HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Thursday, October 19, 2023

COMMITTEE ROOM/VIDEO CONFERENCE

Mental Health Supports for First Nations Communities

Printed and Published by Nova Scotia Hansard Reporting Services

HEALTH COMMITTEE

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Susan Leblanc

[Rafah DiCostanzo was replaced by Lorelei Nicoll.]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Tajikeimik -Mi'kmaw Health and Wellness
Lindsay Peach
Executive Director

Sharon Rudderham
Director, Health Transformation

Mi'kmaq of Nova Scotia Health Directors Committee
Juliana Julian
Co-Chair; Health Director, Paqtnkek First Nation

Elaine Allison
Co-Chair; Health Director, Wagmatcook First Nation

Nova Scotia Health Authority
Dr. Andrew Harris
Senior Medical Director, Mental Health and Addictions

Nadine Wadden
Director, Eastern Zone Mental Health and Addictions

IWK Health Centre
Maureen Brennan
Director, Mental Health and Addictions

Dr. Alexa Bagnell
Chief of Psychiatry

Office of Addictions and Mental Health
Francine Vezina
Executive Director

House of Assembly
Nova Scotia

HALIFAX, THURSDAY, OCTOBER 19, 2023

STANDING COMMITTEE ON HEALTH

9:00 A.M.

CHAIR
John A. MacDonald

VICE CHAIR
Danielle Barkhouse

THE CHAIR: Order. I call the meeting to order. This is the Standing Committee on Health. I'm John A. MacDonald, the MLA for Hants East and the Chair of the committee. I'd like to begin by acknowledging that we are in Mi'kma'ki, the traditional ancestral land of the Mi'kmaw people.

Today we will hear witnesses on Mental Health Supports for First Nations Communities. Please put all your phones on silent. Now I will ask the committee members to introduce themselves for the record by stating their name and their constituency. I'll be starting with MLA Barkhouse.

[The committee members introduced themselves.]

THE CHAIR: For the purposes of Hansard, I also recognize the presence of Chief Legislative Counsel Gordon Hebb to my left, and Legislative Committee Clerk Judy Kavanagh to my right.

Sorry, first time I've had to chair this committee. I'd like to welcome the witnesses. I'd ask them to introduce themselves first. I'll go from Francine Vezina. I'll start with her. Introduce yourself, then we'll do opening statements after.

[The witnesses introduced themselves.]

THE CHAIR: Ms. Vezina.

FRANCINE VEZINA: Thank you for the invitation to join you here today to discuss mental health supports for First Nations communities. This is an important topic. With Sharon, Elaine, Juliana, and Lindsay here today, you have the right people.

In response to your land acknowledgement, I would like to take a minute to reflect on my gratitude for calling Waverley the place where I live and to reiterate my commitment to reconciliation.

We know there is work to be done when it comes to improving access to mental health and addictions services in our First Nations. We know services and support must be available to meet the needs of individuals, families, and communities. The best way to do that is for us to step back and let the community lead the way because they know their communities best. They know what kinds of resources, tools, services, and support are going to work on the ground. They know how to deliver care that is not only responsive to the needs of those communities but also grounded in culture and traditional healing.

Government has a role to play - to support a Mi’kmaq-led, culturally safe, trauma-informed and comprehensive high-quality health care system and we are committed to doing that.

THE CHAIR: Ms. Peach.

LINDSAY PEACH: We are actually going to start with Juliana, if that’s okay, and Sharon will speak for Tajikeimɨk.

THE CHAIR: Ms. Julian.

JULIANA JULIAN: Kwe’. I would like to emphasize the importance of the land acknowledgement. We need to remember that our Mi’kmaw nation has been here for 13,500 years. This land is ours. We are living and working on unceded Mi’kmaw territory.

Your land acknowledgement is particularly significant for this discussion on mental health for First Nations. We need to acknowledge the impact that the loss of land taken with no consent has had on our mental health and wellness. It has deprived us of traditional healing, traditional food, and our way of being. It is a loss of power, and it puts us as Mi’kmaq at a disadvantage from the start.

To bring Mi’kmaw tradition into the room, we have brought a smudge bowl and our sacred medicines, sweetgrass and sage. Teluisi Juliana Julian. I am a Mi’kmaw from Paqtnkek Mi’kmaw Nation and I’m the Health Director for the Paqtnkek Health Centre. Elaine Allison is the Health Director for the Wagmatcook Health Centre. We co-chair the Mi’kmaq of Nova Scotia Health Directors Committee.

Our committee is comprised of health directors from 13 Mi'kmaw communities in Nova Scotia. We work to enhance health and wellness for the Mi'kmaw Nation in Nova Scotia. This includes advancing Tajikeimɨk and identifying priorities to improve our health and wellness systems.

As health directors, we see how the legacy of colonization has led to the intense trauma and loss in our Mi'kmaw communities. The rapid settlement of Nova Scotia drastically changed the connection to our lands, culture, health, and the well-being of our people. Simply put, our culture's high need for mental wellness supports and services is a direct result of colonial policies, trauma and abuse.

Our Nova Scotia Mi'kmaw Client Linkage Registry health data shows that mental health and addictions disorders are high amongst Mi'kmaq compared to Nova Scotians overall. Prevalence is increasing at a faster rate for our people.

Rates of suicide and attempted self harm in our communities are higher. The majority of our people who attempt self harm or have died of suicide are under the age of 40. People in our communities use political outpatients and mental health and addictions services at a much higher rate than other Nova Scotians.

The rate of mental health and addictions related hospitalization is much higher amongst our population. After discharge, our people are less likely to receive follow-up care from provincial mental health and addiction systems, and we are more likely to be readmitted to hospital within 30 days. Our data clearly shows the current mental health and addiction systems are not working.

Mi'kmaq in Nova Scotia need mental health and addiction services and supports that are accessible and available in community that are culturally safe, trauma informed, and include land-based healing, ceremony, and language. By working together differently, we can ensure high quality, culturally safe, holistic wellness to improve health outcomes for Mi'kmaw individuals and communities. Wela'lioq.

THE CHAIR: Ms. Rudderham.

SHARON RUDDERHAM: Wela'lin, Juliana.

Kwe', teluisi Sharon Paul Rudderham. I am Mi'kmaq from the Membertou First Nation in beautiful Unama'ki Cape Breton. I am, as I said earlier, the Director of Health Transformation with Tajikeimɨk. Prior to this, I was the Health Director in Eskasoni First Nation for 20 years.

Tajikeimɨk is a Mi'kmaw word that means to be healthy. We are the new and developing health and wellness organization being created to lead health transformation for the Mi'kmaq of Nova Scotia. Health transformation is the process of Mi'kmaq taking

control in the design and delivery of health and wellness services to improve the overall health for individuals and communities.

Tajikeimɨk is accountable to communities. Our work is guided by the 13 health directors, chiefs, and the Mi'kmaq Grand Council. Our work advances health and wellness as a nation.

As Juliana shared, our health data clearly shows worse mental health and addictions conditions and outcomes for Mi'kmaq compared to non-Indigenous Nova Scotians. This applies across all areas of health. The current health and wellness system is not working for our people, and a different approach is needed.

The work of health transformation cannot be accomplished by the Mi'kmaq alone. We recently signed a trilateral MOU which outlines the commitment of the federal and provincial partners to taking action on long-standing areas of priority for the Mi'kmaq.

The first priority is addressing anti-Indigenous racism within the health system. Specific to mental health and addictions is accessing mental health through the emergency room. Mental health needs to move out of emergency rooms. ERs are not safe spaces for our community members due to racism. Our people delay seeking help or care. When they finally do reach out, it's often at a crisis level, and then they're discharged back to community with no transitions in care or service.

Another priority is addressing the gaps in services that are created by jurisdictional issues. There has always been a misconception that health of Indigenous or Mi'kmaw people is only the responsibility of the federal government. This is false. Unclear policies and jurisdictional accountability create gaps in health services for our people. We must work collectively and collaboratively with provincial health system leadership and those who engage in policy design and health system planning to correct those misunderstandings.

We also need to include Mi'kmaw voices in planning and decision-making. The relationship between the province and the Mi'kmaw is nation to nation, yet historically, we have not been included in health system planning, engagement, or decision-making. Improving mental health and addictions outcomes in communities is not about increasing access to more colonial-based services, but it's about creating a two-eyed seeing approach to mental wellness and addictions that includes culture, language, and tradition. We recognize the funding provided to Tajikeimɨk through the Office of Addictions and Mental Health to create a mental health and wellness strategy is a first step in addressing these priorities, but also understand: much more is needed.

