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BREAKING POINT: THE SUICIDE CRISIS IN INDIGENOUS COMMUNITIES

Report of the Standing Committee on Indigenous and Northern Affairs

**Hon. MaryAnn Mihychuk
Chair**

JUNE 2017

42nd PARLIAMENT, 1st SESSION

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THE STANDING COMMITTEE ON INDIGENOUS AND NORTHERN AFFAIRS

has the honour to present its

NINTH REPORT

Pursuant to its mandate under Standing Order 108(2) and the motion adopted by the Committee on Tuesday, April 12, 2016, the Committee has studied suicide among Indigenous peoples and communities and has agreed to report the following:

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ACKNOWLEDGEMENTS

The House of Commons Standing Committee on Indigenous and Northern Affairs (herein after “the Committee”) acknowledges those who bravely came before the Committee and shared their pain and losses due to suicide. We honour your powerful testimony and recognize your important contributions to this study.

The Committee wishes to express its gratitude to all those who appeared before it during the course of its study of Suicide among Indigenous Peoples and Communities. The Committee is deeply appreciative of the personal experiences shared by community members, leaders and youth representatives which provided us with a deeper understanding of the issues that affect suicide and the provision of mental health services in communities.

The Committee is thankful for the gracious hospitality of First Nations, Inuit and Métis individuals and organizations who welcomed us warmly during youth roundtables and community site visits.

Finally, the Chair wishes to extend her appreciation to her colleagues and staff on the Committee for their dedicated efforts to deal with these important issues.

BREAKING POINT: THE SUICIDE CRISIS IN INDIGENOUS COMMUNITIES

EXECUTIVE SUMMARY

The House of Commons Standing Committee on Indigenous and Northern Affairs adopted a motion in 2016 to examine and prepare a report on suicide among Indigenous peoples and communities. Over the course of the study, the Committee heard from over 50 Indigenous youth representatives, First Nations, Inuit and Métis leaders, leading Indigenous academics and health professional organizations, caregivers such as social workers, health administrators and educators, and mental health advocacy organizations. These witnesses, including many Indigenous youth, shared their difficult personal experiences of suicide, but also expressed hope that through community leadership and resolve, suicide and mental distress can be addressed.

This report, like others before it, finds there is no single solution that will prevent Indigenous peoples from taking their lives. Rather, effective prevention of suicide will require a concerted and united effort, across sectors, governments and Indigenous organizations, working together to address conditions that give rise to mental distress.

Testimony from witnesses provided members with a deeper understanding of the ways in which the suicide and mental distress, along with the social determinants of health, such as housing, educational attainment, poverty and unemployment affect Indigenous peoples. Addressing the social determinants of health was identified by witnesses as critical to improving people's day to day lives in communities. In addition, the Committee heard from Indigenous youth, that addressing the root causes of mental distress in Indigenous communities, including issues related to discrimination and access to health services through community-led solutions is critical. Importantly, the Committee heard that community involvement in service delivery, and increasing community control over local services (as known as cultural continuity) is a key factor in suicide prevention. When First Nations communities assume greater control over their economic, health, social, policing and educational services and have retained the use of Indigenous languages and related cultural infrastructure, they experience lower rates of suicide, overall.

Importantly, the study raises important federal policy considerations, included as recommendations in areas such as: improvements to housing and community infrastructure; closing the educational attainment gap for Indigenous peoples; the importance of Indigenous languages and cultures to community well-being; address abuse and mental distress and support Indigenous peoples and communities to lead the change they want to see.

The Committee heard about promising practices in delivering community-led youth and health programming from Indigenous organizations throughout Canada. These models should be shared widely and communities noted they would benefit from

learning from one another. Promising practices as described by witnesses during public hearings and community site visits are highlighted throughout the report. Such initiatives demonstrate how communities are moving forward to develop innovative models to deliver health care that can also improve other aspects of Indigenous peoples' lives.

As stated by Will Landon, the Assembly of First Nations National Youth Council representative, "let them say that we came together—the Crown, our leaders, our youth, our Elders—that we established a solid foundation of healing and well-being for the future generations, and that we did that together."¹

COMMITTEE MANDATE AND PROCESS

On 12 April 2016, the House of Commons Standing Committee on Indigenous and Northern Affairs agreed to undertake a study of suicide among Indigenous peoples and communities, adopting the following motion:

That, pursuant to Standing Order 108(2), the Committee study the crisis in suicide facing First Nations, Inuit, and Métis on and off reserve; that the committee's study include investigating Canada's place on the Kids Rights Index; that the committee look into traveling to select communities impacted by the crisis; that the witness list include but not be limited to community leaders, health experts, youth advocates, departmental officials, the Minister of Health, as well as First Nations, Inuit, and Métis; and that the Committee report its findings to the House of Commons.

Throughout the course of its study, the Committee held 20 public hearings where it heard from approximately 100 witnesses, including government officials, national and regional First Nations, Inuit and Métis organizations, First Nations and Inuit communities, academics, service providers and respective professional organizations. To ensure the experiences of Indigenous peoples were heard by the Committee, members travelled to urban and remote communities, where in addition to local governments and organizations, the Committee met with over 50 Indigenous youth. The Committee held roundtable discussions in: Kuujuaq, Nunavik; Sioux Lookout, Ontario; Vancouver, British Columbia; Iqaluit, Nunavut.

In addition to public hearings, meetings and community site visits, the Committee sought to engage with the public to hear from organizations that may not have otherwise been able to appear before the Committee. The Committee launched an electronic consultation ("the Survey") of front-line mental health service providers in Indigenous communities. While the intent of the electronic consultation is to obtain a general profile of the mental health care pressures in Indigenous communities, the Survey does not provide a representative sample of all Indigenous communities nor are all issues affecting the delivery of mental health services captured. The Committee received 163 responses from front-line staff working in Indigenous communities. Key findings are in the body of the report and tables summarizing Survey responses are attached as an appendix.

1 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1635 (Mr. Will Landon, National Youth Council Representative, Ontario, Assembly of First Nations).

The report is structured into four parts; the first section describes historic and intergenerational trauma which affects the mental health of Indigenous peoples. The second section outlines the social determinants of health such as housing, education, employment, infrastructure and childhood adversity. The third section describes the conditions which prevent suicide, including cultural continuity, cultural and language renewal and spaces for healing and recreation for youth. The fourth section describes the availability of mental health services for First Nations, Inuit and Métis people. Lastly, the Committee proposes a range of recommendations based on the considerable work being done by a number of dedicated individuals to prevent suicide among Indigenous peoples and communities. We now report on our findings.

AN OVERVIEW OF MENTAL HEALTH IN INDIGENOUS COMMUNITIES

A. Prevalence of Suicide among First Nations, Inuit and Métis people

Indigenous peoples in Canada experience disproportionately high rates of suicide and suicide ideation in comparison to their non-Indigenous counterparts. The issue was brought to light in the landmark special report published by the Royal Commission on Aboriginal Peoples which documented that rates of suicide among Indigenous peoples have dramatically increased. At the time of writing in 1995, the Commission estimated that the national rate of suicide among Indigenous peoples was three times higher than the general public, or non-Indigenous Canadians, and that the rate of suicide among Indigenous youth was five to six times higher than non-Indigenous youth.² Sadly, research indicates that these figures remain unchanged over the past three decades.³ Health service providers who responded to the electronic consultation noted Indigenous youth continue to be at high risk of suicide.⁴

While statistics do not adequately describe the lives lost, and Canada has seen a slight decrease in its rate of suicide since 2002.⁵ Indigenous peoples continue to face elevated rates of suicide. For example, the 2016 Quebec Coroner's Office Inquest Report into the deaths by suicide of five Indigenous people noted, "Between 2000 and 2011, there were 152 suicides among Aboriginals living in their communities. Uashat Mak Mani-Utenam has approximately 3400 inhabitants. The Naskapi in Kawawachikamach are approximately 650.... Between May 1994 and November 2015, there were 44 suicides in the community of Uashat Mak Mani-Utenam."⁶

2 Royal Commission on Aboriginal Peoples, [Choosing Life: Special Report on Suicide Among Aboriginal People](#), 1995.

3 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October, 2016, 1615 (Dr. Ed Connors, Director, Canadian Association of Suicide Prevention).

4 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Survey of Front-Line Service Providers in Indigenous Communities](#).

5 Statistics Canada, [Deaths and mortality rate, by selected grouped causes, age group and sex, Canada](#), CANSIM table 102-0551.

6 [Quebec Coroner's Office Report of Inquest Concerning the Deaths of Quebec Coroner's Office's Report of Inquest Concerning the Deaths of Charles Junior Grégoire-Vollant, Marie-Marthe Grégoire, Alicia Grace Sandy, Céline Michel-Rock and Nadeige Guanish](#), 2016.

Inuit

- The rate of suicide among the four Inuit regions ranges from 5 to 25 times the national rate.⁷ Specifically, these rates were 60 per 100,000 population in the Inuvialuit Settlement Region; 275 per 100,000 population in Nunatsiavut; 113 per 100,000 population in Nunavik; and 116 per 100,000 population in Nunavut.⁸
- Young males are the highest risk group for suicide. The rate of suicide among males aged 15–29 is 40 times the national rate.⁹
- In 2004–2008, children and teenagers in Inuit Nunangat¹⁰ were more than 30 times as likely to die from suicide as were those in the rest of Canada.¹¹

First Nations

- The suicide rate among on-reserve First Nations male youth aged 1–19 was 30 per 100,000. For on-reserve First Nations females in the same age range the rate was 26 per 100,000. These are much higher than the national rate of 11 per 100,000.¹²
- In 2012, 17%¹³ of First Nations individuals living off-reserve between the ages of 18 and 25 as well as 24%¹⁴ of individuals between the ages of 26 and 59 reported having suicidal thoughts in their lifetime.
- 12% of First Nations reported that a close friend or family member committed suicide.¹⁵

7 Inuit Tapiriit Kanatami, [National Inuit Suicide Prevention Strategy](#), 2016.

8 Ibid.

9 Ibid.

10 Inuktitut for the four Inuit regions of Canada, Inuvialuit, Nunavut, Nunavik and Nunatsiavut.

11 Statistics Canada, *Mortality rates among children and teenagers living in Inuit Nunangat, 1994 to 2008*, Catalogue no. 82-003-X, Ottawa, 2012.

12 Health Canada, [National Aboriginal Youth Suicide Prevention Strategy \(NAYSPS\) Program Framework](#), 2013.

13 Statistics Canada, [Aboriginal Peoples Survey, 2012 Past-year suicidal thoughts among off-reserve First Nations, Métis and Inuit adults aged 18 to 25: Prevalence and associated characteristics](#), Catalogue no. 89-653-X, 2016.

14 Statistics Canada, [Aboriginal Peoples Survey, 2012 Lifetime suicidal thoughts among First Nations living off reserve, Métis and Inuit aged 26 to 59: Prevalence and associated characteristics](#), Catalogue no. 89-653-X, 2016.

15 First Nations Information Governance Centre, [First Nations Regional Health Survey \(RHS\) 2008/10: National report on adults, youth and children living in First Nations communities](#), Ottawa, 2012.

Métis

- 16% of Métis individuals ages 18–25,¹⁶ and 19.6%¹⁷ individuals aged 26–59, experienced suicidal thoughts in their lifetime.

Importantly, suicide rates are not uniform – there are significant variations in the rates of suicide across Indigenous heritage groups, communities, regions, and age groups. For example, in British Columbia, the majority of First Nations have low rates or no incidence of suicide, while a small number of First Nations have very high rates of suicide.¹⁸ There are significant data gaps for specific communities, regions and heritage groups, including Métis people.

The rates of suicide may underrepresent the actual number of suicides due to variations in reporting practices, for example, where deaths are categorized as accidents rather than suicides due to a variety of factors including shame or stigma about suicide or where ethnicity is not reported on the death certificate.¹⁹ Finally, statistics related to suicide are captured in periodic surveys targeting specific communities and age ranges, using different methodologies. As such, these results cannot be compared, making it challenging to provide comprehensive statistical trends across all Indigenous communities.²⁰

16 Statistics Canada, [Aboriginal Peoples Survey, 2012 Past-year suicidal thoughts among off-reserve First Nations, Métis and Inuit adults aged 18 to 25: Prevalence and associated characteristics](#), Catalogue no. 89-653-X, 2016.

17 Statistics Canada, [Aboriginal Peoples Survey, 2012 Lifetime suicidal thoughts among First Nations living off reserve, Métis and Inuit aged 26 to 59: Prevalence and associated characteristics](#), Catalogue no. 89-653-X, 2016.

18 Michael J. Chandler and Christopher Lalonde, “Transferring Whose Knowledge? Exchanging Whose Best Practices?: On Knowing About Indigenous Knowledge and Aboriginal Suicide” in *Aboriginal Policy Research, Volume 2: Setting the Agenda for Change*, Thompson Educational Publishing, Inc., 2013. Health Canada, [National Aboriginal Youth Suicide Prevention Strategy \(NAYSPS\) Program Framework](#), 2013.

19 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 1550 (Dr. Jack Hicks, Adjunct Professor, Community Health and Epidemiology, University of Saskatchewan, As an individual).

20 Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 1615 (Dr. Tom Wong, Executive Director, Office of Population and Public Health, Health Canada); and Health Canada, [National Aboriginal Youth Suicide Prevention Strategy \(NAYSPS\) Program Framework](#), 2013.

I. WHAT THE COMMITTEE HEARD

To be properly understood, the elevated rate of suicide in Indigenous communities must be considered alongside its historical context. Hundreds of years of colonization disrupted multiple generations of families, and have had lasting and profound effects on communities. Legislation such as the *Indian Act* and related federal policies of assimilation established residential schools, created the reserve system and forcibly relocated different groups of people. The end result was the removal of children from families, the prohibition and resulting erosion of Indigenous languages, cultures and ceremonies and the wide-scale dispossession of Indigenous peoples from their traditional territories. These policies have left a collective trauma on Indigenous communities, and many witnesses told the Committee that these destructive origins place Indigenous peoples at a higher risk of mental distress and suicide than non-Indigenous people.

As many witnesses noted, the root causes of suicide as well as preventative measures have been well documented in numerous reports including national commissions, coroner's inquests, regional reports and youth forums. It should come as no surprise that over the course of the study, Indigenous peoples clearly expressed their concerns about their future and that of their children. Many of the Indigenous youth painted a portrait of communities that are in perpetual states of crises, lacking the appropriate resources, infrastructure and partnerships to adequately address Indigenous suicide.

While there is no single cause of suicide among Indigenous peoples, witnesses suggested a proper understanding of the conditions which cause mental distress and suicide is essential in preventing suicide from taking place. Specifically, factors identified by witnesses that can contribute to the incidence of suicide include historic and intergenerational trauma, the social determinants of health and mental illness.

HISTORIC AND INTERGENERATIONAL TRAUMA

Don't hold it against us that our families were put into residential schools or that there was the sixties scoop, or the past and all of those things that created this, like the Indian Act. They've all been created to assimilate and to eradicate the Indian problem, and those are real things.²¹

Pamela Glode Desrochers

The Committee heard that shared experiences of trauma due to the legacies of colonization have resulted in specific risks for Indigenous peoples. Bernard Richard, the British Columbia Representative for Children and Youth, explained that trauma experienced by groups of people, can be passed onto the next generation, called

21 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016, 1640 (Ms. Pamela Glode Desrochers, Executive Director, Mi'kmaw Native Friendship Society).

intergenerational trauma.²² Witnesses such as Amy Bombay, Dalhousie University and Carol Hopkins of the Thunderbird Partnership Foundation explained that past traumas experienced by Indigenous peoples have contributed to poorer health, poverty, low self-esteem and mental distress of multiple generations of Indigenous peoples.²³

The vast majority of witnesses described how past colonial activities caused trauma and other complex mental health issues, placing Indigenous peoples at a higher risk of suicide.²⁴ For example, Inuit witnesses identified attendance at residential schools along with forced relocation and the sled dog slaughter as sources of trauma placing Inuit at increased risk of suicide. The Committee heard that sled dogs were an important aspect of Inuit life before settlements and a requirement to feed one's family as a means of transport for hunting and fishing. During the 1950s and 1960s, the federal government forcibly resettled some Inuit and others moved voluntarily to new communities across Inuit Nunangat. While the sled dog's population began to decline once Inuit moved to settlements, some were also "shot by the RCMP and other authorities in settlements."²⁵ Such measures resulted in a limited ability to pursue traditional Inuit activities on the land, restricted mobility, hampered Inuit peoples' means to earn an income and avoid food insecurity.²⁶

While Inuit currently experience some of the highest rates of suicide, Jack Hicks of the University of Saskatchewan observed that suicide among Inuit was uncommon in the years preceding re-settlement of Inuit to new communities. He noted that the incidence of suicide began to increase in the 1960s and 1970s, amongst the first generation of children who grew up in the new settlements.²⁷ He suggested that the rates were more pronounced due to the drastically different conditions in the settlements than life on the land. There was a loss of power and decreased autonomy for Inuit in the new settlements which, in turn, affected Inuit children.²⁸

Further, the Committee heard that Indian residential schools operated in Canada for over 150 years, and were part of the former federal policy of assimilation of Indigenous peoples. Over this period, First Nations, Inuit and Métis children were taken from their

22 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 February 2017, 0950 (Mr. Bernard Richard, British Columbia Representative for Children and Youth).

23 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 24 October 2016, 1530 (Dr. Amy Bombay, Assistant Professor, Department of Psychiatry, Dalhousie University, As an individual); and House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 February 2017, 1015 (Ms. Carol Hopkins, Executive Director, Thunderbird Partnership Foundation).

24 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1340 (Ms. Louisa Yeates, Vice-President, Qarjuit Youth Council).

25 James Igloliorte, "[Qikiqtani Truth Commission Final Report: Achieving Saimaqatiqiniq](#)," Qikiqtani Inuit Association, 2013.

26 Ibid.

27 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 June 2016, 1555 (Dr. Jack Hicks).

28 Ibid.

families and required to attend the schools, often located far from their communities.²⁹ Michael DeGagné from Nipissing University told the Committee that: “a lot of the suicide we see today had its genesis in the residential school programs many decades ago.”³⁰

Many former students reported suffering abuse while at the schools and endured other common cultural losses which have devastating effects on multiple generations, as shared by Mavis Benson of Cheslatta Carrier Nation:

Due to the Indian residential schools, we have lost most of our language, culture, and identity. Our community is fractured and lateral violence is the norm. Alcohol was a part of my life growing up, and violence and sexual abuse came with that.³¹

As noted by Lisa Bourque Bearskin from the Canadian Indigenous Nurses Association on the lasting effects of residential school attendance, “the health of Indigenous youth is intimately related to the history of colonization and residential schools, removal of the child from their home and their culture.”³² Unresolved trauma experienced by former students can affect their descendants today, an occurrence which is commonly referred to as “intergenerational trauma.”³³

Inuit and First Nation youth who participated in youth roundtables with Committee members explained that their parents experienced acute stress and trauma due to residential school attendance and/or forced resettlement. As one young First Nation girl said, “[i]t’s like the adults are children and children take care of their parents. I come from a sad place.”³⁴ As a result, they explained that their parents had poor parenting skills, leaving many children to raise themselves and their younger siblings. Other children raised the issue of violence in the home. One youth reported: “I still remember my mom trying to stab herself when she was drunk. As children, all we could do was run from the room, crying.”³⁵ When asked what they needed to decrease rates of suicide, Inuit youth in Nunavik asked their social workers and teachers to, “fix my parents.”³⁶

Colonial policies disrupted traditional family structures for some in Nunavik and had different effects on men and women. As reported by Inuit counselors, Inuit men are at

29 Indigenous and Northern Affairs Canada, [Indian Residential Schools](#), 2016.

30 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1605 (Dr. Michael DeGagné, President and Vice-Chancellor, Nipissing University, As an individual).

31 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 0815 (Ms. Mavis Benson, Member, Cheslatta Carrier Nation).

32 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1540 (Dr. Lisa Bourque Bearskin, President, Canadian Indigenous Nurses Association).

33 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1615 (Dr. Michael DeGagné).

34 Committee analyst notes from the September and November 2016 community site visits to Kuujuaq, Quebec, Iqaluit, Nunavut, Vancouver, British Columbia and Sioux Lookout, Ontario.

35 Ibid.

36 Ibid.

higher risk of suicide than women as they are no longer the main providers for their families, having had their dog teams slaughtered and being forced to move into settlements. It was suggested that specific programming to restore and renew cultural traditions be targeted for women and men.³⁷

While one young man noted he grew up without a father, he described his involvement in an Inuit land-based camp was important in teaching him about traditional Inuit skills, like how to hunt and fish. He emphasized the importance of land-based programs which emphasized some important Inuit values, such as sharing with others, “the program taught me to be a man. I am a good hunter and I give the meat to the community. I don’t sell it.”³⁸

The Committee heard that an understanding of the effects of colonization and intergenerational trauma experienced by Indigenous youth is critical to ensuring that support is culturally appropriate and free of racism. Specifically, during roundtable discussions First Nations and Inuit youth described their experiences of racism and discrimination from health service providers, educators and social workers. They noted that many of these professionals do not understand the context of historic and intergenerational trauma and the effects of colonization on Indigenous youth today. Experiences of discrimination reduce the likelihood that youth will seek out help during times of distress. As such, Inuit youth recommended that all service providers and public servants across education, justice and health and social service sectors receive mandatory training on Inuit values, culture and history as an important step to reduce racism and discrimination.

