HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

44th PARLIAMENT, 1st SESSION

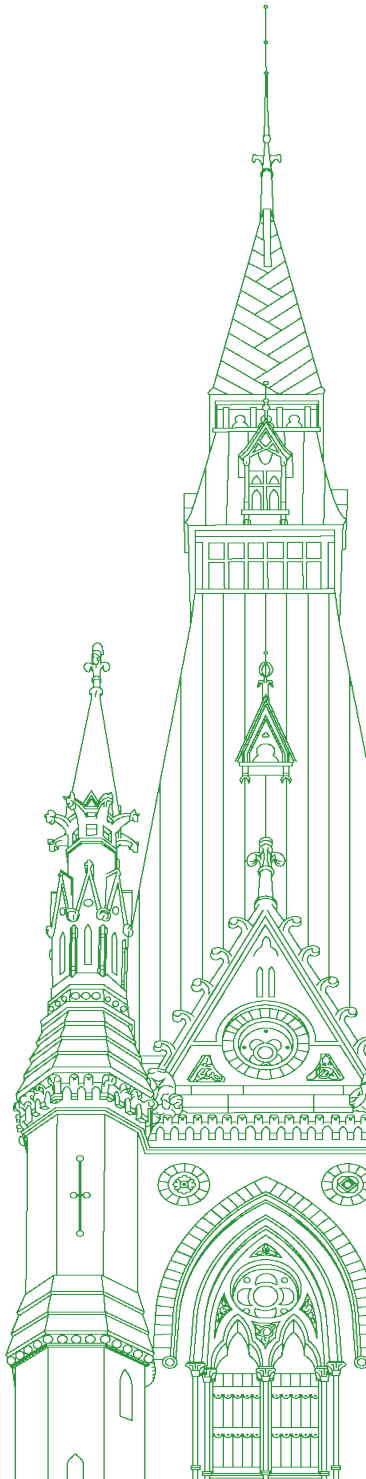
Standing Committee on the Status of Women

EVIDENCE

NUMBER 029

PUBLIC PART ONLY - PARTIE PUBLIQUE SEULEMENT

Monday, September 26, 2022



Chair: Mrs. Karen Vecchio

Standing Committee on the Status of Women

Monday, September 26, 2022

● (1100)

[*English*]

The Chair (Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC)): I call the meeting to order.

Good morning, everybody, and welcome to the 29th meeting of the House of Commons Standing Committee on the Status of Women. Pursuant to Standing Order 108(2) and the motion adopted on Tuesday, February 1, the committee will commence its study on the mental health of young women and girls.

Today's meeting is taking place in a hybrid format, pursuant to the House order of June 23, 2022. Members are attending in person in the room and remotely using the Zoom application.

I would like to make a few comments for the benefit of the witnesses and members.

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mike. Please mute it when you're not speaking. For interpretation for those on Zoom, you have the choice, at the bottom of your screen, of English, French or floor. For those in the room, you can use the earpiece and select the desired channel.

I would remind you that all comments should be addressed through the chair. For members in the room, if you wish to speak, please raise your hand. For members on Zoom, please use the "raise hand" function. The clerk and I will manage the speaking order as well as we can, and we appreciate your patience and understanding as we are going through this.

Today, we are starting a really important study that we have all talked about. It's going to be a very exciting panel. I would like to welcome our guests for our first panel.

From Children First Canada, we have Sara Austin, founder and chief executive officer, and Mégane Jacques, youth representative on the youth advisory council and the young Canadians' parliament.

From Jack.org, we have Rowena Pinto, president and chief executive officer.

From the Centre for Addiction and Mental Health, welcome to Dr. Leslie Buckley, chief of the addictions division, and Dr. Daisy Singla, who is an independent scientist.

As an individual today, in the room, we have Dr. Simone Vigod, professor and head of the department of psychiatry at the University of Toronto's Women's College Hospital. Also as an individual, we have Dr. Peter Szatmari, senior scientist and director of Cundill Centre.

As an individual, we have—only for the first hour, so if you have questions specifically for this person, make sure to get them in during our first hour—Dr. Charlene Senn, professor and Canada research chair in sexual violence at the University of Windsor.

What we'll be doing is providing each organization with five minutes. When you see me frantically start moving my wrist in the air, that means your time is coming up and I will cut you off, probably within 15 to 20 seconds, because we have such an exceptional panel and so little time today. We will be doing committee business, so our questioning period will be only 90 minutes in total today with our presentations.

To get started, I would like to welcome Children First Canada for their first five minutes of presentation.

Ms. Sara Austin (Founder and Chief Executive Officer, Children First Canada): Thank you, Madam Chair, for this opportunity.

My name is Sara Austin, founder and CEO of Children First Canada. CFC is a national charity, and we are a strong, independent and effective voice for all eight million kids in Canada. I'm so pleased to be joined by Mégane Jacques, the chair of CFC's youth advisory council and a member of young Canadians' parliament. Mégane is also a recipient of the inspiring youth award from Canada's Pandemic Heroes for mental health.

As a national charity that engages children and youth, we publish research, raise awareness and mobilize action. We can speak about the mental health crisis facing girls and young women in Canada and also about the innovative and evidence-based solutions that are needed. We do so through an intersectional lens focused on the inequitable impacts of mental health on girls who are racialized; first nations, Métis and Inuit youth; 2SLGBTQIA+ and girls with disabilities.

I also speak as a woman who has experienced poor mental health as a girl and throughout my life, as a parent of a child who has experienced poor mental health, and as someone who has witnessed this crisis unfolding in the homes of families across the country. Our aim is to share our personal perspectives, together with the evidence gathered through CFC's years of experience doing research, youth engagement, policy influence and engagement with the Canadian public. We bring a unique perspective on the challenges at hand.

In April 2021, at the height of the pandemic, when many schools remained closed, CFC joined with children's hospitals across the country in declaring #codePINK. It's a term used for pediatric emergencies. We called on federal and provincial governments for an emergency response. There was overwhelming evidence that children and youth, and girls in particular, were facing threats to their survival. Rates of suicide, depression, anxiety, eating disorders, substance-use disorders and self-harm were alarmingly high.

This #codePINK unleashed a tidal wave. We were flooded by calls, emails and messages from girls and youth, parents, teachers and grandparents across the country who were experiencing this crisis in their homes and who joined us in calling on governments to take action.

Yet, here we are over a year later, and fundamentally nothing has changed for the better. New budget commitments have been announced and promises have been made, but the reality for girls and for young women, and for kids and youth more broadly, remains the same; #codePINK remains in effect.

In our latest “Raising Canada” report on the top 10 threats to children, poor mental health is the number two threat. The data for the top 10 threats is examined through the lens of equity, diversity and inclusion, and we can share with you ample evidence that shows that the threats to children, and to girls in particular, are growing. Many of the top 10 threats, such as poverty, child abuse, systemic racism, discrimination, bullying and climate change, are known as adverse childhood experiences that directly impact the mental health of girls and young women.

From coast to coast to coast, many girls do not make it to their 18th birthday. Suicide remains one of the leading causes of death for children and youth between the ages of 10 and 18. These devastating statistics are too alarming to be ignored. Every girl, and in fact every child, deserves the right to survive and thrive.

We urge this committee to consider the need for prevention and intervention for the mental health of girls from the earliest days of life. Half of all cases of mental health issues begin by age 14, and three-quarters by the age of 24. We urge you to work with a sense of urgency. Every day, every hour, every minute matters in the life of a girl. We urge you to work with girls and young women in defining the problems and the solutions. They have a right to be heard.

On that note, I cede the floor to Mégane to share her perspective.

Thank you, honourable members, for your commitment to address the mental health of girls. I'm hopeful that more deliberate action will be taken in the very near future.

● (1105)

The Chair: Mégane, you have one minute.

Ms. Mégane Jacques (Youth Representative, Youth Advisory Council, Young Canadians’ Parliament, Children First Canada): Thank you.

I believe that society sends very contradicting messages to women: They should look pretty, but not too pretty; they should share their feelings, but not be too open; they're told to strive to be self-reliant and powerful, but simultaneously reminded that they are weak and inferior to men. This causes, as Sara mentioned, an internalizing of their feelings and negative comments towards themselves.