The provincial health system needs to be trauma informed and needs a safe place to address racism where it exists. Tajikeimɨk provides the opportunity for all of us to work together differently as a collective in a more effective and meaningful way.

THE CHAIR: Before we go on, I'll recognize MLA Leblanc to do her introduction.

[MLA Leblanc introduced herself.]

THE CHAIR: I just remind everybody to wait until you are recognized, for the microphones. Just for the people who haven't been here we do 20-20-20, so at the end of 20 minutes, I'll wind up saying "order." I'm not doing it to be rude, but it's to get everybody to get their time. After that, we'll do another round which will be roughly between 7 and 10 minutes. I'm looking at finishing at 10:40 a.m., which will give five minutes for any closing statements that anybody has.

We'll start with the Liberals, 20 minutes, MLA Regan.

HON. KELLY REGAN: Good morning, everyone. Thank you so much for coming out. This is my first time at this committee too. I'll probably interrupt repeatedly, and I'll bet smacked down by the Chair quite nicely.

[9:15 a.m.]

The government released this framework based on some legislation that our party brought in. It talks about how the health care system has systematically created barriers for Indigenous people. It made me think about a conversation that I had back when I was a minister with someone from another department who started off by saying Indigenous people aren't showing up for their appointments.

I was completely taken aback, and I said: Well, hold on there. Perhaps we should ask ourselves: If they're not showing up, why aren't they showing up? Maybe there are really good reasons. Maybe they have experienced racism in their dealings with the health care system. Maybe no one has taken the time to explain exactly what's going to happen. Maybe they've been in this building before and they were treated a certain way.

I was wondering if you could talk about what steps are being taken so Indigenous people feel safe when - or are they? Are they even feeling safe when they are accessing mental health care? The conversation we had was around surgery, but it seems to me this could be applied elsewhere. I think, to one of our witnesses from the Indigenous communities - I don't know who would want to take the lead on that.

THE CHAIR: So you're asking anyone, MLA Regan?

KELLY REGAN: Whoever.

THE CHAIR: Whoever wants to nod? I did see Sharon - I had a feeling I saw her. Ms. Rudderham, we'll let you go first, and I'll see who else wants to go.

SHARON RUDDERHAM: As I stated earlier in my opening comments, many of our Indigenous or Mi'kmaw people who live in community often face many challenges in obtaining services outside the community. They must figure out ways to get there; there are issues with transportation. There are issues, as well, with racism.

When they do access services in mainstream within the Nova Scotia Health system, they do not feel safe. There are no language services that can support them within the Nova Scotia Health Authority or IWK Health Centre system, so they're not effectively able to communicate and receive adequate translation supports to ensure they're being understood. In addition to that, because of the multiple racist experiences they have faced and inadequate care, our people no longer feel safe - especially our elders - when accessing health services. As I said earlier, this often results in our people delaying access to care. They then often go to access hospitals and it's too late. They're beyond - they must go into urgent surgery, or pass, or go into palliative. It's not a good situation.

THE CHAIR: I'm going to check if anybody else - does anybody else want to comment on it? Ms. Peach.

LINDSAY PEACH: If I could add to that: The whole concept around missed appointments in and of itself is a stereotype and racism. We have data that would suggest the opposite, that for some areas, that's less likely to happen amongst Mi'kmaq than non-Mi'kmaq. That in and of itself is a stereotype that needs to be challenged.

To Sharon's point, work is under way currently supported by the health directors and Tajikeimɨk, together with the Nova Scotia Health Authority and IWK Health Centre, to attempt to address that - several initiatives. One of the things to speak to is that there is work under way. We've received funding from the federal government to support the hiring of support coordinator positions. There were two positions previously, but that will be expanded to locations across the province. These will be individuals who can support community members while they're in hospital with some assistance - transportation and support for their family as they're coming to visit, for instance.

There's also a piece of work that we're involved with, together with the Nova Scotia Health Authority and IWK, in the hiring of clinical - Mi'kmaw clinical navigator positions to support individuals as they navigate through the health system. That is a complicated thing, to navigate both a provincial and a federal health system. As Sharon and Juliana referred to, there are jurisdictional gaps in the way that service is delivered. It's important for us to build the capacity within the health system, as well as in communities, to make sure the people understand that complexity of the health system and how they can support individuals.

Those are just a few examples of some of the work.

JULIANA JULIAN: Adding on to what Sharon and Lindsay were saying, there is work being done. There's still, of course, always going to be lots of work that still needs to be done. When you look at ways in which we're accessing our services, it's not so much that we're not accessing - it's not accessing the right services. We're over accessing it because it's not working for our people. If you continually go back to the same place and you're not getting what you need, you will continue to try with hopes that the next time will be better. I think that's ongoing on a regular basis.

The other thing that I would like to say is that really, at the end of the day, if you don't offer something that is more culturally appropriate and more driven from community, community is not going to have as positive an outcome. If you don't have the proper services that are being offered - that really comes from community, so if community doesn't have a say over what they want to see for themselves, then that's not going to happen.

KELLY REGAN: I would say that for most Nova Scotians, the health care system can be daunting trying to access it. Then when you layer over the issues of intergenerational trauma and services that really aren't culturally appropriate, it must be a very difficult task. I commend everyone who is working on this and everyone who's trying to get help.

All of us here at this committee have the goal of ensuring that the Mi'kmaw people of Nova Scotia have access to the services that they need and deserve. Thank you very much. Thank you also for correcting the record about that cynical assessment that I shared with you. At the time, I was very upset and quite taken aback and called the person out in the meeting.

Could you speak to the issue of transportation at all? Ms. Julian, I think you mentioned that you need to have services in community. If you don't have that, then you have to have transportation. Could you speak to that particular issue at all?

JULIANA JULIAN: In our community - I can't speak for all communities - but we do have access to some federal funding that supports people getting to and from appointments. At the end of the day, if you don't have transportation or a vehicle, you can't get there.

We can provide community access. In our community, we have a community van that would take people to and from appointments. It's a scheduling issue. If you have 600 people living in one community and you have one van and you're trying to make sure that everybody gets to their appointment, who's the priority? The ones who have to go to Halifax because it's a specialist appointment. Children who have to go to surgeries.

Those are all your priorities. Everyone else who has appointments locally kind of gets pushed to the side and it's their responsibility to get themselves to and from appointments.

The other thing is that the services really need to be brought to us. I really think that at the end of the day the services need to come to the community because community is already feeling like they're not accepted in those settings, so bring them to the settings where they do feel comfortable.

It's a challenge even to get community to open up to people in health care systems to begin with. Trying to get them to trust them enough to help them in mental health and addictions, when everyone knows that mental health and addictions are very personal things.

Relationships need to be built. It may not even need to be built with the professionals that we are provided from the Nova Scotia health care system, I guess. We need more traditional healers and access to land-based learning. We have the fastest growing youth population and yet our ability to access IWK Health Centre services is not as good as it should be. If we had services in community, maybe we would be able to help more of our young people. I guess I'll leave it at that.

SHARON RUDDERHAM: I also want to add that the current system that the Nova Scotia Health Authority and, I guess the IWK Health Centre as well, has in place, I know those systems are working to become more trauma informed. The issue specific to mental health and addictions is that you have to tell your story over and over again in order to get on the pathway to where you need to go. That is not a trauma-informed approach.

If you have to keep re-traumatizing and telling your story over and over again to multiple providers to obtain a pathway to care, it does not create a trusting relationship. You feel like you're going through an assembly-line system. It does not allow us to build those relationships. Whereas in community, if those services were available and were provided, you can build on those relationships. NSHA also has very strict rules around seeing as many people as they can see, and you can only see so many people for so many visits, and you have to move on through the system, or if you miss an appointment, it impacts your care. Being trauma informed is also another big issue and being able to - as Juliana said, the need to establish a trusting relationship cannot be created if they're not trauma informed.

THE CHAIR: Ms. Allison.

ELAINE ALLISON: I just wanted to add that we really need to meet the clients where they are. We need services right in the community. It's not fair to take someone to the regional hospital. You know the issues we have in ER. They sit, and they sit, and they sit. They don't want to stay any longer, and they walk out. Then we're in trouble. They

come back to the community, and then we have to deal with everything. The continuity of care, the collaborative care, we need to all work together to help the clients exactly where they are. Maybe it means - I'm a registered nurse in the community as well as the health director. I know that sometimes, we just go for a drive, and we talk to the clients. We take them for a drive. We pick them up, and we say, do you want to go to Tim Hortons? We go to Tim Hortons, and we have a coffee. That means that we get in and we get to talk to the client. Lots of providers will not do that, but we need to do that in our communities.

