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Chair

Mr. Ben Lobb

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● (1530)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good afternoon, ladies and gentlemen. We're ready to start our committee meeting this afternoon.

We have two guests appearing by video conference and will start with them, as is our norm.

Before we begin, though, I'd like to get consent from the committee members. We have votes this evening at 5:15. If we can, we will probably cut a few minutes off each panel from the questions part of each so we can have two relatively complete panels, and then head to votes promptly at 5:15. Do I have consent for that?

Some hon. members: Agreed.

The Chair: Thank you very much. That's good.

Today we'll start with those farthest away, starting with Dr. Lalonde, professor of psychology at the University of Victoria.

Dr. Chris Lalonde (Professor of Psychology, University of Victoria, As an Individual): Thank you for the invitation to appear before the committee.

I'm talking to you from the territory of the Coast and Straits Salish peoples, whom I want to acknowledge before I begin.

For over 20 years I've been studying identity development in adolescents and young adults. My work has come to focus on the relationship between identity development and well-being among first nations youth in British Columbia and Manitoba. More specifically, I've been studying how failures in identity development are associated with youth suicide. What we've been trying to understand is why suicide rates vary so widely across first nations communities, from rates of zero in some communities to rates many times higher than the provincial average in others.

We managed to collect data on every suicide that took place in British Columbia between 1987 and 2006. We calculated the suicide rate of nearly 200 first nations communities in British Columbia. What we found was that some communities seem to have solved the problem of youth suicide. In fact our first wave of data collection showed that more than half of the communities had no youth suicides. Others had rates that were below the provincial average, and a minority had rates that were far above the B.C. average.

Our research has been guided by the idea that communities that have enjoyed success in preserving their cultural traditions and in gaining control over their collective social and political future would be better able to provide an environment that protects their youth from the risk of suicide.

We developed a set of indicators to measure what we called “cultural continuity”, things we could assess and verify about each first nation in B.C. We measured whether communities had a building devoted to cultural purposes and events, or had managed to foster the use of their traditional language, or had managed to include their own culture in the school curriculum. We looked at the participation of women in local governance. We looked at the extent to which communities controlled basic civic services—police and fire services, health services, and education. We looked at the history of land claims negotiation and litigation and efforts toward self-government.

We found that the variation in suicide rates is not random. Communities that scored higher on these measures of cultural continuity had lower youth suicide rates.

It shouldn't come as a surprise that higher levels of community control and maintenance of culture are associated with better outcomes for youth, but you need hard data to prove that. That's what we've been doing in B.C., and now in Manitoba.

I could go on about my research, but I want to address the final two points in the invitation I received.

The first concerns the availability of statistics about suicide, and the second asks for comments on best practices for mental health care and suicide prevention.

Since data for first nations people or status Indians are held by the federal government, it was extraordinarily difficult for us to access the suicide data we needed for British Columbia. We benefited from cooperative relations between the B.C. Coroners Service, the Office of the Provincial Health Officer, and what was then Indian and Northern Affairs Canada. We face similar challenges in Manitoba.

Both of these projects I've done are special one-off projects. There's no ongoing surveillance of suicide at the level of individual communities. Even the communities don't know where they stand on the issue of suicide, or any other health outcome relative to other communities, or to the province or the country as a whole.

What I believe we need is a system that creates annual health report cards for each first nation community. Every community should get a report that shows where it ranks in terms of suicide, mental health, addictions, and other health outcomes relative to other first nations, the province, and the country as a whole.

I need to stress that these reports shouldn't be made public. There's nothing to be gained by identifying on the front page of every newspaper in Canada the community with the highest suicide rate in the country, but if communities have no access to their own data, how can they plan or create interventions?

These report cards could also be used to better deploy resources to communities that desperately need them and avoid wasting them on otherwise healthy communities. At the moment, no one can tell those communities apart.

My final comment concerns best practices.

Our research demonstrates what many first nations already understand, that programs aimed at reducing suicide need not target suicide. If we support culture, we support health.

Some first nations elders and newspaper editors warn against talking about suicide for fear of creating copycat suicides. As a researcher, I'm not sure that media reports of suicide, or suicide prevention programs, somehow plant the seed or somehow cause suicides. I am convinced that efforts to promote and support culture work to prevent suicide.

● (1535)

We have the data to prove that. We just we need to do a better job of getting that message across, and we need to do a better job of recording and reporting suicide data. Unless we know what's happening at the community level, we're left with no action plan. Knowing that the suicide rate, the diabetes rate, or the injury rate is higher in aboriginal people tells us nothing. We need to know and, more importantly, specific communities need to know where they stand and what they can do. At the moment, there's no way for any of us to know, and that needs to change.

Thank you for your time. That's all I have to say. I'm happy to take your questions.

The Chair: Thank you very much.

Next up we have Janet Smylie from St. Michael's Hospital.

Can you hear us okay, Janet?

Dr. Janet Smylie (Director, Well Living House, Centre for Research on Inner City Health, St. Michael's Hospital, As an Individual): Yes, I can.

The Chair: Go ahead.

Dr. Janet Smylie: Good afternoon.

I want to acknowledge my colleague, Dr. Lalonde.

[*Witness speaks in Cree*]

My name is Janet Smylie. I'm a family doctor and public health researcher living here in Toronto, the land of the Mississauga people.

I want to touch on four content areas.

The first one is the burden of mental health challenges and the inequities that face indigenous people in Canada compared to non-indigenous people. I'm glad to follow Dr. Lalonde, because he has talked about suicide and put it in a good context for us. I think most Canadians are aware of the disparate rates of suicide experienced by indigenous people and indigenous youth.

I want to discuss some emerging evidence that we have been able to develop in partnership with provincial and local aboriginal health service providers here in Ontario. With the majority of aboriginal people now living in urban areas, we were able to use respondent-driven sampling over the past couple of years, in partnership with an urban aboriginal health access centre called the “De dwa da dehs nye>s Aboriginal Health Centre”, to develop population-based estimates in looking at the determinants of urban indigenous health as well as health status and mental health status indicators.

Respondent-driven sampling has emerged in urban health as a major source of population-based data for hard-to-find groups of people. Unfortunately, in urban areas, our federal statistics are very poor at getting actual counts of aboriginal people, and that's gotten worse with the switch of the indigenous identity question from the long form census to the national household survey. I recently published on this topic in an international journal of statistics.

With respect to this study, which is under final review for the *Canadian Journal of Public Health*, we found out that 42% of the self-identified first nations adults in Hamilton had been told by a health care provider that they had a psychological and/or mental health disorder. I should mention that the dataset is owned by the aboriginal community, and they gave permission to share the data.

Using the recognized tool, the Kessler, we found high rates of depression and anxiety. Shockingly, though, using a PTSD screener, we also found that 33% of the adult population, or one in three self-identified first nations people in this urban centre, met the criteria for post-traumatic stress disorder. Also, 41% had suicidal ideation and over half had attempted suicide. Then, and not surprisingly, I guess, given this high burden of mental health challenges, half the sample reported marijuana use in the last 12 months, one out of five reported the use of cocaine, and one out of five reported the use of opiates.

One remarkable thing, given this and other burdens—including, for example, that 16% of adults in a non-age-adjusted sample had diabetes, and that over half of respondents reported making suicide attempts and one in three had symptoms of active PTSD—we found, using the tool that was developed for veterans, that 25% reported excellent or very good health and 33% reported overall good health. When we asked specifically about mental health, 21% reported excellent or very good mental health and 43% reported good mental health. Three-quarters of the people, if you ask them in a self-reporting way, would say they're doing fine or good.

There are things I wanted to mention. I'm going to drill down a bit on the issues about post-traumatic stress disorder just because I think this is something that we really need to be thinking about if we're going to think about adequate responses to these inequities in indigenous and non-indigenous mental health.

Basically, it's an inadequate measure because what we're really looking at is complex trauma. On this, we have some distinguished scholars, including Dr. Renee Linklater here in Toronto, who's published a book about the nature of the trauma experienced by indigenous people. It's linked to the impacts of multi-generational trauma and trauma in family of origin, as well as ongoing trauma and insults. The PTSD screener was developed for veterans of war who, of course, would have experienced a very severe trauma, but it would have been for a limited period of time.