To address this legacy of colonization, many witnesses that appeared before the Committee referenced the work of the Truth and Reconciliation Commission of Canada³⁹ and underscored the importance of implementing its Calls to Action as long term solutions. The Commission was established following the Indian Residential School Settlement Agreement, and sought to document the history of residential school experience and inform Canadians about what happened at the schools.⁴⁰ The Commission published its Final Report on Indian residential schools in 2015, which included 94 Calls to Action intended to bring resolution to the legacies of Indian residential schools. Among these, the *United Nations Declaration on the Rights of Indigenous Peoples* was identified as a framework for reconciliation.⁴¹ As Isadore Day from the Assembly of First Nations noted,

37 Committee analyst notes from the September community site visits to Kuujuaq, Quebec.

38 Committee analyst notes from the September community site visits to Kuujuaq, Quebec.

39 House of Commons, Standing Committee on Indigenous and Northern Affairs, *Evidence*, 1st Session, 42nd Parliament, 9 June 2016, 1635 (Regional Chief Isadore Day, Assembly of First Nations and Chiefs of Ontario).

40 Indigenous and Northern Affairs Canada, *Indian Residential Schools*, 2016.

41 Truth and Reconciliation Commission of Canada, *Honouring the Past, Reconciling the Future: Final Report*, 2015.

Taking the 94 Calls for Action and the road map that's laid out in the Truth and Reconciliation Report, in those two things combined, there's a plethora of options and alternatives and models for a long-term solution. It's a really big question, but we have the action plans in front of us now, the road map, and I think we just need to get it done.⁴²

SELF-DETERMINATION, COMMUNITY-DRIVEN PRIORITIES AND LONG-TERM, STABLE FUNDING

A. Self-determination

*I do believe that expressions of self-determination are the surest way to build healthy individuals, healthy families, and communities. It's only because I've seen it working.*⁴³

Derek Nepinak

Over a number of years, reports by inquiries, coroner's inquests and commissions have set out recommendations to prevent suicide and identified underlying root causes. These were cited by many witnesses and include the *Report of the Royal Commission of Aboriginal Peoples* (1996), *Nunavut Coroner's Inquest into Suicide* (2015) and the *Office of the Chief Coroner's Death Review of the Youth Suicides at the Pikangikum First Nation* (2011).⁴⁴ Throughout the course of the study, witnesses referenced these reports as having set out important recommendations to address the rates of suicide among Indigenous peoples.

While the study was on-going, another important report was published in Quebec, *2016 Quebec Coroner's Office's Report of Inquest* following the deaths by suicide of five Indigenous peoples in the communities of Uashat Mak Mani-Utenam and Kawawachikamach, Quebec.⁴⁵ The Committee has excerpted a few of the Coroner's key findings into the deaths by suicide to provide a better understanding of the systemic issues that affect Indigenous suicide.

The Aboriginal issue is complex. I was able to see that on reading the many documents and in light of the testimony heard. To correct the problem of suicide in Aboriginal communities, living conditions in those communities must improve, which includes economic, cultural, social and community conditions.

Despite all of the funds and efforts invested in recent decades, despite the treaties and agreements signed and the numerous discussions and negotiations, little has changed.

In Aboriginal communities there are still as many social problems, as many persons struggling with substance abuse and addiction, as many children in need of protection, as

42 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 June 2016, 1635 (Regional Chief Isadore Day).

43 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 February 2017, 0930 (Grand Chief Derek Nepinak, Assembly of Manitoba Chiefs).

44 Committee analyst notes from community site visit to Sioux Lookout, Ontario.

45 [Quebec Coroner's Office Report of Inquest Concerning the Deaths of Quebec Coroner's Office's Report of Inquest Concerning the Deaths of Charles Junior Grégoire-Vollant, Marie-Marthe Grégoire, Alicia Grace Sandy, Céline Michel-Rock and Nadeige Guanish](#), 2016.

many persons incarcerated and as many jobless, and the ratios or proportions exceed those of non-Aboriginal communities.

I believe and see evidence that the great fundamental problem lies with the “apartheid” system into which Aboriginals have been thrust for 150 years or more.

The *Indian Act* is an ancient and outdated law that establishes two kinds of citizens, Aboriginals and non-Aboriginals. The Aboriginal is a ward of the State, someone considered incapable and unfit.

These citizens, who are under a separate system, have been stuck in reserves where they cannot progress or become emancipated. The message that is constantly sent to Aboriginals is: [TRANSLATION] “you are different and incapable... It is time to put an end to this apartheid system, and for all of the authorities concerned to confront that challenge.”⁴⁶

Many witnesses emphasized that promoting community self-determination can help to address effects of colonization such as historic and intergenerational trauma and the erosion of traditional practices, languages and cultures.⁴⁷ The *United Nations Declaration on the Rights of Indigenous Peoples* (“the Declaration”), referenced by Maatalii Okalik from the National Inuit Youth Council sets out a framework and standards for self-determination.⁴⁸ The Declaration establishes that Indigenous peoples have a right to self-determination over their internal affairs, including health services.⁴⁹ Further, Susan Bobbi Herrera of the Confederacy of Treaty 6 First Nations noted that the United Nations Permanent Forum on Indigenous Issues has linked elevated rates of suicide among Indigenous peoples with their relative lack of self-determination. Specifically, she notes that: “[T]hese problems are linked to the lack of recognition of and respect for the right of self-determination of Indigenous peoples.”⁵⁰ While self-determination was raised by many witnesses as an important aspect of suicide prevention for First Nations, Natan Obed from Inuit Tapiriit Kanatami cautioned that for Inuit there was not a clear correlation between self-determination and the rate of suicide of Inuit. He noted more research is required to establish a causal link, as other countries like Greenland have achieved self-government but have not seen decreased rates of suicide.⁵¹

46 Quebec Coroner’s Office’s [Report of Inquest Concerning the Deaths of Charles Junior Grégoire-Vollant, Marie-Marthe Grégoire, Alicia Grace Sandy, Céline Michel-Rock and Nadeige Guanish](#), 2016.

47 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 24 October 2016, 1530 (Dr. Amy Bombay); and House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 February 2017, 0930 (Grand Chief Derek Nepinak).

48 United Nations, [United Nations Declaration on the Rights of Indigenous Peoples](#), 2007 and House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1240 (Ms. Maatalii Okalik, President, National Inuit Youth Council).

49 Ibid.

50 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 February 2017, 0940 (Ms. Susan Bobbi Herrera, Chief Executive Officer, Confederacy of Treaty 6 First Nations).

51 Ibid.

The Committee heard that some treaties and modern land claims agreements also set out a framework with regards to self-determination in that these agreements contain specific provisions for First Nations jurisdiction over health care. For example, Susan Bobbi Herrera referenced Treaty No. 6 which guarantees a right, “to full health benefits as promised through the medicine chest clause.”⁵²

The Committee heard from a few witnesses who noted that comprehensive land claims provide for Indigenous control of health care, languages, education and employment. However, some witnesses noted there were challenges in the implementation of these agreements. While the Nunavut Final Agreement contains a specific provision to ensure its public service is representative of the Inuit population, for instance Peter Williamson emphasized, “they haven’t been respected. We need to start making sure that these provisions are implemented.”⁵³ James Arreak from Nunavut Tunngavik Inc. observed that without a federal implementation policy no provision directs the Government of Canada to “commit to any kind of implementation of their federal obligations.”⁵⁴

Greta Visitor from the Cree Board of Health and Social Services of James Bay noted that self-government under a comprehensive land claim provided more autonomy for communities to implement their own priorities such as land based programming. She told the Committee that the Grand Council of the Crees under the *James Bay and Northern Quebec Land Claim Agreement* were in a better position due to the land claim than those communities in northern Ontario governed by the *Indian Act*.⁵⁵

B. Community Driven Priorities

*The autonomy that we had before the settlers came, that was the autonomy that was broken.... How we go about doing it has to come from us, to tell you what we need, what we want, and then we will involve our Elders, and ... invite people from all walks of life.*⁵⁶

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- 52 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 February 2017, 0940 (Ms. Susan Bobbi Herrera).
- 53 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1600 (Mr. Peter Williamson, As an individual).
- 54 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1005 (Mr. James Arreak, Chief Executive Officer, Executive Services, Nunavut Tunngavik Inc.).
- 55 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 26 October 2016, 1550 (Ms. Greta Visitor, Assistant Executive Director, Miyupimaatisiioon Regional Services, Cree Board of Health and Social Services of James Bay).
- 56 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 26 October 2016, 1620 (Mr. Leo Ashamock, Chairman, Weeneebayko Area Health Authority).

Many witnesses⁵⁷ highlighted that community-driven health services are the most effective means of preventing suicide and fostering good mental health. Honourable Minister George Hickes, Minister of Health, Minister responsible for Suicide Prevention from the Government of Nunavut noted: “We are past the days when we had no other options” and Indigenous peoples need to be full partners in the design and delivery of programs and also have the time to develop the capacity to deliver such services.⁵⁸ Where First Nations communities have achieved greater control over the delivery of programming, their services are more responsive to local needs.

Through Health Canada’s First Nations and Inuit Health Branch (FNIHB), the federal government provides certain health services and programs to status Indians⁵⁹ and Inuit living in their traditional territories. These services are either delivered directly by Health Canada or by communities who have had this responsibility transferred to them. Where comprehensive land claims agreements have been settled with Indigenous communities, health care is delivered in accordance with the provisions of the agreement. Importantly, witnesses cautioned that capacity support and partnerships are essential in order for these community-led models to succeed. As stated by Louise Bradley of the Mental Health Commission of Canada:

There are ways and means to support Indigenous peoples as they action their own solutions to the crisis they now face. ... [A]s an external entity, the Commission, ... waits to be invited to align and partner with Indigenous organizations, as we were privileged to do with the ITK [Inuit Tapiriit Kanatami] ... around the Inuit suicide prevention strategy.... We understand that it can take years to build a foundation of trust.⁶⁰

The Committee heard that Health Canada’s FNIHB is pursuing different health care delivery models to improve the integration of health services in First Nations communities. Isadore Day noted there are many First Nations regional organizations or Health Authorities that are ready or already delivering health services such as the Sioux Lookout First Nations Health Authority, which provides services to 33 remote or isolated First Nations communities.⁶¹

57 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, (Ms. Alicia Aragutak, President, Qarjuit Youth Council); Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 0840 (Mr. George Hickes); and House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 February 2017, 0905 (Chief Candice Paul, Chief, St. Mary’s First Nation, and Co-Chair, Atlantic Policy Congress of First Nations Chiefs Secretariat).

58 Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 0850 (Mr. George Hickes).

59 The term “status Indians” refers to person who is registered under the *Indian Act*. Indigenous and Northern Affairs Canada, [Terminology](#).

60 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1530 (Ms. Louise Bradley, President and CEO, Mental Health Commission of Canada).

61 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 June 2016, 1655 (Regional Chief Isadore Day).

Another example, the Atlantic First Nations Health Partnership is a shared decision-making model between Atlantic First Nations and Health Canada. This partnership enables First Nations to develop action plans in targeted areas, such as mental health, and focus funding on locally set priorities.⁶² Candice Paul from the Atlantic Policy Congress of First Nations Chiefs Secretariat explains: “These plans help us focus limited funding to priorities, but again, there are a lot of communities and never enough resources to meet all the needs, a reality for all communities across the country.”⁶³

The Committee was told by Sheila North Wilson, from Manitoba Keewatinowi Okimakanak Inc. that the organization is assuming greater control over mental health services for the region. The locally identified priorities include training and skill development, crisis response planning across the province and the identification of local best practices with the 64 First Nations in the region.⁶⁴ Susan Bobbi Herrera explained that while a co-management committee was established between Chiefs in Alberta and Health Canada. She describes:

In Alberta, we have ... a co-management table in place, where Canada and representatives from Treaty 6, 7, and 8 First Nations sit and review programs and services for First Nations peoples. Not all of the First Nations belong to co-management. Some have pulled out. Others have joined. It's still a work in progress and under review.⁶⁵

Another model, the First Nations Health Authority, has taken over health service delivery for First Nations on reserve in British Columbia.⁶⁶ The Authority reported that the model has provided a blend of Indigenous cultural practices and therapies with contemporary counselling and mental health services on-reserve and is working to improve coordination with the provincial health system.⁶⁷

Indigenous traditional knowledge and healing approaches, including land-based programs, can be increasingly offered when communities have the capacity to deliver their own health services. As described by Michael DeGagné, “the proof is that when a community is left to its own devices, to design its own programs, that’s often the road they take—the idea of going back to the land, and going back to traditions.”⁶⁸ The *Survey*

62 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 February 2017, 0905 (Chief Candice Paul).

63 Ibid.

64 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 February 2017, 0850 (Grand Chief Sheila North Wilson, Manitoba Keewatinowi Okimakanak Inc.).

65 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 February 2017, 0940 (Ms. Susan Bobbi Herrera, Chief Executive Officer, Confederacy of Treaty 6 First Nations).

66 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1545 (Dr. Lisa Bourque Bearskin).

67 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 1235 (Dr. Shannon McDonald, Deputy Chief Medical Officer, First Nations Health Authority).

68 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1615 (Dr. Michael DeGagné).

respondents identified access to land-based programs or the use of healing circles as important. However, access to such services may be limited as 39% of respondents noted other traditional practices such as traditional counselling or circles are available in their communities.⁶⁹

Traditional healing practices are often offered alongside mental health services and focus on the treatment of the mental, physical, spiritual and emotional health of people. There is high demand for access to traditional Indigenous healing practices. Cornelia Wieman a consultant psychiatrist indicated: “The vast majority of First Nations across the country want to see traditional healing practices as part of their health care, including their mental health care.”⁷⁰

C. Stable, Predictable, Long-Term, Flexible Funding

The Committee heard from many witnesses that stable, predictable, long-term, flexible funding for health services is required for planning, recruitment of health professionals and delivery of key services. As Natan Obed and Isadore Day both observed will require investments across sectors and by “different federal departments.”⁷¹

The Non-Insured Health Benefits (NIHB) is among Health Canada’s largest programs and provides First Nations and Inuit communities with supplementary mental health benefits not covered under provincial health systems. Louise Bradley observed that chronic funding shortfalls in health services have “ill-served Indigenous peoples and harmed Canada’s overall health and reputation.”⁷²

In her appearance before the Committee, the Honourable Minister of Health Jane Philpott acknowledged that there are insufficient mental health supports in Indigenous communities: “I’m not here to deny that many programs in Indigenous communities are under-resourced.”⁷³ The Committee heard from other witnesses that the mental health services provided under the NIHB account for a small portion of its budget. Cornelia Wieman noted that the proportion of Health Canada’s NIHB program dedicated to mental health in 2013-2014 “only accounts for 1.4% of that budget, which amounts to \$14.2 million ... for short-term crisis intervention and mental health counselling benefits to

69 House of Commons, Standing Committee on Indigenous and Northern Affairs, *Survey of Front-Line Service Providers in Indigenous Communities*.

70 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 14 June 2016, 1620 (Dr. Cornelia Wieman, Consultant Psychiatrist, As an individual).

71 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 June 2016, 1625 (Mr. Natan Obed).

72 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1530 (Ms. Louise Bradley).

73 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 November 2016, 1550 (Hon. Jane Philpott, Minister of Health).

address at-risk situations.”⁷⁴ In 2016-2017, the Assembly of First Nations estimated there was a \$136 million shortfall for mental health services in First Nations communities.⁷⁵

The Committee heard that not only was there inadequate investments in mental health services, the transfer of funding through annual contribution agreements made it challenging to deliver community-based programs. The current federal program that funds suicide prevention initiatives for youth, Health Canada’s *National Aboriginal Youth Suicide Prevention Strategy*, was described as funding important community-based programs that integrate culture but having a limited reach.⁷⁶ Youth reported that many Inuit communities are unable to access this funding and that small organizations may not have the capacity to develop annual proposals for consideration.⁷⁷

For instance, funding for the *National Aboriginal Youth Suicide Prevention Strategy* is provided through annual contribution agreements. Short-term agreements present challenges for small, community-based organizations to develop annual proposals; with no funding to sustain operations, employees may be laid off on a cyclical basis and rehired when funding is received.⁷⁸ A few Inuit witnesses noted that federal funding often reaches community programs mid-way through the year, leaving recipients with only 20 weeks to administer a year-long program.⁷⁹

The Committee also heard that the department’s current practice of deducting administrative fees from contribution agreements negatively affects Indigenous communities’ capacity to deliver services and build relevant infrastructure to manage funding, reporting and responsibility. Alika Lafontaine, from the Indigenous Health Alliance, estimated that 6% of all program dollars dispensed by Health Canada is reclaimed in administrative fees. Another 15% to 20% is used for internal costs such as staffing, management, reporting and evaluation. However, the same investments do not appear to be made in enhancing Indigenous communities’ capacity to deliver care.⁸⁰

Sarah MacLaren from the Leave Out Violence Nova Scotia Society noted that the parameters of contribution agreements are too restrictive and that her organization and does not apply for federal programs for this reason. She also noted that flexible funding would enable groups to address important community needs: “You need the money to get to the Elder who’s feeding five children because they’re hungry. You need the money to

74 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 14 June 2016, 1540 (Dr. Cornelia Wieman).

75 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 June 2016, 1655 (Regional Chief Isadore Day).

76 Ibid.

77 Committee analyst notes September 2016 community site visit, Iqaluit, Nunavut.

78 Committee analyst notes September 2016 community site visit Iqaluit, Nunavut.

79 Ibid. and House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016, 1615 (Ms. Sarah MacLaren, Leave Out Violence Nova Scotia Society).

80 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 1020 (Dr. Alika Lafontaine, Collaborative Team Lead, Indigenous Health Alliance).

get to the guy who's running the sweat lodge so he can buy wood to run his sweat lodge. You need the money to penetrate into the community, and that requires a creative approach for how you fund."⁸¹

Some witnesses noted that stable, predictable, flexible, long-term federal funding enables communities to determine local needs and engage in proper planning and coordination across jurisdictions and between initiatives. Inuit leaders emphasized the need for "stable funding with some flexibility.... [W]e need some fluidity within the parameters of the programming so that we can adjust as we recognize things that are working and things that aren't working."⁸²

The Committee repeatedly heard that long-term solutions must include long-term stable, predictable funding based on need to encourage community-driven planning cycles. This will assist Indigenous communities in moving from crisis-response situations to dealing with the social determinants of health; including the economic, political, and social conditions that influence the health of individuals and communities in different ways..⁸³

SOCIAL DETERMINANTS OF HEALTH

*What is required is a real and substantial investment in the social determinants of health, including adequate and safe infrastructure, culturally relevant education, a reformed child welfare system, and economic opportunities.*⁸⁴

Isadore Day

The social determinants of health are economic, political and social conditions that influence the health of individuals and communities in different ways.⁸⁵ Most witnesses that appeared before the Committee highlighted the importance of preventing Indigenous suicide by addressing the social and economic conditions that influence Indigenous peoples' lives. While some Indigenous communities have positive conditions such as self-government, control over land and resources, access to education and employment opportunities, and strong traditions, language and cultures, many others experience great challenges. High poverty rates, low levels of education, limited employment opportunities, inadequate housing and poor access to health services affect a disproportionately high number of Indigenous communities. With Indigenous peoples facing difficult living conditions, they are more likely to feel a sense of hopelessness or despair, leading to mental distress or suicide.

81 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016, 1615 (Ms. Sarah MacLaren).

82 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 0905 (Mr. George Hickes).

83 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1620 (Mr. Calvin Morrisseau, Board of Directors and Ontario Representative, First Nations Health Managers Association).

84 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 June 2016, 1635 (Regional Chief Isadore Day).

85 National Collaborating Centre for Determinants of Health, [Glossary: Social Determinants of Health](#).

Research shows that social determinants such as employment, housing, healthy child development, income, education, gender, and culture can be more important in influencing mental health outcomes than health care or lifestyle choices.⁸⁶ Health cannot be measured without a greater understanding of the social and economic forces that continue to shape it. Social determinants are interrelated, for instance, educational attainment in childhood may affect employment and associated income levels as an adult. Understanding how some of the determinants affect mental health and suicide were outlined by many witnesses heard before the Committee. Specific social determinants of health, including housing, early childhood adversity, education, language, employment, high cost of living, and infrastructure are explained below.

A. Housing

*Then there is housing. This is my personal aspect; we had three generations in one house before. We had about 17 people in my house, in a two bedroom house with a basement. This was when I was about 12, so this was about the time when I was ready to end my life.*⁸⁷

Shurenda Michael

The Committee heard that there is a chronic housing shortage in many Inuit and First Nations communities.⁸⁸ In Nunavut alone, George Hickes estimated that there are “more than 3,000 units short across the territory.”⁸⁹ In Nunavik, the Committee heard that the population of over 13,000, had only 3,000 social housing units.⁹⁰ The housing shortage is not limited to Indigenous communities, as the Committee heard there was also a shortage in Vancouver. A representative of the Metro Vancouver Aboriginal Executive Council noted, “the Lu’ma Native Housing Society has a three to four year wait list for social housing.”⁹¹ With few options to meet the needs of its clients, the Society is left trying to negotiate space from other housing agencies, often with limited success.

