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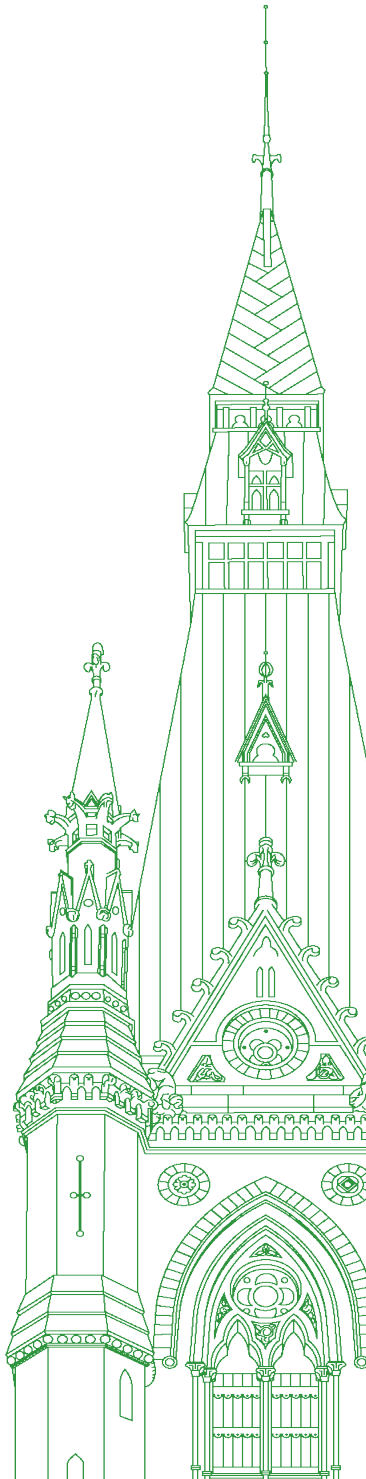

Chair: Mrs. Karen Vecchio

Standing Committee on the Status of Women

Thursday, September 29, 2022

● (1530)

[*English*]

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

Welcome to meeting number 30 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 resume 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, and please mute yourself when you are not speaking. For interpretation for those on Zoom, at the bottom of your screen, you have the choice of floor, English or French. For those in the room, you can use your earpiece and select the desired channel.

This is a reminder 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. We appreciate your patience and understanding in this regard.

Regarding briefs, before we welcome our witnesses, I would like to seek agreement from the committee on accepting briefs until November 1 for the study of the mental health of young women and girls. Is it the will of the committee that briefs be accepted until November 1?

Some hon. members: Agreed.

The Chair: I see a lot of support for this, so we will allow briefs. For anyone who would like to submit a brief, you have until November 1. That gives everybody a month to get that in. Thank you so much, everybody.

I would like to give a trigger warning. It was very obvious as we were sitting here at our meeting this week that this is going to be one of those studies where we need to support one another. I would like to provide this trigger warning: This will be a difficult study. We will be discussing experiences related to mental health. This may be triggering to our viewers, members or staff with similar experiences. If you feel distressed or if you need help, please advise the clerk. As everyone knows, if there are problems, just reach out to me too. Whatever we can do to support one another is the best way we can try to be there for each other.

I would now like to welcome our witnesses. Today, we have three different groups here with us.

For the Boys and Girls Club, we have Owen Charters, president and chief executive officer. I give a little shout-out to the city of London. Also, we have Gwendolyn Moncrieff-Gould, director of public policy and engagement.

From the Royal Ottawa Health Care Group, we have Krystal-Jyl Thomas, social worker, women's mental health program, and Michelle Jackson-Brown, who is a registered social worker.

Also, online today we have Gordon Matchett, who is the chief executive officer for Take a Hike Foundation.

For all our panellists, we'll be providing five minutes for opening statements. At around four minutes and 30 seconds, I will be letting you know that you should start to wrap up your time. For those of you on Zoom, keep an eye out for me if you can.

I'm going to look to the committee as well, as there's a discussion I would like to have for about five minutes, briefly, at the end of the meeting. I would like to add about five minutes for committee business, with some information coming in. The clock up there is about five minutes off, so if you're looking at the clock, we'll probably end our questioning when there are about five minutes left in the meeting and go into two or three minutes of committee business.

I would now like to pass it over to the Boys and Girls Club. Owen and Gwendolyn, you have the floor for five minutes.

Mr. Owen Charters (President and Chief Executive Officer, BGC Canada): Thank you, Madam Chair.