● (1540)

The other thing I wanted to say about this PTSD screener is that one out of three adults in this population is experiencing three or more of the following four symptoms on a regular basis: nightmares of traumatic experiences; actively needing to suppress memories of trauma or avoid situations that remind them of trauma; feeling constantly on guard, watchful, or easily startled; and feeling detached from others or surroundings.

To me this is really a huge and mostly hidden burden. Substance use has been a way of self-managing this huge burden of complex trauma, grief, depression, and anxiety for generations.

Of course it's important to note, as I've mentioned, that there are physical co-morbidities that make it even more complex. What we found in addition to the high rates of diabetes were rates of hepatitis C that were over ten times the rate of those in the general population. Actually 52% of adults and three-quarters of those over the age of 50 report activity limitations.

Given all this burden, there is also an incredible degree of resilience in the self-reported measures, but I would raise concern then, and I have been for years, around the use of these self-reported measures. So here we have one-third of the population experiencing active symptoms that you could compare to those of acute war vets and over half of them having activity limitations, but there's this huge under-reporting when you ask people how they're doing. We see that kind of reporting used still in the reports that are being generated by the federal government, based on studies like the “Aboriginal Children's Survey” and the “Aboriginal Peoples Survey”.

Turning to the root causes, another resource that I would like to bring to your attention is a report that we released in February of this year, commissioned by the Wellesley Institute, a non-partisan institute in Toronto, and called “First Peoples, Second Class Treatment: The role of racism in the health and well-being in Indigenous peoples in Canada”. In this report, with my co-author Dr. Billie Allan, who's another indigenous scholar with a doctorate in social work, we were able to draw on the extensive work of my scholarly colleagues and community members and a council of grandparents.

We detailed the impacts of specific historic and ongoing colonial policies, including the Indian Act, land dispossession and political persecution of Métis, the forced relocations of the Inuit, as well as the traumas of residential schools, the sixties scoop, and the ongoing and contemporary overrepresentation of indigenous children in the child welfare system. As many of you may be aware, there are now more children in care than at the height of residential schools. In the province of Saskatchewan, for example, aboriginal children represent 80% of the children in care.

In this report we were able to detail the pervasive nature of ongoing systemic attitudinal and epistemic racism and its adverse mental health impacts, including trauma and re-traumatization when someone tries to access services.

The adverse impacts of racism on health and mental health have been well documented in the literature internationally for other racialized populations. In fact, we had an international gathering associated with the release of the report so we were able to invite Dr. David Williams, a pre-eminent scholar who developed the measures of racism in the U.S. at Harvard University, as well as our international indigenous colleagues. For example, our indigenous public health colleagues, including Ricci Harris, have been able to demonstrate—because the New Zealand health survey asks about racism—that if you control for class and racism, health inequities actually disappear. Their research has been published in *The Lancet*.

● (1545)

We have less data in Canada, and in the report we discuss the strong stigma that interferes with acknowledgement of racism. However, there is evidence that has been generated, for example, about “racial battle fatigue” among aboriginal students in Edmonton, and a level of perceived racism, described by my colleague Dr. Annette Browne in her study of an inner-city emergency room, that was so severe that clients actually regularly strategized on how to manage racism in their encounters with emergency room staff in advance of their visits. In the Hamilton study that I previously cited, the respondent urban sampling study, we found that half of the self-identified adults had recorded experiencing unfair treatment as a result of racism.

In terms of other routes, of course, one also needs to be thinking about the gendered impacts of colonial policies and how this intersects with—

The Chair: Excuse me, Ms. Smylie, I'm sorry to interrupt you. We're over 10 minutes now. Do you think you can conclude in the next minute or so?

Dr. Janet Smylie: Yes, I could.

The Chair: Okay. Thank you.

Dr. Janet Smylie: Basically, in terms of the roots of these issues, there are the gendered impacts as well as poverty, overcrowded housing, dislocation from traditional lands, and residential school attendance by family members, which have also been linked to negative mental health impacts.

With respect to the insufficiencies of existing services and programs and next steps to take, from what I've said already with respect to systemic and attitudinal racism, it should be clear that there are gaps in the availability of non-stigmatizing and culturally secure services. In fact, the large majority of patients are at high risk of re-traumatization.

If I might, I want to drill down for a second. If we thought about one-third of adults in the country experiencing complex trauma that meets the PTSD criteria I described above, that would be 300,000 people that any health care provider or community member would want to refer for urgent supports, including access to counsellors and therapists with expertise, and culture-based counsellors and supports. We've heard from my colleague Dr. Lalonde about effectiveness, and we know this around identity and culture-based supports. Yet in my clinical work here in Toronto, there's not a single therapist I can refer people to. So I do part-time work as a family doctor focusing on mental health supports and therapy. There's not a single person I can refer people to, yet I would estimate that there would be 10,000-plus aboriginal people needing those kinds of supports.

In summary, complex trauma over hundreds of years impacting hundreds of thousands of people requires lifelong, comprehensive systems. Truth and reconciliation requires restitution and remedies. Acknowledgement is important, but in the current acknowledgement process there are inadequacies, even of the supports, for the survivors who have been reporting, and their re-traumatization has become apparent. An investment in the Aboriginal Healing Foundation from 1998 to 2014 was just a beginning, yet it's been cut.

I believe I've presented evidence for a substantive investment in mental health that includes both aboriginal-specific services and mainstream services. Thank you.

● (1550)

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

Now we have Carol Hopkins, executive director from the National Native Addictions Partnership Foundation.

Ms. Hopkins, you were here for our prescription drug abuse study as well.

Ms. Carol Hopkins (Executive Director, National Native Addictions Partnership Foundation): Yes, I was.

The Chair: Thanks for coming and taking the time again.

Ms. Carol Hopkins: Yes.

[*Witness speaks in Ojibway*]

Good afternoon and thank you. I'd like to begin by thanking you for the opportunity to speak with the committee. Thank you for the invitation.

I'd like to discuss with you mental wellness from a first nations' perspective. I've introduced myself to you in terms of my cultural identity. I am from the Delaware first nation. It's a small community in southwestern Ontario, and I was acknowledging the Anishinaabe people on whose land we are meeting.

I'm excited to share with you a research project that we just finished this past year. It was a CIHR-funded research project that explored the role of culture in addressing substance use issues. The mandate for this research came from "Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada", which said that the approach to research needs to reflect indigenous culture and values.

We constructed a methodology to do just that, and the outline of the priorities for that research is articulated in the Honouring Our Strengths renewal framework. We applied that mandate and conducted research with the national native alcohol and drug abuse programs and the national youth solvent abuse programs across Canada. There were 15 different language and cultural groups participating in our research, from the east coast to the west coast, from the Mi'kmaq, Malaseet, Cree, and Ojibway first nations all across the country to the west coast first nations of Coast Salish, Nuu-chah-nulth, Kwakiutl, Carrier Sekani, and Chilcotin.

Participating in the research were elders, cultural practitioners, and indigenous knowledge keepers. A priority for the research was indigenous knowledge and demonstrating how knowledge development and evidence do exist within culture. We can find the evidence outside of peer-reviewed journals and such, but we did go to the literature as well, and we conducted a scoping study. We found that about 4,500 articles, which talked about culture and its role in addressing substance-use issues, existed in the world.

From that search, we extracted only 19 studies and applied them in our research. In the research we looked at, none of the measures to demonstrate the impact of culture measured wellness from a whole-person perspective. Nine of the 19 studies measured the impact of culture, and most of those focused on physical wellness and behavioural changes. Most of the literature examined changes based on deficits. It didn't talk about wellness; it talked about changes in deficits: How much of a substance are you using today? How much will you be using tomorrow?

We were excited by what the research produced, which was a native wellness assessment instrument. We've also developed a number of other tools, one being an indigenous wellness framework based on indigenous knowledge. We tested the instrument across 18 treatment centres out of 54 nationally to ensure that the instrument was psychometrically sound. In the pilot test of the instrument, we found that it performed well across age and gender. We saw that those with native language dominance reported higher overall levels of wellness. The instrument also demonstrated that clients had been in treatment at least five times prior to the current episode of treatment. Progression of wellness was equally meaningfully demonstrated between repeats and new clients in treatment, which validates the purpose of repeat admissions in the national native alcohol and drug abuse program and the national youth solvent abuse program.

We saw that the length of treatment made a difference as well in achieving different levels of wellness. Programs that were at least 12 to 16 weeks in length achieved the best results, with programs of seven to 11 weeks showing the least amount of change.