KELLY REGAN: Thank you for that really good explanation. There were a number of different aspects. I'm going to try to delve into some of those a little bit further. What Ms. Rudderham was saying reminded me of what we say about sexual assault victims. If you have to retell your story over and over again, you're reliving that pain. You're reliving that trauma. That's not good for healing.

Ms. Allison, you talked about going for a drive. If I were to say to you what would a successful mental health clinic in your community or a series of supports, what would they look like? If I said to you: Okay, what do you need? What would be what you're looking for?

[9:30 a.m.]

ELAINE ALLISON: First, I'm not Indigenous, but I have worked in this community for 25 years, and I did outpost nursing in the north. So I have been over 30 years in Indigenous communities. My dream would be to have a separate - not a separate building, but an area, a culturally safe area, with all the traditional healers available. If it's a traditional healer you need right now, or you need a social worker, or you need a clinical therapist, or you need a psychiatrist, one-stop shopping, you can come. The physician is in the community, the psychiatrists that come to the community, we would be able to have everybody together, and you would only have to come - the community that I work in is only one mile long from one end to the other.

I would be able to pick the client up and bring them to the health centre, but in a safe health centre, not a health centre that looks like a hospital. I don't like that. I think it needs to be culturally safe and built by the community. I would like to have this area where everyone can come together and you would have drumming, you would have sweetgrass, you would have the sweat lodge. You can do whatever the client wants to do first, if that's what they need, and then move on to our modern medicine. I think we need to use traditional medicine more.

THE CHAIR: Anyone else want to comment?

JULIANA JULIAN: I think the other thing is we're already making the assumption that we know what we need. We're not even there. Sometimes we're not even there, so trying to take the time for them to be able to build the trust is huge, and whether that's

traditional healers - because that's been taken away from us as well. We're reintroducing our people to things that we don't know the benefits from until we've actually been able to access it for our own healing purposes.

I think once we give our community members the flexibility, and the ability, and the services, and that it's there for them to decide where to go with it, I think that's the only real opportunity that we're going to have for true healing in communities and amongst - for our people, especially our young people. I think young people especially really need the support of their family, and if that's not their mom and dad, then it's the extended family. I think it's really important to realize the importance of extended families in Mi'kmaw communities.

LINDSAY PEACH: If I could just add to that as well, I think one of the things that we hear from health directors is in relation to crisis supports, and crises in Mi'kmaw communities look different from crises in non-Indigenous communities. Every death has an impact and a significant impact to that community because of the loss that it represents to the family, and to the community, and to culture and knowledge at times. That is one of the things that we've been working with the health directors, and exploring what a crisis response and support service looks like.

As Juliana and Sharon said, and Elaine as well, it is more than bringing western medicine to community. That is important, but we also need to take a two-eyed seeing approach to what the services look like.

THE CHAIR: MLA Regan with a minute and 10 seconds.

KELLY REGAN: We're not going to get a full answer on this, but I was just going to ask about young people, about accessing mental health care in schools. Does that happen? Is it possible? What would you like to see? You can get started on the answer.

THE CHAIR: Who wants to take that one?

JULIANA JULIAN: More. More help, more services, accessibility to proper services, community-based services. There is much more that you can offer and much more that you can't. There's so much that our young people need that they aren't getting now. We have kids who are in group homes. We have kids who are removed from the home for mental health issues and there's no real access to services for them, not enough.

THE CHAIR: Thank you for not making me say, Order. I looked at the clock and I'm going, like, this is not fun when you have to say it. I'm assuming with 10 seconds . . .

KELLY REGAN: You can give my time to the NDP.

THE CHAIR: Okay. MLA Leblanc.

SUSAN LEBLANC: I just wanted to ask - I was going to ask this question that MLA Regan did about in a perfect world, what would adequate and more-than-adequate services look like, and we're getting to it a little bit. I guess hearing the answer that was just given from a variety of people or from several people - and I missed the opening, sorry - but what are the obstacles? To get from where we are to where we need to be or where you need to be, what's required? Is it people? Is it more money? Is it commitment to brick-and-mortar buildings? What would be necessary to get there?

LINDSAY PEACH: I can start because we've had lots of conversations about this as well.

Not even specific to mental wellness resources but more broadly, the funding that's been provided to communities historically tends to be for planning, with never the money to implement, or a short-term two- or three-year pilot project - I hate that phrase - with never the plan to learn from that and sustain it. In some cases, particularly with the federal government, the problem is sometimes with silos and the way that that funding is allocated.

In a small community, trying to patch together all those portions of funding to do something that's impactful and sustainable is difficult. That's part of the opportunity that presents itself with health transformation - to do that differently. It is, in part, the funding but also, in part, the people to be able to do that work. Ideally, there are many of us who are not from community but work in support of community.

Ideally, we would have community members in those positions. Building the capacity of youth in community to enter the health professions in a variety of ways is part of the work that we've taken on as a health organization.

Working with our university colleagues, we have designated seats in many of the health professions but not necessarily a great process to make sure Mi'kmaw students are prioritized for those seats. There may not be a good process to make sure the right people are in those seats and we're supporting them as they're applying to those health professions, in the education programs, in their practice settings, and transitioning into employment.

Very much a part of the work that we see for our organization is to help build that capacity so when we do have the resources, we also have the people who can deliver that service in community.

SHARON RUDDERHAM: With response to the question that was asked, we require community-led mental health and addiction services. We do require a two-eyed seeing approach where we're also offering Mi'kmaw, traditional, and cultural services and supports, but we're also offering Western, clinically based services and supports.

We require a combination of both services broadly across all the communities that are trauma informed and culturally safe. In addition to that, we also need an effective way to respond to crises in community. Our communities regularly face crisis situations, and they have impacts.

When there is a death or a suicide in one community, the impacts are throughout the entire nation. When you lose one person in one community, our families are all connected, and we are all impacted. Understand how there would be so much compounded grief impacting our communities, which often leads to crisis situations. We need a mechanism and community-led services, supports, and infrastructure to provide those services directly within the community.

SUSAN LEBLANC: One of the things I was working on for a while was thinking about sort of an overhaul of the emergency 911 system to include mental health response, which is different from the mobile crisis program we have in HRM. The idea would be that you call 911 and they say: What's your emergency? and you say it's a mental health emergency, and they don't dispatch police or fire or ambulance. They dispatch a mental health emergency worker.

I'm wondering if that sort of community-based approach - so if someone at a particular First Nation calls for mental health supports, that there's a community approach that's an emergency response. It wouldn't be removing the person and taking them to the local regional hospital, because as we've heard, emergency rooms don't work for mental health emergencies.

I'm wondering if someone wants to respond to that idea, and/or is it actually being worked on right now? Is there something in mental health emergency being worked on, in terms of community-based treatment or response?

SHARON RUDDERHAM: Well, crisis response has been an ongoing challenge for our communities. You referenced an HRM crisis service that's available. That's only available in HRM. Right now, if we were to call 911 for those services, it would be police who would be dispatched to our communities. There are long-standing issues with our police as well, within Indigenous communities. We can refer to many reports - Donald Marshall Jr. - all kinds of other reports that have been done with relation to the relationship between police and Mi'kmaw communities. So a police response is often not a safe response in our communities.

I worked in Eskasoni for 20 years. When Eskasoni was dealing with their crisis, they established the Mi'kmaq Crisis Line. That crisis line hasn't received any kind of consistent or sustainable support to operate or to function or to grow. The Eskasoni crisis line was the only service that was culturally safe, that you could speak to someone in your own Mi'kmaw language. They would often support individuals, try to de-escalate, work

with mental health clinicians, and refer them to mental health clinicians in the community where the patient is living.

The support to create a system specific to the Mi'kmaq, like a crisis line, is an important and essential component, I think, in being able to provide an adequate crisis response that is available in Mi'kmaq. Again, as I stated earlier, language services or translation services are not available in the Mi'kmaw language within the Nova Scotia health care system, 911, 811 - no system provides any Mi'kmaw-language services.

SUSAN LEBLANC: I think that's a really big deal, not having translation services. I think this is something that has to be a number one priority for the Department of Health and Wellness and the Nova Scotia Health Authority. It is the first language of the territory we live in. If we can't provide services in the first language, then we've got a real problem. I think that needs to be a high priority for government. Thanks for bringing that to light, Ms. Rudderham.