86 Juha Mikkonen and Dennis Raphael, “[The Social Determinants of Health: The Canadian Facts](#),” *York University School of Health Policy and Management*, Toronto, 2010.

87 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016, 1540 (Ms. Shurenda Michael, Youth Leader, Leave Out Violence Nova Scotia Society).

88 Ibid and House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1250 (Ms. Alicia Aragutak, President, Qarjuit Youth Council); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 0810 (Mr. Scott Clark, Executive Director, Aboriginal Life in Vancouver Enhancement Society); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 0955 (Dr. James Irvine (Medical Health Officer, Mamawetan Churchill River Health Region)).

89 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 0850 (Mr. George Hickes).

90 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1255 (Ms. Louisa Yeates).

91 Committee analyst notes from the September and November 2016 community site visits to Vancouver, British Columbia.

The housing shortage has contributed to significant overcrowding in First Nation and Inuit communities. The Committee heard of situations in northern Saskatchewan where as many as 19 people were living in one house. The realities of living in an overcrowded housing unit were explained by Heather Bear from the Federation of Sovereign Indigenous Nations, stating, “The housing conditions are deplorable.... one family of 19 people living in one house.... Just picture the reality of the children lining up to go to the washroom in the morning.”⁹² In another case, the Committee heard from the Weeneebayko Area Health Authority, “I also think a lot of these kids could do better if they had a place to study. Most of the homes there are overcrowded. A kid goes home and there are 13 people living in a three-bedroom house.”⁹³

The housing shortage and overcrowding lead to “hidden homelessness,”⁹⁴ where people couch surf from house to house dependent on the generosity of others. The Committee heard about the effects of hidden homelessness among Métis women and youth from Sylvia Johnson from the Métis Nation of Alberta:

We also have pregnant young girls; they're homeless and they couch surf. They have nowhere to live and they go from couch to couch, whoever will let them in. Of course, they have to accommodate whoever is letting them into their place.

It's 40-below here today, and I'm very worried about some of these young girls out on the street. They are going to give birth and they are not dressed properly and have nowhere to go.⁹⁵

At times, young families are also part of the population of hidden homeless, which puts parents at risk of being unable to provide for their children.⁹⁶

The housing shortage and overcrowding have a particular effect on youth, who comprise a large portion of the population in many Indigenous communities. In Nunavik, the Committee heard that the housing shortage may lead youth to modify their lifestyle choices in order to obtain housing. For instance, youth may leave school early, as one youth noted, “the more social issues you have, the more points you get on the system, which leads you to get a house faster.”⁹⁷ Youth also reported they may stay in a violent relationship because there are so few spaces to live and “nowhere else to go.”⁹⁸ The housing allocation system in Nunavik also acts as a disincentive for obtaining employment as social assistance offers security that employment does not. Further, when

92 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 February 2017, 0945 (Vice-Chief Heather Bear, Federation of Sovereign Indigenous Nations).

93 [Brief](#) submitted by Weeneebayko Area Health Authority, 26 October 2016.

94 Committee analyst notes from community site visit in Vancouver, British Columbia.

95 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 February 2016, 0920 (Ms. Sylvia Johnson, Co-Minister of Health, Children and Youth, Métis Nation of Alberta).

96 Committee analyst notes from the November 2016 community site visit to Vancouver, British Columbia.

97 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1355 (Ms. Louisa Yeates).

98 Committee analyst notes from the September 2016 community site visit to Kuujuaq, Quebec.

one starts to earn an income they obtain smaller housing subsidies and have higher rental costs which may result in decreased income levels overall.⁹⁹

A lack of housing or poor quality housing can affect one's mental health and personal well-being as noted by George Hickey, "the opportunity for violence in a household when you're living in overcrowded scenarios, I would say is at least 50%. It would alleviate some of the pressures on a lot of our social issues."¹⁰⁰ A social worker in Kuujuaq estimated that "50 to 60% of mental health problems would be solved with safe and adequate housing."¹⁰¹ Inuit youth also connected the housing shortage to mental health and suicide, "Nunavik's inadequate housing situation is also a major factor in our regions' issues that relate to the risk factors and high suicide rates."¹⁰²

Affordable, quality housing was identified as a major determinant of health for First Nations, Inuit and Métis people living in urban, remote and rural areas. Witnesses described how housing can support vulnerable families, as stated by Scott Clark, "Housing is tremendously important. Safe, suitable, affordable housing for the diverse needs of vulnerable children and families is critical."¹⁰³ Louise Bradley testified that recent research found a "housing-first approach ... along with a basket of services" yielded positive outcomes related to reducing homelessness and promoting positive mental health.¹⁰⁴

The Committee heard that, in urban centres, Friendship Centres offer supportive services and are an essential part of transitioning to urban life from smaller communities. As stated by Chris Sheppard from the National Association of Friendship Centres, "Poverty for Indigenous people in urban centres is a real thing. We see it every day. It's why Friendship Centres have food banks. It's why we have clothing that people can pick up. It's why we have homeless shelters."¹⁰⁵

99 Ibid.

100 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 0850 (Mr. George Hickey).

101 Committee analyst notes from the September 2016 community site visit to Kuujuaq, Quebec.

102 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1355 (Ms. Louisa Yeates).

103 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 0845 (Mr. Scott Clark, Executive Director, Aboriginal Life in Vancouver Enhancement Society);

104 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1555 (Ms. Louise Bradley).

105 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 June 2016, 1650 (Mr. Christopher Sheppard, Vice-President, National Association of Friendship Centres).

B. Education

The Committee heard from Inuit and First Nation witnesses that education operates as a key determinant of health as it is seen as an important way to improve one's socio-economic status, leading to better health outcomes.¹⁰⁶ The Committee heard there is a substantial educational attainment gap between Indigenous and non-Indigenous people in Canada, which is greater in rural and remote First Nations and Inuit communities.

For instance, Maatalli Okalik outlined that across the four Inuit regions – or *Inuit Nunangat* – Nunavut, Nunavik, Inuvialuit, and Nunatsiavut, “29% of Inuit aged 25 to 64 in Inuit Nunangat have earned a high school diploma, versus 85% of all Canadians.”¹⁰⁷ Louisa Yeates from the Qarjuit Youth Council estimated that in Nunavik, “[there is] a high school dropout rate of almost 95%, we need to revive and remobilize our region and stimulate change in the perception of education.”¹⁰⁸

Inuit youth indicated they found the education from primary school to secondary school to be of poor quality. The quality of education was viewed as poor due to the limited Inuit involvement in the education system and a narrow selection of courses, which hinders the pursuit of post-secondary education.¹⁰⁹ As a result, some youth may become frustrated and leave school early.

The Committee heard from First Nation students who left their remote communities in northern Ontario to attend First Nations operated secondary schools in Sioux Lookout and Thunder Bay. While all of the students found it very difficult to leave their families and communities, most believed the educational opportunities in Sioux Lookout or Thunder Bay were of better quality than that available at the remote schools located in fly-in First Nations communities in northern Ontario.¹¹⁰ To attend Pelican Falls First Nations High School or Dennis Franklin Cromarty High School, youth have to qualify academically, leave their communities to live in residences or with families in Lac Seul First Nation, Sioux Lookout or Thunder Bay, Ontario.

In addition to greater course selection, youth noted the First Nations schools provided greater opportunities to develop hobbies, play sports, take different courses and develop relationships with staff. One young person noted it is, “nice to see the staff and get to do stuff you never did before ... and you start to realize there are things you love to do.”¹¹¹

106 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 June 2016, 1635 (Regional Chief Isadore Day).

107 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1240 (Ms. Maatalii Okalik).

108 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1255 (Ms. Louisa Yeates).

109 Committee analyst notes from the community site visit to Kuujuaq, Quebec.

110 Committee analyst notes from the community site visit to Sioux Lookout, Ontario.

111 Ibid.

During a roundtable held with teachers and social workers at the primary school, Jaanimmarik School in Kuujuaq, the Committee heard that a critical shortage of Inuit teachers results in the erosion of Inuktitut, and limited, if any Inuit-specific content being taught in the schools. The participants noted there were few Inuit teachers, who could also provide education in Inuktitut, and little parental involvement in the schools as they are distrustful of the school system having attended Indian residential schools, which negatively effects the quality of education children received.

Educators outlined there were systemic challenges to recruiting Inuit teachers to the Kativik School Board, as it is unable to offer Inuit teachers comparable benefits as those enjoyed by non-Inuit teachers, such as access to housing. Educators underscored that differential employment policies create divisions between Inuit and non-Inuit people, making it difficult for Inuit to consider teaching as a viable career option.¹¹²

The poor quality of education in the North was illustrated by the limited availability of core courses or pre-requisites for specific studies in post-secondary institutions. The narrow course selection impedes and discourages Inuit youth from pursuing college or university. While noting the system was improving, Natan Obed who stated, “There are many communities that do not allow for any of their students to go directly into the programs of their choice within post-secondary education because of the lack of infrastructure and the inability for different schools to teach some of the core curricula that are prerequisites for some university courses.”¹¹³ Youth in Kuujuaq noted that once they finished secondary school in Kuujuaq, they were often placed in remedial programs at southern schools, delaying the start of college and their careers.

Inuit youth observed that Canada is the “only circumpolar country without a university”¹¹⁴ and suggested that they would benefit from post-secondary institutions in Nunavut and Nunavik. As distance education opportunities via online learning are largely unavailable in most communities across Nunavut, Nunavik and northern First Nations communities due to insufficient internet bandwidth, the development of institutions in their territories was proposed as an alternative that would benefit youth for generations to come.¹¹⁵

Despite these significant challenges, a couple of promising practices were raised by witnesses. In Kuujuaq, a new program was developed where Inuit supportive staff mentor non-Inuit social workers to deliver prenatal education and child development programs to Inuit families. The initiative has resulted in increased Inuit uptake of early childhood development programming and more Inuit ownership of such programs.

The federal government administers the Aboriginal Head Start On Reserve and the Aboriginal Head Start in Urban and Northern Communities programs. These programs

112 Ibid.

113 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 June 2016, 1625 (Mr. Natan Obed).

114 Committee analyst notes from community site visit to Iqaluit, Nunavut.

115 Ibid.

fund Indigenous organizations that deliver early childhood learning and development programs to First Nations, Inuit and Métis children on and off reserve in rural, remote and urban communities.

Specifically, these services are offered to Indigenous children between the ages of three and five and focus on: Indigenous culture and language, education and school readiness, health promotion, nutrition, social and parental supports. Jack Hicks noted that given the relative success of such programs, that they should be offered in every community in Nunavut.¹¹⁶

The Committee heard the Northern Nishnawbe Education Council established traditional week in response to a series of recommendations made by the Coroner's Inquest into the deaths of First Nations students while boarding in Thunder Bay to attend Dennis Franklin Cromarty High School.

The initiative introduced break weeks during peak times when students experience stress, depression and anxiety due to being far away from home, providing students with an opportunity to spend time with their families. Many youth reported they went hunting, fishing, helped their parents and visited with extended family.

C. Employment and Economic Development

The Committee heard that high unemployment rates in some First Nation and Inuit communities are a contributing factor to suicide rates. Witnesses reported that the lack of jobs leads to challenges in improving one's socio-economic circumstances and providing for one's family. Jack Hicks noted there is a connection between "job losses, unemployment, social despair, and suicide."¹¹⁷ Sheila North Wilson, in describing the recent loss of her cousin to suicide, noted he had trouble finding work when he returned to his home community, "How is a young man, a young father, and a young husband supposed to feel when they don't have any jobs to provide for their family?"¹¹⁸ She noted that job creation and better quality housing will, over the long term, lead to improved health outcomes and health services within First Nations communities.

For those living in remote communities, the Committee heard there is clear connection between unemployment and hopelessness.¹¹⁹ For example, when the Weeneebakyo Area Health Authority asked a young First Nation woman why there are many suicides in her reserve she replied, "It is simple, no jobs, no future and no hope."¹²⁰ Will Landon explained how "a lot of suicides can be linked to low economic opportunity.

116 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 June 2016, 1550 (Dr. Jack Hicks).

117 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 June 2016, 1550 (Dr. Jack Hicks).

118 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 February 2017, 0850 (Grand Chief Sheila North Wilson)

119 [Brief](#) submitted by Weeneebayko Area Health Authority, 26 October 2016.

120 Ibid.

They don't feel there's a lot for them out there. Sitting on welfare is not a great option for them and it gets depressing.”¹²¹

In addition to providing a source of income to provide for their families, work can also be an important aspect of developing self-worth and confidence. For instance, Joachim Bonnetrouge from the Deh Gah Got'ie First Nation noted that about half of his community is currently unemployed and that more opportunities would substantially benefit the community, “If you have a family and a father, and they could give him a job, holy man, you'd see that would make a big difference in anybody's life.”¹²² Isadore Day highlighted the importance of approaches that focus on, “Community development programming, which reduces the risk of suicide, includes skills development and coping skills, job readiness, and recreational activities that decrease isolation and increase peer support for our youth.”¹²³

Job scarcity is exacerbated by the high cost of living in isolated northern regions. Many communities without road access rely on the shipment of goods and supplies by air which makes prices much higher than in the rest of Canada. Youth in Nunavik reported that when they get a job, their pay does not take into account the high cost of living in Nunavik for necessities such as social housing, food, energy and hunting supplies.

Urban areas such as Vancouver also present difficulties for Indigenous youth. Often, youth move to the city for better education and employment opportunities. One young man shared he was homeless for three years, stealing money for food for himself and his younger brother. Due to the high cost of living in Vancouver, he still worries about providing the best support to his brother, “he has a learning disability and I need to make twice as much to help him. We can't keep living on welfare.”¹²⁴

D. Infrastructure

Some witnesses suggested northern and isolated communities such as those in Nunavut, northern Ontario and Nunavik face significant gaps in infrastructure. As Will Landon noted, “In terms of creating jobs, we are also going to have to invest in infrastructure, because it's tough to even start thinking about developing jobs in a lot of the places in the north like Attawapiskat that are isolated and alone.”¹²⁵ A few First Nations youth in northern Ontario reported that poor infrastructure on reserve contributed to their stress and anxiety, with one First Nation youth spending 16 years (her entire life) without clean drinking water. Another young person noted his community has regular power

121 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1635 (Mr. Will Landon).

122 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, (Chief Joachim Bonnetrouge, De Gah Got'ie First Nation).

123 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 June 2016, 1640 (Regional Chief Isadore Day).

124 Committee analyst notes from the November 2016 community site visits to Vancouver, British Columbia.

125 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1635 (Mr. Will Landon).

outages and relies on generators, making the use of essential equipment such as dialysis machines, difficult.¹²⁶

Proper infrastructure was also reported to be an essential part of coordinating between families and service providers during cases of emergency such as suicide. Jennifer Ward from the Canadian Association for Suicide Prevention, who was a counselor in Attawapiskat in 2016 during the suicide crisis explained, “They don't have street names, addresses, or numbers on any of the homes. So they get a report that there's a suicide in progress or somebody is at risk of suicide, and they're trying to respond, and they cannot locate the house.”¹²⁷

E. Childhood Adversity

The Committee heard from some witnesses that childhood adversity, such as sexual abuse or violence, interaction with criminal justice and/or the child welfare systems and food insecurity, contribute to mental distress and suicide. As illustrated by Del Graff, the Child and Youth Advocate for Alberta, individuals who have experienced trauma and/or abuse may be engaging in behaviours such as suicide to cope with those experiences.¹²⁸ Louisa Yeates noted that, “when abuse is in a home and there's nowhere to go, youth often turn to anything, mostly negative outlets, to help them cope.”¹²⁹

With respect to sexual abuse, the Committee heard from Yvonne Rigsby Jones that “many times, one of the root causes of suicide is sexual abuse.”¹³⁰ Further, during youth roundtables, some participants described substance use, self-harming behaviors and suicide attempts as means of coping with sexual abuse, assault or violence. One young woman explained,

I was in an abusive relationship with my boyfriend. The bullying I experienced when I went home to my reserve was bad. I ODeD [overdosed] on sleeping pills because I was upset. I wasn't able to go to sleep. I also cut myself. I broke up with my boyfriend and... I wanted to be the only native girl to not be beat up that I've known in my life.¹³¹

Another First Nation youth shared that she was “raped when I was seven and I thought it was normal to not feel a thing.”¹³² She described how she used to drink to cope

126 Committee analyst notes from the November 2016 community site visit to Sioux Lookout, Ontario.

127 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1600 (Ms. Jennifer Ward, Director and Survivors Chair, Canadian Association for Suicide Prevention).

128 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 0845 (Mr. Del Graff, Child and Youth Advocate, office of the Child and Youth Advocate, Alberta).

129 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1255 (Ms. Louisa Yeates).

130 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 1500 (Ms. Yvonne Rigsby-Jones, As an Individual).

131 Committee analyst notes from a community site visit.

132 Ibid.

and reported she had been sober for six months, “I play basketball and go to cadets. I keep busy on the weekends.”¹³³ These young women received supportive services from a local Indigenous youth organization that provides Indigenous youth with counseling, peer support groups, education supports and access to health care and recreation opportunities. Yvonne Rigsby Jones emphasized that supports for victims of sexual abuse as well as offenders are critical in order to break the cycle of abuse. As she stated, “our nation doesn't have a safe way or a forum for people to receive help.... We're going to continue to have victims of sexual abuse if we can't figure out how to help the offenders.”¹³⁴

The Committee heard from a few witnesses that there was a connection between inadequate resources for mental health services and assessments and interaction with the criminal justice system. For example, Cassidy Caron from the Métis Nation British Columbia provided an example where a Métis youth who identified as being suicidal was unable to access mental health and addictions services until he was in a court ordered program as part of the youth justice system. As she stated, “Tragically, even this support did not come soon enough for Nick, who after less than one week in the program was found hanging in a bedroom closet of the care home where he was staying while attending this program.”¹³⁵

Witnesses noted that interaction with the child welfare system is linked to childhood adversity. The Committee heard from some of the provincial child and youth advocates that Indigenous children are over-represented in child welfare systems; in Alberta First Nations children are 30 times more likely to be in care than their non-Indigenous peers.¹³⁶ In Alberta, seven children died while in government custody between 2013 and 2014. Systemic causes of early childhood adversity included, “family disruption and the legacy of residential schools; early childhood trauma from exposure to family violence, neglect, or abuse; and parents or caregivers who had addictions or mental health problems. Others experienced the death of a family member by suicide.”¹³⁷

The Committee heard that addressing the challenges of the child welfare system would require additional resources and community involvement. Bernard Richard identified that the focus of Child and Family Services is to “remove children rather than work with and support families.”¹³⁸ Engaging Elders in the work of child and family services agencies

133 Ibid.

134 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 1500 (Ms. Yvonne Rigsby-Jones).

135 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 0845 (Ms. Cassidy Caron, Métis Youth British Columbia, Provincial Youth Chair, Métis Nation British Columbia).

136 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 0845 (Mr. Del Graff).

137 Ibid.

138 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 February 2017, 0950 (Mr. Bernard Richard).

was identified as an important preventative approach,¹³⁹ as was addressing the systemic underfunding of mental health services for First Nations children as child and family services. As stated by Cindy Blackstock from the First Nations Child and Family Caring Society of Canada, “fund at actual costs immediately across all government services to ensure that First Nations children are not denied services available to every other child, and that can be done very quickly.”¹⁴⁰

The Committee heard from Derek Nepinak from the Assembly of Manitoba Chiefs who described a First Nations-led initiative undertaken by the Assembly of Manitoba Chiefs called, “Bringing our Children Home.” The initiative assists families to navigate the First Nations Child and Family Services system in Manitoba. He suggested that the program provides a solution “To restore hope toward a solution and family reunification for many, I believe, is key to keeping them alive. I’ve witnessed myself, in my time in leadership, people who have given up once children are taken away.”¹⁴¹

Food insecurity was reported by many witnesses in urban, rural and remote areas; and was reportedly acute in northern and remote Inuit and First Nations communities. As James Morris from the Sioux Lookout First Nations Health Authority explained, there is widespread poverty amongst First Nations families in remote communities and “families often go hungry and are too proud to ask for help.”¹⁴²

The high cost of living is also prohibitive to buying household items and food for families. With remote First Nation and Inuit communities reliant on the shipment of goods and services by air, costs of food are exorbitant. As one youth representative in Kuujjuaq described, “Everything is expensive, both of us are working full time but still we cannot afford anything. It is worse in isolated communities.”¹⁴³ While some of the youth in Kuujjuaq noted they enjoyed mussel picking, hunting and fishing for food, the necessary supplies to “get out on the land” like gas, boats and all-terrain vehicles are too expensive for many to afford.¹⁴⁴

MENTAL HEALTH AND SUBSTANCE USE

The Committee heard that generally speaking, First Nations adults living on reserve experience higher levels (40%) of psychological distress than the general Canadian population (33%). In particular, First Nations adults living on reserve who attended

139 Ibid.

140 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 0850 (Dr. Cindy Blackstock, Executive Director, First Nations Child and Family Caring Society of Canada).

141 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 February 2017, 0930 (Grand Chief Derek Nepinak).