The stigmas regarding girls' mental health—as just being a teen, or full of hormones, or overreacting, or too emotional—are terribly damaging. In fact, women and girls attempt suicide one and a half to two times more often than men and boys.

Now, these women and girls who are struggling are not weak. They just need our support to pick themselves back up, just as I needed when I was told I was too sensitive, rather than anxious, or too intelligent to have depression after I tried to kill myself at 15, 16 and 17. I wasn't asking for big changes then. I just wanted someone to believe me and work with me to make it better.

I am here today to ask you to take action, but also to show you that I'm part of the solution. All girls are part of the solution. As an advocate for mental health, I am leading changes in my community and across the country—

The Chair: Mégane, I'm sorry; I have to cut you off. I did let you go a little bit longer there. We'll make sure that some of this can be asked through the questioning.

I'm now going to pass it over to Jack.org.

Rowena, you have the floor for five minutes.

Ms. Rowena Pinto (President and Chief Executive Officer, Jack.org): Thank you.

Good morning, honourable members.

As mentioned, my name is Rowena Pinto, and I am the president and CEO of Jack.org, a national not-for-profit organization with the mission of improving mental health for youth across Canada.

I speak to you today from Toronto, located on the indigenous territory of the Huron-Wendat, the Haudenosaunee and the Mississaugas of the Credit, which is covered by the Upper Canada treaties and is part of the Dish with One Spoon treaty.

Thank you very much for having me here.

Jack.org provides upstream peer-to-peer mental health education and capacity building for youth in their transition years, aged 15 to 24. We believe that the best way to improve mental health for youth is by engaging them directly, precisely because youth are in the best position to identify their mental health needs and speak to the issues they are facing. Jack.org engages thousands of young people across the country to educate their peers and promote mental health in their communities.

As of 2021, around three-quarters of the young people in our network identify as young women, and 60% identify as having lived experience with mental illness or a mental health struggle.

Looking at the broader research around mental health, we know that suicide has long been the leading health-related cause of death among youth in Canada. Youth aged 15 to 24 experience the highest rates of mental health distress of any age group in Canada.

Over the past decade, and especially during the pandemic, youth have been increasingly reporting worse perceived mental health. This trend is particularly true for young women, who experience higher rates of both diagnosis and reported symptoms of anxiety and depression relative to young men, and have also experienced higher increases in these experiences over time. Black, indigenous and LGBTQ2S+ youth also experience particular vulnerability to mental health distress even as they face greater barriers to care.

The factors influencing youth mental health distress are complex; however, since beginning to survey youth in 2019, our network has consistently identified certain factors as common mental health stressors. Perceived and objective financial strain, academic pressure, and lack of employment and educational participation were raised as particularly salient mental health stressors. Youth have raised that we must also not forget about stress related to minority status for equity-deserving groups and the emerging stressor of climate anxiety.

As you can see, the mental health challenges faced by young women and girls in Canada are prevalent. The underlying stressors are persistent, and the impacts are profound.

What troubles us at Jack.org is that the majority of youth do not seek help when they are experiencing mental health distress. While rates of help seeking are somewhat higher for young women than for young men, just 16% of young women seek mental health support from a professional, while 32% seek informal support from friends, family, the Internet or others in their social networks. We need to pay greater attention to this persistent gap in help seeking while acknowledging and addressing the clear preference for young women to seek informal mental health support.

Fortunately, there are some signs of hope. Investment in upstream youth mental health education to destigmatize mental illness, encourage help seeking, and increase mental health literacy can ensure that young women and girls experiencing mental distress receive the help they need.

Our key recommendation is to broaden federal attention and resources beyond clinical mental health services to focus on the larger mental health-promoting environment. [*Technical difficulty—Editor*] where young women and girls live, learn and work.

What this looks like is efforts to build the capacity of young women and girls to identify signs of mental health struggle in themselves and their peers, engage in effective coping when they experience stressors, and access a range of mental health services when needed. As we bolster their ability to seek help, we must also ensure that they are met with services that align with their needs and preferences. Consistent with youth's preference for informal support, peer-to-peer mental health services can be valuable, provided that youth are equipped with the appropriate education to support one another.

As a final word, too often we speak of these solutions without engaging the voices of the young people we seek to support. We recommend meaningfully engaging young women and girls in efforts to strengthen mental health supports in the way that serves them. They know what is best, what their needs are and what solutions will work for them. There is no substitute for their voices around the decision-making table, and the thousands of youth across Canada who make up our network are keen to offer their insights to better support mental health for themselves and their peers.

Thank you.

● (1115)

The Chair: Perfect, thank you so much.

I'm going to pass it over to Dr. Leslie Buckley, but before we carry on, I just want to do a quick sound check because we see that you have different earpieces in. I'm going to pass you to the clerk just for a sound check.

The Clerk of the Committee (Ms. Alexie Labelle): Dr. Buckley, would you mind just saying a few words? I'm just going to check with the interpreters if the sound is okay.

Dr. Leslie Buckley (Chief, Addictions Division, Centre for Addiction and Mental Health): It's a great pleasure to be here today to present to this esteemed group. I look forward to informing the group about substance abuse disorders in young women.

The Clerk: Your microphone is not properly selected. Would you mind going to the bottom left corner of your screen? There's an arrow where you can select the correct microphone. Once you've selected your microphone, would you mind just bringing it closer to your mouth and we can try that?

Dr. Leslie Buckley: I'm not sure what you mean there, but I certainly don't want to interrupt your proceedings. Are you able to hear me now?

The Clerk: Yes, we can hear you, but we just want to know the choices you have to select the microphone. Right now it seems like it's the audio from your device and not from your microphone.

Dr. Leslie Buckley: This is now from my device instead of my microphone.

The Clerk: I'm just going to wait for the interpreters to confirm if it's okay.

The Chair: Is there a way we could do that off-line so I could go to the next panellist?

[*Translation*]

Ms. Andréanne Larouche (Shefford, BQ): I have a question, Madam Chair.

The Chair: Go ahead, Ms. Larouche.

Ms. Andréanne Larouche: Did our witnesses have the opportunity to test their mikes before the meeting, as is usually recommended?

[*English*]

The Chair: They did, but unfortunately Dr. Buckley was right in between and we had started the meeting right on time.

What I'm going to do is ask, Dr. Buckley, if we can come back to you. I'm going to pass it over to Dr. Simone Vigod in the room, and perhaps we can work with you off-line for a moment.

I'll get back to the Centre for Addiction and Mental Health, but now I'm going to welcome Dr. Simone Vigod, professor and head of the department of psychiatry.

We're going to pass the floor over to you for five minutes.

Dr. Simone Vigod (Professor, University of Toronto, and Head, Department of Psychiatry, Women's College Hospital, As an Individual): Thank you for welcoming me today to assist with your study on the mental health of young women and girls.

[*Translation*]

Thank you for inviting me to appear before you this morning.

[*English*]

As a medical doctor, psychiatrist and researcher, I have spent my career focused on the mental health of women and girls across the lifespan. While there are so many important aspects to this that deserve our consideration, I see pregnancy and the first postpartum year, the perinatal period, as a crucial time for action for our young women.

You may not know that perinatal mental illness affects up to 20% of Canadian pregnancies. This means that it affects up to 80,000 Canadians annually, posing serious risks to young mothers and children at a crucial juncture in both of their lives. But this is also a time of great opportunity. If we successfully treat a young mother's mental illness in the present, we not only improve her well-being, but we may also prevent her child—her girls, her boys, her children—from developing mental illness in the future.

Unfortunately, as few as one in five people with perinatal mental health issues receive the treatment they need to get better in this country. The gap is largest for equity-seeking groups, including our indigenous populations and our youngest women. We know what will help, and that is a stepped-care approach. For mild symptoms, low-cost interventions like trained peer support are highly effective. So are short-term structured psychotherapies, which we have shown in our own research can be delivered by non-mental health specialists like public health nurses, midwives and even lay people. For more severe illnesses, we need to go up a step, where specialized therapies adapted for the perinatal period and medical treatments are also highly effective. People must be seamlessly transitioned between the steps, depending on their level of need. There are so many opportunities to close this one-in-five gap.