[9:45 a.m.]

This idea of the sustainability of services, and this idea that there's money for pilot projects - listen, I come from the arts sector. That's basically the only way the arts sector's been funded for many years. I am so frustrated by it. It's so bad.

Is there discussion? The question really is: Is there someone of Mi'kmaw heritage in a high-up position in the Nova Scotia Health Authority to say: Don't forget we need these things, when planning and policy is being made? Don't forget about the Mi'kmaw Nations and the people who are living off reserve. Don't forget about that.

Is there someone in the department or at the Nova Scotia Health Authority responsible for that?

THE CHAIR: Your question is to . . . ?

SUSAN LEBLANC: Anyone. Someone from the Nova Scotia Health Authority or . . .

SHARON RUDDERHAM: No. There are no Mi'kmaw or Indigenous people at senior levels within the Nova Scotia Health Authority or IWK Health Centre system. I think that's a big gap in our system.

How can we effectively impact change? Direction comes from leadership within your health system. If we have no Mi'kmaw leadership at that level, then it's not being addressed.

SUSAN LEBLANC: Again, I agree. That is something we need to address at the department, the IWK Health Centre, and the Nova Scotia Health Authority levels so we can have that leadership at the top bringing that voice and that lens.

I also want to talk about the reserved seats for education for health care workers. Ms. Peach, you were saying there are designated seats but maybe not prioritization of Mi'kmaw students. Who are the seats designated for if they're not prioritizing Mi'kmaw people?

LINDSAY PEACH: Several of the programs recently have announced sort of designated Indigenous seats or seats available for Indigenous candidates.

Recently, Dalhousie Medical School has established an Indigenous pathway that would go with those seats or support those seats. We've been involved in some of that work with them. That actually has community members who are a formed part of the panel that helps make the decision on individuals who have applied and who is best and most appropriate for those designated seats.

That matters because, whether we like to admit it or not, there are individuals who claim ancestry who aren't of Indigenous ancestry or don't have a connection to community. It's important for us that there is, in addition to the designated seats, a process for selection to make sure students don't continue to be disadvantaged during that process.

They also must understand there is a system and a support there for them when they do self-identify. Asking students to self-identify during an application process to a health profession actually puts a target on them.

If they know they're likely to experience racism because they've self-identified - if you're going to ask people to do that, then you need to put the supports around them as well. What we have said is that it's great that there's a program that has designated seats, but let's try to do the work to put some process around it.

We've done some work specifically around nursing - with the support of the Office of Healthcare Professionals Recruitment, the Department of Health and Wellness, and the Department of Advanced Education working with the schools of nursing - to ask if there's something we can do to support that application process and, more importantly, support the students when they're in the programs.

Every time there is a new health profession program that's announced with designated seats, I would also like to see a consideration of what that means and what supports you're going to put in place to support those students who are self-identifying.

SUSAN LEBLANC: I have two follow-ups. Are there designated seats in the social work program at Dalhousie University? Second, what is the percentage of designated

seats? For medical school, for instance, what's the percentage of designated seats versus open seats - for lack of a better description - for nursing, medicine, and pharmacy.

LINDSAY PEACH: I may not be the best person to answer that. That may be a better question for the Department of Advanced Education. They would probably have the summary of the numbers of designated seats by program.

My understanding is there are designated seats within the social work program, both at Dalhousie University and the new one that's being established at Cape Breton University, if I understand that correctly. I think there are a number, but that may be a follow-up question that I wouldn't want to misspeak.

SHARON RUDDERHAM: I wanted to provide clarification. There is a program within Dalhousie University's School of Social Work that is specific to Mi'kmaq and Indigenous people.

SUSAN LEBLANC: Thank you for that clarification. That's helpful to know.

I'm wondering about data collection in general. Ms. Julian, you were talking about data collection in your data shows. I was happy to hear you referencing data because for a long time, we - there was no data being collected in a number of different streams in the health system. Who's collecting that data, how long has it been collected for, and is it working? It sounds like it is. It sounds like you know lots from the data. I wanted to dig into that a little bit more.

JULIANA JULIAN: I am going to refer this question to Sharon, who has been in the data collection business a lot longer than Paqtnkek. We kind of joined in on them. We kind of hopped on their coattails (laughter) because they knew what they were doing.

SHARON RUDDERHAM: Regarding data collection, the Nova Scotia Mi'kmaq have been working for many years. In collaboration with the Department of Health and Wellness, we have developed what's called the Nova Scotia Mi'kmaw Client Linkage Registry. That allows us to be able to extract information from provincial data sources. Now it includes - it's beyond the Department of Health and Wellness. It also includes the Nova Scotia Health Authority and the IWK Health Centre. The Department of Health and Wellness, business analytics; I'm not sure what the name is - they provide the support for us. They work collaboratively with us in the development and selection of indicators and the development of various reports that are reviewed by our communities. The same process is done with the Nova Scotia Health Authority and the IWK, as well.

That's what our data system is. Yes, the data is very extensive. It's all the various programs within the provincial system that currently collect data.

LINDSAY PEACH: I'll add to this quickly. It is a gold standard, that client linkage registry and the information it contains. It is what every other First Nation organization across the country is striving for in health transformation. The Mi'kmaq of Nova Scotia have it already as a foundation for the health transformation work, so it's pretty amazing.

THE CHAIR: MLA Leblanc, with 10 seconds.

SUSAN LEBLANC: That's fine.

THE CHAIR: Okay. MLA White.

JOHN WHITE: Very interesting conversation - I'm sitting here listening to, mostly, the value of community. That's what really gets me. I think that's core in everything, but you folks have made that extremely clear today, which is obvious, of course. Nonetheless, it's nice to hear you talking about it.

Ms. Peach, my first question - I only have two to start - I'm wondering about the mental health and addiction strategies for Indigenous people. Are you able to tell us a little bit about consultations that have happened or work that's been done on that file already?

LINDSAY PEACH: As was said earlier, we certainly acknowledge that any mental health and addictions strategy and work that we do needs to be more than just bringing western medicine to community. That is a piece of it. We also need to bring a two-eyed seeing approach, cultural and traditional healing practices back, as well. That's a big part of our work.

We were fortunate to receive funding in March 2022 from the provincial government to develop a Mi'kmaw mental health and addictions strategy. That really built on years of work that the health directors had done previously and some collaboration, as well. There were two federally funded integration initiatives where the province and the health authorities worked with the Mi'kmaw communities around identifying needs as they relate to mental health.

What we've done so far with the strategy is taken a look back at some of that information from the previous work that was done to see what's been achieved and what's still outstanding. We've also looked at the data from the Nova Scotia Mi'kmaw Client Linkage Registry, which is a wealth of information around needs and outcomes and utilization of services.

We've brought together the 13 health directors representing the community, as well as representatives from a number of partner organizations such as the Nova Scotia Native Women's Association, the Mi'kmaw Friendship Centre, and the Native Alcohol and Drug Abuse Counselling Association of Nova Scotia which provides treatment centre services to

communities. We brought all of those groups together to identify what the current priorities are, what's been done, and what's left to do.

That formed the initial foundation work. We've done other consultations that are not specific to mental wellness. It's hard to separate mental wellness and healing from the rest of the health transformation work that we're doing.

We had a mawio'mi last year. It was a large gathering of about 300 people. They were representatives from community and leadership coming together to advise us on their priorities for the organization and our health transformation work. That really reinforced some of the priority work that the health directors had shared related to mental wellness.

We've also done knowledge gatherings. We've brought together elders and knowledge keepers working with the Confederacy of Mainland Mi'kmaq and the Union of Nova Scotia Mi'kmaq to learn from those knowledge keepers about traditional practice as it relates to mental wellness, healing, and land-based healing and how we can bring some of that work back and support it and build that capacity. That's another consultation that we've done.

We just returned from two days in one of the communities. We're having mawio'mi and community engagement in each of the 13 communities as well over the next two months. We're busy with that. That is also reinforcing all of the messages about youth services and the need to support youth differently.

We'll compile all of that information ultimately into a strategy, but this will look different than other strategies, as it should. As Juliana has said, it's really important to reflect the needs of the community in that work.

JOHN WHITE: I'm extremely happy to hear you talk about just how much the community has been involved. That is what we're talking about when you're talking about a counselling session. It doesn't matter if it's a walk-and-talk or sitting across a desk. It's that trust that these folks were asking about earlier and that's what you're talking about there. I hope it does look different. I really hope it does. I hope that you keep your foot on the gas and keep us to the pedal.