142 Committee analyst notes from the September community site visits to Sioux Lookout, Ontario.

143 Committee analyst notes from the September community site visits to Kuujjuaq, Quebec, Iqaluit, Nunavut.

144 Committee analyst notes from the September community site visits to Kuujjuaq, Quebec, Iqaluit, Nunavut.

residential school were more likely to report moderate or high levels of psychological distress (55%).¹⁴⁵

Inuit also report higher prevalence of depression and suicidal ideation than the general population with 43% of respondents in Nunavut's *Inuit Health Survey* reported feeling depressed some or a little of the time with 9% experiencing depression most of the time. Among respondents, 48% had contemplated suicide and 29% made prior attempts.¹⁴⁶

Due to the scale of the tragedy of suicide across the north, Inuit experience constant exposure to suicide, which can contribute to suicide.¹⁴⁷ Natan Obed described suicide as "normalized" across the four Inuit regions.¹⁴⁸ Some First Nations witnesses reported high exposure to suicide which can lead to depression, hopelessness and potentially, suicide attempts. Rod McCormick noted that suicide has become a part of daily life in some First Nations communities and he explained that "[t]he predominant community gathering for most communities has become the funeral."¹⁴⁹

Substance use and mental illness were identified by witnesses as factors which contribute to mental health issues and suicide, affecting youth and their parents. Some discussed substance use as a means to cope with unresolved trauma due to residential school, experiences of abuse or violence, or to forget about difficult living conditions such poor housing or hunger.

As described in the preceding section, some youth noted they used substances to cope with some of the traumatic experiences they had endured while others described it as an outlet to compensate for having few recreational activities available through their schools or communities. The Committee heard from one First Nation youth who explained, "I wasn't involved in basketball or hobbies, alcohol was a part of my whole life" and "there was nothing else to do, I was getting high and drinking."¹⁵⁰

James Morris of the Sioux Lookout First Nations Health Authority noted that some youth began to use solvents because they were hungry and substance use helps

145 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 24 October 2016, 1530 (Dr. Amy Bombay).

146 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1640 (Dr. Gwen Healey, Executive and Scientific Director, Qaujigiartiit Health Research Centre).

147 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1455 (Ms. Sheila Levy, Executive Director, Nunavut Kamatsiaqtut Help Line); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1240 (Ms. Nina Ford, Youth Representative, Nunatsiavut Government).

148 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 June 2016, 1600 (Mr. Natan Obed).

149 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1550 (Dr. Rod McCormick, Professor and Research Chair, Thompson Rivers University, As an individual).

150 Committee analyst notes from community site visit.

one go without food. A First Nation youth living in Vancouver reported seeing more people affected by fentanyl in the past year, “I’ve seen my friends go downtown, try fentanyl and die.”¹⁵¹

Youth in Iqaluit also described substance abuse as a factor which affects the health of Inuit. Many of the youth the Committee met with shared that they had lost someone they knew to suicide and other Indigenous youth reported losing many people to suicide. One youth said that of the people he knew who died of suicide, the majority were intoxicated at the time.¹⁵² He discussed that substance use was linked to the high suicide rates among Inuit due to the legacy of residential schools and re-settlement endured by his parents and grandparents and its effects on kids today, “Take a tree. Rip it out by its roots and transplant it. Build four walls around it, and pour alcohol over it every day. That's what happened to us, and we won't survive. We'll wilt and die.”¹⁵³ Greta Visitor, who lost family members to suicide noted, “I talked about my brother-in-law, my sister, and my niece. They were all struggling with addictions, and so was I when I contemplated suicide.”¹⁵⁴

Two health authorities in northern Ontario described the increasing rates of opioid dependence among remote First Nations communities as contributing to drug-related deaths and suicide attempts in the past few years.¹⁵⁵ They estimated that, in some communities, between 50% and 70% of First Nations adults is addicted and described opioid use as affecting the health of individuals and their families in their community. They also pointed out given the high cost of a single dose and the use of up to eight doses daily coupled with relative poverty mean that substance use on this scale can have grave consequences for children, leaving them vulnerable to hunger, not attending school and/or being taken away from their families and into protective services.¹⁵⁶

SUICIDE PREVENTION: CULTURAL CONTINUITY

Protective factors are attributes in individuals, families, communities or the larger society that, when present, prevent or reduce the likelihood of someone dying by suicide. Many of the protective factors identified by witnesses serve to build self-esteem, confidence, positive identities and skills to deal with stress or adversity and to overcome challenges in life. The following section describes the protective factors specific to Indigenous peoples as identified by witnesses, which include: cultural continuity and self-determination, community-led health services, identity and cultural education, culturally appropriate mental health care and community spaces for healing, culture and recreation.

151 Ibid.

152 Committee analyst notes from September 2016 community site visit to Iqaluit, Nunavut.

153 Committee analyst notes from September 2016 community site visit to Iqaluit, Nunavut.

154 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 26 October 2016, 1550 (Ms. Greta Visitor).

155 [Brief](#) submitted by Weeneebayko Area Health Authority, 26 October 2016 and Committee Analyst notes from the November 2016 community site visit to Sioux Lookout, Ontario.

156 Ibid.

A. Cultural Continuity

In their appearance before the Committee, Michael Chandler from the University of British Columbia and Christopher Lalonde from the University of Victoria explained that their research found that First Nations communities in British Columbia with greater control over their affairs experienced substantially lower rates of suicide. Specifically, he noted that in British Columbia, “communities that have achieved some measure of self-determination and self-governance have lower or absent rates of suicide relative to counterpart communities that do not have such self-governance instruments.”¹⁵⁷ They identified six protective factors, which when taken together are known as “cultural continuity,” whose presence contributed to healthy First Nations communities. The protective factors identified by Michael Chandler and Christopher Lalonde include: community control over land claims; self-government; education services, police and fire services, health services delivered by communities; and cultural facilities.¹⁵⁸ Cultural continuity operates as a path to community well-being, and prevents suicide as communities have control over their present and the future. This finding was cited and confirmed by many witnesses appearing before the Committee.¹⁵⁹

Another important aspect of their work is the additional measures of cultural continuity present in communities with lower or absent rates of suicide that involve governance and culture. Some of these factors including the importance of Indigenous languages, the role of women in leadership and self-determination, which are discussed in greater detail below.

B. Language

Indigenous languages were considered to be another key marker of cultural continuity, as noted by Maatali Okalik, “Our language and our culture are key.”¹⁶⁰ As a measure of the strength and resiliency of culture and community well-being, the use and retention of Indigenous languages is an important marker of cultural continuity. Inuit and First Nation witnesses regarded that Indigenous language education, retention and use as important part of their cultures and identities.

The Committee heard that the loss of languages affects First Nations and Inuit communities. James Arreak noted that the loss of language in Nunavut is “the most

157 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 26 September 2016, 1545 (Professor Michael Chandler, Professor Emeritus, University of British Columbia, Department of Psychology, As an individual).

158 Ibid.

159 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 June 2016, 1635 (Regional Chief Isadore Day); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1705 (Dr. Margo Greenwood, Academic Leader, National Collaborating Centre for Aboriginal Health); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1635 (Dr. Michael DeGagné).

160 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1245 (Ms. Maatalii Okalik).

serious threats facing Inuit today. The biggest factor in the erosion of Inuit language and culture is the predominantly non-Inuit school system.”¹⁶¹

In Nunavik, Inuktitut as the language of instruction is offered from daycare to kindergarten and grade three, the only choice of language instruction afterwards is English or French. The consequences of this policy are profound, leading to the limited use of Inuktitut by children, causing difficulties in communicating with one’s parents.

C. Women

The election of women to band councils and assuming leadership roles in First Nations communities was identified as an important aspect of cultural continuity. Christopher Lalonde explained that when women were involved in governance matters, such as forming a majority of the band council, “suicide rates were lower than in those communities than where women were absent or a minority.”¹⁶² When researchers spoke to these women about their respective roles in the community, women commonly noted they were involved in raising children and working with the next generation, preparing them for the future by instilling a solid cultural foundation, “to equip them to be able to walk in two worlds, in the Indigenous world and the non-Indigenous world.”¹⁶³

D. Cultural renewal and identity development

Culture strengthens the community from within. They develop their own solutions and create astounding outcomes.

Carol Hopkins¹⁶⁴

The Committee heard that the development of healthy identities is an important part of child development. Reconnecting youth with the history, values, and cultures of their Indigenous background is an important aspect of suicide prevention and mental health promotion. Lynne Groulx of the Native Women’s Association of Canada observed that research shows that “high self-worth, strong family ties, strong social networks, and education can help prevent suicide.”¹⁶⁵ The disruptive effects of colonization have made positive identity development difficult.

In the context of suicide, Indigenous youth told the Committee that some youth are ashamed of their heritage and may be confused about their identities as Indigenous peoples. Youth described the importance of spending time with one another doing positive

161 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1005 (Mr. James Arreak).

162 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 26 September 2016, 1545 (Professor Michael Chandler).

163 Ibid.

164 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 February 2017, 1015 (Ms. Carol Hopkins).

165 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 November 2016, 1720 (Ms. Lynne Groulx, Executive Director, Native Women's Association of Canada).

activities to the development of their identities. Accordingly, Inuit youth called for a network of youth organizations to be established across the country including multi-year federal funding.¹⁶⁶

Developing peer-to-peer support provides youth with a social network that can strengthen resilience and coping skills by decreasing individual isolation and can help children and youth learn about their backgrounds and cultural identities. Accordingly, First Nations youth across Canada called for support to attend regional gatherings related to suicide prevention along with training opportunities on how to be supportive peer mentors.¹⁶⁷ Friendship Centres offer important services for Indigenous peoples, particularly for those who have relocated to a city and may have not yet developed the social supports in their new city of residence. As stated by Eric Klapatiuk:

One of the things the [F]riendship [C]entres across B.C. and across Canada really advocate for is the urban Aboriginal population in the nation. When we say urban Aboriginal people, we talk about virtually anyone who is seeking help, but mainly our First Nations, Inuit, and Métis brothers and sisters who are moving away from their own home communities and relocating into urban centres, whether that be for employment or education. When we talk about urban people, these are the people we're talking about, people who are moving from their home communities to these big urban centres where supports are not as easily available. Their social circles are not the same; they diminish.¹⁶⁸

There was a broad consensus among witnesses that cultural education has positive effects on Indigenous peoples' identity and, correspondingly, rates of suicide. Witnesses explained that cultural programs are an essential element of promoting health and well-being, and are increasingly in demand where offered. For example, Rod McCormick from Thompson Rivers University told the Committee that "one of the paths to healing is reconnecting to those sources of meaning we've been disconnected from; reconnecting with family, community, culture, nature, the land, and spirituality."¹⁶⁹ Accordingly, Ed Connors from the Canadian Association for Suicide Prevention noted the revival of Indigenous cultures in the form of languages, tradition, spirituality, ceremony and healing practices protect from the negative effects of colonialism on Indigenous cultures.¹⁷⁰

166 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1245 (Ms. Maatalii Okalik).

167 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1635 (Mr. Will Landon, National Youth Council Representative, Ontario, Assembly of First Nations).

168 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 1035 (Mr. Eric Klapatiuk, President Provincial, Aboriginal Youth Council, British Columbia Association of Aboriginal Friendship Centres).

169 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1550 (Dr. Rod McCormick).

170 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1550 (Dr. Ed Connors).

The Committee heard that learning about culture, traditions, ceremonies and language,¹⁷¹ particularly among youth, is a crucial element of suicide prevention. Correspondingly, learning about one's cultural identity supports positive identity development for youth, increasing self-esteem and reducing hopelessness, despondency and despair. As Cornelia Wieman observed, sharing stories of accomplishment enables youth to "see possibilities for themselves in the future, and ultimately it would result in them flourishing."¹⁷²

To this end, the Committee heard that there are a number of promising practices that have been adopted across the country that facilitate positive identity development. These practices include the development of youth peer support circles, land based programming, language programs and Elder supports.¹⁷³

However, Natan Obed cautioned the Committee that cultural programming should not overshadow the broader issues that affect the health of populations, such as historic and intergenerational trauma, social and economic conditions and investments in preventative public health initiatives:

Many times when ... Inuit are asked by well-meaning Canadians what needs to be done, the response [they] are looking for is one that has nothing to do with creating social equity, nothing to do with providing mental health services, and nothing that goes beyond historical or intergenerational trauma. What they're looking for, in many cases, is a particular component of suicide prevention that is Indigenous only, that usually has something to do with on-land camps or cultural continuity, that is relatively cheap, and that has nothing to do with the relationship between government services and overarching populations and their overarching health.¹⁷⁴

E. Facilities for Healing, Sports, Recreation, Education

Northern Ontario First Nations youth explained that there are few community spaces or youth centres in many of their communities. Where such a facility exists, it was empty with no equipment, staff, games or supplies with which to engage in healing, develop hobbies, spend time with peers or family or learn about their culture.¹⁷⁵ First Nations youth in the Fort Francis Tribal Area asked for safe places to go before an

171 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1755 (Ms. Amy Nahwegahbow, Senior Manager, Partner for Engagement and Knowledge Exchange, Native Women's Association of Canada); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1005 (Mr. James Arreak).

172 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 14 June 2016, 1630 (Dr. Cornelia Wieman).

173 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1635 (Mr. Will Landon); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 26 September 2016, 1650 (Mr. Jakob Gearheard, Executive Director, Ilisagvik Society).

174 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 June 2016, 1600 (Mr. Natan Obed).

175 Committee Analyst notes from the November 2016 community site visit to Sioux Lookout, Ontario.

emergency occurs, where people are welcoming of youth with food, crafts, healthy activities and events that bring youth together.¹⁷⁶

Educators and service providers the Committee met with in Nunavik noted there is an urgent need for a crisis centre where children can go to after hours or on weekends due to the lack of housing and overcrowding in the territory. An example of how a community centre can support positive individual and family health outcomes, Lawrence Kirmayer from McGill University and the Jewish General Hospital told the Committee that:

It was possible not only to give them some support there but to bring in the family and talk to the family and try to defuse the crisis in some way. Therefore, there is potential to do much more good and, moreover, to have a positive intervention that would have a spill over or ripple-outward effect in the community, as opposed to simply taking the child out of the community.¹⁷⁷

During all of the youth roundtables held with Committee members, youth acknowledged the positive role that space to pursue healing and recreation activities plays in developing self-esteem, goals, confidence and pride in being an Indigenous person. Appropriate infrastructure and related programming is important in small communities, especially for some youth, where life at home may be difficult or unsafe.

One young woman provided an example of the importance of having hobbies, setting goals, peer supports and “forward thinking”. She focused most of her early life on her interest in art, which helped her to set goals for the future in the face of much hardship at home, “I can’t imagine what it was like without those goals.”¹⁷⁸ The programming offered by the Urban Native Youth Association in Vancouver supported her and she is now pursuing studies in fine arts at a university.¹⁷⁹ She observed that the lack of positive recreation activities can negatively affect youth who live on reserve.

The Committee heard that the Urban Native Youth Association in downtown Vancouver, and the programs offered through its youth centre, led to many positive outcomes. For instance, youth had a place to gather with their peers, obtain referrals to health services, obtain counselling, learn music, finish school and receive training on developing their resumes or applying for jobs; they recommended that all Indigenous youth have access to such space.

For youth living in urban, rural or northern areas, Friendship Centres are often an essential space to gather. Christopher Sheppard told the Committee that “Recreation, the

176 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 November 2016, 1755 (Ms. Amy Nahwegahbow).

177 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 24 October 2016, 1710 (Dr. Laurence Kirmayer, Professor and Director, Division of Social and Transcultural Psychiatry, McGill University and Director, Culture and Mental Health Research Unit, Institute of Community and Family Psychiatry, Jewish General Hospital, As an individual).

178 Committee Analyst notes from the November 2016 community site visit to Vancouver, British Columbia.

179 Ibid.

safe space, and the ability for these young people to have somewhere to go are life changing. Most friendship centres have youth programs, after-school programs, that they can go to.”¹⁸⁰ To ensure that urban Indigenous youth are receiving appropriate services, Christopher Sheppard recommended re-establishing Urban Multipurpose Aboriginal Youth Centres, previously funded through Heritage Canada. These centres offered services to Indigenous youth living in towns larger than 1,000, providing community-based, culturally relevant programs, along with mental health and skills and employment training.¹⁸¹

MENTAL HEALTH SERVICES IN INDIGENOUS COMMUNITIES

A. Coordination

The Committee heard evidence that the multiple authorities involved in the delivery of health services make coordination difficult between territorial, provincial and federal governments. As specialized mental health services are limited in communities, health authorities must coordinate and sometimes negotiate with provincial hospitals or mental health facilities for access. For example, Leo Ashamock from the Weeneebayko Area Health Authority described the consequences of a lack of coordination between federal and provincial health systems on a patient’s care:

my granddaughter, who needed mental health treatment. There was quite a confusion about where to send her. The main referral point is Timmins and District Hospital, where they have a mental health unit, and that’s where her doctor is.... She was told there were no beds in the health unit in Timmins. Then we went to North Bay and to Sudbury. All these places were closed. They said we had to take her to Moose Factory.... Where did she end up? It was in a jail cell.... That’s not a good place. The very least that could be done for those types of situations is to allow for a safe room right on site in Fort Albany.... For those kinds of things there has to be better coordination for these youth who are being sent out with mental health issues.¹⁸²

Due to the lack of locally-based mental health supports in First Nations communities, some Health Authorities serving remote First Nations have observed that hospitals’ emergency department admission rates for mental health services have increased significantly over the past five years. However, there were reports that some First Nations people are turned away from a hospital without accessing any supports or services.¹⁸³ Alika Lafontaine observed that no one should be denied care due to jurisdictional disputes over payment for services as the provinces receive per capita funding for Indigenous patients from the federal government.¹⁸⁴

180 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 June 2016, 1550 (Mr. Christopher Sheppard).

181 Ibid.

182 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 26 October 2016, 1610 (Mr. Leo Ashamock).

183 Committee Analyst notes from the November 2016 community site visit to Vancouver, British Columbia and Sioux Lookout, Ontario.

184 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 1020 (Dr. Alika Lafontaine).

As Indigenous peoples may transition between different locations frequently, improved systems coordination will help to provide follow up care after suicide attempts, continue treatment plans or ensure patients see health professionals in their home communities after discharge from treatment.¹⁸⁵

The Sioux Lookout First Nations Health Authority noted they would like to implement patient-centred care in the region, based on the Nuka System of Care. This was described as a “whole health care system” approach implemented in Alaska by Indigenous peoples that is driven by patient needs. Differing jurisdictions, funders and service providers work together to deliver flexible services to patients whereby a patient has one entry point to access clinical care, traditional practices, mental health and other services.¹⁸⁶

Jordan’s Principle¹⁸⁷ was adopted by the House of Commons in 2007 and the Government of Canada adopted the expanded definition in 2016 to ensure First Nations children have comparable access to health and social services as other children. The Principle helps to ensure all First Nations children receive access to health and social services regardless of what level of government is responsible for the payment of such services.¹⁸⁸ This Principle directs the government of first contact to fund the service and aims to address coordination problems between different jurisdictions involved in service provision.¹⁸⁹ The Committee heard from Cindy Blackstock who explained that the full implementation of Jordan’s Principle provides an example of a “simple solution”¹⁹⁰ to address the coordination between different levels of governments with regards to access to services for Indigenous children.

The *First Nations Mental Wellness Continuum* and the *National Inuit Suicide Prevention Strategy* both propose solutions to the coordination of health services. Both the *Framework* and the *Strategy* stress the importance of shifting systems from a provider-centred model to a patient, family or community-centred model which enables smooth coordination between jurisdictions, particularly in urgent cases where patients living in remote locations require access to specialty care or mental health facilities.

185 Committee Analyst notes from the November 2016 community site visit to Vancouver, British Columbia.

186 Committee Analyst notes from the November 2016 community site visit to Sioux Lookout, Ontario.

187 Indigenous and Northern Affairs Canada, [About Jordan's Principle](#), 2017. Jordan River Anderson was a First Nation child who passed away in the hospital before the province and federal government could decide on who should fund his care in a medical foster home. Source: Indigenous and Northern Affairs Canada, [“Jordan's Principle.”](#)

188 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 0855 (Dr. Cindy Blackstock).

189 Committee Analyst notes from the November 2016 community site visit to Sioux Lookout, Ontario.

190 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 0910 (Dr. Cindy Blackstock).

B. Existing Indigenous-Specific Suicide Prevention Strategies

*The way forward ... requires the full implementation of the First Nations Mental Wellness Continuum Framework. The Framework outlines opportunities to build on community strengths and control of resources in order to improve existing mental wellness programming for First Nation communities.*¹⁹¹

Will Landon

*A national Inuit suicide prevention strategy, I believe, is a good step forward, not only in increasing awareness, but also in giving people more hope. I look forward to seeing this strategy implemented for the benefit of Nunatsiavut and Inuit Nunangat.*¹⁹²

Johannes Lampe

The Committee heard from a range of witnesses that First Nations and Inuit leaders have designed the appropriate strategies to engage all levels of government and stakeholders to prevent suicide. The strategies go beyond a narrow focus on health interventions, to address the systemic and social issues related to mental health, such as poverty, historic trauma, mental distress and grief and loss. Many witnesses recommended that these be immediately funded for implementation. The *First Nations Mental Wellness Continuum Framework* and the *National Inuit Suicide Prevention Strategy* set out a series of interventions, including health system reforms, to address the demand for mental health services among their respective communities.