At Women's College Hospital, I lead a Canada Foundation for Innovation-funded women's virtual care laboratory. Our CIHR-funded research is supporting the argument that virtual care can be used to complement our face-to-face services, which is especially important for traditionally hard-to-reach populations. We've even studied a virtual stepped-care approach where a care coordinator works with patients who access a platform that we developed to help them determine which of the stepped-care options is right for them. It recommends specific virtual and in-person care opportunities in their communities. The platform then automatically provides follow-up and monitoring so that people don't fall through the cracks.

At the end of six months, three-quarters of the patients in our study of this approach were better, versus only half in a comparison group who received the usual available care from the health system.

In March 2022, invited by Dr. Carolyn Bennett, Minister of Mental Health and Addictions, I chaired a national round table on perinatal mental health. It was attended by individuals with lived experience and health care providers with multiple and diverse perspectives from across the country. What did we hear? We heard about gaps in peer support, lack of trained therapists and a "postal code lottery" of specialized services. There are only about 10 specialized clinics across the country and a lack of consistent approaches in other places. We heard about the fundamental importance of equity, diversity and inclusion in any systems solution.

With this in mind, I believe the greatest impact on a national level would be to invest in the following five concrete and actionable priorities.

One, fund community organizations across the country to increase daytime and weekend access to paid virtual and in-person peer support, allowing for targeting to specific groups, such as indigenous populations, Black and LGBTQ2S+, young adults and more, so that no matter who you are across this country, you click, you phone, you go to a safe community space, and you have inclusive, personalized experience.

Two, fund training of perinatal health care and lay providers in short-term structured perinatal mental health psychotherapies, so that perinatal mental health care would be integrated like treatment for diabetes or blood pressure in pregnancy, conditions just as serious but 10 times less common.

Three, fund the training of personnel for new specialized perinatal mental health teams for underserved regions and end this Canadian postal code lottery for specialized care.

Four, to support this, invest in the technical infrastructure of these virtual stepped-care platforms that can be used to coordinate nationally or by provinces and regions.

Five, establish Canadian national guidelines for the prevention and treatment of perinatal mental illness, and work with the Standards Council of Canada to develop and monitor national standards. This is a mechanism to ensure a national shared understanding of what care needs to be delivered, and standards against which we can measure our progress.

I believe a national coordinating centre for perinatal mental health could deliver on the training and supervision required to action these initial priorities and establish a national network for sustainable education, research and monitoring of progress going forward.

● (1120)

Thank you so much for listening this morning.

The Chair: Thank you so much.

We're now going to move over to Dr. Peter Szatmari, from Cundill Centre.

Peter, you have the floor for five minutes.

Dr. Peter Szatmari (Senior Scientist and Director, Cundill Centre for Child and Youth Depression, Centre for Addiction and Mental Health, As an Individual): Thank you very much.

Good morning, honourable members.

My name is Peter Szatmari. I'm a child and youth psychiatrist and director of the Cundill Centre for Child and Youth Depression at the Centre for Addiction and Mental Health.

Thank you so much for the invitation to present to the Standing Committee on the Status of Women. I am very pleased to see that you are addressing an issue that I and many of my colleagues see as a major public health problem in Canada: the mental health of young women aged 12 to 24 years and the widening gender gap in mental health, not only in Canada but also globally.

Sex and gender differences—for simplicity I will refer to gender only—are pervasive in youth mental health. Three disorders—anxiety, self-harm and depression, which very often occur together in a cluster—represent the main causes of adolescent disability worldwide as reported by the World Health Organization. Data in 2014 from Ontario, the only province for which population-based data exist, estimated that up to 20% of adolescents experienced a mental health disorder, again, predominantly anxiety, depression and self-harm.

This triad of conditions shows striking gender differences, each disorder occurring roughly two times more commonly in adolescent females compared to males. Again, data from that 2014 survey show that 10% of adolescent girls report a major depressive disorder, compared to 5% of boys, and 20% of adolescent girls report an anxiety disorder, compared to 10% of boys.

What is even more alarming is that, not only in Ontario but also in most high-income countries globally, rates of these three mental health conditions have increased over time, particularly among girls. The gender gap for this triad of mental health conditions is not only large but becoming greater over time.

The reasons for these gender-based inequities are not clear and are likely to be complex. Some risk factors for anxiety, depression and self-harm are more common in girls, while girls appear to be more vulnerable than boys to the impact of other common risk factors. Female hormonal changes associated with puberty have a profound effect on the developing brain, and early puberty, something that is becoming more common worldwide, is a potent risk factor for depression. Other risk factors for this widening mental health gender gap include the increasing prevalence of sleep disruption among girls and the higher rates of sexual abuse and bullying experienced by adolescent females compared to males.

We know that, during the pandemic, Canadian adolescents reported alarming rates of worsening mental health. Statistics Canada reported that at one point roughly 50% more adolescent girls than boys judged that their mental health was somewhat or much worse compared to prepandemic times.

We are likely to experience even more population-level risk factors in the future, whether that is another pandemic or the challenges associated with the climate crisis. I have only to point to wildfires on the west coast and cyclones in the Atlantic and their impact on the mental health of young people. The mental health of young women in Canada is at heightened risk in the face of these and other similar yet unforeseen disasters.

I have two recommendations that I believe are within the federal mandate for health and that might go some way toward mitigating these challenges.

First, young girls and women throughout Canada should have ready access to consistently high-quality services tailored to their gender, culture and other aspects of identity. The federal government can play a role in encouraging the provinces and territories to come together and support this unified vision, as well as in advocating for a common platform of measurement-based care and outcome monitoring to ensure that gender-based inequities in mental health do not widen further.

● (1125)

Second, Canada is the only G7 country that does not have a population-based survey of the mental health of children and youth that includes repeated measurements over time. As a result, we do not have population-based data on the health, including the mental health, of young people. As a result, we cannot say with confidence that rates of actual disorder or that mental health inequities have truly increased postpandemic, compared to prepandemic. The Canadian health survey on children and youth—

The Chair: Dr. Szatmari, I am going to have to cut you off. You've passed your time. I will cut you off right now and then we'll get back into the questions.

I'm now going to pass it back to the Centre for Addiction and Mental Health. Dr. Leslie Buckley and Dr. Daisy Singla, I'll pass it over to you.

You have five minutes.

Dr. Leslie Buckley: Thank you so much, Madam Chair and honourable members.

It's a privilege to be able to—

The Chair: Before you get started, could you put the microphone closer to your mouth?

Dr. Leslie Buckley: Okay.

Is that better?

The Chair: That's great. Thanks.

Dr. Leslie Buckley: Thank you so much for your patience.

My name is Leslie Buckley, and I'm the chief of addictions at CAMH, the Centre for Addiction and Mental Health. I've been an addictions psychiatrist for many years, mostly focusing on women.

What I'm going to focus on today is the current landscape of substance use for young women and girls, and I will talk about why we need to worry about substance use and what we can do. I'll speak about these subjects separately.

I'll start with alcohol.

Alcohol is extremely important, because we know of the significant harms that are related, whether it's accidents from falls, head injuries, etc., or legal issues, violence, crime, drinking and driving, or its important role for young women in sexual assault. There is a double impact from substance or alcohol use by the perpetrator, which is more common. Also, sometimes they target women who are using substances. They are more often the victim in sexual assault in that context.

All of this, of course, is in addition to the chronic harms that we know about to the liver and the cardiac system, and more recent information highlighting the impact on cancer and elevated rates associated with alcohol. We know all of those chronic harms happen faster in women who are more vulnerable to alcohol.

In terms of trends, we've seen that over the last 20 years, there has been a slight reduction in alcohol use among youth. That is according to the OSDUHS, the Ontario student drug use and health survey that CAMH runs. What's interesting with alcohol, and cannabis as well, is that although we see boys decreasing their substance use, women have not decreased theirs to the same degree. What we're seeing is that they're meeting and we've diminished the gap between young women and young men.

At this point, I see that I'm two and a half minutes in, so I'm going to pass it over to Dr. Singla for her portion.

