policies.

As is always the case when it comes to research, we are in the situation your colleague referred to earlier. We want to find out which policies had an impact and to what extent the impact of those new policies was positive. Can we establish any correlations? Without question, Quebec is currently experiencing a lower suicide rate, and it is holding steady. Year after year, we've seen an absolutely phenomenal drop in Quebec's suicide rate. Which programming elements and which preventative measures were applied, specifically? Establishing the cause-and-effect relationship —not just the correlation—is still a challenge. I would certainly be happy to send you the relevant documentation.

One thing is clear, however, and it was certainly noticeable when we looked at the various interventions used in the U.S., Australia, Greenland, and Canada. To be effective in preventing suicide, the interventions must be heavily adapted to local socioeconomic conditions and local communities and, as my colleague said, rely on community engagement. Of course, youth-focused models are paramount, and they will vary tremendously from one community to another and grow based on the level of remoteness.

Unfortunately, it won't work to simply take Quebec's prevention policies, lock stock and barrel, and apply them to Nunavut. I can't stress enough how important that is to understand.

It's equally important to understand which elements can be imported and how they can be tailored. I gave you the example of a researcher who took prevention programs that had been successful elsewhere and, working hand-in-hand with the communities, adapted them to first nations. These tailored programs have been met with tremendous success. Clearly, that's one solution that is worth a much closer look.

● (1705)

Mr. Rémi Massé: Thank you.

That's important because, even though, as you say, the number of deaths by suicide has dropped significantly, our statistics show that the number of suicide deaths in the province of Quebec still sits at 753 among men and at 219 among women. That's still a lot, so there's a long way to go yet.

Dr. Alain Beaudet: The situation was alarming because the suicide rate was one of the highest in the world not that long ago. Today, that is still true in Canada, but for Inuit populations, as you know. Unfortunately, we still hold the sad distinction of having the world's highest suicide rate among young men.

Mr. Rémi Massé: Thank you.

I have another question for the Health Canada officials responsible for implementing the aboriginal health programs.

In July 2015, the federal government announced its commitment to ongoing funding for aboriginal health programs, including $13.5 million per year for the national aboriginal youth suicide prevention strategy. How many suicide prevention projects have been funded under the strategy, and what have the outcomes been?

Dr. Tom Wong: Thank you for the question.

[*English*]

Indeed, the strategy has funded more than 130 projects. For me, that is just a start because many more projects could be funded with additional resources in the future, but we are already seeing some of the outcomes. In some of the projects, some of the participants are reporting that they are seeing more hope. They are seeing a future for themselves, and they are actually starting to attend school more. Those are all elements that predict a better future, and therefore less propensity for mental diseases and suicide as well.

[*Translation*]

Mr. Rémi Massé: Thank you.

Could you describe some of the projects that were put in place? What tangible measures were taken under the 130 projects being funded? That may help to partly answer the question asked by my colleague, Michael McLeod. I'd like to know what solutions were adopted, concretely speaking, under those projects.

[*English*]

Dr. Tom Wong: Yes, that's very much so.

For example, I was talking earlier about a project in the Northwest Territories where there was a camp for adolescent teen girls, and through the camp activities they've learned to have self-confidence and they've learned about the linkage to culture. As a result of that they are reporting all of those factors that I talked about, the feeling of hope, the feeling of the future, and as a result of that, their connection to schools and all of those things have increased.

Another project is through the development of community, working together with the local police to try to help the young people understand their strengths and help them to do physical activities. As a result of that, they are finding that they will no longer be complaining that there is nothing to do in life. They now seem to look to there being a place for them in the future.

The Chair: Thank you very much for that.

The next questioner is Cathy McLeod, please.

Mrs. Cathy McLeod: Thank you, Chair.

I do want to pick up on my namesake in terms of the fact that it doesn't appear to be one lead in this, so the sense I'm getting is a scattering of services and programs across a whole host of departments. Some have been evaluated; some haven't. I think there are certainly ways it can be brought together with a little more clarity, but you've been embedded in the system and perhaps you see it more clearly than I do.

I do want to also pick up on this. I think if you had the money tomorrow you would never be able to fill 70 teams of mental health workers. I've delivered health care and been responsible for getting services in rural and remote communities, and I think it is really tough in terms of HR manpower and getting people with the right skills. I always believed that to some degree the money is better spent in terms of recreation and capacity building.

To that end, first of all, I know that Dr. Beaudet talked about the mental health first aid program being adapted to first nations communities and rolled out. Is it being rolled out in 600 communities across the country, or 20 communities? To what degree has it been evaluated, and to what degree is it showing any kinds of results?