● (1555)

Part of this native wellness assessment instrument is self-rating as well as observer-rating, and the combined measure of change between the two demonstrated at least an 18% increase in wellness between an entry and an exit assessment.

The wellness assessment instrument and the indigenous wellness framework does measure wellness from a whole-person perspective, and we have put forward in this framework culturally based indicators that reliably measure wellness and change over time.

The culturally grounded definition of wellness, as I said, is based on the whole person. So it looks at wellness from a spiritual, emotional, mental, and physical perspective, and the indicators of wellness are hope, belonging, meaning, and purpose. Investments in spiritual wellness through identity, values, and connection to belief produce a level of hope. And investments in emotional wellness—those being connection to culture through family or cultural definitions of family, community, relationships, and having an attitude toward living—produce a level of and a sense of belonging.

Investments in mental wellness, being rational and intuitive and thought-based in culture, when those two are put together, create an understanding, which is an outcome of meaning for and about life. Finally, physical wellness is achieved through a sense of wholeness and understanding a unique way of being and a unique way of living from the culture, which achieves purpose.

When we presented this indigenous wellness framework across the country in many different venues, it resonated well in both the community and treatment centres that did not participate in the research. We also found that there were 22 common ways of talking about culture as an intervention. This is significant in that there is no homogeneous culture but are distinctions across the land based on language and connection to the land. Nonetheless, across those cultures there are 22 common ways of talking about culture.

In our limited data in the national native alcohol and drug abuse program, we know that 90% of people who complete treatment have had access to cultural interventions. What's important about this is that treatment centres have been using culture for a long time, but it hasn't been well defined and it hasn't been documented. Now, this wellness assessment instrument is going to be embedded in a national database we've developed called the addictions management information system. This national information management system was deployed last year across all treatment centres.

A challenge in the full use of the database is that there were no resources nationally to build capacity among treatment providers to use the addictions management information system, so we're relying on things such as webinars to teach people in the treatment centres to use the full capacity of the addictions management information system.

Our hope is that over time we can demonstrate the significance and importance of the AMIS system so that we have service providers fully utilizing the system. Then we'll have an evidence base that we build across the country to demonstrate the importance of culture and the strengths of the NNADAP and the NYSAP programs in addressing substance abuse and mental health issues.

We've also developed a cultural adaptation of the drug-use screening inventory, which is both a screening and an assessment tool that has been adapted to measure trauma from a first nations perspective that considers not only the long-term intergenerational effects of trauma but the community aspects of trauma that layer onto people across generations as well.

As I said, the addictions management information system needs more support in terms of building capacity across this system to be able to use it.

● (1600)

This fall we're also going to pilot test the native wellness assessment instrument in the Indian residential school health supports program and the mental wellness teams.

A good example I wanted to offer around collaboration and partnerships—and also to demonstrate the impact of the conversation around these wellness indicators of hope, belonging, meaning, and purpose—is the development of the national first nations mental wellness continuum framework. When we presented the research, across the regions those indicators resonated with people as well. So they've been embedded in the first nations mental wellness continuum framework. Also, what people have said is that culture has to be the foundation of whatever investments we make in wellness or towards wellness, and the outcome should be measured in terms of hope, belonging, meaning, and purpose.

The other point I wanted to make about the collaboration—

The Chair: Sorry, Ms. Hopkins. We're over time. Would you be able to summarize quickly. Thank you.

Ms. Carol Hopkins: Sure.

What we heard in the development of the mental wellness continuum framework, in terms of moving forward in addressing mental wellness and promoting culture, is that we have to move forward from a systems perspective from an examination of deficits to a discovery of strengths. We have to move from using evidence that is absent an indigenous world view, values, and culture to indigenous knowledge setting the foundation for evidence. We have to move from a focus on inputs for individuals, based on those deficits, to a focus on outcomes for families and communities. Then we have to move from uncoordinated and fragmented service to integrated models for funding and delivery of services.

One more point I wanted to make about suicide is that we've heard from young people across the country—and this came from a conversation that the AFN facilitated in one of their health forums—that they need more conversation about how to live life than about suicide and dying. So they've put forward the concept of life promotion versus suicide prevention. That also was validated in the Chiefs of Ontario health forum two years ago, in 2013. The youth are saying that they want to talk about living life and want more information about how to live life.

We also have evidence from the youth solvent abuse program, where young people report that they don't intend to commit suicide but they accidentally commit suicide because they see the attention that is given to other young people when they make these attempts. So they'll make attempts and then run back home so they can hear their names being announced on the community radio, for example.

I'll end there.

● (1605)

The Chair: Thank you very much.

That concludes our presentations.

We'll likely have enough time for a round each for questions, of roughly seven minutes. We'll have to keep you tight to the time.

Mr. Rankin, go ahead, sir.

Mr. Murray Rankin (Victoria, NDP): Thank you, Mr. Chair.

Thank you to all of the witnesses. This was a very moving presentation.

I guess the unifying theme I took from it is the importance of culture in some of the processes we might use to turn around some of these very disturbing conclusions.

I'd like to start, if I could, with Professor Lalonde and Dr. Smylie on a practical point. Dr. Lalonde, you talked about the availability of statistics on suicide being "extraordinarily difficult", particularly from the federal government, even though they have responsibility for status Indians. Also, Dr. Smiley, you used the expression "gotten worse" when you described the move from the long form census to the household survey. I'd like each of you to elaborate, if you would, on those difficulties you've faced.

Perhaps, Dr. Lalonde, you could start.

Dr. Chris Lalonde: As I said, the problem is that the health data is held in different places. So the province has some data, the federal government has some data, and now in British Columbia aboriginal organizations are holding data. The problem is that no one feels they have the authority to actually share information at the community level. What we get told is that we need to create working relationships with the communities to access that data. Well, in British Columbia that's logistically impossible. You can't have personal relationships with 200 communities.

So I think the bottom line is that what gets recorded and reported gets worried about and acted on. I think the fact that we don't have a community-level surveillance of suicide is very troubling, and I think we should.

Mr. Murray Rankin: Dr. Smylie, I have a limited amount of time. Do you have any comments on that point of access to data you raised?

Dr. Janet Smylie: Yes. Canada is doing poorly internationally with respect to indigenous specific data.

There are two issues. One is the need to build partnerships with indigenous communities and governing organizations. We were moving well in that direction about five years ago, but it's gone backwards with the cutting of the resources of our national aboriginal organizations and health directors at provincial and territorial levels.

The other big issue, which makes us unique among relatively affluent countries with minority indigenous populations is that we do not identify indigenous people in our health data set. Here we lag far behind New Zealand, Australia, and the U.S., as I know from having sat on an international indigenous health measurement group. Every other relatively affluent country is able to identify indigenous people. We're hidden in our data sets.

The way you would develop good statistics would be to have indigenous identity on vital registration and health service records. We're hidden in there.

Mr. Murray Rankin: Thank you. That's troubling. I say that because, as Dr. Lalonde pointed out, there is such great variation amongst the communities, and if we can't get a handle on what the problem is we aren't likely be able to solve it. I found that a troubling part of your presentation.

I'd like to go to Ms. Hopkins, if I could. Thank you for your excellent presentation. You talked about the investment in spiritual wellness. I like that expression. You talked about how you've looked at communities from across the country. I assume Inuit people are involved in this as well in the north?

Ms. Carol Hopkins: No, it was first nations.

Mr. Murray Rankin: Just first nations, aboriginal people.

Many of those first nations people are living in our large cities—Vancouver, Regina, Montreal, Toronto, Winnipeg, as examples—and yet they're cut off from the cultural roots you talk about being so important to addressing some of these spiritual wellness issues. I wonder if there is anything you can think of that can be done, if you accept the premise that in the cities it's more difficult to reach people within their cultural framework and have the kind of healing you've talked about. Are there things that could be done, such as training counsellors? If there are fewer people in the aboriginal community involved that can work with them, would it help to have people, or would it be irrelevant to have people, who were trained in counselling but aren't part of that cultural tradition?

● (1610)

Ms. Carol Hopkins: Any access to mental health services will make some difference, but you're never going to make as much difference without culture. No matter where you live in Canada, whether you live on a first nations reserve or in an urban environment, access to cultural support is difficult. It's difficult because there isn't the evidence that people look for to provide funding to support them.