● (1130)

Dr. Daisy Singla (Independent Scientist, Centre for Addiction and Mental Health): Thank you, Dr. Buckley.

Thank you so much for the invitation to speak today. My name is Daisy Singla. I am a clinical psychologist by training and very much a global mental health researcher at heart. I've worked in some of the most remote areas of sub-Saharan Africa and South Asia, only to learn that many of the lessons that we have implemented and learned abroad are completely applicable to our context here in Canada.

As my colleague Dr. Simone Vigod said, one in five pregnant and postpartum women experiences common conditions of depression, anxiety and trauma. If they are left unaddressed, there are long-term negative consequences for the woman, her child and future generations.

In my travels and in my research, I have learned three key lessons to address these common problems.

The first is that brief talk therapy works. Some of you may have heard of cognitive behavioural therapy or interpersonal psychotherapy. These brief talk therapies are among the most effective treatments in medicine, yet fewer than 10% of women have access to these psychological treatments.

The second is the power of telemedicine to deliver these treatments. COVID has catapulted our health care systems to reconsider how mental health care can be delivered. Telemedicine allows pregnant women and new mothers to overcome common challenges of finding transportation and child care and allows for flexibility.

Finally, we will never have enough psychologists or psychiatrists to address the mental health treatment gap. Thankfully, there is a growing literature demonstrating that non-mental health specialists—individuals without a specialized degree in mental health, such as nurses, midwives, peers and teachers—can be trained to deliver these effective treatments.

As I mentioned, all of these lessons can be applied to our context here in Canada. In 2020, we launched SUMMIT, the largest talk therapy trial for pregnant and postpartum women in the world. We are funded by a U.S. organization called Patient-Centered Outcomes Research Institute, which asks whether nurses and midwives are as effective as specialist providers and whether telemedicine is as effective as in-person talk therapy.

Our trial is showing promising preliminary results, and the full results will be available in January 2024. The results will ultimately inform the stepped-care model that Dr. Vigod referred to and the delivery of effective patient-centred talk therapy for pregnant and postpartum women.

Today I want to invite all of you to be stakeholders in this exciting initiative to ensure that our results materialize into service and also to invest in the stepped-care models that Dr. Vigod referred to earlier today. Psychological treatments are effective. Innovative solutions, such as telemedicine, exist to improve access.

In summary, I believe we can do better as clinicians, researchers and policy-makers and as a society to serve women and other populations with these effective treatments.

Thank you.

The Chair: Thank you so much.

Finally, for our last presenter, we have Dr. Charlene Senn, professor and Canada research chair in sexual violence, University of Windsor.

Charlene, you have the floor for five minutes.

Dr. Charlene Senn (Canada Research Chair in Sexual Violence and Professor, University of Windsor, As an Individual): Thank you very much, Chair and honourable members.

I'm Dr. Charlene Senn, professor of psychology at the University of Windsor and a tier 1 Canada research chair in sexual violence. I'm a social psychologist whose research focuses on prevention of sexual violence on university campuses and for younger high school-age girls. I'm an expert on sexual violence prevention generally and on sexual assault resistance and bystander education interventions particularly.

Your committee's work is focused on girls' and young women's mental health. My testimony to you today, in a nutshell, is that unless and until we address the realities of sexual violence experienced by girls and young women, and put efforts into preventing sexual violence, our country will not be successful in improving girls' and women's mental health.

Sexual violence creates numerous physical and mental health consequences, some of which are specifically named in the motion. If we focus only on mental health supports, then we are mitigating harm but not preventing more citizens from experiencing the harm in the first place.

I care deeply about and want to combat all sexual violence. However, the vast majority of victims are girls and women, our focus today. Cisgender men and boys are 98% of the perpetrators of sexual violence against girls and women, and most are known to the victims, not strangers.

How big is this problem? Young women are at higher risk of sexual assault than women over 25. By conservative estimates, on university campuses one in five women will experience sexual assault before graduation. However, research shows that 50% of the rapes that women experience occur by the time they are 18, which means we need to start earlier in our prevention efforts.

In a recent study we conducted in Ontario with teen girls, we asked about their experiences of unwanted sexual contact and rape since the age of 14 by male peers. For this study, male peers included boyfriends, friends, classmates and strangers who were not adults, so these are underestimates.

One in three girls reported experiencing unwanted sexual contact as a result of the guy telling lies, threatening to end the relationship or spread rumours about her, making false promises, showing displeasure, criticizing her or getting angry. Almost one in four girls had experienced oral, vaginal or anal rape accomplished with threats of force, force, or alcohol or drug facilitation; and one in five had experienced attempted rape.

Young women also report being repeatedly asked, pressured or coerced into sending nudes. In a recent U.S. study, between 12% and 40% of teen girls reported sending a sexual message or image because they were pressured to do it. We know this can have mental health consequences, especially when these images are then shared without their consent. We call this image-based sexual abuse.

The physical health effects of sexual violence include unwanted pregnancies, sexually transmitted infections, increased cigarette smoking and alcohol and drug consumption, and many others. Psychological effects include depression, PTSD, suicidal ideation, lack of sexual enjoyment, and fear. Fear of rape also affects the quality of life for young women who are not sexual assault survivors, leading them to restrict their movements as a precautionary strategy and limiting their employment, education and recreational opportunities.

Research clearly supports the need for increased resources for sexual assault crisis centres and other experts in providing trauma-informed care to survivors to address the varied physical and mental health outcomes of sexual violence—but this point is often made. I am directing your attention to the fact that prevention of sexual violence is equally important.

The Flip the Script with EAAA program that I developed for women in university is an example of the impact we can have. Participation in the program reduced the risk of attempted and completed rape in the next 12 months by 50% and reduced self-blame, which is linked to worse mental health outcomes if women did experience rape. An adapted version of the program for girls 14 to 17 is being tested in a randomized control trial starting in January with Public Health Agency of Canada funds.

You should know that research also suggests that providing comprehensive sex education supports prevention efforts. Sexual violence prevention takes time, resources and expertise, and requires dedicated investment.

● (1135)

Thank you.

The Chair: Thank you very much.

We'll now start with our rounds of questions. The first round will be six minutes, and we will begin with Shelby Kramp-Neuman.

Shelby, you have the floor for six minutes.

● (1140)

Mrs. Shelby Kramp-Neuman (Hastings—Lennox and Addington, CPC): Thank you, Chair.

Thank you to all the witnesses for their testimony today.

We can all acknowledge that, growing up, there are rapid development changes physically, and clearly, very deep emotional changes happen. For a lot of girls, this can be very exciting. For other girls, this is very daunting, confusing and uncomfortable. My first point is about why this is happening and what some examples are. Then I'll get to my actual question.

As parents, aunts and grandparents, I think we need to be watching for social cues. We need to be watching for how they're eating and how they're sleeping. We need to be watching for patterns with their relationships with other girls, with coaches, with parents, with other adults, with teachers, with themselves, with food and with their social media. Self-esteem and body image are huge. There are bullying, pressures, trends, drinking, smoking and cyber addiction. This is not news to any of you.

In the midst of my comments, I'd like to acknowledge you, Mégane Jacques, because I think it's brilliant that you are here speaking with us. Thank you for being open. I agree that being part of the solution is paramount. In my opinion, youth are the most important people to be talking about this. My one question for you would be this: Do you feel that there are enough youth actually involved in being part of the solution?

Second, taking the mom hat off and putting on the hat of the legislator, I think there was a comment made by Ms. Austin with regard to new budgets, promises made and nothing being done. To me, that's the disturbing part. It's brilliant that we're all here talking about it, but it's pathetically alarming if all we do is talk about it and not actually do anything about it.

My question, perhaps to Sara as well, is with regard to prevention and intervention. What specific mediums are we using to get to these young adults and actually help them?

Thank you.

The Chair: Ms. Jacques, you can start.

Ms. Mégane Jacques: Thank you for the question. I believe there are actually more youth who are interested in speaking up and working toward better mental health, but there's a kind of barrier where we're not always trusted to make our own decisions or make our own choices regarding the issue. That's scary for a lot of teens. I was lucky enough to find an organization that was ready to listen to my voice and accompany me during my process, but not all teens or youth have that opportunity or that luck.