My next question is: I understand that an MOU has been signed with the 13 First Nation communities, the federal government, and the provincial government. I'm wondering if you can give us an idea on the improvement of mental health and addictions services that may have for Indigenous people.

LINDSAY PEACH: I'm happy to do that. The MOU that was signed by the 13 Mi'kmaw communities in Nova Scotia as well as the provincial government and the federal government is part of our health transformation process.

As Sharon referenced, health transformation for us is the transfer of federal funding and responsibility to us as an organization to deliver on behalf of the Mi'kmaq of Nova Scotia in a very different way than what's previously been done by the federal government.

It will be similar to the work that was done in B.C. with the creation of their First Nations Health Authority. We will be the second province-wide first nations health authority to British Columbia. There are a few other initiatives in other jurisdictions across the country.

[10:00 a.m.]

The MOU was critical to that work. It's the first step in the health transformation process. We acknowledge, as Sharon said, this is bigger than the transfer of federal responsibility. This is working with our provincial partners differently. The MOU signifies the coming together of the parties to work differently, but we have also been able to demonstrate through action working differently.

We now have committees with senior leadership within the health system, where we have an opportunity to explain the jurisdictional gaps and the challenges and to address some of that work. We have worked on policy changes in the home care space, for instance. One of the areas with mental health, in addition to the strategy - there were recently opportunities before the MOU to expand access to western services into community. There has been lots of conversation around how that can shift, grow, and expand. There has been conversation around, as Sharon said, how we can sustain and support the Mi'kmaq Crisis Line that is delivered through Eskasoni. What does that look like?

The MOU and our establishment as an organization have created space and conversation in planning discussion in a very different way than what the communities would have done before. That has created a lot of new opportunities to be part of service planning conversations.

JOHN WHITE: I really want to take more of your time, but I know I must pass it along to MLA Barkhouse.

You said it was critical. It's critical to making real change. The work you're talking about is amazing.

THE CHAIR: MLA Barkhouse.

DANIELLE BARKHOUSE: The four of us must share the 20 minutes, so we try to be equal. My understanding of the two-eyed seeing approach is that one eye sees through the Indigenous and one eye sees through the western, and they come together to try to see the perspective. Please correct me if I'm wrong; that's just what I know. I would like to ask

about the two-eyed seeing approach and how that is incorporated into health for communities. That can be to anyone who wants to answer.

SHARON RUDDERHAM: I can start, and others can add.

The two-eyed seeing concept was developed by elders Albert and Murdena Marshall, who are from Eskasoni First Nation. I have had many discussions with Albert and the late Murdena. You are correct in your interpretation. It's about bringing those two worlds together and figuring out a common path and how we can utilize both worlds to achieve better outcomes and better healing pathways for all our people. We have strong connections to our culture and our land.

You have probably heard of the medicine wheel. That's a concept you have heard of in other Indigenous communities. It's about creating a balance. It goes beyond - it's not just your physical illness or about your physical symptoms. It's about finding balance in your being - your mental, your spiritual, and your physical health. It's about creating healing pathways and working together in two worlds to create a pathway - specific to mental health and addictions - about creating those pathways that can support the overall individual's healing and wellness.

JULIANA JULIAN: To add on to that: two-eyed seeing, if you go even one step further, is acknowledging that Indigenous people - First Nations people, Mi'kmaw people - had our own medicine. We had our own way of healing our people when they were sick. It's acknowledging the connection between the stars, the land. I know that sounds like that's all heebie-jeebie or whatever you want to call it, but the connection is there, and the healing opportunities with the way our moon is at certain times of the year, and our prayers, and our connection to the land - it's all there.

We had a way of being able to heal ourselves and heal our people. It's hard to try to go back to something that was taken away from us so abruptly. So trying to reintroduce those, not only to society but to our community members, and acknowledging that our medicines actually do work - and they probably work even better than western medication. It's just one step further, I guess.

DANIELLE BARKHOUSE: The *Baby Smiles* book. I kind of love this a lot. Well, not kind of. Let me try to put my words around what I'm thinking. It's a project that work partnerships that went into creating this. On your website, you mention - there's where my notes come in - that the partnership aims to create "a new way of thinking about health and the delivery of health services."

I'm wondering - and I'm pretty sure it would be Ms. Peach - if you could elaborate on this. I think it's absolutely wonderful.

LINDSAY PEACH: I can start. Sharon may want to add to this too. This was an initiative that started when she was health director in Eskasoni (inaudible).

For those who don't know, in amongst all the other work we're doing, we also published a book in our first two years as an organization. I think it demonstrates the innovation from community to sort of step in, see a need, and do something really creative in terms of how that need is met. It is an example of bringing culture and language into the work that we do, which is part of the larger and broader work of health transformation.

Sharon, did you want to speak to the details of the project? We're pretty proud of it.

SHARON RUDDERHAM: The reason that I started this plan or this idea was related to - the data informed us that many of our people were accessing emergency rooms for dental services. We were like: That's completely wrong. Why are people going to - I know it's an urgent issue and whatever else. Access to dental services has been a challenge for our people. They face racism when going in to try to access dental services as well. Not all providers are willing to accept our plan and refuse to provide services to our people. In addition to that, there's been a lot of trauma related to dental care because of the Indian Residential School system that has impacted generations of our people.

With that, we're now seeing increased numbers of emergency room visits because of dental issues. We're also seeing increased numbers of children going to the IWK Health Centre to access pediatric dental services because of tooth decay. So we have developed maternal/child health and Early Years services in our communities. We thought it was - I thought it was essential. It needs to start at an early age - education around oral health. Books are distributed as a resource through our Children's Oral Health Initiative team members, or our maternal telehealth, or Early Years team members who work in the community that could have a resource to share with families who have new babies.

As the other members said, we have some of the fastest growing populations and the highest rates of births in our communities, so we thought it was an essential resource that needed to be developed and shared. We're quite happy with the result. There's been lots of requests from right across the country to look at translating the book into other Indigenous languages as well.

DANIELLE BARKHOUSE: I'll be quick because I do have to share my time. I can see the pride, love, and commitment in your eyes, and I understand why. Thank you for talking a little about that because I don't think a lot of people do know. Thank you, and I will pass it over to MLA Palmer.

THE CHAIR: MLA Palmer, with three minutes, 10 seconds.

CHRIS PALMER: I love this committee. I love being on this committee and learning so much every time we come in here to meet with different groups or stakeholders in health care, and today's no different - to learn about the health needs in your community.

I represent Annapolis Valley First Nation in my constituency. At a powwow last weekend, I had a chance to meet with the lady who was there promoting the medical sciences pathway at Dalhousie University. That's part of the question I want to ask, because you've hit on a lot of the things that I was going to talk about here with the seats and with the Dalhousie program. You've also talked a little bit about the importance of Indigenous representation and care in your community.

I was going to ask, maybe Ms. Peach, if you could expand on that and the importance of having First Nations people in their community delivering those health services, understanding that we're still - you're moving toward traditional health care and exploring that - bringing that forward. As far as the promotion of health care in First Nations youth or mature students, can you talk about how you're doing that more? I met a lady who was at the powwow talking to people, but can you talk about how that's being promoted to people - those opportunities in health care in First Nations?

THE CHAIR: With a long preamble . . .

CHRIS PALMER: Sorry. (Laughter)

THE CHAIR: One minute, Ms. Peach. He knows why I grilled him. Ms. Peach, for one minute and 30 seconds.

LINDSAY PEACH: I'll try to answer that quickly. I think representation and people seeing themselves in the positions they aspire to is important. We've done work around promoting young Indigenous nurses so others can see them as role models and supports. That is important. That's important to have that in all aspects of the health professions, not only for services in community, but it improves the services in the rest of the provincial health system too. Having Mi'kmaw health professionals working in the health professions across the rest of the health system matters and is important, and we all need to support that.

A lot of the work we're doing to encourage youth to pursue careers in health professions is done through a partnership with other organizations. Whether that be the education system or the post-secondary system, the health directors do a lot of that work in their communities. As well, each of the individuals working in those communities spends a lot of time supporting other youth in the communities who are aspiring to enter into the health professions.

Some of the things that have happened recently - we've got cohorts within the nursing program, where that education started within community . . .

THE CHAIR: Order - I apologize. (Laughs) I know how you feel now, MLA Regan. (Laughter) The next round is going to be nine minutes - we're going to go until 10:41 a.m.