Just recently through the residential health schools support program first nations people have had access to cultural supports. They also have access to mental health support therapists, but they're inclined to use more of the cultural supports.

Whether you live on a reserve or off a reserve, you have, through the non-insured health benefits program, access to crisis counselling, which doesn't address the depth of trauma and the intergenerational trauma. Definitely the answer to that is an appreciation for the evidence that is founded in our culture and the cultural practices.

There are some good examples. For example, there are off reserve programs, such as the aboriginal healing and wellness strategy, funded by the Ministry of Health and Long-Term care in Ontario. The Wabano Centre is an example here in Ottawa that provides cultural types of programming and cultural interventions. That doesn't necessarily mean those kinds of supports are available if you live on a reserve. Access is challenged by acceptance of knowledge and evidence.

Mr. Murray Rankin: May I ask a very specific question about the ending of your presentation, Ms. Hopkins? You talked about the addictions management information system. You said it sounded like a valuable database and a tool that could be used, but your problem is that despite creating a few webinars, you don't have the resources you need to make those available to the people who could use those. Have you costed how much money that would take? Which department would be the one that you would expect to assist, if it's a federal department?

Ms. Carol Hopkins: There have been some regions of the first nations and Inuit health branch of Health Canada that have invested in training. For example, in the Quebec region, they provided $5,000 to five treatment centres so they could train all of their staff and invite community members in who would be using the system to make referrals and access to the assessment tools. So $25,000 for a whole region to be trained on this system is money well spent in terms of the data we would be able to collect over time.

Mr. Murray Rankin: Especially if you're saving lives.

Ms. Carol Hopkins: Yes.

Mr. Murray Rankin: Thank you.

The Chair: Thank you.

Ms. McLeod, go ahead.

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

Thank you to all of the presenters today. I think we're talking about some very important issues.

I'm going to date myself a bit, as I originally got into the health care field in the eighties. At that time, of course, every health card for a first nations person had a special identifier, so the data was readily available. However, if I recall, that drove some significant concerns about identifying individual personal concerns.

There was a real thrust at that time to say that this is wrong and we need to remove any identifiers that attach to our health care card. It goes to that personal ability to share information as you desire versus perhaps the desire of researchers and policy developers to have that information. That includes, to be quite frank, the national household survey versus having significant penalties attached to it. It's that voluntary nature that you, as a Canadian, you, as an aboriginal person, share that freely and willingly.

How do we square that circle in terms of very legitimate privacy concerns versus the value that data can provide?

Ms. Hopkins, could you start with that one?

Ms. Carol Hopkins: Dr. Smylie was talking about aboriginal organizations having more control over data, so there's a great appetite for information and data, and control and access and protection of data.

First nations governments, organizations, have developed capacity and interest since 1980 in terms of how information is collected and used. In the eighties, the concern was around discrimination and stigma related to the identifier. That kind of information was largely outside of the control and use of first nations organizations and first nations people. The further concern was about the analysis and the use of that information.

Now, for example, with the First Nations Information Governance Centre, which does the regional longitudinal health survey, we have first nations governance over information and data. We have the OCAP principles, and we have much more capacity now and much more interest. It's not enough, certainly.

There are some regions that have partnered with provincial governments and organizations to look at ways to have data sharing agreements and to structure governance around data information related to health so that it's accessible to first nations organizations to use.

I think the difference is around the control and use and protection of data and information.

● (1615)

Mrs. Cathy McLeod: What I think I'm hearing is that we need to move along in partnerships and collaboration. Things like the federal government perhaps doing a mandatory survey is not a respectful way to move forward in that particular instance. I did hear the concerns expressed by our previous witness in terms of moving to voluntary...but, again, and I'll speak quite frankly, sharing of personal information is just that; it's very private for many people.

Having said that, part of the reason we're having these hearings is that the Mental Health Commission of Canada has taken mental health and put a real focus and a priority on it. As we've committed in this budget to renewing the mandate of the Mental Health Commission of Canada, can you talk about how you could see that mandate supporting you in the work you're doing?

Ms. Carol Hopkins: I think the support could definitely focus on the implementation of the first nations mental illness continuum framework—not doing it for us but in collaboration, taking leadership from first nations organizations. There is a national team that is focused on the implementation of that framework. It's a team that is reflective of the social determinants of health and a number of different federal government departments.

There is good opportunity there for collaboration. I know there was previous first nations involvement in the fifth strategic direction of the national strategy. As for where that's gone in terms of implementation, it's reflected in the mental wellness strategic action plan that was the predecessor to the first nations mental wellness continuum framework. But it is the continuum framework that defines what first nations people have said across the country in terms of the model to address suicide, depression, anxiety, and all of the issues that come out of institutional care, whether it's a residential school history, the child welfare system, or the justice system. It's a complex model that takes a population health approach and looks at collaboration across governments, across service sectors, and across national organizations.

The National Native Addictions Partnership Foundation, the Assembly of First Nations, and the Native Mental Health Association have had some conversation with the Mental Health Commission about the mental wellness continuum framework and expect to see it in the strategic action plan.

Mrs. Cathy McLeod: Okay.

I loved your reference to “life promotion versus suicide prevention”—some very powerful words.

Do I have any time left, Mr. Chair?

The Chair: You have about 30 seconds.

Mrs. Cathy McLeod: Then I think I'll leave it, thanks.

The Chair: Okay.

I'd like to welcome Mr. Easter to our committee. He's been so generous today, he's given his seven minutes to Mr. Toet.

Thanks, there, Mr. Easter.

Hon. Wayne Easter (Malpeque, Lib.): I don't think so.

The Chair: I'm just kidding. That was a little bit of committee humour there.

Voices: Oh, oh!

Hon. Wayne Easter: Lawrence may be my neighbour in the Justice building, but I won't give him my time.

I thank all the witnesses for coming. This isn't my regular committee—I'm on the public safety committee—and I can't help but sit here and think about the study we did on the economics of policing. One of the cost drivers in that particular study was that 70% of the people who are in prisons have a mental health issue to a greater or lesser degree.

From my perspective, expenditures in this area should be seen more properly as an investment in people's well-being, and probably a saving in terms of our social and economic infrastructure as a country. But before you can make those kinds of decisions, you need data to make them on. Two witnesses' key points related to data. I think more and more Canadians recognize that the loss of the long form census was a huge, huge mistake that set the country back years in terms of making decisions. Regardless, that decision was made; hopefully it will change.

Dr. Lalonde, you mentioned the availability of statistics and the fact that the federal government holds a lot of the information related to the aboriginal community. What's the problem in terms of getting that data? They would have the data. Why can you not get it?

● (1620)

Dr. Chris Lalonde: This goes back to the earlier concerns about privacy. As researchers, we don't want identifying data. We don't want people's names. And all we really wanted here was the rate of suicide in this particular community versus that particular community.

Now, there's been a huge movement, which I am strongly supportive of, for communities to have ownership, control, access, and possession of their data. It's extremely frustrating for communities when they say, “We think we have a cancer crisis in our community, but we don't know because we can't get access to the data.” I think that's understandably frustrating for communities. We need a system. If we're collecting all this data, if we're holding all this data, then we need to be doing something about it. We can't intervene in a situation until we know the size of the problem.

First we need the data. Then we need interventions that we know will actually work, so culturally based interventions, and we need all the infrastructure that's needed to support those things. At the moment, I'm not convinced we have that.

Hon. Wayne Easter: From your perspective, does the federal government have that data? Maybe they don't. Either Dr. Lalonde or Dr. Smylie, do they actually have the data?

Dr. Janet Smylie: No.

Hon. Wayne Easter: They don't.

Dr. Janet Smylie: No. There's a huge international double standard around indigenous data collection, and it's in a shameful state in Canada in terms of actual health assessment data.

We can have both. We can have indigenous communities in charge of the governance of our data, and we can have high-quality data. The reason is that health is run by the provinces and the territories. In a place like Ontario there's an Institute for Clinical Evaluative Sciences, where I'm an adjunct member, and unlike the rest of the people in Ontario, as aboriginal people we're hidden in that database.

I also need to remind the audience that 40% of the aboriginal population—30% to 40% actually—won't be identified by an Indian status card. There's no reason why in population health data we should be using only a federal registry that comes from a piece of legislation that's systemically problematic.

We do not have the health data. To get accurate rates of illness and death, you need to have vital statistics and hospitalization data. We do not have that in Canada for indigenous people. It's shocking.