● (1710)

Dr. Alain Beaudet: The answer is no, not to the 600 communities.

We are funding research, so our role is to demonstrate that an intervention is effective. Then our role is to work with our colleagues to ensure that the effective interventions are scaled up in a way that is appropriate for the various communities where they are being scaled up.

Mrs. Cathy McLeod: How many communities are you researching? The program was adapted—

Dr. Alain Beaudet: It depends on the program, but I am thinking about one where there are—

Mrs. Cathy McLeod: This is the mental health first aid one.

Dr. Alain Beaudet: —12 communities in one program, the same number. There are relatively small numbers of communities where the research is carried out.

Don't forget that, again, we support the research so we cannot support care, which often goes with implementation science to a very large scale.

Mrs. Cathy McLeod: Okay. My next question will to go Health Canada.

I've seen demonstration project, after research project, after primary health care project that is shown to be effective. Do you have a system whereby you can reallocate resources from things that aren't effective to.... Let's say, for example, this mental health first aid kit was showing amazing results. What kind of nimbleness and flexibility do you have to scale that kind of thing up?

Dr. Alain Beaudet: Is that question for me?

Mrs. Cathy McLeod: No, it's for Health Canada.

If the results come in from CIHR and the mental health tool kit is amazing, how are you going to scale that up?

Dr. Tom Wong: One of the ways we do it is in working together with CIHR.

Health Canada's first nations and inuit health branch actually collaborates with CIHR on the original pathways initiative, and it is an initiative that includes mental health and suicide as one of its components. Because we collaborate with CIHR on those projects, when there are demonstration projects showing that there are promising practices through our networks we facilitate the sharing of those best practices and promising practices. In addition, we internally reallocate funding, working together with communities, in order to try to scale up those promising practices.

As part of CIHR—perhaps Dr. Beaudet can speak on this as well—there's a small scale-up component to the pathways project as well.

Dr. Alain Beaudet: There is, absolutely—

Mrs. Cathy McLeod: Sorry, I think we'll probably have to take this offline.

How many of the communities, the 600 and some, have reasonable broadband access available? To what degree is telemedicine and also things like...? There are some very good preventative mental health programs that are quite catchy for young adults in terms of these online supports, like WalkAlong, for example. Are we scaled up across the country for broadband? Are we scaled up across the country in terms of the ability in the majority of the communities, 50% of the communities, to deliver both telemedicine and to have capacity to administer some programs that are perhaps effective?

Dr. Tom Wong: The short answer is not enough. We really would like in the future to have enough bandwidth and broadband so that those services can be actually brought to the most remote fly-in communities, but at the moment, unfortunately—

● (1715)

Mrs. Cathy McLeod: Would you say 50%?

Dr. Tom Wong: It's less than that, yes. In many of the communities remember it is dial-up, so doing any kind of download is extremely slow.

Dr. Alain Beaudet: If I may add, scaling up is not easy. We are realizing it is a problem we are facing worldwide. The World Bank is coming to us to ask how to scale up projects in western Africa, and how to deal with different cultural backgrounds and the scale of a project. We're dealing with a science that is a new science, the science of scaling up. How does it work? How do you do it? How do you do it efficiently? We are just seeing the beginning of that and we'll be way more effective in scaling up in the near future.

Mrs. Cathy McLeod: Thank you.

The Chair: Thank you.

The final question will go to Charlie Angus. The bells might start to ring or the lights will blink while we're in this question. It's a 30-minute bell, I understand, for a 5:45 vote, so we should be fine to get through it.

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

Thank you for this. It's been a very interesting afternoon.

I want to go back to the issue of child welfare because it appears in the case of this young person who was lost in Lake of the Woods. It's been raised again and again as one of the key drivers in terms of the lack of opportunities for indigenous children.

The government has placed $71 million for immediate relief, I understand, for responding to the child welfare gap, but I'm looking at your own submission to the Human Rights Tribunal, at tab 248, which says at the time it was submitted the gap was $108 million, which now with inflation would be about $121 million or $122 million. Your own internal document said that the gap was much larger than what's been provided, so how can you be in compliance with the Human Rights Tribunal ruling, which has ordered you to immediately end the underfunding?

Ms. Paula Isaak: When we had—

The Chair: If I could, our procedure requires me to ask for unanimous consent for the committee to carry on when the bells are ringing. As I said, it's a 5:45 vote. Do we have unanimous consent to carry on to the end of this seven-minute question?

Some hon. members: Agreed.

The Chair: It looks like we have it.

Sorry for the interruption, please proceed.