Thank you, committee members, for having me. My name is Owen Charters. I'm the president and CEO of BGC Canada. We've been known for many years as Boys and Girls Clubs of Canada. We now increasingly go by our acronym.

My colleague with me is Gwendolyn Moncrieff-Gould, whose name does not fit on a name tag, apparently, but questions can be directed to either of us.

For over 120 years, BGC Canada and our clubs have been creating opportunities for millions of Canadian kids and teens. We are Canada's largest child- and youth-serving charitable organization. Our clubs serve over 200,000 children, youth, teens and their families at almost 800 locations across the country, many in your ridings. I noticed some acknowledgement of recognition when our name came up.

During vital out-of-school hours in small and large cities, in rural and indigenous communities, our trained staff and volunteers provide programs and services that help young people realize positive outcomes in self-expression, academics, job readiness and—most relevant today—mental health.

Our clubs have seen an increased need for mental health supports for young girls, women and workers in the youth sector for quite a number of years, and that trend has only been exacerbated by COVID-19.

A recent Statistics Canada report that you are likely familiar with shows that youth saw the most significant drop in self-reported mental health since the pandemic. One in two young women now says their mental health is fair or poor. That's compared to 27% of young men. It's almost double in young women.

We've also seen this disproportionate impact in our workforce. The vast majority, 96%, of early childhood educators in Canada are women, and child and youth workers are also disproportionately women. They have faced additional burdens during the pandemic, including providing essential services, as well as the extra burden of unpaid caregiving. Two-thirds of our staff are also youth themselves.

We recently conducted a study on the mental health of frontline staff working with children and youth with several other national charities, including the YWCA, CMHA, and the Canadian Child Care Federation. We found that frontline staff are struggling with their mental health and are experiencing burnout at much higher rates. Yet, only one-third of these employees have access to programs to prevent burnout, and only one-third say they would feel comfortable talking to their supervisor about mental health issues. Without additional support for frontline staff in programs—most of whom, again, are young women—children and youth will be unable to receive the highest quality of care.

The undervaluing of child care work has meant a steady decrease in the number of people entering the child and youth sector. Approximately 50% of early childhood educators leave the field within the first five years. This staffing shortage only adds to additional stress for existing staff—because of additional workloads—and many frontline staff report feeling guilty for taking days off because of the impact it would have on their co-workers, who are already overworked and stretched.

Multiple governments across the country recognized the importance of investment in mental health for frontline health care workers over the course of the pandemic, and now we are calling for similar investments and supports for frontline workers and organizations in the child and youth sector. Investing in mental health services not only supports young women and girls today, but will have long-term impacts in the future.

One study has found that there is a $23.60 return on every dollar of investment in preventing and treating mental illness in adolescents. Our recommendations for how government can address these pressing workforce issues and address mental health for young women and girls include funding to support organizations that work in the child and youth sector, like our clubs; ensuring that every child, youth and caregiver can access evidence-based, culturally safe and responsive community-based mental health supports; and funding to organizations for frontline staff working with children and youth to access mental health first aid training so staff can better support the mental health of children and youth in their programs.

Allow me a quick anecdote that came from one of our clubs recently that I think really demonstrates the story of how this impacts families, children, youth and workers. It's a story of a family arriving at a club, including a single mom, who staff reported had a car accident, unfortunately, in the parking lot of the club. When they went out to see if everyone was okay, the mother was unconscious. Unfortunately, as you may have seen in today's Globe and Mail, the opioid epidemic is getting into a worse stage in terms of numbers. This young mother was under the influence of opioids and was practically unconscious.

When the club takes care of these kids and tries to get them into care with children's aid services, they have responded that there's really no capacity left in the system for them to provide support.

What you have in these sorts of situations is a family that's traumatized, a young mother who is struggling, a family whose children need support and have experienced trauma, and the colleagues, the workers, who are experiencing that trauma first-hand and don't have the supports they need. I think that perfectly illustrates the challenges we're talking about.

● (1535)

Thank you.

The Chair: Thank you so much for sharing that story today.

I'm now going to pass it over to the Royal Ottawa Health Care Group.

Krystal-Jyl and Michelle, you have the floor for five minutes.

Ms. Krystal-Jyl Thomas (Social Worker, Women's Mental Health Program, Royal Ottawa Health Care Group): Thank you very much.

My name is Krystal-Jyl Thomas. I am a social worker focusing on the field of mental health, psychotherapy and family intervention services. Joining me today for the question and answer period is my colleague Michelle Jackson-Brown, also a social worker and peer support worker, focusing on mental health, perinatal and peer support services. Together, we lead the women's mental health program at the Royal Ottawa mental health centre, located in Ottawa.