Hon. Wayne Easter: If you were a member of this committee, then, what would you recommend at the end of the day? What kind of recommendation, what wording would you use to ensure that the federal government, number one, has the data, and two, makes the information that you need in order to deal with the issues available to you?

Dr. Janet Smylie: We need to have some national standards around indigenous health data collection. Statistics Canada was moving in that direction. I sit on the National Statistics Council, though, of course, I'm here as an individual today. When I first joined the council five to ten years ago they were meeting with our national aboriginal organizations and working on those kinds of partnerships, and there still is some good partnership work, but we need to have national standards.

I became a co-chair of a national committee on birth outcomes and we liaised with all five national aboriginal organizations. It can be done...the pieces to invest in the partnerships. In order to do that, the national aboriginal organizations have to be supported, and then to simply have proper data quality. That's the first course I took at Johns Hopkins in public health, if you take health informatics 101. As a physician, it's like I'm in the emergency room and I see people in incredible distress. I'm talking of hundreds of thousands of people with these urgent symptoms, but I don't have any diagnostic equipment to treat them with.

It's a sorry state of affairs for an affluent country like Canada.

● (1625)

Hon. Wayne Easter: You say Statistics Canada was moving in that direction. Why did they stop, and how do we get them back on track so that they do keep that data?

The second question I have, which is for Ms. Hopkins, is what needs to be done? The $25,000 investment for your addictions management information system, to me, seems to be a small number. What needs to be done to implement that system?

Dr. Janet Smylie: You would have to reinstate the health directorates for our national aboriginal organizations. The funding for the health portfolio was cut for the Native Women's Association of Canada. It was significantly cut for Inuit Tapiriit Kanatami and the Métis National Council. I believe there were significant cuts to the Assembly of First Nations and the Congress of Aboriginal Peoples as well.

When I started, there were actually people in a portfolio who would have that expertise. Now, even at the provincial and territorial level, I'll go to meetings...because this urban data that I was talking about, that is owned by the communities. We negotiated that, so it can be done.

If you look at New Zealand, they have seven ways of identifying Maori in their health system, and the Maori feel empowered. There are actually protocols to ask people in a respectful manner.

The Chair: Okay.

Dr. Janet Smylie: So the first thing is to actually reinvest in our national aboriginal organizations so they can sit at the table, then recognize that there need to be some national standards, because the other thing that has happened is that FNIHB and PHAC decided that all of this should happen at the regional level. But to my mind, we need to have some national standards.

Thank you.

The Chair: Thank you.

We're right at the end of this round.

Ms. Hopkins, do you have a final thought on what Mr. Easter asked, or was it all covered?

Ms. Carol Hopkins: I'm in for training.

The Chair: Okay, that's brief. I like that.

We're going to conclude this round. We are going to bring in our new panel, two of them by video conference. So we're going to suspend for a couple of minutes, bring them up, and be right back.

● (1625)

(Pause)

● (1630)

The Chair: We're back in session. We have another three guests to present.

We'll have Janet Currie, coordinator and founder of the Psychiatric Awareness Medication Group.

Because you are the farthest away, we'll have you present first. Go right ahead.

Ms. Janet Currie (Coordinator and Founder, Psychiatric Awareness Medication Group): Thank you very much for asking me to submit to you today. As the chair said, I'm presenting for the Psychiatric Medication Awareness Group, which is a web-based information support group for people on psychiatric drugs. I'm also the co-chair of the Canadian Women's Health Network, and have contributed to many Health Canada regulatory hearings, and was a member of the expert advisory panel on the vigilance of health products for five years.

I'm going to bring to the session today my background in working with families, parents, and children in tapering them safely off psychiatric drugs. These are people who have faced a myriad of side effects related to psychiatric drugs, which have increased their mental health and emotional problems. I'll be discussing gaps and barriers in the mental health strategy and proposing some best practices.

I want to talk first about the context in which our mental health services are delivered, and this is really a unique and unprecedented context.

First of all, we have very high stated prevalence rates of mental illness and high diagnostics in many areas of mental health, and these rates are continuing to rise. I think in Canada now we consider that 20% of Canadians may be exposed to a mental illness, and in some cases the rates are much higher. The World Health Organization is now saying that depression will be the major cause of disability globally by 2020. Thirty years ago, depression was considered to affect a very small number of people and to be self limiting.

So in terms of statistics, what does this manifest itself in? We have 6% of boys from 6 to 14 taking psycho-stimulants. We have a quarter of our seniors in our care homes taking antipsychotics, even though they do not have a diagnosis of schizophrenia. We have 20% to 25% of women in middle age and older taking antidepressants. We have a tenfold increase in the number of children who are being prescribed antipsychotics, which are very potent drugs not approved for this group. And we have large numbers of people taking benzodiazepines—15% to 25% in some cases. I was very disturbed to learn that Canada is the third-largest user of antidepressants among 22 comparable OECD countries.

So what does this mean in terms of the individual and their mental health? All psychoactive drugs have side effects. They are very potent drugs that affect the structure of the brain and the neurotransmitters that are the chemical in the brain. All of the drugs can either exacerbate or create new mental health problems or new kinds of emotional problems for the user.

For example, someone taking a tranquillizer like Ativan, which is a very commonly prescribed drug, will eventually become depressed if they take it long enough, and then they will go back to their doctor and say they are depressed, and their doctor will either increase the dosage of benzodiazepines or prescribe an antidepressant to deal with the depression, which is a side effect of the tranquillizer. This kind of pattern is called the prescription cascade, and anyone who's on a psychoactive drug for long enough is going to be taking other drugs to deal with the side effects of the drug they are already taking.

It's the same for antidepressants. Someone on antidepressants may become agitated and develop akathisia, which is a form of restlessness. They may have agitated depression, and so they may be put on a tranquillizer, or they might be put on an antipsychotic to deal with those symptoms.

The point I am making is that we need to take adverse drug reactions from psychiatric drugs very seriously. These drugs not only cause impacts on the sense of mental well-being of patients, but they also cause physical effects. For example, tranquillizers cause dizziness and falls that lead to hip fractures. Antidepressants can lead to suicide or suicide ideation and sexual dysfunction. Antipsychotics can lead to cognitive impairments, memory loss, and issues like that, as well as a predisposition to diabetes and stroke. So we really need to take these things seriously.

● (1635)

I think the other thing that we need to recognize is that if a person stays on a psychoactive or psychiatric drug for a long period of time, their brain is going to adapt to it and they're going to become addicted. I know that's a strong word that we don't like to use in relation to the drugs we prescribe. But it actually is the same mechanism as addiction. When a person tries to reduce their dose or change their dose, they may be affected by an upsurge of symptoms that can be really very unpleasant, including increased anxiety and increased agitation, to the point of hallucinations and irrational violent behaviour. I think in the media we're seeing stories of people engaging in very frightening homicidal or suicidal acts that are associated with prescription drugs. We feel that prescription drugs are definitely a contributor in these cases.

So what do we need to do about it? We need to reassess the degree to which we're prescribing psychiatric drugs. A recent study in the United States is showing that the rate of prescription of psychiatric drugs to children has grown by about 31% in the last decade, yet the children who are prescribed these drugs are ones who are considered to have really moderate issues, whereas children with very severe issues are falling through the cracks. So I think we really need to reassess the degree to which we are prescribing psychiatric drugs. In order to do that we need to provide more supports in the community to families, to women who are pregnant and who are having post-partum difficulties, to young people, to teenagers, to seniors, so that they can address their sense of isolation and find cognitive help that's accessible and reasonable in terms of access. I think a central place to provide these services for families is in the schools, where in the past there were school counsellors and groups that would help parents deal with their family issues and their children.

I also think that we need to really assess people's use of drugs and the impacts these may be having on mental health. We talk about dealing with polypharmacy, but I think anyone who comes in to a health provider with a mental health symptom needs to be assessed in terms of the drugs they are taking. It is not only psychiatric drugs that cause mental health symptoms. There are also common cardiac drugs, antibiotics, the corticosteroids, smoking cessation drugs, and acne treatments. All of these can be associated with mental health issues that the person or physician don't associate with the drug. I would say, too, that we really need physicians and health care providers who are skilled not only in assessing the side effects or the adverse drug reactions caused by psychiatric drugs, but also physicians who understand how to taper the use of these drugs, how to design tapers, how to support people, how to understand what a person is going through on a taper. I've done tapers for dozens of people. It's an arduous job, but it's really miraculous the degree to which people can recover their health. However, it needs skilled health care providers to provide that kind of service.