Ms. Paula Isaak: Thank you, Mr. Chair.

When we undertook that work in 2012 we had also looked at scaling up the funding, so that's what the current budget investments do. They start at $71 million and scale up all the way to $176 million over the five years and then ongoing. This is the same philosophy we looked at when we did that previous work. It's because agencies needed to ensure that they could hire and get the appropriate social workers and the appropriate programs in place in order to expend the dollars over time. That was the thinking behind the scaling up of the money over the number of years, and that was the same thinking that existed when we did the previous thinking.

Mr. Charlie Angus: I guess a question, though, in terms of being in immediate compliance, because we're talking about children who are falling through the cracks nightly and daily.... In 2012 you identified a gap that is much larger than now, so the scaling up is going to take five years, but at the end of that five years, you still will not be at $200 million, which is what the litigants against the government are saying is the shortfall.

If the Human Rights Tribunal has ruled in favour of Cindy Blackstock, and she says it's $200 million, and in five years you're still not going to be there, then how can you be in compliance with the ruling?

Ms. Paula Isaak: The tribunal as of to date hasn't indicated that $200 million is the number for compliance. They have asked for the information, and we've just recently provided the detailed breakdown. We expect they will get back to us if they have further questions or further orders.

As I said, we've updated the numbers we had used in 2012, which showed ultimately a $108-million gap, and now we see about $175-million gap in ramping up.

It remains to be seen if the tribunal has more information for us.

● (1720)

Mr. Charlie Angus: What happens if the tribunal says it doesn't cut it? This has been a 12-year process. They have been telling you. You have been aware of this. Your own documents show that the numbers are serious.

How do you become in compliance if your plan over five years is to not even meet the target? Do you have a contingency plan then at that point?

Ms. Paula Isaak: We will address what the tribunal orders us. We will look at the order at that time and address it at that time.

Mr. Charlie Angus: Would that money come out of other program dollars then? That's what has happened in the past, right? Money's coming out of infrastructure to deal with shortfalls in child welfare every year.

Ms. Paula Isaak: In the past we reallocated money, that's right. Now the hope is that we will not have to reallocate money from other programs. We will deal with the tribunal order in the future should they order something different.

Mr. Charlie Angus: So $71 million is what has been allocated. Do you know how much money is expected to actually go out to service children?

Ms. Paula Isaak: I don't have the detailed breakdown right in front of me, but we've provided that breakdown and we can give it to the committee.

Mr. Charlie Angus: That would be good because, if it's only $50 million and the rest is being held back for whatever other administration issues, then we're still not in compliance, so that would be helpful to us.

Ms. Paula Isaak: We'll provide the breakdown.

Mr. Charlie Angus: Thank you very much.

Dr. Wong, I wanted to return to you in terms of staffing up to wherever we're going to go with the mental wellness teams.

If we have 10 mental wellness teams servicing 5%, 10%, or 20% maximum and we need to get to 80%, are there targeted plans in terms of how we get there? Are we just hoping or...?

Dr. Tom Wong: Right now we are seeking resources and sources of funding. As I said before, 10 teams are not sufficient, so we would like to actually increase it.

If we look at 80 teams, we would be looking at $40 million to $50 million.

Mr. Charlie Angus: Okay. You would need to find that money so that would have to come from Treasury Board. That's roughly the area of what you would need to meet that shortfall?

Dr. Tom Wong: Approximately, yes.

[*Translation*]

Mr. Charlie Angus: I'd like to pick up on a question my colleague, Mr. Massé, had regarding the decrease in Quebec's suicide rate. It's really incredible. If you look at the difference between Quebec's Cree population and Ontario's, it's like night and day.

The Quebec government and the province's Cree population signed an agreement known as the peace of the braves, and it set out an engagement process for resource development, economic development, and land protection. The situation is entirely different from that of the James Bay Cree in Ontario.

Would you say there's a link between the improvement in the Quebec Cree population's economic conditions and the drop in the province's suicide rate?

[*English*]

The Chair: Could you just take less than a minute, please? I'm afraid we're over time.

[*Translation*]

Dr. Alain Beaudet: I can't really answer that.

As I said earlier, the government took a slew of preventative measures, including improving access to mental health care, creating suicide prevention centres, and, even, erecting barriers along railways to stop people from throwing themselves in front of passing trains. A whole slew of measures were taken.

The real question, then, is which of those measures were truly effective, but I can't answer your question, specifically.

[*English*]

The Chair: Thank you very much.

I wish to thank all the witnesses today for their time and very thoughtful presentations. Your contribution will make a tremendous impact on our study. Thank you very much.

We are adjourned. Thank you.