That's something we should definitely work on in order to harness the full power of youth engagement. If it's too much of an effort to actually stand up for yourself...because sometimes that might be a little bit difficult, especially if you have mental health issues like a lot of youth who advocate for mental health have. For example, with my own anxiety, it was very hard to reach out to an organization or just be in the group and talk about it, because I was so anxious in every way and everywhere. Having a place that feels safe would definitely help regarding youth engagement.

I think the young Canadians' parliament that we're working on exists for this very purpose. Every young girl, every young boy and every youth work together with the government to find solutions and protect our rights, because we're ready and we want to make a change.

Thank you.

Mrs. Shelby Kramp-Neuman: Thank you.

Sara, I'm not sure how much time you have left.

The Chair: [*Inaudible—Editor*]

Mrs. Shelby Kramp-Neuman: Thank you.

Ms. Sara Austin: Thank you, Madam Chair and honourable members.

Thank you to Mégane for her courage and bravery today, and to many young people like her who are speaking up asking for help.

Far too often we see that when young people do have the bravery to ask for help, they simply don't have that help available to them. In the province of Ontario, for instance, kids can be on wait-lists up to two and a half years waiting for mental health supports. When we think about the issues and the gravity of things like self-harm, substance use disorders and suicide, to expect a young person to wait for so long for mental health supports is unacceptable. This is partly why we see such a rise in young people seeking mental health supports in emergency rooms. They need to know that they can go there if they're in crisis, but they should be receiving supports within a clinical setting within their communities and within their schools.

We are proud to have been able to launch the young Canadians' parliament at the very beginning of the pandemic to provide young people with a platform to be heard by parliamentarians and to be able to speak up for themselves in decisions that were being made in real time throughout the pandemic. However, we are dismayed at how slow it has been for funding to flow, and funding that has been announced has not often been directed to young children and adolescents. There has been funding for organizations like Kids Help Phone, which is very important and we have commended those efforts, but other funding has been slow to flow. We continue to call for designated funding for children and youth to start in the early years, to start with prevention, but of course also to provide the crisis support that's needed for children.

I urge and reiterate the point that was made around data collection, that we don't have systematic data collection at the federal level from coast to coast to coast, so we're often operating on limited information around different provinces or territories or municipal-level studies, so—

● (1145)

The Chair: Thank you, Sara. I'm going to have to interrupt so that we can get to our next line here.

I'm going to pass the floor over to Emmanuella.

Emmanuella, you have six minutes.

Ms. Emmanuella Lambropoulos (Saint-Laurent, Lib.): Thank you, Madam Chair.

I'd like to thank all of our witnesses for being here with us today, especially Mégane for being so brave and coming to testify here on behalf of all the young women she's representing here today.

A lot of people mentioned the higher amount of attempted suicide, depression and anxiety that is reported in young girls. I think it's two to one; that's the statistic that I heard around the table. I'm wondering if you can let me know, based on research that you have done, whether or not that might be because boys don't necessarily come out and express themselves as much. Are we missing that part? Apparently, according to research, there is a higher rate of suicide among young boys than there is among girls. I don't know if anyone around the table can confirm that, but I wonder if you can speak to this notion. I think that quite a few of you have touched on this subject.

I'm going to start with Mr. Szatmari, because I think he was the one who mentioned specific stats around the ratio.

Dr. Peter Szatmari: It's important to distinguish suicidal ideation and suicidal attempts from completed suicide. There's no question that young girls experience suicidal ideation or make a suicidal attempt that's non-fatal two to three times more commonly than boys, and young boys do complete suicide more commonly than young girls.

What's quite disturbing is that the gender gap on completed suicide—boys completing more commonly—is narrowing over time, not only in Canada but internationally as well. The gender gap where boys are more commonly affected—like antisocial behaviour, substance use and completed suicide—is narrowing over time, suggesting that the mental health of girls is being differentially impacted by things that are happening not only in Canada but globally.

I don't think it's a matter of reporting, because boys do report depression and anxiety, but certainly nowhere near as commonly as girls do. I hope that answers your question.

Ms. Emmanuella Lambropoulos: Thank you. In some ways it does. I appreciate your answer.

I'm sorry; this is a hard topic for me.

Mégane, earlier, when you were giving your testimony, I was wondering if you wanted to finish your comments, because I don't think you got to finish them. If you want to take the floor, go ahead. I know you already answered a question, but if you'd like to finish what you were saying in your opening statement, I'd like to give you an opportunity to do so.

Ms. Mégane Jacques: Thank you.

What I wanted to conclude on earlier was actually that I would like to ask this committee to really recognize girls as experts in our own lives and to respect our right to be involved in a decision that affects us. I want to say thank you to all of you, because you've been welcoming and open to the fact that there is a younger girl sitting at this table just as you are. I think it's a really good first step for making true change. Perhaps you could just continue in that way and listen to different girls of different backgrounds all the time.

● (1150)

Ms. Emmanuella Lambropoulos: Thank you so much.

Dr. Vigod, you are in the room. You spoke about perinatal mental health problems. No doubt, parenting style has a lot to do with how kids turn out and how well supported they feel at home, and obviously intergenerational trauma has an effect on kids and childhood trauma has an effect on kids throughout their life. Do you think there is enough support out there, and if there is, do you think it is accessible? What can the Canadian government do to help support mental health across the nation? I know that it's mostly a provincial jurisdiction because it falls under health. What can the Government of Canada do specifically to help the situation and make mental health supports more accessible to the most vulnerable?

Dr. Simone Vigod: Thank you for the question.

In answer to your other question about the 2:1 ratio, between menarche and menopause, depression and anxiety are twice as common in girls and women as they are in men. It's thought that this is because of some of the unique reproductive issues we were talking about related to menstruation and pregnancy, as well as because of the fact that women and girls are disproportionately affected by risk factors for mental illness, as we've heard today, like violence, poverty, lack of education, etc. That's what feeds into that.

Unfortunately, as you said, a healthy parent means a healthy baby. We talk about how the years before five last the rest of their lives. You actually need to take a step even further back and say that if we could make our young parents well during pregnancy, that could prevent issues in children and youth's mental health down the road. When I talk about the fact that we know that in Canada as few as one in five pregnant and postpartum people have the support they need, that's a big problem.

What can the federal government do? One of the things would be—and this has been done before—to fund community organizations across the country to deliver peer support to specific populations—adolescents or indigenous populations, for example.

My time is up, but if I had to prioritize one thing, I would say that if we could do that, we could make a huge inroad.

The Chair: Thank you so much.

We're now going to pass it over to Andréanne.

Andréanne, you have six minutes.

[*Translation*]

Ms. Andréanne Larouche: Thank you very much, Madam Chair.

I'd like to thank the witnesses for being here today to talk about this issue.

I agree that this is a very sensitive issue, Ms. Lambropoulos. We've heard some very moving testimony from some of our witnesses about the impact mental health issues can have.

For the sake of transparency, I'd like to say that I lost a cousin during the pandemic. He committed suicide. He was in the age group we're examining today. I also have family members experiencing mental health issues.

Dr. Vigod, I have a seven-month-old daughter, so I have experienced perinatal mental health issues. What we're talking today is very close to home for me.

Thank you for your testimony, Mégane. You mentioned the double standard for young women, and I'd like to sharing something a colleague said to me. She told me that now that I'm a mother and an MP, I'll always feel that I'm not being a good enough mother on the one hand, and that I'm not doing my job properly as an MP on the other.

I'd like you to talk about this double standard and how it can affect young women and girls' mental health.

Ms. Mégane Jacques: We always feel like we're walking on eggshells. We never know how we're supposed to act or how society expects us to act, which makes us even more anxious. Like any other young person, we want to please our peers and adults and find the gang we belong to. But that's almost impossible because different messages come in from all sides. They tell us to be this, or that, or the other thing. That makes us feel disappointed or ashamed all the time. No matter how we act, there's always someone who's going to be disappointed. This applies to girls more than boys, because we're always held to higher standards as girls.