Before I continue, I think it is important to highlight the current situation in Iran in regard to the rights of women and human rights. The Canadian government, as a world leader, has the responsibility to stand with and support the freedom of choice for the women and girls in Iran.

Since January 2021, almost 500 youth aged 18 to 24 have been referred to the Prompt Care Clinic at the Royal, a clinic designed to meet the rapidly growing mental health concerns since the beginning of the pandemic. Of those referred, 67% were women and 65% were assessed with mental health care for the very first time. Additionally, of those referred, 17% were at high risk and 22% were at moderate risk for suicide.

Women continue to make up the majority of frontline child, family, elderly and home care workers, while simultaneously facing sexism, gender inequality, discrimination and violence. We can do better for those who identify as women in this country.

Our first recommendations include ensuring that each province and territory has protected funding for targeted girls' and women's mental health programs and tailored programs for women belonging to the BIPOC and 2SLGBTQ+ communities, as well as required services that address language, travel and wait-time barriers. Hand in hand can be national standards for screening tools to assist in early intervention, such as perinatal mental health concerns and gender-based violence.

To expand, sexism and inequalities are amplified with the indigenous population of Canada. To move forward, it's imperative to cease challenging various court rulings in relation to the obligations of the federal government. Continuous delay increases poor mental health and perpetuates a message of undervalue for the communities that indigenous girls and women belong to, and it is an obstacle to creating self-determined grassroots indigenous programs.

Next, our current system continues to be focused on crisis intervention, meaning that many services are not available until the point of crisis or emergency. In most cities, police are used for intervention. Creating mandated programs for mental health training for police or programs that support trained mental health professionals to be deployed independently or with police can yield better outcomes of de-escalation and connection to appropriate services.

Assisting with easing crisis-focused services would include expanding transitional services for youth as they age out of programs—so, violence against women shelters, perinatal mental health programs, abortion and miscarriage supports, as well as mother and baby health outreach teams and psychiatric units.

Public schools can be a primary goal for implementing preventative educational programs that focus on the empowerment of girls, along with how to care for and address mental health. Normalizing these conversations with children and their families about sexism, women's rights and mental health can help equip them to grow into adults that lower stigma and create equitable societies.

Lastly, the International Initiative for Mental Health Leadership has deemed peer support as the fastest-growing workforce in the mental health field. Peer support workers can be key in bringing experienced learning through personal and valuable connection. Peer support is an untapped workforce available to assist in various vacant clinical positions. Utilizing peer support skills benefits both clients and families through lived shared experience, resilience and strength. In the U.S., there are federal requirements to state plans to ensure peer support programs. Canada can look to provinces and territories to do the same.

Thank you. *Merci*. *Meegwetch*.

● (1540)

The Chair: Thank you so much, and thanks for your presentation.

I'm now going to pass it over to Gordon Matchett at the Take a Hike Foundation.

Gordon, you have the floor for five minutes.

Mr. Gordon Matchett (Chief Executive Officer, Take a Hike Foundation): *'Uy' skweyul siem*. It means “Good day, respected ones” in Hul'q'umi'num.

My name is Gordon Matchett and I use the he/them pronouns.

Today I'm Zooming in from downtown Vancouver. I'm surrounded by the beauty of the Salish Sea and the North Shore mountains. It's the traditional home of the Musqueam, Squamish, and Tsleil Waututh people since time immemorial.

Land acknowledgements are so important to us at Take a Hike because one-third of the women and girls we serve self-identify as indigenous. It's one of the more visible parts of our organization's commitment to reconciliation and helping young indigenous people find success, however they define it.

Right now I'm thinking about Kishi. She's a young indigenous woman who found herself in Take a Hike because she was masking the pain of intergenerational trauma with substances and skipping school. In Take a Hike, Kishi found a safe and caring environment with safe and predictable adults who were able to form relationships with her, improve her connection to school and find healthy ways to cope with what is happening in her life. Today Kishi is working as a support worker in the Downtown Eastside of Vancouver, which is the epicentre of B.C.'s homelessness and opioid crises.

Kim is a trans youth who's in their second year of Take a Hike. Kim was assigned female at birth and, like about 10% of the youth we serve, is questioning their gender identity. Kim used to face bullying in their previous school and constantly fought with their family. There was really no place they felt safe. In Take a Hike, they found adults who provided continuity of care for both Kim and their family. Last year, they were able to rebuild the relationship with their family and for the first time found community at school. We're so happy to be able to provide this continuity of care for Kim, so that they are able to continue the good work they started last year.