Finally, I would say that when we consider mental health in general, we need to consider it as a gender issue. Two-thirds of the people who are diagnosed with mental health issues and who receive prescription drugs are women. Women are subject to many stressors related to their role in society and the expectations placed on them. I think we really need to build that back into our assessment of the most effective mental health treatment.

Thank you.

● (1640)

The Chair: Okay, thank you very much.

Next up by video conference in Toronto from the Centre for Addiction and Mental Health we have the director, Jurgen Rehm.

Go ahead, sir.

Dr. Jürgen Rehm (Director, Social and Epidemiological Research Department, Centre for Addiction and Mental Health): Thanks a lot for allowing me to present the point of view of the Centre for Addiction and Mental Health, the largest hospital for psychiatric illnesses.

I would like to start with a definition of “addiction” since we were asked to talk about addiction. Usually this term comprises substance use disorders, but also more recently it has been expanded to gambling and gaming disorders. For example, the DSM-5 and the current proceedings of the ICD-11 will also include something to that degree.

If you look into those addictions, and we take the full spectrum of addictions, we have to say that alcohol use disorders are the most prevalent of the addictions. There is a question mark here with tobacco use disorders, because they're usually not assessed in general population surveys like the CCHS. If you go into how many people are actually concerned with addictions, alcohol again is also the highest. About 1 in 20 men in Canada—and that's of all age groups—would have alcohol use disorders, and it's 1.7% for females.

The second most important addiction would be cannabis use disorders, and all other drug addictions would be about half of cannabis, at about 0.7%. Again, the usual prevalence is higher for men compared to women by a factor of 2:1 for most of those addictions.

In terms of harm, we do have a lot of disorders resulting from the legal substances that are associated with far more [*Inaudible—Editor*] in terms of mortality and morbidity, but also disability, than the illegal substances, and all of those addictions have a pattern of high comorbidity with other mental disorders. This means we usually have comorbidities with mood disorders. About one in five people with addictions would also have a concurrent mood disorder, and if you go into generalized anxiety disorders, it's about one in ten. Mood disorders, of course, would be what we would normally call depression, and they include a whole number of psychiatrically defined depressions.

Now to your questions with regard to the mental health strategy and how addictions are treated, addictions overall are covered by the mental health strategy, and there are a lot of very important things to be said about them. But if you look into the practice and if you look into the national policies and the strategic approaches, we see that a lot has been regulated by the national anti-drug strategy of the Government of Canada, and that leads to a conflict of objectives and a conflict of different overarching approaches.

When we look at the national anti-drug strategy we welcome the recent addition of non-medical use of prescription opioids and non-medical use of other drugs as a good step. Part of that, as you heard in the first submission, of course is a result of addictions having been caused in part by the medical system.

The two most costly substances from both a health and economic standpoint, however, are tobacco and alcohol, and these remain completely outside the strategy. I would just mention again that gambling and gaming, although lesser in scope and money, are also outside of and not covered by the national anti-drug strategy.

Overall we would like stress that all addictions and substance use disorders should be a health issue, and substance use should be dealt with by a public health approach. That means we should have a four-pillar approach for illicit drugs, prevention, harm reduction, treatment, and enforcement. The same is true for legal drugs.

● (1645)

We also have to state that the current approach to illegal drugs in Canada is overly enforcement focused. That means that if we look into the balance between a four-pillar approach and the current Canadian approach, we have an emphasis on enforcement, both in terms of money spent and the overall efforts of society. We would like to add to this a harm reduction approach, which is currently missing altogether. The more Canada can shift its overall approach into the public health sphere, the better our chances are for reducing the overall harm.

For the first point, I would like to summarize that addictions in Canada should be addressed through a public health approach, more or less in the way we have seen it in the mental health strategy. If we go into this public health approach, we would have to change some of the things in the national anti-drug strategy, but it would be rewarded by better strategies for tackling addictions and reducing the harm related to addictions.

For the second part of my submission, I would like to look at the stigmatization issue. You've asked specifically about stigmatization for addictions, and unfortunately addictions are very stigmatized in our society. We are not alone in the world. Addiction issues are the most stigmatized mental disorders in all high-income countries, in North America, Europe, and Japan.

From surveys, we know that while the overall stigma associated with mental health has been reduced over the past decades, for addictions this is unfortunately not the case. People with addictions are seen as unpredictable and dangerous. The overall causal attributions that are made see them as not being morally intact and as responsible for their own addictions. This, of course, makes a problem not only for the people afflicted with addictions, but also for the health care system in total because it is leading to the lowest treatment rates of all mental disorders.

While the treatment rates of mental disorders are still below the treatment rates of somatic disorders, among the mental disorders, addictions stand out. For example, in people with alcohol use disorders, only one out of ten in Ontario would get adequate treatment, and would be treated.

Contributing to that is our tendency to see the world in black and white, usually as dichotomous people with having or not having a disease, and not as a continuum. The problem of this dichotomous approach, of not seeing addictions as heavy use over time, as one end of a continuum—which we all share—is leading to these people being more stigmatized and more outside of our society. As a result, they do not seek treatment because they do not want to open themselves up to admitting that they're addicted. That leads to problems in the whole health care system, both in primary health care and in specialist health care.

Stigma interferes with a seamless continuum of treatment, and this is part of what is currently plaguing addictions.

I will remain here. I have 10 minutes, and I have used the 10 minutes, and I would like to just summarize.

● (1650)

All addictions should be seen as a public health problem and should be dealt with from a public health perspective. Stigmatization is one of the major barriers not only for mental health in general but also for addiction specifically.

Thanks a lot.

The Chair: Okay, thank you.

Next up, from the Royal Ottawa Health Care Group, we have Mr. George Weber, president and CEO.

Go ahead, sir.

Mr. George Weber (President and Chief Executive Officer, Royal Ottawa Health Care Group): Thank you very much, Mr. Chairman.

Ladies and gentlemen, good afternoon. Bonjour.

I am pleased to appear before you, as the chair has noted, as the president and CEO of the Royal Ottawa Health Care Group, to share our views on the mental health strategy for Canada.

[*Translation*]

Thank you for inviting me to take part in this important forum.

[*English*]

I also applaud your efforts focusing on a critical issue in health care today, the mental health care of our families and communities. For us at the Royal Ottawa, you can't talk about health unless you support mental health. Understanding the link between mental and physical health is paramount to understanding the complexities of the brain.

Along with my senior management team, I'm responsible for leading and managing the operations of an academic health science centre specializing in the treatment of mental health and mental illness and addictions. We serve a large spectrum of clients receiving services through more than 15 specialized programs at the Royal. Our mandate is to treat patients as young as 16 years of age with complex mental health needs to geriatric patients with age-related issues, including dementia, behavioural problems, and chronic medical issues. We run a 222-bed treatment centre in Ottawa, which has served more than 1,600 in-patients and 14,000 out-patients in the past year.

[*Translation*]

We also hold over 1,000 telehealth consultations every year.

[*English*]

We have also used technology, through the creation of apps for mental health awareness, early identification of mental health problems, and a self-management tool. In Brockville, we operate a 630-bed forensic treatment facility, including two beds for the Correctional Service of Canada.

[*Translation*]

This year, we also started looking after female prison inmates, who increasingly need mental health services.

[*English*]

We also provide mental health treatment and clinical services to 100 male offenders serving provincial sentences at the St. Lawrence Valley Correctional and Treatment Centre for the Government of Ontario.

We are very proud of the work we do in our operational stress injury clinic, as the only academic health science centre in the network of OSI clinics for Veterans Affairs Canada. We offer specialized mental health care treatment and research to veterans, soldiers, and RCMP officers. These are men and women who perform a great service for our nation and for the peace and security of the world. Whether they were deployed in combat duty, on peacekeeping missions, or domestic operations many of our veterans and Canadian Forces members are experiencing psychological consequences as a result of their courageous service. The number of soldiers seeking help is on the rise. Last year we saw a 238% increase in referrals compared to five years ago. We are doing our best to provide the necessary treatment and help them to regain a quality of life.