In response to the need to integrate culture as a primary aspect of wellness, Health Canada, the Assembly of First Nations and mental health experts developed the *First Nations Mental Wellness Continuum Framework* (“the Framework”).¹⁹³ The Framework recognizes that not all mental health services will be available in every First Nations community. It proposes coordination and planning across all jurisdictions, to identify the key services required, services to be offered in a community nearby or in the provincial health systems. Marion Crowe from the First Nations Health Managers Association noted, “Health services integration among federal, provincial, and territorial programs is critical to its success.”¹⁹⁴

The Committee heard from Inuit witnesses about the importance of implementing Inuit Tapiriit Kanatami’s *National Strategy for Inuit Suicide Prevention* (“the Strategy”) across all four Inuit regions. The Strategy takes a comprehensive approach and calls for long-term partnerships, sustainable funding and coordination across health, justice and

191 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1635 (Mr. Will Landon).

192 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1635 (Mr. Johannes Lampe, President, Nunatsiavut Government).

193 Assembly of First Nations and Health Canada, *First Nations Mental Wellness Continuum Framework*, 2015.

194 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1635 (Ms. Marion Crowe, Executive Director, First Nations Health Managers Association).

social sectors and all levels of government to effectively prevent suicide from taking place. As described by Natan Obed, “We need to do more to ensure that we have proper education systems, proper mental health systems, and justice systems that reflect our needs; that we address violence and sexual abuse in our communities; and that we end poverty.”¹⁹⁵

C. Mental Health Services for First Nations and Inuit People

*We need to understand that suicide is a circle. There are prevention, postvention, and intervention, and they all work together.*¹⁹⁶

Jennifer Ward

The Committee heard that suicide prevention requires a number of interrelated measures such as Indigenous cultural renewal, quality education, improved housing and infrastructure, Indigenous language revitalization, economic development and increased employment, healing from Indian residential schools, and spaces for healing, culture and recreation.¹⁹⁷ Many witnesses identified a number of essential health services in the areas of suicide prevention, crisis support and aftercare, which are commonly referred to as a continuum of mental health services, to be discussed below.

Prevention

Health Canada, through the First Nations Inuit Health Branch offers the Non-Insured Health Benefits (NIHB) program to ensure that eligible First Nations and Inuit people have access to certain medical services that are not covered by provincial healthcare systems. As part of the NIHB, short term intervention for mental health counselling¹⁹⁸ may be provided by a registered mental health therapist in the event of a crisis or at-risk situation where no other service is available to the recipient.¹⁹⁹

195 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 June 2016, 1640 (Mr. Natan Obed).

196 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1610 (Ms. Jennifer Ward).

197 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 June 2016, 1600 (Dr. Jack Hicks); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 9 June 2016, 1630 (Regional Chief Isadore Day); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1240 (Ms. Maatalii Okalik); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016 (Ms. Lindsay Jones, Indigenous Nursing Student, Canadian Indigenous Nurses Association).

198 The NIHB will cover costs associated with the initial assessment and counselling sessions up to a maximum of 15 one hour sessions over a 20 week period.

199 Health Canada, [Mental Health Counselling Benefits](#).

Individuals that do not qualify for health services under the FNIHB, such as non-status Indians²⁰⁰ and Métis individuals, access health care through provincial and territorial health care systems.

The Committee heard that a stable primary health care system was a critical component of delivering preventative mental health services²⁰¹ to First Nation and Inuit people. However, John Haggarty from the Northern Ontario School of Medicine and St. Joseph's Health Care group described the primary health care system as offered on reserve to First Nations²⁰² as fragile and underperforming which poses a challenge to building supplementary services such as mental health.²⁰³

A few other witnesses, such as Alika Lafontaine and Isadore Day, acknowledged "our communities are in perpetual crisis, and that crisis is worsening."²⁰⁴ Isadore Day observed that the recent "crises in numerous First Nation communities across Canada have highlighted the need for ... specific mental wellness programming."²⁰⁵ James Irvine who works in northern Saskatchewan noted that suicides have been occurring on and off reserve and in Métis communities for decades and will "continue unless really long-term supports and strategies are enhanced and sustained."²⁰⁶

Alika Lafontaine emphasized that in order to effectively respond to the emergencies in communities, the health system on reserve has to fundamentally change the way health care is delivered.²⁰⁷ He suggested the primary health care systems in the Canadian provinces are good examples of functional delivery systems. This is due to the existence of processes and institutions to transfer funds, supports for the coordination of patients between different jurisdictions and measures and institutions responsible for the accountability of funds and quality of care. He noted the FNIHB health care delivery system that operates on reserve has few of these mechanisms, contributing to its poor performance.²⁰⁸

200 The term "non-status Indian" refers to a person that is not registered under the *Indian Act*. Indigenous and Northern Affairs Canada, [Terminology](#).

201 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 24 October 2016, 1545 (Dr. John Haggarty, Professor and Chief of Psychiatry, Northern Ontario School Medicine and St. Joseph's Care group).

202 Ibid.

203 Ibid.

204 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 1005 (Dr. Alika Lafontaine, Collaborative Team Lead, Indigenous Health Alliance, As an individual).

205 The Assembly of First Nations, *Investment Supplements: The Mental Health Crisis in First Nations; Much Needed Resources*, Document submitted to the Standing Committee on Indigenous and Northern Affairs, 9 June 2016.

206 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 1000 (Dr. James Irvine, Medical Health Officer, Mamawetan Churchill River Health Region).

207 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 1005 (Dr. Alika Lafontaine).

208 Ibid.

The Committee heard from Shannon McDonald from the First Nations Health Authority that effective suicide prevention includes access to locally based mental health supports before emergencies, like suicide, occur.²⁰⁹ Where mental health services are locally available, the Committee heard that they are reactive rather than preventative in nature.²¹⁰ Most mental health services are not easily reached by adults or youth on reserve or in remote Inuit communities. When supports are there they are often not available after hours or on weekends, may be culturally insensitive or difficult to access.²¹¹ In Iqaluit, Toby Otak noted, “I would like to see more mental health workers within the smaller communities. I would like to see more than one there to help because I've noticed that during the school year there are always emergencies....”²¹²

A few witnesses described that many First Nations and Inuit people have complex mental health, substance use and addictions needs. For instance, James Morris the Executive Director of the Sioux Lookout First Nations Health Authority, highlighted the exposure of many First Nations community members to “multiple sources of trauma which contributes to an on-going need for counselling services.”²¹³ He noted, however, that there are not enough mental health workers trained in trauma available to meet the demand.²¹⁴

A promising practice was identified in the development of a community-based suicide prevention plan. For example, the Ojibways of Onigaming listened to youth to develop their suicide prevention strategy. Youth identified seven important areas: Recreation, music and arts; Employment; Access to broader education; Access to healing and supports; Community infrastructure; and Connections to culture. The approach with youth involves a team which includes a school counsellor, customary care counsellor, crisis coordinator and shares case management systems with families and local leadership. Direct counselling, after school programs and cultural activities are offered.²¹⁵

Crisis Services

Crisis services were described as relatively rare or fragile in remote First Nations communities in northern Ontario, and in Inuit communities in Nunavik and Nunavut. Youth in Iqaluit reported that when someone is suicidal, the only place to go was the hospital's

209 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 1235 (Dr. Shannon McDonald).

210 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1620 (Mr. Calvin Morrisseau, Board of Directors and Ontario Representative, First Nations Health Managers Association).

211 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 February 2017, 0850 (Vice-Chief Heather Bear).

212 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1555 (Ms. Toby Otak, As an individual).

213 Committee Analyst notes from the November 2016 community site visit to Sioux Lookout, Ontario

214 Ibid.

215 Source: Vision 2020 Youth Engagement Report, Ojibways of Onigaming.

emergency department. While there, counselling is not necessarily available nor is follow up care arranged when the patient is discharged.²¹⁶

With no crisis centre available in Kuujuaq, Inuit youth reported that when they were in distress, they were kept “under suicide watch, strapped on a board”²¹⁷ in the local hospital for the night. The Committee heard that many First Nations youth in northern Ontario communities have very few crisis centres. As a result, the Committee heard of two instances where Indigenous youth who were in distress or were suicidal were held in a jail cell overnight for 24-hour supervision while awaiting transportation to psychiatric care in southern Canada.²¹⁸

Another promising practice, the Inuit Values and Practices team of the Nunavik Regional Board of Health and Social Services, composed of counsellors and social workers who established mobile trauma response teams in Nunavik.

When suicide emergencies occur in small communities, the Team provides services to communities for extended periods to facilitate healing sessions and provide aftercare as a part of an Inuit-specific continuum of care.

The ability to provide services in Inuktitut and understanding Inuit needs and history means these teams are in high demand but are limited by financial and human resources in widening their service area.²¹⁹

Mental Wellness Teams are NIHB’s supports for community-based, interdisciplinary health care teams that can serve First Nations communities in crisis and provide mental health and addictions services.²²⁰ In the spring of 2016, Health Canada announced additional funding to increase the number of Mental Wellness Teams to 43 over the next three years.²²¹ In his appearance before the Committee, Isadore Day advised that in order to serve all First Nations communities, 90 Mental Wellness Teams are required, serving approximately seven First Nations communities each.²²²

216 Committee Analyst notes from the September 2016 community site visit to Kuujuaq, Quebec and Iqaluit, Nunavut.

217 Ibid.

218 Committee Analyst notes from the September 2016 community site visit to Kuujuaq, Quebec; House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 26 October 2016, 1620 (Mr. Leo Ashamock).

219 Committee Analyst notes from the September 2016 community site visit to Kuujuaq, Quebec and Iqaluit, Nunavut.

220 The Assembly of First Nations, *Investment Supplements: The Mental Health Crisis in First Nations; Much Needed Resources*, Document submitted to the Standing Committee on Indigenous and Northern Affairs, 9 June 2016.

221 Government of Canada, “[Government of Canada to provide immediate support for Indigenous mental wellness](#),” 2016.

222 The Assembly of First Nations, *Investment Supplements: The Mental Health Crisis in First Nations; Much Needed Resources*, Document submitted to the Standing Committee on Indigenous and Northern Affairs, 9 June 2016.

In the absence of local mental health supports during suicide emergencies, non-Indigenous professionals from outside of the community are often appointed to provide services. The Committee heard that in the event of a suicide crisis, very little of the funding allocated to address suicide is invested in building the community's capacity to handle emergencies. Alika Lafontaine explained that most of the investment announced for one particular community is typically allocated to external agencies assigned as "suicide task forces" by the federal government.²²³ Accordingly, Rod McCormick commented that Health Canada may fly-in mental health workers to deal with suicide crisis on a short-term basis which does not ensure the mental health supports are culturally appropriate or locally based.²²⁴

Inuit also face challenges in accessing appropriate mental health counselling services, as noted by Jakob Gearheard from the Ilisaqsivik Society:

In most cases the mental health services available to Inuit are from fly-in, southern-based counsellors and social workers who have minimal to no knowledge and experience with Inuit culture, do not speak Inuktitut, and do not understand the historical and cultural context of where they are working.²²⁵

The committee heard about a promising practice in that provides supports during suicide crises. The Nunavut Kamatsiaqtut Help Line offers support services in Inuktitut. The Help Line is run by volunteers who sustain operations by fundraising and serve clients in an area which includes Nunavut, Nunavik and other parts of the western Arctic.²²⁶

Specialty Care

Health services that are not available in the community, such as specialized care like psychiatry, are accessed through provincial/territorial healthcare systems, requiring the patient to travel out of their community to access health care.²²⁷

Where mental health services are not available in the community, the FNIHB may cover the medical transportation costs associated with traveling to the nearest medical centre under the Medical Transportation Benefits Policy.²²⁸ Health Canada also approves whether an escort can accompany a minor under the same policy. Leo Ashamock noted escorts are not always approved to travel with a minor in distress.²²⁹ As he described,

223 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 1005 (Dr. Alika Lafontaine).

224 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1610 (Dr. Rod McCormick).

225 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1655 (Mr. Jakob Gearheard).

226 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1455 (Ms. Sheila Levy).

227 The National Collaborating Centre for Aboriginal Health, [The Aboriginal Health Legislation and Policy Framework in Canada](#), 2011.

228 Ibid and Health Canada, Non-Insured Health Benefits, [Medical Transportation Benefits Information](#).

229 [Brief](#) submitted by Weeneebayko Area Health Authority, 26 October 2016.

“There’s even an issue about the escorts who are provided for these kids. They don’t even invite the parents sometimes to go along with them. They need to be involved in that treatment plan; that’s very important.”²³⁰

Psychiatric care and/or residential treatment for substance use was reported to be difficult to access for those living in Nunavut and Nunavik. Youth reported having to leave Nunavik for mental health facilities in the south and having to be away from home, sometimes alone, for weeks at a time.²³¹ Inuit youth also told Committee members that although there is a growing need for substance abuse treatment, there are few beds available in Nunavik. The residential facility in Kuujuaq – which is intended to service a population of 14,000 – has “only nine beds and is able to treat approximately 45 people a year.”²³² One youth who lost two sisters to suicide due to alcohol use recommended another treatment centre be available in Inukjuak, on the western coast of Nunavik.

Health infrastructure is lacking in Nunavut as well. Kimberley Masson from the Embrace Life Council noted community members asked for “infrastructure—community centres, addictions treatment facilities, and shelters—and for multi-year or core funding to support this infrastructure.”²³³

Aftercare

*With regard to postvention for those who have gone through trauma, virtually nothing has been done for Inuit who have experienced trauma in relation to suicide or who have attempted suicide but then not received any sort of follow-up.*²³⁴

Natan Obed

There was broad agreement among the witnesses that aftercare services can protect against suicides. As explained by Jennifer Ward, a lack of access to services following treatment or an attempt increases the likelihood of another attempt. Specifically, “we often fail to recognize or address the suicide-related grief, which may have been the very experience that brought somebody to thoughts of suicide or suicidality in the first place.”²³⁵

It was reported many Indigenous communities do not have access to such services.²³⁶ Due to the “normalization” of suicide within some First Nations and Inuit

230 Ibid.

231 Committee Analyst notes from the September 2016 community site visit to Kuujuaq, Quebec.

232 Ibid.

233 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1435 (Ms. Kimberly Masson).

234 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 June 2016, 1640 (Mr. Natan Obed).

235 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016, 1540 (Ms. Jennifer Ward).

236 Ibid and House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 June 2016, 1640 (Mr. Natan Obed).

communities, the lack of aftercare programs is a critical service gap. The need for aftercare services is also essential in urban areas. Shawn Matthew Glode, who shared the devastating loss of his son due to suicide, noted his daughter required mental health supports and was unable to get an appointment.²³⁷

The Committee heard that communities are implementing flexible approaches to meet the needs of their clients. Kathy Kishiqueb from the Ojibways of Onigaming noted their approach is proactive and creative which includes providing services “after-hours situations, allowing open door policies (not restricted to appointments)”²³⁸, drop-in appointments and home visits. Aftercare services are offered via a shared case management system to ensure a client receives check in appointments, home visits and other services after a crisis like a suicide attempt.²³⁹

Another part of aftercare services is the adherence to a treatment plan after a patient is discharged from a provincial facility due to a suicide attempt or after residential treatment for substance use. Due to coordination challenges between federal and provincial health care systems, some witnesses observed there is little follow up after a patient’s release. At times, the local health care provider or the patient’s family is unaware of someone’s release from a facility to return home or of the patient’s ongoing treatment plan.²⁴⁰

The Committee heard that aftercare services can take different forms such as mainstream mental health therapies, traditional Indigenous therapies, faith-based counselling, or spending time with Elders or family members. Shawn Matthew Glode shared how an important aspect of grieving following the loss of his son involved participation in traditional Indigenous practices:

After Cody passed, a younger member of council came to my house. He brought a smudge bowl and an eagle feather, and he reached out to us and said they were going to have a sweat that night for the family.... We had another individual come into the house.... He came in and sat with my children. The kids from the community were there and he drummed with them. He stayed there for 18 hours a day to drum and pray with the kids.²⁴¹

D. Survey Results: The Quality and Availability of Mental Health Services

The Committee was interested in obtaining a better understanding of the importance, availability and quality of mental health services from the perspective of front-line service providers working in Indigenous communities. The *Survey* was available

237 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016, 1700 (Mr. Shawn Matthew Glode, As an individual).

238 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 14 February 2017, 0855 (Chief Kathy Kishiqueb, Ojibways of Onigaming).

239 Ibid.

240 Committee Analyst notes from the November 2016 community site visit to Sioux Lookout, Ontario.

241 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016, 1705 (Mr. Shawn Matthew Glode).

to all service providers in Indigenous communities, and in addition, was specifically distributed to witnesses that had appeared before the Committee. While the intent of the electronic consultation is to obtain a general profile of the mental health care pressures in Indigenous communities, the *Survey* does not provide a representative sample of all Indigenous communities nor are all issues affecting the delivery of mental health services captured. Those that responded to the survey lived in Ontario (28%), Quebec (18%), Saskatchewan (12%) and British Columbia (11%). Most of the respondents lived in rural (28%), remote (27%) or remote fly-in (29%) communities with another 26% living in urban areas. The *Survey* measured the availability of key mental health services along a continuum of mental health care, including prevention and early intervention, crisis services, aftercare and specialist care.²⁴²

Early intervention services were raised by a few witnesses as an important aspect of suicide prevention as such programs support families to raise healthy children. The *Survey* respondents agreed that the following early intervention services were important or critically important to prevent suicide: pre-natal care; Aboriginal Head Start;²⁴³ specialty care for those with dual diagnoses; school based prevention programs; extracurricular activities; family strengthening programs; mental health assessments; and, Indigenous-specific mental health supports.²⁴⁴

With regards to the availability of early intervention services, pre-natal care was available in 69% of communities and Aboriginal Head Start was available in 56% of communities; suicide prevention awareness education for school-aged youth was available in 40% of communities; and extra-curricular activities were available in 70% of communities. Family strengthening programs were available in approximately 40% of communities; assessment and programs for children requiring specialized services such as autism screening or brain related injuries were available in 24% of communities; services for those with dual diagnosis, such as mental health condition and addictions were only available in a limited basis in 27% of communities.²⁴⁵

The *Survey* highlighted that, while counselling services were reportedly available (70%), there were often wait times to access these services (73%) and sometimes clients went without care. Overall, respondents assessed the quality of mental health services as poor or below average (61%) and noted there were not enough health care workers serving Indigenous communities. The majority of respondents (73%) indicated that there were times over the past year when a patient required mental health services and did not receive it.²⁴⁶

242 House of Commons, Standing Committee on Indigenous and Northern Affairs, *Survey of Front-Line Service Providers in Indigenous Communities*.

243 Ibid.

244 Ibid.

245 Ibid.

246 Ibid.

With regards availability of traditional Indigenous therapies and practices, respondents indicated that traditional counseling or circles were available in 40% of communities and Indigenous cultural approaches such as ceremonies or spiritual counseling were available in 45% of communities.²⁴⁷

The *Survey* results reveal that 68% of front-line workers had worked with a patient in the past 12 months who had seriously contemplated suicide. While 58% noted crisis response services were available, only 23% indicated there was a community-based suicide prevention plan or program and 40% noted they did not know if one was in place. About half of those who responded to the survey reported a 24-hour crisis line was available to clients in their communities.²⁴⁸

For the most part, psychiatric services, psychological services or addictions treatment were reportedly available outside of the community. Almost half of the respondents indicated that aftercare services, care following a suicide attempt or discharge from a mental health facility, were available in the community, however, there was only limited access to specialists such as psychiatrists (26%) or psychologists (37%). Access to or being able to refer a patient to addictions treatment was possible in 34% of communities.²⁴⁹

E. Urban

*[W]e need front-line mental health workers in the communities. That's a given.... We need to have those people there ... so that when a crisis like Cody's happens at 1 a.m., we have a mobile crisis team or somebody who can react. We don't have that. We have nothing.*²⁵⁰

Shawn Matthew Glode

Access to culturally appropriate mental health services is challenging in urban settings. Christopher Sheppard notes Friendship Centres have seen there is a “growing need for mental health supports”²⁵¹ but that resources for mental health programs have not kept pace with demand. Youth living in urban areas such as Vancouver emphasized that access to culturally appropriate mental health supports are especially important after hours and during holidays when crises typically occur.²⁵²

247 Ibid.

248 Ibid.

249 Ibid.

250 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016, 1700 (Mr. Shawn Matthew Glode).

251 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 June 2016, 1530 (Mr. Christopher Sheppard).

252 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016 (Mr. Richard Taylor, Operations Manager, Leave Out Violence Nova Scotia Society); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016, 1650 (Ms. Pamela Glode Desrochers, Executive Director, Mi'kmaw Native Friendship Society).

The network of Friendship Centres was highlighted as an important part of existing infrastructure for essential services. One Friendship Centre reported it was able to obtain limited funding to provide mental health services; however, these programs were difficult to sustain over the long term as they are only funded on a short-term basis.²⁵³

In large urban areas, Indigenous peoples, especially youth, face additional challenges accessing culturally appropriate health services. For example in Vancouver, requests for help may go unnoticed, especially if someone has recently moved to the city. Culturally appropriate, emergency mental health services and residential support for addictions were also relatively unavailable to Indigenous youth in Vancouver. For example, the Committee heard from a youth counsellor in Vancouver who reported that there are no “wrap around services,” meaning services before, during or following a suicide attempt. The only point of service is hospital emergency rooms which were seen as ill-equipped to deal with Indigenous youth in crisis. A counsellor reported that hospitals simply contain youth in the emergency room for “supervision” to ensure they do not self-harm, for up to seven hours until they are no longer suicidal. According to the counsellor, going to a hospital when in crisis may actually increase suicidal thoughts as youth are re-traumatized due to the poor quality of care received.²⁵⁴

Committee members were told by Metro Vancouver Aboriginal Executive Council that there are no mechanisms in place to coordinate services between on and off reserve systems and between urban and remote/rural settings. For instance, if someone dies by suicide in Vancouver, those grieving the loss remain in the person’s home community, and may be at increased risk of suicide themselves. Mental health supports are required in the on reserve home community, rather than in Vancouver where the suicide occurred.