LORELEI NICOLL: I'm not on the committee, but I fully agree that health is everything, and health - the saying is sound mind and body, so it is how we all have it in balance. Articulating 13,500 years of generational trauma, that's a lot of years and a lot of trauma. I want to preface that because, at the end of the day, generational trauma is insidious. Our children pick it up and we don't even realize that they're picking it up. That's spoken from experience.

[10:15 a.m.]

I want to ask, with regard to - as a woman, and as an Indigenous woman - there was a study done in 2019 that said Indigenous women are more likely to have mental health issues around the birth of a baby, and 62 per cent were at increased risk for experiencing mental health problems like depression, anxiety, and substance abuse.

I just wondered - everyone here is working with the IWK Health Centre or other hospitals with regards to pregnancy care - how that is being looked at. Except for one gentleman, we're all women here so I really wanted to ask that.

THE CHAIR: Who did you want to ask?

LORELEI NICOLL: I would like to give an opportunity - because I want to compliment each of you who are doing the grassroots work in the community. We have two, I think, from institutions here that I would like to hear from. I'm hearing a lot from the bottom up, but I now want to hear from the top down. There are two doctors.

THE CHAIR: Pick one.

LORELEI NICOLL: It's women's issues, but then again . . . they can both go.

THE CHAIR: I'm going to go with Dr. Bagnell.

DR. ALEXA BAGNELL: I can speak to our program at the IWK Health Centre on reproductive mental health.

We have a group led by psychiatry with multiple disciplines who work with women who either have mental health issues or developed them during their pregnancy. They follow them pre-delivery and then a year afterwards. They do a lot of outreach in the community.

Also, the team has no Indigenous clinicians. I will say that, across the health centre, is an area that we're really working on because a lot of people walk into services and don't see themselves. That immediately makes it feel unsafe. That's not just for Indigenous folks, but for other minorities and people who have been racialized.

With our reproductive mental health, they would do a lot of outreach in the province space as well, and work with family physicians, primarily, in terms of early recognition and then maternal health and well-being. That makes a huge difference in that first year, which as a child and adolescent psychiatrist, I can tell you is incredibly important for the long-term development of that child and their mental health, as well as their overall health and well-being. I'll stop there.

THE CHAIR: I assume you'd like Dr. Andrew Harris . . .

LORELEI NICOLL: Especially the latter part of my question with regard to not just depression and anxiety but substance abuse. I see that you're addictions, as well, so I wanted you to sort of elaborate on that.

THE CHAIR: Dr. Andrew Harris.

DR. ANDREW HARRIS: I am unqualified, being the one man on the committee today. (Laughter) I think it's a good question really to speak to the relationship that we have amongst the two authorities of mental health and Tajikeimɨk.

We have worked, hopefully, very closely and collaboratively. We have learned a tremendous amount about how we provide our systems of care. I really would endorse the two-eyed seeing approach, which is to look at this through both lenses.

We're very fortunate to have this group of individuals, the health directors and the executive in Tajikeimɨk, who are great guides for us to tell us what we need to do, and how we need to provide services. We're completely on board with the approach that's being taken.

With regard to specifics around women's health and peripartum, I don't know if I could give you a specific answer that would answer your question. I think your broader context for this question, which is how we are working together, I would say that we're working together very effectively.

We have a lot of work to do. We've been at it for a while, but this type of work does take time.

THE CHAIR: MLA Nicoll with just under four minutes.

LORELEI NICOLL: I want to express to Juliana, thank you for that approach. A lot of times, when it comes to mental health, a lot of it - we don't trust the healing. A lot of the medicines in the Indigenous community, we could benefit from, and how that whole two-eyed seeing approach would benefit everyone at the end of the day.

The whole thing with - because I grew up on Isle Madame, a little Acadian community in Cape Breton - dental health is hard to get. Is there anything to expand on what we've discussed about dental health? Are we - do we have to have a seat for - to get dentists from the Mi'kmaq community?

THE CHAIR: And that's to . . .

LORELEI NICOLL: They're already nodding, so I don't . . .

THE CHAIR: You say that. I think I saw Ms. Rudderham's hand go up, so I'm not sure if she wants to speak to it. They love deferring to her, so Ms. Rudderham. (Laughter)

SHARON RUDDERHAM: I think there is work that needs to be done. I would like to see some work based on the learnings that they have completed at Dalhousie University and the learnings that we're going to achieve through our relationships that we're building with the nursing schools. I would really like to see it go beyond those two areas and see it further expanded. I think that there's definitely a need for improving a pathway to ensure that more Mi'kmaw or Indigenous people can access or obtain their dental qualification or certification.

We have just recently also begun some discussions with the Nova Scotia Dental Association and the regulatory board, and they're going to require a lot of education. They were not really aware of the racism or the issues that our community members were facing when being refused services and being - they wouldn't term it as "refused services." They're refusing our dental program, which is a federally funded dental program, similar to your provincial dental program, but they still have the ability to refuse our dental program. I don't know if there's something that can be done around that point, but there is a tremendous amount of work that still needs to be done with relation to dental services.

LORELEI NICOLL: To that point, I'm just going to say I have adopted saying the word "orders" of government, and I know the Prime Minister - I think I escalated it to there because he says it, because at the end of the day, we are all orders of government, and it includes the Indigenous community as an order of government when you use that term. That's all I have to say at this time. I'm impressed and I'm encouraged, but there's a lot more work that needs to be done.

THE CHAIR: MLA Burrill.

GARY BURRILL: I certainly feel very aware of the breadth of expertise that's represented by all of you here this morning. I did want to ask about initiatives in suicide prevention in First Nations communities, about how you would characterize the adequacy of the work that's being done. What are some of the strengths about it and some of the areas that we can see where improvement is needed? I'm unsure who to best direct this to.

SHARON RUDDERHAM: Yes. Some of the resources that we receive from Indigenous Services Canada, Health Canada, the funding that we do receive to support mental health services is for upstream services. That is to support suicide prevention training, assist training, various other types of training programs that we can offer in our communities. Of course, that's very minimal.

I also would like to talk about the importance of being able to have an effective response in community when there is a suicide. It goes beyond more than prevention. You can do prevention and education, but the ability of communities to have an effective response mechanism when a suicide does occur, or the ability to have a crisis line available 24/7 that is sustainable and funded and supported, are other factors.

I think that our communities have also done significant research and worked in the research field around looking at models of care with relation to youth suicide. One example that I can refer to: when I worked in Eskasoni, we were involved in Integrated Youth Services and the ability to have youth services and supports provided to young people in the community through bringing kids together for various learning and teaching suicide prevention, but also other opportunities to learn about culture and ceremony and others. The model in Eskasoni was where they would provide clinical supports in that same location and being able to build those relationships and build those trusting relationships between young people and youth in our communities is also essential.

I was pleased to see that the Nova Scotia government had supported the roll-out in the IWK of the Integrated Youth Services, and we're looking forward to that work expanding and being able to be provided within all of our Mi'kmaw communities here in Nova Scotia.

JULIANA JULIAN: Just to add onto what Sharon was saying, I think crisis teams are really needed in community, crisis teams that can respond in a different manner than what we would get accessing services at an emergency room. We get to the ER and it's not adequate services for our community members, and I think that some of the work that communities are doing in trying to respond to suicide in our communities is crucial and hugely needed.

We do have many suicide attempts, but we have just as many - in our community, it would have been new for us to have suicides. We never had any, and then boom, we've got two of them back to back really fast. Being able to respond in a way that is really mindful that - it has a trickle effect. Us trying to really put some investment in crisis response teams,

which is one of the biggest reasons we're really pushing to try to get crisis response teams in our communities, because it's greatly needed. I think we can't always respond to our own crises within our own communities, so we look to our neighbouring communities to come into our community.

NSHA is really good to say: Is there something we can do? I want to say yes, but they can't respond in a way that our own people respond to each other when we're in crisis. I think that's one of the biggest things. I think we're really moving towards trying to create those crisis teams within community so that we can have community members helping each other all across Mi'kma'ki.

GARY BURRILL: I'd like to ask too - in the Truth and Reconciliation Commission Calls to Action, mental health figures pretty prominently, and a lot of calls on orders of government for initiatives and programming. I'd like to ask whoever would like to offer comment on this about an assessment of where Nova Scotia is, kind of a thumbnail report card. Is Nova Scotia at the head of the pack? Are we somewhere in the middle? Are there particular areas where we're falling short of what the TRC has called for in mental health?