So not only does that uncertainty make us more anxious, we also constantly feel inadequate, like we're not good enough or we're not doing enough, and that there's just no place for us in this society. That's one of the most damaging things, especially because when we try to talk about it, many times we're told it's not a matter of being a girl, and we're just more sensitive. When we bring up the situation, what we say often gets swept under the rug. It's really sad when young girls are undervalued like that.

● (1155)

Ms. Andréanne Larouche: I feel we can all agree that there needs to be more support. Dr. Vigod, you talked about community organizations and the health care system helping young people like Mégane. Many other witnesses have brought it up too.

I'm proud of what's already being done in Quebec. I'd like to point to a community organization in my constituency, for example. I did a day camp tour this summer under the Canada summer jobs program. I visited community organizations like the Centre de prévention du suicide de la Haute-Yamaska, as well as youth centres. Everyone said anxiety and mental health issues were on the rise.

However, we do have some great initiatives. For instance,where I'm from, a youth centre in Waterloo works very closely with École secondaire Wilfrid-Léger. People in these organizations say they need more support. They do get support from the Quebec health care system. A cross-party committee on sexual matters has also studied how sexual assault can affect young women's mental health, all in a non-partisan way in Quebec. As I say, the community organizations and health care system that help them need support.

I'd like to hear what Dr. Vigod or another witness has to say about this important issue, the need for more funding in the health care system. The organizations and the system could sure use it. We're establishing good local initiatives, but to do that we need a transfer. Quebec and the provinces are all asking for a 35% health transfer. We need the financial resources to help our young women and girls.

Dr. Vigod, do you want to tell us a bit more about the effect more funding for community organizations would have and what that might mean in terms of prevention?

Dr. Simone Vigod: I'll answer in English, if I may.

[*English*]

Thank you very much.

I think that if we could fund community organizations where the people in those organizations had the ability to support their communities...we know from evidence that this can prevent postpartum depression and can treat mild and moderate illness.

This whole conversation also really made me think about how much more we can do federally with cross-training. If we had a national collaborative centre, for example, it would be okay if there was expertise in Quebec but not in Saskatchewan. We could cross-train. We could have licences that run across.

Finally, with respect to the other question, I would say that there was a pediatrician in the early 20th century by the name of Donald Winnicott, who talked about the concept of the “good enough mother”, and we now talk about the “good enough parent”, the thinking that it's okay not to be perfect. In fact, that's what we want to do. That's the example we want to set, so that people know that they cannot be perfect and can still be worthwhile and move forward.

In listening to all of this, I think that's the messaging we need to put forward.

The Chair: Thank you so much.

I'm now going to move to Leah for the next six minutes.

Leah, you have the floor.

Ms. Leah Gazan (Winnipeg Centre, NDP): Thank you so much.

I just want to acknowledge, before I start, that this is a very difficult topic for many people around the table, so thank you, Andréanne and Emmanuella, for sharing. I know that these discussions can be very painful.

I want to start out with Children First Canada. Mégane, thank you for sharing your truths and your story. It was very powerful. Also, Sara, thank you for sharing. I think we need to normalize talking about mental health so we can get rid of the stigma and so that it's not based on shame but just telling and living our truths.

My first question is for you, Mégane. You talked a little bit about stigma and the stigmatization of young women being overly sensitive, hysterical—all of that. If you feel comfortable sharing, when you were going through mental health issues, did that result in minimizing your own experience as a result of the minimization that was happening around you?

● (1200)

Ms. Mégane Jacques: Absolutely. At some point, I wasn't even realizing that I still had mental health issues and I was still struggling, because everyone around me said that I had to be okay. I had to pretend to be okay; I had to just smile and continue walking, doing my thing. Those stigmas of just being too much of something or not enough of something always put you in a difficult place when you have mental health issues.

I would say that, for me, it led to my not taking care of myself as much as I had to and not seeking the help I needed, because I didn't feel that I was worthy of needing help or I didn't think that my issues were intense enough. I was waiting and waiting for the point of being really sick, because I had to be my perfect self out of the house and even in my house.

My friends were always telling me, “Well, I feel kind of stressed, too”, even if I said, “No, I'm not stressed; I'm very anxious right now. I have physical issues with my mental health.” People don't realize how much what they say has power over the mind. That point is really something that we should change among young girls and among adults as well. Even teachers at some point were trying to cheer me up and help me, but the very basis of what they said was solely that I should just continue.

Ms. Leah Gazan: Thank you so much for sharing that.

The next question I have is for Dr. Vigod. I'm glad that we're talking about postpartum depression. I know that, when I was born, my mother wasn't allowed to talk about it, but when I had my son, I was, with the public health nurse. That was top of mind, asking how I was feeling and all that. I'm glad we're talking about it.

One of the things you brought up is concerning to me, looking at the Canada Health Act. There are a couple of things, but one is that we often talk of provinces, except that certain groups are not funded under the province, particularly populations of first nations, Inuit, federal inmates, Canadian Forces veterans and refugees, depending on status. This is concerning. You spoke about access, but also how it's more pronounced in remote areas. We know that remote areas have the lowest proportion of women and girls, 55.8%, who reported very good or excellent mental health.

With all of those factors, particularly prenatal care and women having to be shipped away from families to hospitals alone for a month, how does that intensify mental health issues?

Dr. Simone Vigod: With the lack of access to care, you have to remember that one of the biggest reasons for developing a mental health issue around pregnancy and postpartum is lack of social support. We could prevent it so easily with some pretty low-intensity, low-cost interventions. That's why I made the second point that I did, and Dr. Singla raised this as well, that short-term, structured psychotherapies can be delivered by lay individuals. They can be delivered by public health nurses. They can be delivered in remote areas. Because of virtual medicine and telemedicine, we can do supervision.

We have ways we can help people. People should receive care in their communities because the other issue, as you said, is that you want to understand the experience of being a refugee or the experience of being indigenous.

● (1205)

Ms. Leah Gazan: Picking up on that, according to the Canada Health Act, mental health services and treatments outside of a hospital setting by non-physicians, such as psychologists, social workers, occupational therapists and other mental health workers, do not fall under the purview of the act. The only coverage is for services that are provided by a physician or a psychiatrist. That contradicts what you just said.

Do you feel that we need to make changes to the Canada Health Act to be more inclusive of service providers for people experiencing mental health issues?

Dr. Simone Vigod: No. I am biased, but I see mental health as a medical issue and a health issue. Why would we deliver certain medical care and not certain other medical care?

The Chair: Thank you so much.

We're now going to pass it over to Michelle Ferreri. We're in our five-minute rounds.

You have five minutes on the floor.

Ms. Michelle Ferreri (Peterborough—Kawartha, CPC): You gave me an impossible task, Chair. I need a whole lot more than five minutes for this conversation.

Thank you to everyone.

Mégane, you are definitely a star in this committee. Everybody is outstanding, but you are definitely a star. Thank you for being here.

I want to say on the record that we need to acknowledge that if we're going to treat youth mental health in girls, specifically, we need to be mindful that we need to invest in mental health for parents, caregivers and men. If we are not doing this, we cannot help young girls. To your point, Mégane, if the people around you had known how to trust you and how to empower you to recognize your own feelings, I believe you would have been in a much better position.

I want to go right to Leslie Buckley, if I can. Leslie, do you know if there is any data on an intervention time period that determines the success of stopping addiction disorders?

Dr. Leslie Buckley: Thank you so much for that question.

There is an incredible interaction between substance use disorders and other psychiatric disorders—we're talking about depression and anxiety—and we can certainly see certain relationships and patterns. One example could be social anxiety in a young person which, if unaddressed, could lead to increased substance use at the time when people start socializing more outside of their house, at age 15 or 16, and that could escalate over time.

That would be one example of how a mental health issue can lead to a substance issue, but it can also happen the other way. Somebody may not be experiencing anything from a mental health side and may start using substances. Again, it's important to note that risk factors for substance use are a combination of genetic and social factors. It's about fifty-fifty. Everybody has a different experience with substances, and some people are much more at risk.