Even in cities, access to specialist care, such as psychiatrists and psychologists, can be challenging. Shawn Matthew Glode explained that his son passed away by suicide while on a waiting list to see a psychologist and died by suicide before he was able to obtain treatment.²⁵⁵

F. Métis

The Committee heard from a few Métis witnesses who described that Métis experience higher rates of mental distress and rates of suicide, including attempts, than the general population. Unlike First Nations bands and Inuit communities, Métis communities do not qualify for the health services provided by the First Nations and Inuit Health Branch of Health Canada, and have no access to culturally appropriate care.²⁵⁶

253 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016, 1655 (Ms. Pamela Glode Desrochers, Executive Director, Mi’kmaw Native Friendship Society).

254 Committee Analyst notes from the November 2016 community site visit to Vancouver, British Columbia.

255 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016, 1635 (Mr. Shawn Matthew Glode).

256 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 February 2016, 0935 (Ms. Sylvia Johnson).

For instance, a Métis witness indicated the new help line launched by Indigenous and Northern Affairs Canada was oriented to connect clients with Non-Insured Health Benefits, and provided referral services only for First Nations and Inuit.²⁵⁷ Sylvia Johnson suggested that a help-line would assist those in Alberta discuss mental health issues and prevent suicide.²⁵⁸

Cassidy Caron observed Métis in British Columbia would like to work with their citizens to determine their health needs, including mental health, to ensure youth and their families can access care when needed. She described a case of a Métis youth in British Columbia who died by suicide while in custody after his family had difficulties finding culturally appropriate treatment for his addiction.²⁵⁹ Sylvia Johnson noted Métis children also live in remote, isolated communities with limited access to mental health supports; and access to mental health specialists are located far from communities. The Committee heard that there is a lack of information, statistics and data with regards to the mental health of Métis people.

She also observed there is a need to build the self-worth of Métis youth through culturally specific youth programming. She also called for “equitable and proper mental health supports and services tailored to the specific needs of Métis Albertans.”²⁶⁰

G. Health Professionals

*There are urgent needs for mental health workers in our communities to speak Inuktitut and understand our culture. We must train Inuit to fill these roles.*²⁶¹

James Arreak

Indigenous communities require adequate numbers of skilled health service providers to serve their community members. The Committee heard considerable evidence that there are insufficient numbers of health professionals working in Indigenous communities. In some communities, specific conditions can limit the capacity of service providers to work effectively with clients such as multiple suicides over a short period of time, high needs amongst clients and staff burnout. Citing the 1996 *Report of the Royal Commission on Aboriginal Peoples*, Michael DeGagné recalled that when the report was released there was an “urgent need to train 10,000 new community-based health

257 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 1055 (Ms. Tanya Davoren, Director of Health, Métis Nation British Columbia).

258 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 February 2016, 0935 (Ms. Sylvia Johnson).

259 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 1040 (Ms. Cassidy Caron).

260 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 28 September 2016, 0935 (Ms. Sylvia Johnson).

261 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1000 (Mr. James Arreak).

workers.”²⁶² The Committee heard that many positions in communities remained unfilled or were filled only temporarily.²⁶³

Witnesses described that the shortages of health professionals in Nunavut are particularly pronounced. Adam Akpik observed that in 2006, Nunavut also had the “lowest ratio of physicians, the lowest ratio of registered nurses, and the lowest ratio of psychologists.”²⁶⁴

Kathy Kishiqueb noted that continuous staff turnover affects the continuity of health care and presents difficulties for First Nations, “Clients who have experienced trauma get tired of telling their stories over and over to new faces.”²⁶⁵ Staff shortages affect the rate of burnout and youth in Kuujuaq and Iqaluit noted social workers and mental health workers rarely stay in their positions longer than three months at a time.²⁶⁶ As explained by Jakob Gearheard:

They fly in, they get traumatized, and they leave. If you’re a client ... they’ll complain about the mental health worker who just flew in. They’ll say things like, “I went in there and I had to spend the first 30 minutes explaining to them Inuit history.”²⁶⁷

Witnesses described the importance of Indigenous-specific mental health supports, from people who can provide services in the local language and understand the community’s history and culture. However, there are very few Indigenous mental health specialists. Cornelia Wieman, a First Nation psychiatrist, described that due to low numbers of Indigenous psychiatrists, in her estimation there may be six in the country, “virtually all psychiatric care across this country to Aboriginal people is provided by non-Aboriginal psychiatrists.”²⁶⁸

The Committee heard that recruiting and retaining health professionals in Indigenous communities is challenging, often leading to shortages that affect the delivery of mental health services. Lisa Bourque Bearskin indicated it was difficult to retain health care professionals as staffing shortages contributed to the burnout of front-line nurses:

262 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1620 (Dr. Michael DeGagné).

263 Committee Analyst notes from the September 2016 community site visit to Kuujuaq, Quebec and Iqaluit, Nunavut; House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1540 (Dr. Lisa Bourque Bearskin); Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 1645 (Dr. Tom Wong); and [Brief](#) submitted by Weeneebayko Area Health Authority, 26 October 2016.

264 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1620 (Mr. Adam Akpik, As an individual).

265 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 14 February 2017, 0855 (Chief Kathy Kishiqueb).

266 Committee Analyst notes from the September 2016 community site visit to Kuujuaq, Quebec and Iqaluit, Nunavut.

267 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 5 October 2016, 1720 (Mr. Jakob Gearheard).

268 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 14 June 2016, 1545 (Dr. Cornelia Wieman).

“One nurse was in her community for three weeks providing 24-7 care. There’s no way we’re going to be able to retain that nurse. She’s going to be burnt out. There’s a huge lack of community support.”²⁶⁹

The Committee heard that increasing Indigenous peoples’ involvement in the delivery of health services is an important long-term solution to the shortages of health professionals. Local communities need to be supported through training to build their internal capacity to address issues regarding the retention of health care workers. As shared by Lisa Bourque Bearskin, “Indigenous nurses who have been trained, you’ll see the retention is higher for them to stay in their communities. Our Indigenous nurses are staying and working within their own communities.”²⁷⁰

Calvin Morrisseau from the First Nations Health Managers Association explained that health managers have an important role to oversee health care delivery in communities.²⁷¹ Health managers offer a solution to recruitment and retention as these positions manage health professionals and lead the development of planning, reporting and cyclical recruitment of health professionals.²⁷²

Community based workers in Indigenous communities also provide mental health services with regards to referrals, emergency coordination and other services. Front line service providers who responded to the *Survey* observed these workers also require training and support. In Nunavik, efforts are underway to equip community members and paraprofessionals often at the front line of a suicide crisis to recognize signs and symptoms of distress through training such as the Applied Suicide Intervention Skills Training. Jack Hicks and Christopher Sheppard acknowledged the importance of intervener, or gate-keeper training, which can provide important information on “how to keep someone alive long enough to get them to someone who could really change their circumstances.”²⁷³

The Committee heard from many witnesses, including Indigenous youth, that many non-Indigenous health professionals providing care in First Nation or Inuit communities require training on Indigenous values, history, culture and knowledge.²⁷⁴ Training existing

269 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1635 (Dr. Lisa Bourque Bearskin).

270 Ibid.

271 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1620 (Mr. Calvin Morrisseau).

272 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1600 (Ms. Marion Crowe, Executive Director, First Nations Health Directors Association).

273 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 June 2016 (Mr. Christopher Sheppard).

274 Committee Analyst notes from the September 2016 community site visit to Kuujuaq, Quebec and Iqaluit, Nunavut and the November 2016 community site visit to Sioux Lookout, Ontario. House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1545 (Dr. Lisa Bourque Bearskin); House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1455 (Ms. Sheila Levy).

non-Indigenous health professionals who work in Inuit and First Nations communities to provide culturally appropriate care will enhance the quality of mental health services and reduce racism and discrimination in health care delivery as reported by youth.²⁷⁵ Culturally appropriate training materials have already been developed by Indigenous organizations, such as Canadian Indigenous Nurses Association, which could help support access to culturally appropriate health services: “This training can help reduce racism and discrimination, which is found to have a significant impact on people’s health. A study ... has revealed that people living in these rural settings are even further marginalized by bias-informed care.”²⁷⁶

Correspondingly, health professionals stand to improve and expand their clinical care skills by learning about Indigenous culture and history. As stated by John Haggarty, “We need to learn that. I’m thinking of the residents, medical students, and trainees in social work. This really matters.”²⁷⁷

Results from the *Survey* indicate that the training needs amongst health care providers are high. Of those who participated in the *Survey*, 55% reported they had not received community-specific training to provide culturally appropriate mental health services. Another 40% had completed such training on a wide range of topics specific to treating grief, loss, trauma and post-traumatic stress disorder; historic and intergenerational trauma and colonization; training from Indigenous Elders such as medicine wheel teachings; youth or child therapy; cultural competency; amongst many others.²⁷⁸

With regards to the training needs of paraprofessionals delivering services in Indigenous communities, the Committee heard evidence of the importance of Health Canada’s *Aboriginal Health Human Resources Initiative*. The Initiative provides \$4.5 million for two streams of programming, including \$3 million in scholarships and bursaries for Indigenous students to pursue careers in health and “the remaining \$1.5 million nationally is split among the Health Canada First Nations and Inuit health regional offices. This amount is insufficient to meet the current professional development and certification needs in our community.”²⁷⁹

275 Committee Analyst notes from the September 2016 community site visit to Kuujuaq, Quebec and Iqaluit, Nunavut and the November 2016 community site visit to Sioux Lookout, Ontario.

276 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1545 (Dr. Lisa Bourque Bearskin).

277 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 24 October 2016, 1620 (Dr. John Haggarty).

278 House of Commons, Standing Committee on Indigenous and Northern Affairs, *Survey of Front-Line Service Providers in Indigenous Communities*.

279 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 17 October 2016, 1540 (Ms. Marion Crowe).

H. Broadband Infrastructure And Social Media

Improving access to health care and education

The Committee heard that nurses that work in remote First Nations and Inuit communities often work in isolation from other networks of health professionals. Through the course of their work, these front-line service providers may need to consult with other health professionals, such as physicians or psychiatrists, for guidance on complex mental health issues. However, the remoteness of communities, often only accessible by air or winter road, makes collaboration with other health professional difficult. At times, nurses may not have specific training to treat people with trauma, or those with special needs such as youth.²⁸⁰

The Committee heard that there are a number of models under consideration that can enhance primary care and mental health services on reserve. For example, John Haggarty described the Rapid Access to Consultative Expertise which provides supportive networks for nurses and paraprofessionals in isolated communities. The model enables a nurse to consult with another health professional such as a physician, psychologist or psychiatrist at a distance using video-health.²⁸¹

The Centre for Addictions and Mental Health in their submission to the Committee, described another model, Project ECHO, enables a nurse to reach out for tele- or video assistance for a patient experiencing “common mental disorders such as depression and anxiety.”²⁸² The ECHO model as it is being deployed in Ontario enables 28 teams of health care providers working in Indigenous communities to work remotely with a team of interdisciplinary health care providers situated at the Centre for Addiction and Mental Health in Toronto. Another new partnership model connects psychiatrists in Toronto with primary health care providers working in rural and remote communities in the north where they meet regularly through the Ontario Telemedicine Network to support those who may be treating patients with complex mental health or substance abuse problems.²⁸³

Optimizing and widening the use of broadband Internet services in rural and remote communities is an important consideration which would support the implementation of emerging models of care.²⁸⁴ Witnesses appearing before the Committee discussed health care models that can address some of the gaps in mental health services on reserves, in Inuit communities and between urban centres where hospitals or specialized mental health services are located. Different regions are advancing tele-health, tele-psychiatry and mental health support at a distance via text message or social media and have identified

280 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 24 October 2016, 1545 (Dr. John Haggarty).

281 Ibid.

282 [Brief](#) submitted by the Centre for Addiction and Mental Health, 4 October 2016.

283 Ibid.

284 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, February 2017, 0915 (Dr. Cindy Blackstock).

that, with appropriate investments in broadband infrastructure and cellular coverage, they would be able to do so.

Online services and social media can play a role in health care delivery, particularly for youth who utilize this mode of communication. While the Committee heard testimony that youth are accustomed to using social media and text messages, as Laurence Kirmayer noted, “there is good evidence that the internet and telecommunications can be used to have meaningful engagement with people to offer them support, to do psychotherapy...That said, there’s no substitute for a physical presence.”²⁸⁵ Cassidy Caron also noted “yes, we do engage in social media to connect the youth. However, it’s not the same as being together....”²⁸⁶ While Heather Bear described interaction on social media can be negative “Cyber-bullying is a problem,”²⁸⁷ Susan Bobbi Herrera also noted “Social media is a good tool to stay connected....”²⁸⁸ James Irvine from the Mamawetan Churchill River Health Region described the recent cluster of suicides of young girls under the age of 15 in northern Saskatchewan and that over the last few years the “clusters have spread geographically, and it’s thought that part of this may be because of social media.”²⁸⁹

The Committee heard from Ed Connors who provided an example of a First Nation youth in crisis in Attawapiskat who was connected with culturally appropriate art therapists at a traditional healing centre in southern Ontario via the Internet.²⁹⁰ Sheila Levy from the Nunavut Kamatsiaqtut Help Line, which provides crisis assistance via phone in Inuktitut noted they would like to extend their supportive services via text message and social media but are limited by funding and inaccessible broadband networks in the North.²⁹¹ Inuit youth in Kuujuaq noted if Internet was of better quality in the region, they would be able to engage in distance learning opportunities which would supplement the poor quality of education in the region.

285 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 24 October 2016, 1710 (Dr. Laurence Kirmayer).

286 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 2 November 2016, 1040 (Ms. Cassidy Caron).

287 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 February 2017, 0945 (Vice-Chief Heather Bear, Federation of Sovereign Indigenous Nations).

288 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 7 February 2017, 0925 (Ms. Susan Bobbi Herrera).

289 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 16 February 2017, 0955 (Dr. James Irvine, Medical Health Officer, Mamawetan Churchill River Health Region).

290 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 19 October 2016 (Dr. Ed Connors).

291 House of Commons, Standing Committee on Indigenous and Northern Affairs, [Evidence](#), 1st Session, 42nd Parliament, 23 September 2016, 1455 (Ms. Sheila Levy).

II. WHAT THE COMMITTEE FOUND: CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Throughout the study, the Committee learned about important ways to address suicide and heard tangible recommendations from many witnesses, including Indigenous youth. Many of the Indigenous youth and leaders painted a portrait of communities that are in a perpetual state of crisis, lacking the appropriate resources, infrastructure and partnerships to adequately address suicide. Recognizing these concerns, the Committee believes that effective approaches to prevent suicide must be comprehensive, involve all sectors and be driven by Indigenous communities' priorities. Solutions must take into account the social, economic and cultural determinants that affect the health and well-being of Indigenous peoples.

A. Self-determination and reconciliation

The Committee recognizes that broader changes are required to renew the relationship between Indigenous and non-Indigenous peoples. The Committee acknowledges the testimony of witnesses concerning the Truth and Reconciliation Commission of Canada: Calls to Action, which set out a framework by which to heal from the legacy of Indian residential schools and to acknowledge and work towards the elimination of systemic discrimination towards First Nations, Inuit and Métis people. The Calls to Action urge all levels of government, as well as public and private institutions to engage in concrete activities in order bring about resolution to the legacy of residential schools.

Witnesses expressed clearly that Indigenous peoples experience systemic racism and discrimination. The Committee heard from Indigenous youth and adults alike that experiences of discrimination negatively affect their health when seeking governmental services and is a source of trauma.

Many of the Commission's Calls to Action identify activities intended to increase awareness and understanding of the legacy of Indian residential schools through education. Specifically, we refer to Calls to Action 62 and 63, that asks for educational materials to be developed for students and educators alike and to ensure Indigenous content and pedagogy is used in the schools. The Committee views societal education as a key measure to better understand the effects of intergenerational trauma on the contemporary lives of Indigenous peoples.

A foundational international instrument, the *United Nations Declaration on the Rights of Indigenous Peoples*, was identified by the Commission as a framework for reconciliation. Both frameworks set out the importance of protecting the rights of all Indigenous peoples. The Declaration affirms that Indigenous peoples have an inherent right to self-determination. The Committee heard that land claims are an expression of

self-determination. Some witnesses explained that increased control over the delivery of services improved health outcomes and empowers communities to deliver culturally appropriate services to respond to their unique needs. Witnesses emphasized that community-led solutions are crucial and the Committee finds promoting self-government in this area is a key measure to address suicide over the long-term.

As such the Committee finds that work is needed to address the systemic causes of racism and discrimination and renew the relationship with Indigenous Peoples and recommends as follows:

Recommendation 1

That the Government of Canada work in partnership with Indigenous communities to facilitate the goal of self-determination and ensure communities have adequate resources to exercise their jurisdiction.

Recommendation 2

That the Government of Canada recognize the Truth and Reconciliation Commission of Canada: Calls to Action and the United Nations Declaration on the Rights of Indigenous Peoples as foundational frameworks for Indigenous peoples to realize self-determination.

Recommendation 3

That Indigenous and Northern Affairs Canada review its land claims policy, as self-government and cultural continuity within Indigenous communities has been shown to be an important hedge against suicide.

B. Social Determinants of Health

Housing First

The Committee acknowledges that the issue of housing is one of the most important, challenging and urgent issues for the Government of Canada to address. Over the course of the study, First Nation, Inuit and Métis youth and other witnesses noted that the shortage of housing stock has wide-ranging consequences on the health of Indigenous peoples, impedes education and leads to increased vulnerability for youth. The Committee recognizes the important contributions in the recent reports produced by the Senate Standing Committee on Aboriginal Peoples entitled, *We Can Do Better: Housing in Inuit Nunangat* (2016) and *On-Reserve Housing and Infrastructure: Recommendations for Change* (2015).

The Committee heard how quality housing was a major determinant of health for First Nations, Inuit and Métis people living in urban, remote and rural areas. It was made evident that safe, suitable, affordable housing for the diverse needs of vulnerable children and families is critical. A housing-first approach along with a basket of services has been

proven to yield positive outcomes related to reducing homelessness and promoting positive mental health.

Affordable, quality housing in rural and remote communities, on and off reserve and in urban areas, will significantly improve the living standards of Indigenous families. The Committee recognizes the Government of Canada is developing a National Housing Strategy that will include housing for Indigenous communities.

Recommendation 4

That the Government of Canada expand investment through long-term sustainable funding based on need to improve housing for Indigenous peoples, with particular attention paid to addressing homelessness, affordability and transitional housing; and that expanded investment be in partnership with Indigenous peoples and governments.

Optimal Childhood Development and Education

The Committee heard that early learning is important to develop the skills for success in school and subsequent careers. Indigenous children who grow up in poverty experience challenges that prevent them from learning such as food insecurity, inadequate housing and lack of access to essential services.

The Committee acknowledges the testimony of witnesses and *Survey* respondents who emphasized the importance of the Aboriginal Head Start On Reserve and Urban and Northern Communities programs. Given the relative success of these programs, the Committee recommends as follows.

Recommendation 5

That the Government of Canada expand support for the Aboriginal Head Start On Reserve and Urban and Northern Communities programs.

The Committee heard testimony from First Nations, Inuit and Métis people that the strength and resilience of Indigenous peoples is rooted in Indigenous languages and cultures. Culture, language, values and practices were all raised as important parts of building healthy Indigenous identities, and in turn, preventing suicide. Testimony from a number of witnesses connected cultural continuity with low or absent rates of suicide in some First Nations communities. Examples of cultural continuity included community control over services, cultural infrastructure, women in leadership positions and knowledge of Indigenous languages.

Further, the Committee acknowledges the need to revitalize Indigenous languages, to ensure their languages remain vibrant and will be used by families for generations to come. Indigenous language speakers are central to this effort, and the Committee emphasizes they must be hired to teach the languages.

The Government of Canada has committed to implement the Truth and Reconciliation Commission of Canada: Calls to Action, which includes recommendations on Indigenous languages. The Committee recognizes the importance of supporting Indigenous languages and cultures, and the development of a long-term strategy to preserve Indigenous languages. We therefore recommend:

Recommendation 6

That the Government of Canada develop the forthcoming Indigenous languages strategy in partnership with Indigenous organizations and communities.

The poor quality of education in rural and remote First Nations and Inuit communities contributes to an educational attainment gap between Indigenous and non-Indigenous children and youth. Indigenous youth noted they found the education offered on reserve and in small Inuit communities was of significantly poorer quality than education offered in urban areas. Further, Indigenous youth noted that the lack of Indigenous educators, content and languages within the school systems creates an unwelcoming learning environment. The Committee is concerned that children will be impeded in moving towards post-secondary education as they may leave school early due to systemic constraints. We therefore recommend as follows:

Recommendation 7

That the Government of Canada, in partnership with provincial, territorial and Indigenous governments work to ensure that outcomes for Indigenous students are equivalent to non-Indigenous counterparts, with an emphasis on their ability to participate in post-secondary education and/or vocational training.