[10:30 a.m.]

THE CHAIR: Ms. Rudderham's hand goes up very quickly, but I'm going to check to see - I'm going to get to you second on this one, Ms. Rudderham.

FRANCINE VEZINA: I just want to open by saying that the Office of Addictions and Mental Health does aim to address the Calls to Action, which would be No. 18, by working closely with Tajikeimik and the Nova Scotia Mi'kmaw health directors in developing universal mental health and addictions care. It's clearly in its infancy, but we want to ensure that universal mental health and addictions care is provided in a way that's appropriate for our Indigenous communities.

SHARON RUDDERHAM: There is no plan. There is no strategy. That's my first point. There needs to be an action plan. There needs to be a strategy with the government of Nova Scotia on how they're going to respond to the TRC. It doesn't exist. It's very piecemeal.

THE CHAIR: Thank you. MLA Burrill, with a minute, roughly.

GARY BURRILL: No, thank you very much.

THE CHAIR: You're done? MLA Leblanc.

SUSAN LEBLANC: I just wanted to unpack a little bit about the previous answer, when you were saying, Ms. Julian, that a crisis response would look different in your

community than it would with settler health care. Can you just give us a quick example of what it might look like?

JULIANA JULIAN: Really quickly, it would be community members responding in community. It would be them coming into community, not just going and sitting at the health centre. It's going over to the family members, going over to the friends, seeking out those close ties to the person who either attempted suicide or was a suicide. Stuff like that.

THE CHAIR: MLA Palmer.

CHRIS PALMER: Ms. Peach, I don't know if you remember our question and what I asked you. Would you like to just sort of finalize that on how promotion of . . .

LINDSAY PEACH: Thank you, I was hoping you might come back to that one. I think I was speaking about the cohorts.

There was one program done in collaboration with Cape Breton University with a nursing cohort based in Eskasoni. That's resulted, as I understand, in a significant number of Mi'kmaw students in the nursing program, more than they've seen before, as a result of that work.

There's also work that's been done with the Nova Scotia Community College and a Mi'kmaw Indigenous cohort based at the Pictou campus that has work under way. We're also hoping that will increase the number of Mi'kmaw LPNs and Indigenous LPNs.

There has also been similar work done with continuing care assistant programs, particularly Eskasoni. As it's opening up Kiknu, the new long-term care facility, there was an interest in recruiting and promoting health professions.

There has been lots of work done by different organizations, but all supporting that goal of increasing the number of Mi'kmaw health professionals.

CHRIS PALMER: I have one last question. I'm going to maybe have an opportunity for Ms. Wadden, who's been patiently waiting for a question to come her way, and maybe for representatives of the IWK Health Centre as well.

In preparing for the meeting here today, I discovered that there are about eight patient navigators in the Mi'kmaw Indigenous Patient Navigator program. Could you tell us a bit more about that program and what parts of the province that it will be involved in?

NADINE WADDEN: Just to note, it is a privilege to be able to sit here with our colleagues and hear and continue to learn from the group. I'm so happy to be a participant during that.

The Mi'kmaw Indigenous Patient Navigator program is definitely an initiative that's come through the Nova Scotia Health Authority and is not specific to the mental health and addictions program. It is my understanding that it is an attempt at making those connects and making that access to services more conducive.

I believe there are two per Zone, but I'm not entirely sure. I know that they're still in the recruitment phases. It's very early in the work. I know that through a mental health and addictions program lens, we look forward to the opportunity of how we can integrate and leverage that role in individuals who are accessing and receiving care and support through our Mental Health and Addictions program through the Nova Scotia Health Authority.

Apologies that I don't have more information just yet on those roles, but it's demonstrating a recognition of the need to have their navigation coming from Indigenous individuals within the Nova Scotia Health Authority.

CHRIS PALMER: I believe Ms. Peach may want to take a stab at that.

LINDSAY PEACH: I can add a little bit in terms of responding to the question around the allocation. There will be two in Central Zone, two in Eastern Zone, one each in Western and Northern Zones, and two at the IWK Health Centre. Those roles are very much to support the clinical navigation. We'll work with colleagues within the health system to prioritize the program areas. We also acknowledge they will have a role to play in identifying some of the themes of what's working and what's not within the health system and being able to advise leadership where they are seeing examples within each of those organizations about work that needs to be done to address racism. We're looking forward to those positions.

THE CHAIR: I apologize for the construction noise. It's annoying.

CHRIS PALMER: Thank you all again for being here. Before I pass it on to my colleague, the summary I am getting today from everyone here is that there's progress being made and more to do. I think there's a willingness amongst everybody to pursue that more-to-do part, so thank you very much for being here. I'll pass on to my colleague.

THE CHAIR: MLA Young, with four and a half minutes left.

NOLAN YOUNG: Thanks, everyone, for being here today. It is quite informative.

I have a question for the Office of Addictions and Mental Health. Are there any other initiatives or programs that the Nova Scotia government implemented to address mental health and addictions issues among Indigenous communities? How are they funded and prioritized?

FRANCINE VEZINA: Thank you for the question. Before I start, I want to recognize up front that naming off our investments can sometimes feel a little bit tokenistic, so apologies to my First Nations partners at the table. It's not the intention. It's the beginning, so we're starting and, as you mentioned, we are open to the collaboration.

We have been working on access to psychiatry services. We've been working with the Nova Scotia Health Authority and the Department of Health and Wellness's physician services in Mi'kmaw communities to increase access to psychiatry services.

As Sharon mentioned, we've also been working with Eskasoni over the last two years about investing in the Eskasoni Crisis and Referral Centre. We've been working with Eskasoni for a few years, with our IWK Health Centre and NSHA partners, looking at pathways from Indigenous communities and services into NSHA and IWK health services, where required.

We have been working with colleagues at the Department of Health and Wellness in supporting the development of a health equity framework. We also have invested most recently in a Mi'kmaw clinical services pilot. Work is under way right now that includes a jurisdictional scan of similar programs, and we're working closely with Tajikeimɨk and First Nations directors to look at identifying what we could possibly do in that area.

The Tajikeimɨk Mi'kmaw mental health and addictions strategy as well work, which Lindsay has spoken to - government has been providing investment there.

As Sharon pointed out, the Truth and Reconciliation Call to Action No. 18 is broad and beyond us, but we certainly will show up. We have that commitment to continue to work together with our First Nations partners.

THE CHAIR: Does anybody have any closing remarks?

FRANCINE VEZINA: Just a few words, and I say this humbly and with humility, that we're learning. We're committed to learning more, and we're also committed to collaborating with our First Nations partners and embracing them leading the way for us. It's a changing environment that we're working within. We have to consistently be looking at new and innovative ways to work differently with our partners.

We're committed to the hard work, and we'll show up. Thank you very much to all of my colleagues who are here today.

THE CHAIR: I know Ms. Rudderham put her hand up. I'm going to check on the room first. No? Ms. Rudderham, you get the final say.

SHARON RUDDERFORD: Wela'lin. Thank you so much for the invitation to provide and share our experiences on behalf of our Mi'kmaq nation. I just want to reiterate

that we really believe that moving mental health and addiction services out of the emergency room needs to happen ASAP. We also highlighted the importance of the need for Mi'kmaw translation services and access to our language, and also, most importantly, that we need to support and provide community-led mental health, addictions, and crisis-response services in our communities to ensure that these services are community-led and culturally safe for our Mi'kmaq. Maybe that does require a commitment around looking at the TRC recommendations to ensure that they're put in place. Maybe we do need Mi'kmaw senior leadership at various levels within the government and health authority structures.

THE CHAIR: On behalf of the committee, I'd like to thank all of you here for coming. I'm sure everybody has learned - maybe not as much as I just learned, but I'm sure everybody's enjoyed it.

You're now free to leave. We're going to take a three-minute recess, and then we'll be back to deal with that - so at 10:45.

We're in recess.

[10:42 a.m. The committee recessed.]

[10:46 a.m. The committee reconvened.]

THE CHAIR: Order. The committee is back. We have some committee business. I'm going to deal with that first. The approval of the annual report of 2023. This was previously circulated twice to the committee. Does anybody have any comments or discussion on it? Is someone prepared to make a motion for the standing committee to accept the 2023 annual report as circulated, and that the Chair table it to the House of Assembly?

DANIELLE BARKHOUSE: I'll make that motion.

THE CHAIR: It's moved. Any discussion?

All in favour? Contrary minded? Thank you.