Kishi and Kim are just two of the young women we've worked with at Take a Hike. Their struggles and successes are reflective of the overall population we serve.

Over the years, we've seen an increasing number of young women attend the Take a Hike program. They present with a variety of mental health and substance use concerns. The women we're working with this year are presenting with eating disorders; self-harm, including cutting and hair-pulling; very high and debilitating anxiety and mood disorders; intense gender dysphoria and expressions of themselves leading to debilitating anxiety; and negative impacts from their online reality. They're internalizing the “norm” of oversexualization and we're seeing a great deal of body image concerns.

We're also seeing mental health disorder self-diagnoses becoming a major part of the young women's identities and lives. As they seek to live out these self-diagnoses, it becomes increasingly difficult to shift the manifestation of the diagnosis.

What we're hearing from the young women and girls we serve is that they want mental health services delivered right in their schools, where it reduces barriers related to stigma, availability, affordability, transportation, the inability to build relationships with a new counsellor, and continually being bounced between counsellors.

Take a Hike is a unique, innovative and evidence-based program that partners with public school districts in B.C. to identify underserved youth and provide mental health services embedded right in the classroom. We use the outdoors to build relationships, engage with youth, and learn on and from the land. Therapy happens in the classrooms, on the basketball court and on the hiking trail, and it's normalized.

School districts provide everything that they are provincially mandated to deliver. Take a Hike layers on top mental health supports and covers the costs of outdoor activities. These things are above and beyond the mandate of the public school system.

Take a Hike has seen some incredible success over the last 22 years. In the last three years, we've more than tripled the reach of the organization. We're now serving 220 youth in multiple regions of B.C. In the 2020-21 school year, at the height of the pandemic and the last year that we have results for so far, we saw 75% of the youth we serve improve their mental health. I'm super impressed because I know my mental health did not improve during that time.

Take a Hike is poised to grow at an exponential rate. One barrier to growth we are experiencing is accessing government funding. As an innovative program, we don't fit into any of the traditional government funding options. We're continually bounced between ministries and jurisdictions. We know that there are not enough mental health commissions in our country to meet the increasing demands of the mental health crisis.

Thank you for the opportunity today to share the mental health challenges we're observing in the young women and girls we serve, the barriers to accessing support and our innovative model of serving youth. We encourage you to find ways that the government can support innovative and evidence-based programs that remove barriers and help young women and girls improve their mental health.

Thank you.

● (1545)

The Chair: Excellent. Thank you so much for that.

We're now going to start our rounds of questions. The first round of questions are six minutes each.

We'll start off with Michelle Ferreri for six minutes.

Ms. Michelle Ferreri (Peterborough—Kawartha, CPC): Thank you, Madam Chair.

Thank you to all of our witnesses today. It's a super important topic that all of us are very passionate about.

Owen, thank you for your testimony. Our Boys & Girls Club in Haliburton—Kawartha Lakes—Brock is fabulous, so I'm happy to be speaking on behalf of it. It's just outside of my riding.

You really touched on what I would like to expand on. You talked about the mental health of the frontline workers. I'm curious if there's any data or if you guys have invested in any data about the increase in children, young girls, who are having mental health concerns or issues that are developing into illnesses where the parents are struggling at home.

What I'm trying to draw a connection to here is that we have an affordability crisis right now. We have four out of five people who are sometimes using food banks or saying they're going to. There's a lot of stress in the home right now with inflation and housing. I'm wondering if there is data to show that impact on the kids and how it's transferred.

Mr. Owen Charters: I wish I could say I had data. Unfortunately, we don't. We have multiple anecdotes, and multiple anecdotes don't make data, but we have multiple anecdotes of families who are reporting increased stress. We're hearing it from the kids. So, whether it's Amy Terrill at the Kawartha Lakes club or clubs across the country.... We're actually meeting with our clubs in the next two weeks, and I think we'll hear more of those stories where they've said food costs are a problem.

However, prior to that, the pandemic has led to all sorts of situations at home that have exacerbated what have been incidents, for instance, of domestic violence. Kids come to the club reporting that there is greater unsafety or uncertainty and, I think, risk when it comes to economic safety at home.

I'm sorry that we don't have the data. It might be something that would be great to connect. Our challenge is often one of resources and capacity to get validated data from the youth about what that kind of impact looks like, unfortunately.