The Committee understands there is a strong link between higher levels of education, employment and greater potential for success later in life. Witnesses highlighted the importance of supporting Indigenous children and youth to receive a quality education, so that they can pursue post-secondary studies. Supporting schools operating in rural and remote Indigenous communities to offer important pre-requisite courses so that youth are prepared when they enter college or university is an essential aspect of education systems. Improving broadband infrastructure to enable schools to offer distance learning opportunities for students was another important observation raised by youth.

Closing the educational attainment gap in high school completion rates between Indigenous and non-Indigenous youth, is likely to foster greater opportunities later in life in the areas of post-secondary education and employment. In addition, Inuit youth noted they would prefer to remain in their territories and pursue their studies while making a positive contribution to their communities. As Canada is the only circumpolar country without a university in the Arctic, students would significantly benefit from direct access to a university in the North.

Recommendation 8

That the Government of Canada work to rebrand the Canada Student Loans, Grant and Bond programs and increase the flexibility of the application process to reflect the unique needs of Indigenous students; and work with respective First Nations communities to expand the flexibility of the Post-Secondary Student Support Program, with increased funding to support a greater number of students.

Recommendation 9

That the Government of Canada, working in partnership with Indigenous organizations and territorial and regional governments, establish a university in the North.

Recommendation 10

That the Government of Canada, in partnership with provincial, territorial and Indigenous governments, recognize the fundamental role of economic development and job creation in advancing Indigenous-specific youth suicide prevention strategies.

Recommendation 11

That the Government of Canada develop comprehensive employment wrap around services for Indigenous people, including transportation, transitional housing and employment coaching.

Childhood Adversity

The Committee is of the view that childhood adversity, such as sexual abuse or violence, interaction with criminal justice and/or the child welfare systems, contributes to mental distress and suicide. Witnesses, including Indigenous youth, provided moving and difficult testimony which described substance use, self-harming behaviors and suicide attempts as means of coping with sexual abuse, assault or violence.

The Committee understands that Indigenous children are over-represented in child welfare systems. The Committee is of the view that different approaches are needed to address the systemic issues underlying the removal of children from their homes and communities. Addressing the challenges of the child welfare system requires additional investments and community involvement with an increased focus on the prevention of childhood adversity and support to parents and children to build healthy families. The Committee therefore recommends as follows:

Recommendation 12

That the Government of Canada ensure that mental health services in Indigenous communities are trauma-informed and provide safe spaces for young people to disclose adverse childhood events and provide culturally appropriate follow-up care.

Recommendation 13

That the Government of Canada completely overhaul Child and Family services for First Nations communities to increase prevention support for children and their families, keep more children out of foster care and support them growing up with a secure personal cultural identity. Further, that the Government of Canada work, on an urgent basis and in partnership with First Nations, and other partners to deliver comprehensive child welfare reform on reserve that puts the well-being of Indigenous children first.

Friendship Centre Infrastructure

The Committee heard from Indigenous youth and service providers in urban areas that youth centres and Friendship Centres are critical to assist Indigenous peoples as they transition to urban centres. Friendship Centres are an important part of the urban infrastructure across Canada and provide essential programs and services to Indigenous peoples that help them complete their studies, develop social networks, enhance skills and training as they seek employment, engage in cultural practices and obtain assistance in finding housing and other services.

The Committee is aware that Indigenous and Northern Affairs Canada is reforming the Urban Indigenous Strategy that funds Friendship Centres to better meet the needs of recipients. To meet the needs of Indigenous peoples living in urban areas, we therefore recommend as follows:

Recommendation 14

That the Government of Canada ensure Friendship Centres receive adequate funding over multiple years to enable continuous programming, services and investments in infrastructure to support Indigenous peoples.

Community Centres for Healing and Cultural Renewal

First Nation and Inuit youth who spoke with the Committee expressed the need for community spaces and networks for youth organizations, where they can access mental health supports, spend time after school to study, practice hobbies, play sports, and importantly, learn about their cultures.

The Committee believes that spaces for learning, recreation and culture can help build self-esteem and healthy identities among youth and can bring communities together. Indigenous youth told the Committee they want to be connected to one another, to share best practices and learn. Accordingly, we recommend as follows:

Recommendation 15

That Indigenous and Northern Affairs Canada increase funding to Indigenous communities for youth and community centres; and work with communities to provide sustainable culturally appropriate programming.

C. Mental Health Services

Indigenous specific Mental Health Frameworks and Strategies

The Committee is of the view that a continuum of mental health services grounded in Indigenous culture and traditions will improve the health and well-being of Indigenous peoples. The Committee recognizes the need for tailored responses to suicide prevention, to be led by First Nations, Inuit and Métis peoples, who best understand their needs and priorities.

As emphasized by many witnesses who appeared before the Committee, we believe that frameworks to address the social determinants of health will strengthen approaches to suicide prevention. The Committee finds that a narrow focus on suicide prevention in isolation of the wider economic and social conditions of Indigenous people will not have a significant impact on the rates of suicide.

Best practices in this regard are the *First Nations Mental Health Continuum Framework* and *National Inuit Suicide Prevention Strategy*, developed by and for Indigenous peoples themselves. Both approaches situate culture as a path to healthy communities, while acknowledging the importance of improving the quality of life of Indigenous peoples. The Committee notes the recent federal commitments to implement both approaches, however believes that progress must be monitored to ensure the Frameworks are appropriately resourced. Métis people also require adequate supports.

We therefore recommend as follows:

Recommendation 16

That the Government of Canada, in partnership with respective First Nations, Inuit and Métis communities, support Indigenous-specific Mental Health Frameworks and Strategies and ensure they are provided with adequate, long-term funding; and develop measures to track progress concerning the implementation of these strategies and report on progress.

Indigenous communities observed they require adequate partnerships, investments and resources to appropriately address suicide and to provide a continuum of culturally appropriate mental health care. In this regard, the Committee believes Health Canada could facilitate and fund the development of relationships and partnerships between Indigenous communities and regional and national organizations with expertise in mental health, such as the Canadian Mental Health Commission, to learn from one another. As such, we recommend as follows:

Recommendation 17

That Health Canada facilitate and support discussions, partnerships and the exchange of tools between Indigenous communities and regional or national organizations with expertise in suicide prevention and mental health.

Stable, predictable, long-term, flexible funding

First Nations and Inuit communities are dealing with fixed funding allocations for health services and mental health services. The Committee heard that health care delivery in rural or remote regions is costly due to the unavailability of specialty care, resulting in higher costs for the transportation of patients and health professionals. Communities would benefit from stable, predictable, long-term, flexible funding and multi-year agreements in order to develop long-term plans.

While the Committee is encouraged to hear of recent investments for community mental wellness resources, the Committee finds that the funding formula for the provision of mental health programs in Indigenous communities affects the quality of care provided. The Committee therefore recommends as follows:

Recommendation 18

That the Government of Canada implement a funding formula to provide long-term, predictable, stable funding to support the provision of mental health services for Indigenous peoples; and that the funding formula take into account population growth, inflation and remoteness.

Improving jurisdictional coordination

Witnesses provided testimony which identified some problems in inter-jurisdictional coordination between federal health care systems on reserve and provincial or territorial facilities which can delay or impede treatment. It was suggested that a solution to the problems is the implementation of Jordan's Principle. The Principle enables access to health and social services to all First Nations children comparable to other children, no matter where they live or what level of government – provincial or federal – is responsible for coverage.

The Committee acknowledges that Jordan's Principle was widened in 2016 to apply to all First Nation children and recognizes the commitments to the implementation of Jordan's Principle and to strengthen First Nations Child and Family Services. The Committee recognizes that in 2016 the Government of Canada expanded Jordan's Principle to apply to all First Nations children and also invested \$382.5 million to support children through this expansion.

The Committee believes there is a significant amount of work to do in order to ensure all Indigenous children have comparable access to health and social services as non-Indigenous children. We therefore recommend:

Recommendation 19

The Government of Canada immediately and fully implement Jordan's Principle; and that it engage with First Nations communities and partners with regards to an equitable funding model for access to health and social services for Indigenous children.

The Committee understands that existing agreements such as treaties and modern claims contain provisions with regards to the responsibility for the delivery of services. However, inter-jurisdictional challenges continue to exist, and the Committee heard that First Nations and Inuit patients have challenges navigating the jurisdictional boundaries to access health services. We therefore recommend as follows:

Recommendation 20

That the Government of Canada, in consultation with Indigenous communities and organizations, clarify areas of community, provincial/territorial and federal obligations with regards to health care provision.

Community-driven priorities

In order to improve service delivery over the short term, federal programs require alignment and integration within the broader *First Nations Mental Wellness Continuum Framework* or *National Inuit Suicide Prevention Strategy*. By and large, the Committee heard considerable evidence that communities who have greater flexibility to manage and deliver their own programming are able to tailor approaches to local needs. Cultural continuity factors, such as community-led service delivery, the presence of a cultural centre and self-government contribute to lower incidence of suicide.

The Committee recognizes that more First Nations and Inuit communities manage their own community-based health services and that these models support improved health outcomes. The Committee is of the view that it is essential that Health Canada continue its approach of providing authority to regional organizations such as First Nation Health Authorities or regional organizations for mental health service delivery. We therefore recommend as follows:

Recommendation 21

That Health Canada increase Indigenous control over service delivery through partnerships with regions, health authorities and Indigenous organizations.

Suicide Prevention

Funding for specific program areas such as Health Canada's *National Aboriginal Youth Suicide Prevention Strategy* can be unpredictable, undermining community efforts to plan. The Committee heard from witnesses that connections to the land, Indigenous culture and language is foundational to healthy Indigenous identities and brings families and communities together. Connection to the land fosters healthy childhood development, language learning and retention, healing from the past and strong connections for the future.

We understand that Health Canada provides annual funding for communities to build their own approaches to suicide prevention for Indigenous youth under the *National Aboriginal Youth Suicide Prevention Strategy*. While some challenges were raised related to the Strategy, such as year to year funding, proposal-based allocations and not serving all First Nation and Inuit communities, the Committee feels strongly that access to culture-based healing is an effective tool to prevent suicide. Accordingly, the Committee believes that all Indigenous communities should have access to youth suicide prevention strategies and we therefore recommend:

Recommendation 22

That the Government of Canada, in partnership with respective First Nations, Inuit and Métis organizations and communities, develop Indigenous specific youth suicide prevention strategies; and ensure they are provided with stable, predictable, long-term, flexible funding.

Federal policy review regarding access to health services

Where counselling, psychiatric treatment, substance abuse treatment or care following suicide attempts are unavailable in an isolated First Nation or Inuit community, the patient is transferred to a provincial health care system. Often, the transfer of a patient between federal and provincial systems is disjointed, resulting in negative outcomes for clients.

Often, such approvals are based on federal policies such as the Medical Transportation Policy. The Committee finds that federal policies which facilitate access to provincial systems should be based on the best advice from a local health professional, and on evidence-based medicine, creating a supportive environment for health professionals to send patients in distress to treatment and therefore recommends as follows:

Recommendation 23

That the Government of Canada ensure that medical transportation benefits are available to all eligible residents of remote Indigenous communities, and those individuals requiring assistance with mental health issues be entitled to bring an escort.

Enhancing Mental Health Service Delivery

The Committee found that the coordination of health services between jurisdictions is complex and can result in gaps in health services and unequal access to health services. Services are required in a “circle” where prevention, crisis services and aftercare work together and are extended to individuals directly or indirectly affected by suicide, with special attention to the needs of youth. Additionally, substance use treatment should be addressed within this continuum.

The Committee is of the view that local mental health supports are effective in providing early intervention services and identifying those at risk of mental distress or suicide. The Committee heard that flexible approaches to local service delivery such as after-hours appointments or home visits are an effective way to deliver care to patients. Community based workers working in Indigenous communities also provide mental health services with regards to referrals and emergency coordination. In Nunavik, efforts are underway to equip community members and paraprofessionals, often at the front line of a suicide crisis, to recognize signs and symptoms of distress through training such as the Applied Suicide Intervention Skills Training.

The Committee recognizes the important contributions of a number of previous reports, including the 2016 *Quebec Coroner's Office Report of Inquest* following the deaths by suicides of five Indigenous peoples in the communities of Uashat Mak Mani-Utenam and Kawawachikamach, Quebec.²⁹² The Report outlines a number of health interventions required along a continuum of care. We therefore recommend as follows:

Recommendation 24

- **That the Government of Canada support Indigenous communities to develop forward plans to identify specialized resources and intervention protocols across education, social, justice and health sectors, ensuring these individuals can provide services in the local language.**
- **That the Government of Canada, following the lead of Nunavik and Nunavut, support gatekeeper-like training for informal helpers, community-based workers, and/or youth to communicate about mental distress and to intervene during suicide crises.**

292 [Quebec Coroner's Office Report of Inquest Concerning the Deaths of Quebec Coroner's Office's Report of Inquest Concerning the Deaths of Charles Junior Grégoire-Vollant, Marie-Marthe Grégoire, Alicia Grace Sandy, Céline Michel-Rock and Nadeige Guanish](#), 2016.

- That the Government of Canada supports the use of social media networks to identify youth at risk of suicide and develop more effective prevention programs.
- That the Government of Canada support Indigenous communities to ensure resources be available after hours and on weekends when emergencies typically occur, with special attention paid to the needs of youth directly or indirectly affected by suicide.
- That the Government of Canada supports communities to develop infrastructure so emergency responders can locate and reach individuals in distress.
- That the Government of Canada makes available safe spaces to support youth and their families in case of crisis to ensure youth can recover from distress or suicide attempts.
- That the Government of Canada work in collaboration with Indigenous peoples and communities to improve mental health services in all Indigenous communities on a needs basis.

Aftercare

- Subject to privacy laws and the wishes of the patient, that the Government of Canada, the respective provincial and territorial governments, work to improve discharge planning between jurisdictions so family or friends on reserve or in Inuit communities are notified of discharge plans from psychiatric facilities, residential treatment centres or hospitals.
- Following the notification of discharge from such facilities, patients should receive follow up appointments after they return to their communities with local health or social services.

Substance Use

The Committee understands that substance use is a problem affecting rural and remote communities, on and off reserve and in urban centres and contributes to elevated rates of suicide. Access to treatment services is limited for Indigenous peoples, and the Committee remains concerned that individuals cannot voluntarily request access to treatment for substance use. To address these concerns the Committee recommends as follows:

Recommendation 25

That the Government of Canada address mental health and substance abuse issues with increased investment in culturally appropriate infrastructure and programming.

Broadband Infrastructure to Improve Access to Services

The Committee heard of promising health care delivery models that may improve access to specialists and culturally appropriate care through the use of technology. Some witnesses suggested social media, text-based and video and tele-health services are underused due to low or no Internet connectivity. Evidence from the *Survey* of front-line service providers indicates that only half of communities are using tele-medicine. Some organizations, such as Facebook, are using social networks to monitor and identify those that are contemplating suicide to connect them to service providers via live chat in real time.

Improved broadband services are an important part of improving access to mental health counselors, specialists and referral networks between patients and health professionals. For remote and isolated Indigenous communities, improved broadband access can also support the use of distance education, tele-health services, social media and text-based communications. We therefore recommend as follows:

Recommendation 26

That the Government of Canada ensure that First Nations and Inuit communities have adequate broadband connectivity for the use of tele- and video-health services; that communities be funded to explore the use of social media to widen access to mental health services and, that Indigenous communities are supported through capacity-building to operate and use such services.

Culturally Relevant Health Services

Unresolved trauma due to the legacies of colonialism continues to affect the lives of Indigenous peoples. Culturally relevant approaches to mental health services combine knowledge about historic and intergenerational trauma, Indigenous healing practices and contemporary mental health practices. Witnesses who testified before the Committee observed that often health care professionals lack knowledge in these areas, which can negatively access health services and outcomes. A key area with which the Committee is concerned relates to the potential discrimination of Indigenous youth from health and other service providers in their communities.

Over half of the front-line service providers who responded to the *Survey* noted they had not completed specialized training on the provision of culturally relevant mental health services. Indigenous professional organizations such as the Canadian Indigenous Nurses Association and the First Nations Health Managers Association have expertise in

this area to train and support health professionals to provide culturally relevant health care to Indigenous clients.

Given the Government of Canada's commitment to the implementation of the Truth and Reconciliation Commission of Canada: Calls to Action, and the specific recommendations related to the recognition of Indigenous healing practices, training and education on Indigenous history, language and values for existing and new health professionals (Calls to Action, Numbers 22, 23 and 24), we believe training and education on Indigenous culture and history will have positive benefits for health professionals and patients alike. We therefore recommend:

Recommendation 27

That the Government of Canada, in collaboration with relevant organizations, seek to develop culturally appropriate guidelines and best practices to be used to train to health professionals and public servants on Indigenous values, culture and history in order to enhance its provision of culturally relevant services to Indigenous clients.

Indigenous Health Professionals

The Committee found that front line service providers, such as those working in remote First Nations in northwestern Ontario or in Nunavik, lack supportive professional networks. The Committee feels strongly that a low level of support operates as a major impediment to the retention of qualified staff in First Nations and Inuit communities.

The establishment of supportive networks by investing in Indigenous health professional associations can enable communities to engage in community-to-community learning and may assist in retaining staff.

The Committee finds that increasing the involvement of First Nations, Inuit and Métis people in the delivery of health care will over time build the capacity of Indigenous communities to respond to health needs. As local Indigenous peoples are more likely to remain working in a community over the long term, it is important steps are taken to augment existing initiatives to increase Indigenous peoples working in health.

The Committee heard evidence that Health Canada's *Aboriginal Health Human Resources Initiative* supports capacity building through training and certification of Community Based Workers, including First Nations Health Managers. The Initiative also provides scholarships and bursaries for Indigenous people pursuing careers in health. The Committee understands the Initiative aims to build the capacity of current workers and increase the number of Indigenous people working in health in the future.

We believe strongly this is an important initiative, and should be widened, to address the short term needs of training and long term needs to increase the number of Indigenous peoples working in health careers, with a focus on mental health. The Committee therefore recommends:

Recommendation 28

That Health Canada and Employment and Social Development Canada, in partnership with respective Indigenous organizations, develop strategies to recruit, retain and train Indigenous individuals for careers in health and mental health.

LIST OF RECOMMENDATIONS

Recommendation 1

That the Government of Canada work in partnership with Indigenous communities to facilitate the goal of self-determination and ensure communities have adequate resources to exercise their jurisdiction..... 56

Recommendation 2

That the Government of Canada recognize the Truth and Reconciliation Commission of Canada: Calls to Action and the United Nations Declaration on the Rights of Indigenous Peoples as foundational frameworks for Indigenous peoples to realize self-determination. 56

Recommendation 3

That Indigenous and Northern Affairs Canada review its land claims policy, as self-government and cultural continuity within Indigenous communities has been shown to be an important hedge against suicide. 56

Recommendation 4

That the Government of Canada expand investment through long-term sustainable funding based on need to improve housing for Indigenous peoples, with particular attention paid to addressing homelessness, affordability and transitional housing; and that expanded investment be in partnership with Indigenous peoples and governments. 57

Recommendation 5

That the Government of Canada expand support for the Aboriginal Head Start On Reserve and Urban and Northern Communities programs..... 57

Recommendation 6

That the Government of Canada develop the forthcoming Indigenous languages strategy in partnership with Indigenous organizations and communities. 58

Recommendation 7

That the Government of Canada, in partnership with provincial, territorial and Indigenous governments work to ensure that outcomes for Indigenous students are equivalent to non-Indigenous counterparts, with an emphasis on their ability to participate in post-secondary education and/or vocational training..... 58

Recommendation 8

That the Government of Canada work to rebrand the Canada Student Loans, Grant and Bond programs and increase the flexibility of the application process to reflect the unique needs of Indigenous students; and work with respective First Nations communities to expand the flexibility of the Post-Secondary Student Support Program, with increased funding to support a greater number of students. 59

Recommendation 9

That the Government of Canada, working in partnership with Indigenous organizations and territorial and regional governments, establish a university in the North. 59

Recommendation 10

That the Government of Canada, in partnership with provincial, territorial and Indigenous governments, recognize the fundamental role of economic development and job creation in advancing Indigenous-specific youth suicide prevention strategies. 59

Recommendation 11

That the Government of Canada develop comprehensive employment wrap around services for Indigenous people, including transportation, transitional housing and employment coaching. 59

Recommendation 12

That the Government of Canada ensure that mental health services in Indigenous communities are trauma-informed and provide safe spaces for young people to disclose adverse childhood events and provide culturally appropriate follow-up care..... 60

Recommendation 13

That the Government of Canada completely overhaul Child and Family services for First Nations communities to increase prevention support for children and their families, keep more children out of foster care and support them growing up with a secure personal cultural identity. Further, that the Government of Canada work, on an urgent basis and in partnership with First Nations, and other partners to deliver comprehensive child welfare reform on reserve that puts the well-being of Indigenous children first. 60

Recommendation 14

That the Government of Canada ensure Friendship Centres receive adequate funding over multiple years to enable continuous programming, services and investments in infrastructure to support Indigenous peoples..... 60

Recommendation 15

That Indigenous and Northern Affairs Canada increase funding to Indigenous communities for youth and community centres; and work with communities to provide sustainable culturally appropriate programming. 61

Recommendation 16

That the Government of Canada, in partnership with respective First Nations, Inuit and Métis communities, support Indigenous-specific Mental Health Frameworks and Strategies and ensure they are provided with adequate, long-term funding; and develop measures to track progress concerning the implementation of these strategies and report on progress. 61

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- That the Government of Canada work in collaboration with Indigenous peoples and communities to improve mental health services in all Indigenous communities on a needs basis.
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APPENDIX A

SURVEY — QUALITY AND AVAILABILITY OF MENTAL HEALTH SERVICES IN INDIGENOUS COMMUNITIES

TABLE 1

What is your profession?