Today, I would like to comment on three critical barriers to mental health and where a national strategy, advocacy, and funding could change the lives of people and their clinical outcomes.

The first is access to care. It's not a new word, not a new concept, but something we just can't guarantee in our current mental health system. There is no question that our anti-stigma campaigns are reaching Canadians, breaking down social barriers, and encouraging people to seek help. The problem is that awareness campaigns are not tied to treatment options. Realizing that you need help is the first step. Trying to get the right treatment at the right time is the real challenge. With no increase in our global operating budgets in the last six years, we have streamlined operations to make them more efficient in order to get more people into our care; however, a growing number of people are trying to get in. We know, according to the latest statistics from the Public Health Agency of Canada, that one in three Canadian will be affected by a mental illness during their lifetime. We had always thought that the figure was one in five. Those are the latest statistics. The numbers of those seeking treatment are rising, not decreasing.

Every day, I look at the schedule of our wait lists and the number of people looking for treatment. Funding is available to help people navigate a fragmented mental health system in Ontario, but not for specialized treatment that will give people their lives back.

● (1655)

We are doing our communities an injustice when we focus on working around holes in the system rather than building the services that will bring about recovery. How we approach access to care has an impact far beyond the individual patient. Mental illness touches the entire family in every way possible. It also impacts friends, colleagues, and employers.

[*Translation*]

Mental health affects all of us. It is a social problem that demands our attention.

[*English*]

I talked to a mother last week who urged me to have her 20-year-old son Andy admitted to the Royal, as he continues to harm himself. I had to tell her that the first available appointment in our concurrent disorders, an addiction program, is in three months' time. What will Andy do during that time? Will he be able to stay with his parents? He has already threatened them several times, and police have been called. Ending up in jail is a real possibility for him. What is the chance that he will be able to wait at home, holding on to some hope about getting help? It's more likely that, without the benefit of a specialized team who know how to treat his complex disorders, he will grow anxious and frustrated trying to manage his disorders and addictions.

There is a long list of people like Andy. As a matter of fact, as of yesterday we had 1,858 patients in the greater Ottawa area on our waiting list, with 500 still to be triaged, and this story isn't unique to our organization. In talking to some of my colleagues across our country, the situation is basically the same from one province to another and in the territories.

The Government of Canada succeeded in the past with their wait-list national policy for certain medical procedures, which was introduced in 2004. Many Canadian lives benefited from this much-needed government action. The reports from the Canadian Institute for Health Information clearly showed how a $1 billion investment significantly reduced wait times across the country and enhanced quality care. Can we not do the same for mental health?

As reported by the Mental Health Commission of Canada, Canada spends about 7% of every public health dollar on mental health. Countries like New Zealand and the U.K. have devoted up to 10% or 11% of public health spending to mental health in order to bring in addressing the needs of their citizens.

[*Translation*]

We support the commission's recommendation to increase mental health-related expenditures to 9% over a 10-year period.

[*English*]

The question we need to ask ourselves today is what is preventing us from reaching this realistic objective?

We know that more than 75% of mental illnesses will manifest during adolescence. Can we not show our youth that they really do matter, and that services and treatments are available for them in real time should they develop a mental illness? Those who suffer from mental illness need a national voice and funding for specialized treatments in addition to much-needed awareness campaigns.

● (1700)

[*Translation*]

We must make the mental health of Canadians a priority.

[*English*]

Morally and socially, increasing support for mental health care is the right thing to do, but it also makes economic sense. A 2011 report prepared for the Mental Health Commission of Canada reported that mental health problems and illnesses cost the Canadian economy, in both direct and indirect costs, over $48.5 billion every year. This means that the right thing to do is also the smart thing to do.

Another significant issue is our aging population, as you've heard many times before. It is a factor driving significant demographic change. As we know, the proportion of seniors with dementia will more than double by 2031 in Canada; by 2028 more than 310,000 seniors in Ontario alone will have dementia.

[*Translation*]

We are seeing a significant increase in the age groups between 65 and 90. We need to go in a new direction with this issue.

[*English*]

We know that we can change the outlook with a targeted course of action. Research in the last decade in Canada, the United States, and Europe has clearly shown that late onset of depression is a prodrome, an early symptom for dementia. If we are concerned about the lives of our seniors and the futures of our younger generations, we need to invest in earlier treatments that will address the significant risk factor for dementia and reduce those alarming statistics. We have the opportunity to stem the tide before it turns into a tsunami.

You heard from Dr. Merali last week about the important depression research being conducted at the Royal's research institute and his perspective on the need for national collaboration, as co-founder of the Canadian depression research and intervention network. We need to invest more in mental health research to improve the clinical outcomes for depression. Let's get more people treated better and faster.

My third and final point is about the minimal amount of research funding in mental health and, in particular, suicide prevention research. Understanding the brain is the last frontier of discovery that will enable personalized treatments for mental illness. Suicide prevention research funding and national coordination are needed to advance best practices across the country.

As co-chair of the Community Suicide Prevention Network in Ottawa for the last four years, I know too well what suicide does to families. We have made the Ottawa region a suicide-safer community and have brought together the key community agencies, hospitals, police, government agencies, United Way, schools, colleges, universities, clients, advocates, and youth to help us identify the gaps, break down the silos, and better coordinate our efforts in order to save lives.

We have been inspired by the Nuremberg community model of reducing suicides in Germany and have learned from their experience. In Ottawa, we have set an objective of reducing suicides by 20% by 2020. We have championed new initiatives that train and empower our youth to reach out and help each other. We've also generated awareness among youth about who they can turn to for support and have created community gatekeepers in order to build a climate of trust and safety for all our youth.

The Royal, with the support of DIFD, a youth-led initiative, and the Mach-Gaenslenn Foundation, has established a Canadian chair in suicide prevention research. There are many initiatives across the country on suicide prevention, but do we really know what is evidence-based or more effective in reducing suicides? We want to find the answers and we hope we can lead a collaborative and supportive effort across the country. We owe it to our clients—

The Chair: Mr. Weber, we're quite a bit over time here. I'm sorry to interrupt you. Would you be able to wrap up?

Mr. George Weber: Yes, I'm wrapping up now.

Thank you for inviting me to share my thoughts as a mental health leader. Our minds are critical assets in this global knowledge-based economy, and I encourage you in your deliberations to see the value of investing in treatment and mental health research to change the pathways of mental illness.

Thank you very much.

The Chair: Thank you, sir.

Ms. Moore is next. She's going to ask her questions in French, so we'll do a little test for our video conference people to make sure they're getting the interpretation.

Go ahead, Ms. Moore.

[*Translation*]

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Thank you, Mr. Chair.

I just want to check whether Ms. Currie can hear me clearly in English.

[*English*]

Ms. Janet Currie: I can. Oh no, I can't.

The Chair: Try it again.

● (1705)

[*Translation*]

Ms. Christine Moore: Are you hearing me clearly in English?

Ms. Janet Currie: Yes, fine.

[*English*]

Yes, now.

[*Translation*]

Ms. Christine Moore: Okay.

My questions go to Ms. Currie.

I talk with a lot of parents. They are concerned about the whole issue of attention deficit hyperactivity disorder. We routinely see children taking medication at a young age. Sometimes, they start in daycare. A lot of parents are worried since it is a new phenomenon. When I was in school, practically no children were taking medication to go to class. They were just considered children who were more naturally inclined to move around. It seems that very few alternatives to medication are being provided in these cases. In your view, are there any alternatives? Is research being done to find some?

I recently read about stationary bikes being installed under desks so that children can move while they are in class. Are you familiar with that initiative to reduce the use of medication, especially for children?

[*English*]

Ms. Janet Currie: I think your question is a very good one, and I think that parents are very frustrated because it falls upon the family to make these decisions. I think there are a number of options.

Can you hear me okay?

[*Translation*]

Ms. Christine Moore: Yes.

[*English*]

Ms. Janet Currie: Are you able to hear me?

Ms. Christine Moore: Yes.

Ms. Janet Currie: I can give you an example of a colleague who works as a social worker in an urban school system in Canada. She sees children who have these kinds of problems. As an experienced teacher and social worker, she is able to work with the families and with the children in terms of modifying behaviour, particularly in supporting the parents, because many parents are under a great deal of stress and the child is a kind of manifestation of this stress.