Let's say a young woman starts to develop a substance use pattern. That may lead to certain specific events, such as doing less well in school. Maybe it is an impact of, let's say, cannabis use, which is increasing in women. We could see an impact of increased anxiety or mood related to that cannabis. There's been very poor education in that realm. There's misinformation, in fact, where people think that cannabis may be helping their anxiety or their depression, but in fact evidence shows the opposite.

This young person may be developing an anxiety or a depression issue into their twenties and then struggling with other life events, like school or relationships, which, again, is that spiral downward. Often, we see substances and mental health issues spiralling together in that way.

There isn't an exact trajectory. I wish I could answer your question more specifically.

Ms. Michelle Ferreri: That's okay. Thank you. There's a lot of data that I would like to accumulate, and I'm going to come back to that.

If I can, I'll go to Ms. Singla.

Daisy, you mentioned how we have such a huge gap and people do not have access, especially to talk therapy. Do you think there is room for modernizing health care to close the gap for access to mental health care—especially when we're targeting 12- to 24-year-olds—utilizing things like social media?

Dr. Daisy Singla: To clarify, I'm also a professor and can be addressed as Dr. Singla, if you wish.

In any case, with regard to social media, we know that with regard to psychological treatment, the most effective treatments are those involving a therapist. As we've emphasized, it does not have to be—

● (1210)

The Chair: Could we hold for one moment? There may be a problem with the translation.

There was a bit of a problem with the interpretation. Could you start that again, Dr. Singla?

Ms. Michelle Ferreri: If I can just get the answer fairly quickly, I have one more question I want to squeeze in.

Dr. Daisy Singla: Sure. You asked about the impact of social media. Certainly, we can leverage social media to improve access to psychological treatment.

However, we actually have the technology available—we're using it right now to connect with all of you in Ottawa from across Canada. We can use Zoom and other secure platforms to have therapists—again, they don't have to be psychiatrists or psychologists—deliver these effective treatments. They can be a whole wide cadre of non-specialists. We've done this around the world. We're doing it here in Canada in our SUMMIT trial to deliver these psychological treatments, so I would very much emphasize leveraging our—

Ms. Michelle Ferreri: I'm sorry, but I have only 20 seconds left, so I'm going to go to Ms. Austin quickly.

You called #codePINK, and fundamentally nothing has changed. There are $45.2 billion allocated for mental health. How will that best be used, do you think, to implement action right now for mental health in youth?

The Chair: Could you take that in about 10 to 15 seconds, Sara?

Ms. Sara Austin: I think it needs to focus on prevention and early intervention. It should look at prevention of mental health issues from the early years by looking at the effects of abuse and poverty and the systemic issues that are feeding into the poor mental health of girls and young women, but also the early intervention when young people are coming forward with their needs.

The Chair: That's perfect.

I'm now passing it over to Marc Serré.

You have five minutes, Marc.

[*Translation*]

Mr. Marc Serré (Nickel Belt, Lib.): Thank you, Madam Chair.

I'd like to thank all the witnesses for being with us.

We could use more time. If the witnesses have any additional information for the committee, it's very important that they send it to us.

[*English*]

I don't really know where to start. In Sudbury, in northern Ontario, Denise Sandul started Crosses for Change. There are a lot of deaths of youth and other individuals in the community. Minister Bennett came to visit in the summer and we had round tables and meetings with individuals. We were talking more specifically about Ontario, but the conversation was around 6,000 different organizations. There seem to be some challenges with coordination.

When we look at the stats that you identified today, there is a massive issue, but there are still some gaps when we look at the federal, provincial, municipal and volunteers. We heard from Dr. Vigod that community funding is important. I wanted to ask.... Maybe we'll start with Dr. Pinto from Jack.org. When we look at negotiations right now with the provinces on bilateral agreements, how important is it to get this right with statistics and evidence-based information, as we heard earlier? There is a massive urgency right now to fund organizations on the ground, yet we have to find a way to look at best practices with provinces.

I'll go down the list of witnesses, starting with Dr. Pinto and maybe Dr. Buckley and Dr. Singla afterwards. What are the best practices that the federal government and provinces should be utilizing when we look at organizations?

Ms. Rowena Pinto: I'm not a doctor, just for the record, but thank you so much.

As you know, Jack.org engages thousands of youth across the country, and what we have really focused on is that upstream support for youth and their mental health. As one of the other witnesses mentioned, there is never enough money to go around in terms of accessing services, so how do we build resilience, take away the stigma and improve help-seeking behaviours among youth? We've really focused on peer-to-peer support, because often that is where youth, and young women especially, will go if they need help. Sometimes they don't know what services are available or can't access them, and that has been proven to help.

I would agree that more support can be given to organizations that already have the constituency and already have trust with different communities. I think that is definitely something that should complement whatever investment we make in the system as a whole.

● (1215)

Mr. Marc Serré: Dr. Buckley, go ahead.

Dr. Leslie Buckley: Thank you so much for bringing up the story of Sudbury, which has had one of the highest rates of opioid overdose in the country.

We can think about two clear directions, and I think that has come from this group today as well. It's clear that we need prevention and we need treatment. For the treatment side, I think there will be a lot of comments about that. I think Dr. Vigod spoke about having a champion group that may be made up of many groups that help to oversee and perhaps distribute information and supervision to community groups.

On the prevention side, there's a lot we can learn from the addiction world, because we've had, in some ways, more experience in prevention than the mental health side has. It's not enough to just talk about prevention or talk about disorders or identify them, because we found with research in addictions that education doesn't have the impact we thought it would. You need to have skills-based education. You have to help people understand the harms of substances, of course, but we focus too much on that. Sometimes even just bringing up substances has actually led to an increase in substances in low-use schools, although it would reduce it in a high-risk school.

It's complicated. We have to do it right. We need to think about the centralized prevention tools that we have. In addictions, the best is accessibility. If you increase the cost, if you have fewer store hours, if you have fewer stores, you have fewer substances. It's important that we know those indicators; we're not winning that political war.

I guess my last comment is not to forget about addictions in the treatment that we're talking about today, because it's an important part of young women's experience.

The Chair: Excellent. Thank you so much.

What I'm going to do is mess around with this a little bit, because I'm looking at the time, and there are so many great questions still left to come.

The Bloc and the NDP are next. I'm going to increase your time to three and a half minutes and then not give you a final round. I'll just give you some additional time now. Then we'll get the last two questions by Mike and Jenna, if that's okay. So you'll get three and a half minutes now rather than two and a half minutes. Then we'll go for three minutes to Mike Lake and three minutes to Jenna, and then that will be the end.

Kristina, you have three and a half minutes.

[*Translation*]

Ms. Kristina Michaud (Avignon—La Mitis—Matane—Matapédia, BQ): Thank you, Madam Chair.

Thank you for having me.

I'm very pleased to be here. I'm the Bloc Québécois youth critic, so it really makes sense for me to be here today. I was with Ms. Austin on the weekend because I spoke to some young people from the Quebec Youth Parliament who are interested in democracy. Madam Chair was there with me as well.

My question will be for Ms. Austin specifically but if others would like to speak, I'd be happy to hear their comments.

I wonder how social media are affecting young women. We're seeing social media taking up more and more of our lives and millennials' lives, due in large part to the the advent of the internet.

We've seen this before. TV, movies and advertising have an impact on women's body esteem, what young women think of themselves, their self-esteem and their self-confidence. I feel the pandemic has exacerbated this with the increased use of social media. More and more studies on the subject show that young women feel frustrated and have comparison tendencies.

Ms. Austin, do you see a correlation, a direct link between social media addiction and the mental health issues some young women are developing, such as eating disorders and lack of self-confidence?

[*English*]

Ms. Sara Austin: Thank you very much for the question. We were really honoured to welcome you to the young Canadians' parliament on the weekend and to hear from Mégane and many of her peers.

Certainly social media is prevalent in the lives of girls and young women, and the lives of all children and youth, even from the very early stages of life. We know that young people are using technology from the earliest days. It's playing a role in preschool years and certainly well into their teen years.

We have heard about this extensively from young people. Back in 2017, we created the Canadian children's charter through extensive consultations with kids from coast to coast to coast, identifying the challenges they face growing up in Canada and the solutions they envision. They named the role of changing technology in their lives as one of their primary concerns, and it was framed in the children's charter as an area that they believe warrants urgent action.