Answer	Count	Percent Answer
General practitioner	19	11.7%
Community-health nurse	4	2.5%
Nurse practitioner	2	1.2%
Psychiatric nurse	4	2.5%
Therapist	12	7.4%
Social worker	26	16.0%
Program administrator	18	11.0%
Community health worker	11	6.7%
Other	67	41.1%
Not answered	0	0%

TABLE 2

Do you self-identify as an Aboriginal person?

Answer	Count	Percent Answer
Yes	92	56.4%
No	68	41.7%
Don't know	1	0.6%
Prefer not to answer	2	1.2%
Not answered	0	0%

TABLE 3

Are you:

Answer	Count	Percent answer
First Nation	56	34.4%
Inuit	16	9.8%
Métis	18	11.0%
Prefer not to answer	2	1.2%
Not answered	71	43.6%

TABLE 4

What province or territory do you work in?

Answer	Count	Percent Answer
Alberta	14	8.6%
British Columbia	18	11.0%
Manitoba	8	4.9%
Nova Scotia	1	0.6%
New Brunswick	0	0%
Newfoundland and Labrador	10	6.1%
Ontario	46	28.2%
Prince Edward Island	0	0%
Quebec	29	17.8%
Saskatchewan	20	12.3%
Northwest Territories	9	5.5%
Nunavut	8	4.9%
Yukon	0	0%
Not answered	0	0%

TABLE 5

How would you characterize the community you work in?

Answer	Count	Percent Answer
Rural	45	27.6%
Remote	29	17.8%
Remote fly-in community	47	28.8%
Urban	42	25.8%
Not answered	0	0%

TABLE 6

Is the community you work in:

Answer	Count	Percent Answer
Inuit community	37	22.7%
Métis settlement	1	0.6%
On-reserve	69	42.3%
Off-reserve	56	34.4%
Not answered	0	0%

TABLE 7

What type of facility do you predominantly work in:

Answer	Count	Percent answer
Hospital	22	13.5%
Long-term care facility	1	0.6%
Community Health Facility	42	25.8%
Nursing station	13	8.0%
Treatment centre	5	3.1%
Other	80	49.1%
Not answered	0	0%

TABLE 8

Are your clients predominantly

Answer	Count	Percent answer
First Nation	114	69.9%
Inuit	40	24.5%
Métis	9	5.5%
Not answered	0	0%

TABLE 9

Do you have access to continuing professional development training for your profession or specialty?

Answer	Count	Percent answer
Yes	116	71.2%
No	30	18.4%
Don't know	14	8.6%
Prefer not answer	3	1.8%
Not answered	0	0%

TABLE 10

Is the continuing professional development sufficient to meet the standards in place for your professional certification?

Answer	Count	Percent answer
Yes	73	44.8%
No	28	17.2%
Don't know	11	6.7%
Prefer not to answer	4	2.5%
Not answered	47	28.8%

TABLE 11

Have you completed specialized training on the provision of culturally appropriate mental health services to Indigenous people, with a focus on the people, community or nation you work with?

Answer	Count	Percent answer
Yes	66	40.5%
No	90	55.2%
Don't know	2	1.2%
Prefer not to answer	5	3.1%
Not answered	0	0%

TABLE 12

In the past 12 months, did you miss work for more than a half-day due to workplace stress?

Answer	Count	Percent answer
Yes	63	38.7%
No	95	58.3%
Don't know	3	1.8%
Prefer not to answer	2	1.2%
Not answered	0	0%

TABLE 13

Overall, how would you describe the quality of mental health care available in the community you work in?

Answer	Count	Percent answer
Prefer not to answer	0	0%
Don't know	5	3.1%
Very poor	51	31.3%
Below average	50	30.7%
Average	35	21.5%
Above average	19	11.7%
Excellent	3	1.8%
Not answered	0	0%

TABLE 14

What are the reasons why the quality of the mental health care available is below average or very poor?

Answer	Count	Percent answer
Not enough staff	84	51.5%
Too many patients, residents or clients	64	39.3%
Poor communication	48	29.4%
Not enough supplies	24	14.7%
Equipment not available or not working	19	11.7%
Not trained adequately	71	43.6%
Don't know	2	1.2%
Prefer not to answer	1	0.6%
Other	16	9.8%
Not answered	62	38.0%

TABLE 15

How would you rate the availability of each of the following early intervention services to reducing vulnerability to suicide?

Matrix row	Not answered	Available	Only available outside of the community	Not available	Don't know
Pre-natal care	2 (1.2%)	112 (68.7%)	9 (5.5%)	10 (6.1%)	30 (18.4%)
Early childhood interventions e.g., Aboriginal Head Start	4 (2.5%)	92 (56.4%)	17 (10.4%)	18 (11.0%)	32 (19.6%)
Assessment and programs for those children requiring specialized services e.g., autism screening, brain-related injuries, Fetal Alcohol Spectrum Disorder	3 (1.8%)	39 (23.9%)	65 (39.9%)	32 (19.6%)	24 (14.7%)
Awareness education for school-aged children and youth	5 (3.1%)	65 (39.9%)	14 (8.6%)	37 (22.7%)	42 (25.8%)
Extra-curricular activities e.g., sports, culture, arts or other for youth	1 (0.6%)	114 (69.9%)	7 (4.3%)	21 (12.9%)	20 (12.3%)
Family strengthening programs, e.g., to connect generations, life skills	2 (1.2%)	65 (39.9%)	10 (6.1%)	50 (30.7%)	36 (22.1%)
Programs to build resilience and coping skills e.g., cultural education, social, emotional development	1 (0.6%)	64 (39.3%)	16 (9.8%)	52 (31.9%)	30 (18.4%)
Mental health assessments	1 (0.6%)	80 (49.1%)	47 (28.8%)	16 (9.8%)	19 (11.7%)
Indigenous-specific mental health services and supports	4 (2.5%)	54 (33.1%)	21 (12.9%)	57 (35.0%)	27 (16.6%)

Matrix row	Not answered	Available	Only available outside of the community	Not available	Don't know
Applied Suicide Intervention Skills Training (ASIST) for community members or staff	2 (1.2%)	80 (49.1%)	27 (16.6%)	27 (16.6%)	27 (16.6%)
SafeTALK workshop for community members or staff	2 (1.2%)	44 (27.0%)	20 (12.3%)	50 (30.7%)	47 (28.8%)
First Nations Mental Health First Aid for community members or staff	1 (0.6%)	43 (26.4%)	25 (15.3%)	48 (29.4%)	46 (28.2%)
Addictions treatment, e.g., residential treatment or ability to refer to	2 (1.2%)	76 (46.6%)	58 (35.6%)	16 (9.8%)	11 (6.7%)
Services for those with dual diagnosis e.g., mental health condition and addictions	5 (3.1%)	45 (27.6%)	58 (35.6%)	33 (20.2%)	22 (13.5%)

TABLE 16

How would you rate the availability of following mental wellness services to your patients?

Matrix row	Not answered	Available	Not available	Only available outside of the community	Don't know
Indigenous therapeutic approaches e.g., traditional counseling, circles	1 (0.6%)	64 (39.3%)	56 (34.4%)	21 (12.9%)	21 (12.9%)
Indigenous cultural approaches e.g., education, ceremony	3 (1.8%)	74 (45.4%)	44 (27.0%)	16 (9.8%)	26 (16.0%)
Western group or individual counseling	2 (1.2%)	114 (69.9%)	10 (6.1%)	18 (11.0%)	19 (11.7%)
Telemedicine	1 (0.6%)	80 (49.1%)	23 (14.1%)	9 (5.5%)	50 (30.7%)

Matrix row	Not answered	Available	Not available	Only available outside of the community	Don't know
24 hour crisis line	1 (0.6%)	90 (55.2%)	25 (15.3%)	33 (20.2%)	14 (8.6%)
Crisis response	2 (1.2%)	95 (58.3%)	24 (14.7%)	19 (11.7%)	23 (14.1%)
Community mental health support and aftercare	2 (1.2%)	85 (52.1%)	31 (19.0%)	18 (11.0%)	27 (16.6%)
Psychiatric services	1 (0.6%)	50 (30.7%)	29 (17.8%)	72 (44.2%)	11 (6.7%)
Psychological services	4 (2.5%)	60 (36.8%)	22 (13.5%)	65 (39.9%)	12 (7.4%)
Addictions treatment, e.g., residential treatment or ability to refer to	3 (1.8%)	66 (40.5%)	12 (7.4%)	73 (44.8%)	9 (5.5%)
Services for those with dual diagnosis e.g., mental health condition and addictions	3 (1.8%)	48 (29.4%)	28 (17.2%)	63 (38.7%)	21 (12.9%)

TABLE 17¹

In your opinion, how important is it that the Government of Canada focus attention on each of the following?

Matrix row	Not answered	Not important	Important	Critically important	Don't know
Increasing community mental health services	0 (0%)	5 (3.1%)	19 (11.7%)	137 (84.0%)	2 (1.2%)
Increasing access to mental health care professionals (including psychiatrists, social workers, etc.)	0 (0%)	4 (2.5%)	27 (16.6%)	131 (80.4%)	1 (0.6%)

Matrix row	Not answered	Not important	Important	Critically important	Don't know
Developing more safe affordable housing for persons with mental illness	0 (0%)	5 (3.1%)	28 (17.2%)	128 (78.5%)	2 (1.2%)
Training more mental health care workers	1 (0.6%)	4 (2.5%)	35 (21.5%)	121 (74.2%)	2 (1.2%)
Increasing funding for regional mental health services	0 (0%)	7 (4.3%)	23 (14.1%)	131 (80.4%)	2 (1.2%)
Increasing funding for coordinated mental health research	2 (1.2%)	6 (3.7%)	55 (33.7%)	93 (57.1%)	7 (4.3%)
Providing support for families caring for those with mental illness	1 (0.6%)	4 (2.5%)	26 (16.0%)	128 (78.5%)	4 (2.5%)
Having the federal, provincial and territorial governments work together on a coordinated mental health plan	2 (1.2%)	8 (4.9%)	26 (16.0%)	122 (74.8%)	5 (3.1%)
Investing in dedicated mental health funding for Indigenous communities and people	1 (0.6%)	5 (3.1%)	14 (8.6%)	141 (86.5%)	2 (1.2%)

[†] Respondents could select multiple options.

TABLE 18

When a patient requires immediate care for mental health, how long do they usually have to wait before they get an appointment with a therapist, social worker or another care provider?

Answer	Count	Percent answer
On the same day	30	18.4%
The next day	6	3.7%
In 2 to 3 days	19	11.7%
In 4 to 6 days	9	5.5%
In 1 or 2 weeks	15	9.2%
Between 2 weeks and one month	24	14.7%
One month or more	29	17.8%
Don't know	31	19.0%
Not answered	0	0%

TABLE 19

During the past 12 months, was there ever a time when you felt that your patient needed mental health care but did not receive it?

Answer	Count	Percent answer
Yes	119	73.0%
No	15	9.2%
Prefer not to answer	3	1.8%
Don't know	7	4.3%
Not applicable	19	11.7%
Not answered	0	0%

TABLE 20

In the past 12 months, have you worked with a patient who had seriously contemplated suicide?

Answer	Count	Percent answer
Yes	111	68.1%
No	28	17.2%
Don't know	13	8.0%
Prefer not to answer	11	6.7%
Not answered	0	0%

TABLE 21

Does your community have a suicide prevention plan or program?

Answer	Count	Percent answer
Yes	37	22.7%
No	53	32.5%
Don't know	65	39.9%
Prefer not to answer	8	4.9%
Not answered	0	0%

APPENDIX B LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
Canadian Institutes of Health Research Dr. Alain Beaudet, President	2016/05/31	16
Department of Health Keith Conn, Assistant Deputy Minister Regional Operations Dr. Tom Wong, Executive Director Office of Population and Public Health		
Department of Indian Affairs and Northern Development Paula Isaak, Assistant Deputy Minister Education and Social Development Programs and Partnerships Sector Daniel Leclair, Director General Community Infrastructure Branch, Regional Operations		
National Association of Friendship Centres Yancy Craig, Director Strategic Development Christopher Sheppard, Vice-President	2016/06/02	17
As an individual Jack Hicks, Adjunct Professor Community Health and Epidemiology, University of Saskatchewan	2016/06/07	18
Inuit Tapiriit Kanatami Natan Obed, President		
Chiefs of Ontario Isadore Day, Ontario Regional Chief	2016/06/09	19
Manitoba Regional Chief Assembly of First Nations Kenneth Young, Former Regional Chief		
As an individual Dr. Cornelia Wieman, Consultant Psychiatrist	2016/06/14	20
As individuals Adam Akpik Caroline Anawak Jack I. Anawak David Joanasie	2016/09/23	23

Organizations and Individuals	Date	Meeting
As individuals	2016/09/23	23
Hon. Paul Okalik, Member of the Legislative Assembly Constituency of Iqaluit-Sinaa		
Toby Otak		
Emiliano Qirngnuq		
Brian Tagalik		
Peter Williamson		
Louisa Willoughby		
Embrace Life Council		
David Lawson, President		
Kimberly Masson, Executive Director		
Government of Nunavut		
Hon. George Hickes, Minister of Health Minister responsible for Suicide Prevention		
Karen Kabloona, Associate Deputy Minister, Quality of Life Department of Health		
Shuvinai Mike, Director of Inuit Qaujimagatuqangit Department of Culture and Heritage		
National Inuit Youth Council		
Maatalii Okalik, President		
Nunatsiavut Government		
Nina Ford, Youth Representative Youth Division		
Johannes Lampe, President		
Nunavut Kamatsiaqtut Help Line		
Sheila Levy, Executive Director		
Nunavut Tunngavik Inc.		
James T. Arreak, Chief Executive Officer Executive Services		
Jeannie Arreak-Kullualik, Director Department of Social and Cultural Development		
Qarjuut Youth Council		
Alicia Aragutak, President		
Louisa Yeates, Vice-President		

Organizations and Individuals	Date	Meeting
<p>As individuals</p> <p>Michael Chandler, Professor Emeritus University of British Columbia, Department of Psychology</p> <p>Christopher Lalonde, Professor University of Victoria, Department of Psychology</p>	2016/09/26	24
<p>As an individual</p> <p>Shawn Matthew Glode</p> <p>Leave Out Violence Nova Scotia Society</p> <p>Sarah MacLaren, Executive Director</p> <p>Shurenda Michael, Youth Leader</p> <p>Richard Taylor, Operations Manager</p> <p>Mi'kmaw Native Friendship Society</p> <p>Pamela Glode Desrochers, Executive Director</p>	2016/09/28	25
<p>As individuals</p> <p>Michael DeGagné, President and Vice-Chancellor Nipissing University</p> <p>Rod McCormick, Professor and Research Chair Thompson Rivers University</p> <p>Ilisaqsivik Society</p> <p>Jakob Gearheard, Executive Director</p> <p>National Collaborating Centre for Aboriginal Health</p> <p>Margo Greenwood, Academic Leader</p> <p>Qaujigiartiit Health Research Centre</p> <p>Gwen K. Healey, Executive and Scientific Director</p>	2016/10/05	27
<p>Canadian Indigenous Nurses Association</p> <p>Lisa Bourque Bearskin, President</p> <p>Lindsay Jones, Indigenous Nursing Student</p> <p>First Nations Health Managers Association</p> <p>Marion Crowe, Executive Director</p> <p>Calvin Morrisseau, Board of Directors, Executive and Ontario Representative</p>	2016/10/17	28
<p>Assembly of First Nations</p> <p>Will Landon, National Youth Council Representative Ontario</p> <p>Canadian Association for Suicide Prevention</p> <p>Ed Connors, Director</p> <p>Jennifer Ward, Director Survivors Chair</p>	2016/10/19	29

Organizations and Individuals	Date	Meeting
<p>Mental Health Commission of Canada</p> <p>Louise Bradley, President and Chief Executive Officer</p> <p>Ed Mantler, Vice-President Programs and Priorities</p>	2016/10/19	29
<p>As individuals</p> <p>Amy Bombay, Assistant Professor Department of Psychiatry</p> <p>John Haggarty, Professor / Chief of Psychiatry Northern Ontario School Medicine / St. Joseph's Care group</p> <p>Laurence J. Kirmayer, Professor and Director, Division of Social and Transcultural Psychiatry, McGill University Director, Culture and Mental Health Research Unit, Institute of Community and Family Psychiatry, Jewish General Hospital</p>	2016/10/24	30
<p>Cree Board of Health and Social Services of James Bay</p> <p>Greta Visitor, Assistant Executive Director Miyupimaatisiuiun Regional Services</p> <p>Weeneebayko Area Health Authority</p> <p>Leo Ashamock (Loone), Chairman</p> <p>Deborah Hill, Vice-President of Clinical Services and Chief Nursing Executive</p>	2016/10/26	31
<p>Aboriginal Life in Vancouver Enhancement Society</p> <p>Scott Clark, Executive Director</p> <p>As individuals</p> <p>Sam George</p> <p>Cody Kenny</p> <p>Gertrude Pierre</p> <p>Yvonne Rigsby-Jones</p> <p>Ray Thunderchild</p> <p>British Columbia Association of Aboriginal Friendship Centres</p> <p>Eric Klapatiuk, President Provincial Aboriginal Youth Council</p> <p>Cheslatta Carrier Nation</p> <p>Mavis Benson, Member</p> <p>Deh Gah Got'ie First Nations</p> <p>Joachim Bonnetrouge, Chief</p>	2016/11/02	32

Organizations and Individuals	Date	Meeting
<p>First Nations Health Authority Shannon McDonald, Deputy Chief Medical Officer Patricia Vickers, Director Mental Wellness</p>	2016/11/02	32
<p>Métis Nation British Columbia Cassidy Caron, Minister, Métis Youth British Columbia Provincial Youth Chair Tanya Davoren, Director of Health</p>		
<p>Provincial Health Services Authority Cassandra Blanchard, Program Assistant Indigenous Health Gabriella Emery, Project Manager Indigenous Health</p>		
<p>Department of Health Simon Kennedy, Deputy Minister Sony Perron, Senior Assistant Deputy Minister First Nations and Inuit Health Branch Hon. Jane Philpott, Minister of Health</p>	2016/11/16	34
<p>Native Women's Association of Canada Lynne Groulx, Executive Director Amy Nahwegahbow, Senior Manager Partner for Engagement and Knowledge Exchange</p>		
<p>Confederacy of Treaty 6 First Nations Susan Bobbi Herrera, Chief Executive Officer</p>	2017/02/07	42
<p>Federation of Sovereign Indigenous Nations Heather Bear, Fourth Vice-Chief</p>		
<p>Métis Nation of Alberta Sylvia Johnson, Co-Minister of Health, Children and Youth</p>		
<p>Assembly of Manitoba Chiefs Derek Joseph Nepinak, Grand Chief</p>	2017/02/09	43
<p>Atlantic Policy Congress of First Nations Chiefs Secretariat Candice Paul, Chief, St. Mary's First Nation, and Co-Chair, Atlantic Policy Congress of First Nations Chiefs Secretariat</p>		
<p>Manitoba Keewatinowi Okimakanak Inc. Sheila North Wilson, Grand Chief</p>		

Organizations and Individuals	Date	Meeting
Representative for Children and Youth Bernard Richard, Representative, British Columbia	2017/02/09	43
Thunderbird Partnership Foundation Carol Hopkins, Executive Director		
Ojibways of Onigaming Kathy Kishiqueb, Chief	2017/02/14	44
Pimicikamak Okimawin Catherine Merrick, Chief Kendall Robinson, Youth Councillor		
First Nations Child and Family Caring Society of Canada Cindy Blackstock, Executive Director	2017/02/16	45
Indigenous Health Alliance Dr. Alika Lafontaine, Collaborative Team Lead		
Mamawetan Churchill River Health Region Dr. James Irvine, Medical Health Officer Denise Legebokoff, Director Mental Health and Addictions David Watts, Executive Director Integrated Health		
Office of the Child and Youth Advocate Alberta Del Graff, Child and Youth Advocate		

APPENDIX C LIST OF BRIEFS

Organizations and Individuals

Canadian Counselling and Psychotherapy Association

Centre for Addiction and Mental Health

Healey, Gwen K.

Helin, Linda

Jong, Michael

Métis Nation British Columbia

Mulay, Shree

National Collaborating Centre for Aboriginal Health

Nunavut Tunngavik Inc.

Nuu-chah-nulth Tribal Council

Pollock, Nathaniel J.

Provincial Health Services Authority

Weeneebayko Area Health Authority

Young, T. Kue

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings* ([Meetings Nos. 16–20, 23–25, 27–32, 34, 42–46, 54, 59, 63 and 64](#)) is tabled.

Respectfully submitted,

Hon. MaryAnn Mihychuk

Chair