The motion is carried.

We received correspondence from the Minister of Health and Wellness in response to the committee's request during the September 12th meeting arising from the correspondence from Matthew Casey. This was received on October 17th and distributed to the committee. Does anybody have comments or questions on that? Okay.

Correspondence: October 18th email from Strongest Families Institute. This was received October 18th and distributed to the committee. Does anybody want to comment?

Any other business?

HON. KELLY REGAN: I think I would like to put a motion on the floor. Based on what we heard here today, I think we heard loud and clear about the need for more Indigenous Mi'kmaw representation in the upper echelons of the Nova Scotia Health Authority and the IWK Health Centre. At the Department of Community Services several years ago, when I was still minister, what we did was we actually implemented a position for an African Nova Scotian adviser on our executive team so that when we were making decisions, we had that lens on what we were doing. I think it improved our understanding and moved a lot of things forward and just gave us a better understanding of the issues.

Also, sometimes you don't even think about something because you don't know what you don't know. I move that the Chair write, on behalf of the committee, to the Minister of Health and Wellness, to the acting CEO of the Nova Scotia Health Authority, and the CEO of the IWK Health Centre, to let them know what we heard about the need for Mi'kmaw representation in higher levels of the health system and encourage them, as a starting point, to each appoint - each of the health authorities to appoint a Mi'kmaw adviser to the executive team of those health systems.

SUSAN LEBLANC: I would support that wholeheartedly - just a nice letter, no challenging, just what we heard and what we think should happen.

CHRIS PALMER: Just a little confused - so you want to write - what you are suggesting is the committee, through the Chair, write a letter to the Minister of Health and Wellness.

THE CHAIR: MLA Reagan.

KELLY REGAN: See, (a) it's Regan and (b) we both knew that was going to happen, right? Not Reagan. Regan.

THE CHAIR: I apologize, MLA Regan. Sorry.

KELLY REGAN: So we write to both the CEOs and the Minister of Health and Wellness. Let them know what we heard from the Mi'kmaw health experts, who are here before committee today, about the need for there to be Mi'kmaw representation at the higher levels of the health systems. That way, when they're creating systems or programs or whatever, the Mi'kmaw perspective is included, and when they are creating programs for the Mi'kmaw, there's a lens on that. We can encourage them to do this as a starting point - to actually appoint advisers to each of the executive teams in those two health authorities.

THE CHAIR: I just want to be clear on this one. You want to write a letter to let them know about it, then request they do this, or are we just doing this as a letter for them to understand what we've received? As Chair, I'll get you next. Just to be clear.

KELLY REGAN: I would encourage - that we would encourage them to consider doing this.

CHRIS PALMER: We've clarified it enough. I guess we don't need to banter it around much more. The letter will have a call to action or just notification of what . . .

AN HON. MEMBER: A call to action.

CHRIS PALMER: You want a call-to-action letter.

THE CHAIR: MLA Regan. (Interruption) I'm going to get her to answer and go back to you.

KELLY REGAN: I'd like to hear Mr. Palmer.

CHRIS PALMER: My point is that there is a bit of a distinction there, between call to action and just notification. I'm wondering if it's an opportunity for another committee meeting at some point in the future - topic selection or anything like that - to bring forward. We can support this, Chair.

THE CHAIR: MLA Regan, I just want to confirm that you did say it's both.

KELLY REGAN: It is both an information and a call to action. I'm not sure we need another meeting. I think we heard plenty here that underlined - I mean, we would probably need another meeting to check on the progress, on what progress has happened after this. I really think there's a lot going on in the health care system, and our role here can be to assist the CEOs and the Minister of Health and Wellness. When we hear a good idea, just bring it to their attention. This could be better.

LORELEI NICOLL: Anyone who knows me knows I don't like meetings for the sake of meetings. Therefore, to do this we'll just respond in a governance way, as a letter back to this committee, so it's not necessarily all the heavy lifting being done by this letter. It's just going to come back here in a letter as to what could be done - what will be done.

JOHN WHITE: I'd like to speak from what I know, not from what I assume. I really like the idea of expressing what we heard today. I think community involvement is key to everything. I can support what we heard, but a call to action - I don't know if there is any action already being taken. I really don't know that. If that's what you really want, I don't know if I can support that.

I can certainly support what we heard. What I am asking is that MLA Regan tell us a little bit more of what she wants, because I really am confused as to which one we're asking for. Tell us which one you want, and give us a recess to think about it for a second, please.

KELLY REGAN: As I said originally, that we write a letter and we tell what we heard here today, that the health authorities add, as a starting point, a Mi'kmaw adviser to the executive teams of both the IWK Health Centre and the Nova Scotia Health Authority. If it's already being done, they'll let us know, but from what we heard today, it doesn't sound like it's being done, right? (Interruption) That's right. We don't know. They may write back to us and say: Look, it's already being done, in which case, no harm, no foul.

But at the very least, we heard some things here today. We heard about young people dying of suicide. We heard about things that need to happen in the health care system, and a good way to get that rolling is to have Mi'kmaw advisers in there saying: Look, this is what you need. This is a problem. This won't work. This will work. That kind of thing. It really helped us at the Department of Community Services when we brought someone in who had a different perspective than everybody else sitting around the table. It led to more change, I believe, at DCS, as a result of the fact.

This is not a big ask. It's not meant to embarrass anybody. It's to make the health care system better.

THE CHAIR: Just to let everybody know, the clerk will not be summarizing. She would send a transcript of this to them. She's not going to summarize. Obviously - I just want to make that clear. It's not going to be anybody's view. It's going to be: Here's the transcript. That's what would be attached.

KELLY REGAN: Excellent. Super.

THE CHAIR: I just wanted to let you know - at least everybody knew. If somebody said: Well, I wanted it summarized - that's not happening. We're just going to send a transcript of it.

CHRIS PALMER: I'd like to make just a little amendment to this, if I could. What I'd like to propose is requesting a letter from the Department of Health and Wellness asking for an update on the hiring practices of what we discussed today - highlighting what we heard but asking for an update from what they're already doing about this. That could be presented or read by you, Chair, at a future meeting at some point. But just - the letter would not be a demand. It would be asking for - requesting what's been done. What's being currently done by the department - what they're doing.

THE CHAIR: Just a sec. MLA Burrill, on your point of order.

GARY BURRILL: This is not an amendment. It is an entirely different motion, and therefore, I question whether it's in order.

THE CHAIR: I was about to ask the member a question before you did that. I'm going to go back and ask him.

MLA Palmer, are you saying, as opposed to requesting that they have one - an adviser of Mi'kma'ki - what is their status on having that in place? Or are you going - I'm just trying to . . .

CHRIS PALMER: Just basically, I think what I'm asking is if we could amend - if I could propose an amendment to the motion, if that's possible, just suggesting that we ask for an update on the practices in relation to what we heard for this meeting.

THE CHAIR: So instead of asking for - a request for them to do that or think about it, you're asking for them to update what their status of doing it is?

CHRIS PALMER: That's correct. That's what I'm asking.

THE CHAIR: I'm going to ask this guy a question.

Okay. I've confirmed with - on my clarification of what MLA Palmer - that's not out of order. He's not changing the intent of it. All he's saying is, as opposed to saying: I want you to do it, he's saying: We'd like to know the update on your doing it. Correct? That's the amendment?

KELLY REGAN: I don't have an objection to adding that to the letter that I have proposed, but I do think we should ask for an adviser on this. If they've got one already, great; they'll tell us. But certainly say: What are you doing around this? That's fine to have. I'm sure they would include it anyway. From everything I've seen, they would include what they're doing in any response.

I do think it's important that we note that there should be Indigenous, specifically Mi'kmaw, representation on the executive teams of the two health authorities.

AN HON. MEMBER: We're running out of time here.

KELLY REGAN: We need to vote, yea or nay.

THE CHAIR: But I think his is just - as opposed to the request, he's saying: What's the status on doing that? That was his amendment - correct?

[11:00 a.m.]

Time is met. The next meeting will be Tuesday, November 14th from 1:00 p.m. to 3:00 p.m. Note that if the House is still sitting that day, the meeting will be held from 9:00 a.m. to 11:00 a.m.

The topic is Home Care and Community Care. Witnesses are the Victorian Order of Nurses Canada, the Department of Seniors and Long-term Care, Nova Scotia Nurses' Union, and the Canadian Union of Public Employees Nova Scotia.

This meeting is adjourned.

[The committee adjourned at 11:01 a.m.]