Again, the young Canadians' parliament, in their most recent report and in the bills they tabled in February of this year, highlighted the role of technology in changing their lives and its pervasive role in impacting their mental health.

Our latest “Raising Canada” report is full of data on this, and we'd be pleased to share that with you as well. It's extensive. It's a problem but also, in many ways, young people see technology as playing a role in creating the solutions that they need. We use digital technology to facilitate programs like the young Canadians' parliament. We see the harms that it caused, but we also see the role it can play in helping provide access to support.

We heard from other witnesses how technology is being used to deliver clinical services to young people and make them accessible to young people in their homes, their schools or other places where they need support. We need to continue to fund those innovative and evidence-based solutions to ensure that they have access, and we need to have them at the table when decisions are being made around how to deliver these services.

Mégane and many others want to be able to have a role in the policies and programs being delivered for them.

● (1220)

The Chair: Thanks so much, Sara.

We're now going to move on to Leah for three and a half minutes.

Ms. Leah Gazan: Thank you so much.

I have a very brief amount of time and two questions. My first question is for Ms. Pinto.

You spoke about climate anxiety and the impact it is having on youth. I know that, in the DSM-5 or something—I'm not a psychologist—that's one of the categories they're looking at in terms of mental health stress on youth. I'm wondering if you can expand on that. I just feel that, as legislators, we're a disaster zone in terms of dealing with the climate crisis, and we're leaving an unlivable world for young people.

Can you please expand on that?

Ms. Rowena Pinto: As everyone knows, we're confronted with the climate change situation every day, most recently in Nova Scotia and the Maritimes just over the weekend. I think this is having a huge impact on youth, and it's coming out. We're seeing youth take to the streets around climate change, and we're seeing that, in many cases, they're demanding a place at the table. I think that really is the crux of all of it, that we're potentially leaving all of these issues that are going to have the most effect on youth, but we're not bringing them to the table as part of the decision-making.

All of you have seen how amazing it has been to have Mégane here, because she is such a strong voice, and she knows what she is talking about.

We can do that more, we have thousands of youth—

Ms. Leah Gazan: Thank you so much.

I have one last question, for Charlene Senn.

You spoke about how we will not improve the mental health of young women and girls if we don't deal with sexual violence. You indicated that one of the ways to address it.... You spoke about the importance of sex education. I'm wondering if you can expand on why that's critical.

Dr. Charlene Senn: Thank you for the question.

There are a couple of ways. One, we know that without comprehensive sex education, which most youth do not have and most adults have not had, we are not talking about the important issues around our sexual rights. We're just talking about bodies, anatomy and those kinds of things, which are not what we need as tools to go into relationships or tools to go into the world and actually interact with people who are attempting to get us to do things that we may or may not want to do, or even to initiate sex that we do want.

We know that this is a foundation. Without that, we're limited in what we can prevent. It's possible to do that really well, as we know from research, starting really young with what is developmentally appropriate and then expanding. That is a foundation. In fact, my program, which is the only university-based program that actually shows substantial and sustained decreases in sexual assault, has a three-hour emancipatory sex education unit as part of it. We think that really helps with the verbal resistance and response to verbal coercion. Knowing what you want is a foundation for then being able to deal in the world with all of these kinds of attempts to get women and girls to do what they don't want to do.

● (1225)

The Chair: Thank you so much.

I'm now going to pass it over to Mike Lake.

Mike, you have three minutes.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): Thank you.

A lot of you on this panel are friends and people I know very well. I respect so much of your work.

Rowena, I've had the chance to work with Jack. I was just down at the UN General Assembly and talking a lot, actually, with others about the incredible resource you have with the BeThere.org website. Could you explain a little bit about the partnership you have with the Lady Gaga foundation and BeThere.org?

Ms. Rowena Pinto: Sure. Thank you.

We put together a certificate program, which can be done completely online, called BeThere.org. The program is about four hours. We ask young people or other people who have young people in their lives to go through the program. It teaches you not only how to identify when you are undergoing some mental health struggles, but also how to support people in your life. As Mégane mentioned, so many times she went to her peers and they didn't necessarily know how to respond to her. This will actually walk you through. There are role-playing exercises. At the end, we actually see uplift in terms of mental health literacy as well as people feeling more confident in terms of supporting people in their lives.

This is a partnership we have with the Born This Way Foundation, Lady Gaga's foundation. We launched it just a few months ago, but about 10,000 people have completed it. I really do recommend that all of you who have young people in your lives look at it. It's a great online program.

Thank you.

Hon. Mike Lake: I think that reinforces what Dr. Singla and Dr. Vigod were saying about peer support and those kinds of things.

As we're having this conversation, one thing that jumps out at me is that these are issues that we talk a lot about right now. My concern is.... We have these great conversations. We have fantastic witnesses here. We're doing a lot of talking, but the reality is that there's very little action. During an election campaign almost a year ago, all parties had significant initiatives put forward on mental health, but the party that won, the Liberal Party, promised $4.5 billion for a Canada mental health transfer, and $875 million was to have been delivered by now and hasn't been. We're a country that is spending more money than we've ever spent, by far, and yet we still can't find the money to deliver on promises that were made in the election campaign a year ago.

How much of a difference could the $875 million make if the money was invested by now, as promised?

The Chair: You have about 15 seconds, please.

Hon. Mike Lake: That's for anyone.

Go ahead, Dr. Vigod.

Dr. Simone Vigod: I think it would make a huge difference. The federal government could fund specifically these coordinating centres to get everything on board and get the standards going so that we could monitor and really make sure we're doing a good job. The bottom line is that it could fund people, because we still need people to treat people, whatever—

The Chair: Perfect. Thank you very much.

I see we have other hands up, but we're coming to the last three minutes, and I'm passing them over to Jenna. You may be able to respond to Jenna's question.

I'm passing it over to Jenna for the next three minutes.

Ms. Jenna Sudds (Kanata—Carleton, Lib.): Thank you very much, Chair.

Thank you to all the witnesses for the incredible work you do every day and for sharing your expertise with us today.

As we've heard a lot today, this is a difficult topic and one that I know is touching so many young people and women across our country. We've heard again and again from our government that mental health is health. It's important as we move forward to continue the dialogue with the provinces and the territories to ensure that we move forward collaboratively and make the progress that I know we all want to make.

I'd like to go back to Dr. Singla, if I may.

You mentioned in your testimony that there are not enough professionals to meet the needs of young women who are seeking mental health support. I'd like to dig into that a bit, because we haven't touched on it today. Can you elaborate? Is this a problem with retention? Is it training opportunities? I'd love to hear your thoughts on that.

● (1230)

Dr. Daisy Singla: This is a multifold problem where we simply do not have enough people in Canada, or in the world, due to a lack of trained individuals who are available to deliver these effective interventions.

The good news is that we don't need folks like me or my colleagues on this panel to deliver these effective psychological treatments. We have shown time and again, in all corners of the world, that individuals without a specialized degree—that is, peers, lay providers, nurses, midwives and teachers—can all be supported and trained to deliver these effective treatments for conditions across the youth period and the perinatal period.

Investing in non-specialist providers will allow us to have a return. Every dollar invested in this initiative would allow for a return of three dollars in savings to your health care system, as well as to work productivity. These are data that have been accumulating for the last 30 to 40 years.

Here in Canada and across the U.S., we are implementing non-specialist-delivered psychological treatments led by nurses and midwives, and I'm quite confident we will show that they are as effective as psychiatrists and psychologists delivering the exact same treatments.

The Chair: That's fantastic. Thank you so much.

We have come to the end of the panel for today. I know we have had some expertise here and absolutely not enough time.

On behalf of the committee, I would really like to thank Sara, Mégane, Rowena, Leslie, Daisy, Simone, Peter and Charlene. Thank you so much for bringing your voices here. I'm sure there will be more conversations coming out, because I've written all your names down, saying, “I think I need to learn more from these ladies and gentlemen.”

We are now going to suspend for a few minutes and go into a closed session.

[*Proceedings continue in camera*]