She works with the family in helping the family develop methods of behaviour control and with the school in terms of arrangements, because some kids do find it much harder to sit still and much harder to concentrate. I think that reintroducing things like physical education back into the schools and keeping the physical activity levels high, especially for young boys, is particularly an issue, and I know families that have looked at things like diet and have worked in terms of family relationships because the child needs very careful boundaries and support.

I think all of these alternatives are possible. The problem is that they're not really systemized or offered in schools because the fallback has been medication. That is one of my points: we need to be looking at and developing these alternatives. I know families who have worked very successfully with this model. There are books and resources and there are even health providers who will work with families and not prescribe drugs.

When you have prescription drugs as the fallback, it means that there's a kind of easy answer, although in my opinion it's very risky. You're exposing children with developing brains to a class of drugs related to cocaine and methamphetamines. I've certainly talked to people in the school system who will say that there is an immediate effect, but it's not long-lasting. When you look at the evidence, you see that there's really not a huge amount of evidence that over the long term these drugs accomplish what parents expect them to do.

I don't think there's an easy answer right now, but I would like the schools in particular to start developing options instead of falling back on the medication as the first line of treatment.

The Chair: Mr. Rankin, you can have a brief question, and then we'll move on.

Mr. Murray Rankin: Thank you.

My question is for you as well, Ms. Currie. You talked about the "prescription cascade" and the fact that sometimes these antidepressants cause other medication to be taken, which itself has side effects. You seemed reluctant to use the word "addiction". Why? Isn't that exactly what is going on here?

Ms. Janet Currie: It's exactly what we're talking about. I think there's been a reluctance, particularly by the medical profession, to feel that a drug they're prescribing actually can result in addiction. But there's no question that the dynamics in the brain are similar to.... In fact, researchers with some very good reputations have done comparisons, for example, of Effexor, a very common antidepressant, with other drugs such as cocaine. These drugs affect the structure of the neurons. They affect the neurotransmitters and we don't know a lot about how, as the brain is very complex.

But over a period of time, and it can be a very short time.... Benzodiazepines, in my opinion, should only be used for a period of less than a week. Over a period of time, even a short time, a person either will need a higher dose of the drug for the same effect or will start exhibiting symptoms such as anxiety, agitation, or panic, depending on the drug, symptoms that are indicative of addiction. We call that phenomenon “between dose withdrawal”. I have many individuals who come to me and say that they just don't know what's happening to them, that they're taking a drug for anxiety and having panic attacks. The first thing I look at is how long they have been on the drug and what drug they are taking.

You're absolutely right: “addiction” is the word we should use.

● (1710)

The Chair: Thank you.

Mr. Young.

Mr. Terence Young (Oakville, CPC): Thank you, Chair.

Thank you, everyone, for your time today.

Janet Currie, first of all, when we talk about mental health, we always end up talking about drugs. Drugs are always involved, either street drugs or prescription drugs. To what extent do over-prescribing and overuse of psychiatric drugs contribute to the suffering of mental health patients and extend their illnesses or, in other words, worsen mental health across Canada?

Ms. Janet Currie: Well, I mean, you've summed it up. I think the contribution of psychiatric drugs and the extent to which we are using them is contributing to chronic mental health problems and people seeing themselves as chronically ill. I think psychiatric drugs make a huge contribution to that.

Let me talk about my friend Daisy, who is in her 60s. She was prescribed—

Mr. Terence Young: Can I interrupt for a second? I have just a few minutes, and I was hoping to get two more questions in. Could you please make a brief answer? Thanks.

Ms. Janet Currie: Okay.

She was prescribed a heavy-duty sedative when she was a student at university. She had all kinds of psychiatric diagnoses and took more and more psychiatric drugs. She lived a very dysfunctional life for 40 years until she tapered off each one of the psychiatric drugs. She's now living a very positive life.

I think that's part of the reason why we're seeing so much chronicity and long-term disability for mental health patients. I think psychiatric drugs are playing a huge factor in extending those symptoms and the chronic conditions.

Mr. Terence Young: Thank you.

If patients were given clearly worded safety warnings for anti-depressants with regard to suicide, that SSRIs and SNRIs can lead to suicide, could suicides be reduced?

Ms. Janet Currie: I don't know how much attention people pay to safety warnings. I think it's one small component of drug safety. I think it should be done.

I think people underestimate side effects. I think health providers need to know that when a person is starting on an anti-depressant they should be very carefully monitored. I'm talking about daily monitoring. That is what the drug manufacturers recommend. Who monitors a person getting an anti-depressant? Does the physician tell the patient not to increase their dose, reduce their dose, or try to stop without discussing it with them? Does the physician tell the patient to call them when they are experiencing side effects, or talk to the family?

I think those kinds of things might be more effective.

Mr. Terence Young: We know that there are much higher rates of suicide amongst first nations youth. We also know that the prescribing of anti-depressants is much higher for first nations youth. Do you make a connection with those two facts?

Ms. Janet Currie: Absolutely. When you look at the aboriginal population, and aboriginal women particularly, that group gets a high level not just of psychiatric drugs but also opiates and opiate painkillers. That's a dynamite combination, opiates and psychiatric drugs. I definitely think this is something we should look at. We certainly cannot dismiss the socio-economic factors and other issues as contributors to suicide. I'm not in any way trying to dismiss that. But we really need to look at the contribution of psychiatric drugs, and of other drugs a person might be taking, to depression. I would really welcome that kind of analysis.

I was also going to say that in the case of prisoners, as mentioned by a previous speaker, in terms of working with people who have been incarcerated or who are on parole, again, this is another population group that uses a very high rate of prescription drugs. One needs to look at their ability to function in relation to the drugs they're taking.

● (1715)

Mr. Terence Young: Thank you.

Dr. Rehm, I want to ask you about the relationship between crime, alcohol, and marijuana. I just read in the Carleton University paper today that a former student, 26 years old, has gone to prison for a year because several years ago, after a night of smoking marijuana and drinking, he raped a sleeping woman—a woman who had trusted him. She has PTSD. She has attempted suicide. He's gone to prison. This is a tragedy all around.

How often does marijuana lead to psychiatric illness, either through crime or as a reaction to smoking this powerful narcotic?

Dr. Jürgen Rehm: Basically, there is clear evidence that marijuana and smoking marijuana can trigger mental disorders—for example, psychotic symptoms and schizophrenia, as has been shown—in vulnerable people. That means that overall we do have this connection.

This is not a very frequent connection. If you look into the deaths and the very serious events related to marijuana, the most important effect on mortality is actually traffic—that means smoking marijuana and being in traffic—and lung cancer. That has the same effect as smoking cigarettes, albeit, of course, on a way smaller scale, because marijuana is smoked by fewer people.

Mr. Terence Young: Thank you.

The Chair: Thank you very much.

The bells are ringing. The votes aren't until 5:45. Ms. Fry hasn't asked a question yet. Is there unanimous consent to allow Ms. Fry to have a question so she can get a question on the record? It may not be a full round, but at least one question—

Mrs. Cathy McLeod: We're a long way from the Hill, so—

The Chair: Okay, Ms. Fry, a brief question so you are on the record.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much.

I want to thank the committee for allowing me this opportunity to ask a question.

We've heard about the dangers and the adverse effects of drugs in certain mental illnesses, but we also know there is a need at certain times for appropriate medication for certain mental illnesses.

Mr. Weber, I wanted to talk about an integrated community approach, with early risk factors being picked up in, say, a school and then that person moving into support systems, with the particular child being referred to the right person to look after them, whether a psychotherapist or a tertiary care person.

You talked about the German Nuremberg model. Can you tell us a little about that? It sounds like a very innovative model for dealing with the problem.

Mr. George Weber: It's a model, as we have done here in the Ottawa area, that brings all elements of the community together that may have some influence in early identification of people with suicidal ideation and then dealing with that, by pulling all the resources together, because nobody has the ultimate, whole package of resources.

The first thing to do is to investigate where the suicides took place and the means, and things of that nature, and start at the front end to try to take away some of those means. That has also been done in subway stations in some parts of Canada. So it deals with that. Then, fundamentally, early identification is probably the big area, and then making sure that for those people who have high levels of suicidal ideation, there is a wraparound of resources from the community to help them get through that and build in resilience so they can handle whatever is affecting their vulnerability.

It's total community support.

● (1720)

The Chair: Thank you very much.

Thank you, Ms. Fry.

We can't go any further, or I'll get impeached.

The meeting is adjourned.