● (1550)

Ms. Michelle Ferreri: It's always critical when we're looking at that funding. You need the data to support it, but you need the funding to get the data, so it's kind of a chicken-and-egg situation. If we can look into the impact on children when the rise of adult mental health concerns is high, which correlates with your frontline workers, that's where I'm coming back to that point.

I was going to chat with the other witnesses here about this. There's a lot of research around neuroscience and co-regulation. We can't show up and be the best parent or the best employee or the best frontline worker when we are so distracted. So, we're taking away from children's ability to be children, basically, which is detrimental to their long-term health and these long-term issues that we see.

I would love to see in this committee if we can start to focus on data, because I think it will give you more opportunity to access funding, quite frankly, because that's what we need to see.

If I could turn to Krystal.... I really loved what you were talking about with regard to the education system. When we look at mental health, in children and young girls in particular, there's the prevention, the end of things that really saves us those dollar-figure amounts here in our health care system.

Are you familiar with the work of Dr. Stuart Shanker or self-regulation, co-regulation and its being offered as a...? Would you support its being offered as a federally funded program, or more federally funded programs that teach children to recognize their emotions, their responses to their emotions, their feelings, and give a name to them so they can better self-regulate?

Ms. Krystal-Jyl Thomas: I'm not really familiar with the work, but the description that you just gave I would absolutely support. Anything that, again, is going back to those preventative measures is really going to save dollars down the road, but it's also going to save a lot of crises and internal conflict for the women and young girls. The earlier we can get programs like that in, where we can start to understand our own mental health....

At the Royal, we have a program, mental health first aid, and it's now being offered to everybody in the city, in the different components, which is great, but why not have this for children? Why not have this in schools and start this early so that we can start to recognize this, especially as we're going through transitions into the teen years and whatnot? It's definitely something I would support.

Ms. Michelle Ferreri: Mental health first aid is a great point that you brought up, and I would love to see it mandatory, much like CPR, where it's implemented from that very young age without burdening children with adult problems. There is a very grey area that we have to be extremely mindful of, and it's that we are not putting adult-age problems onto children. I think there's a delicate dance here because sometimes we give them too much information, and we don't let them be children, either. I think mental health first aid, age-appropriate, is absolutely critical.

I saw you shaking your head about Stuart Shanker, so can I assume, Owen, that you are on board with his work?

Mr. Owen Charters: We're more than on board. We've been asking kids to identify their emotions. Dysregulation is a challenge for children when they come in after school, so it has been something the clubs have worked on forever.

To your point about programs, a lot of what we realize is that children don't engage in formal or traditional mental health programs. We have several programs, such as Flex Your Head and Bounce Back League, that use recreational programs—a lot like what Gordon spoke about—to talk about mental health issues in a context that, I think, is appropriate for where kids want to talk about things, not because they are talking about mental health. It makes an enormous difference. We, too, would echo the need for mental health first aid.

Ms. Michelle Ferreri: Thank you so much.

When we have mentally healthy children, we have mentally healthy adults.

The Chair: Awesome. Thank you so much.

Michelle, we're going over to our next set of questioners. Then we'll make sure you have an opportunity.

I'm going to pass it over to Jenna Sudds.

Jenna, you have six minutes.

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

Thank you to all the witnesses who have joined us today, not only for being here, but for the incredible work they do every day.

I'll direct my first question toward Ms. Thomas.

First of all, the work of Royal Ottawa, and in particular women's mental health, is phenomenal. As an Ottawa MP, I can attest to that. I have stories, and I'm sure MP Vandenbeld also has many stories, of lives you have changed and touched with your work here in our city. My thanks for that.

You made a few recommendations. There were two I would love to hear more about. I'm wondering if you can expand on that. One of them was about expanding transitional programs for youth. I would love it if you could expand a bit on your thoughts about that piece first.

● (1555)

Ms. Krystal-Jyl Thomas: Absolutely. This is a big problem that we see often. We have a youth program within the Royal. This is happening across the city, not just within the Royal. When a young person turns 18, they are now aged out of the program. Then they have to go all the way back to the start of the race line to try to get back into services that are appropriate for them.

On top of that, the wait is so long for services that sometimes by the time they get to that service, the needs have become so acute that they no longer qualify for that service. They need another service, so they are left waiting more. This is detrimental to their health. It's detrimental to the workers. It's very hard to continuously have to turn people away and have completely full caseloads.

We could create either buffer programs that are in the middle, or some kind of case management where we come in and don't just discharge somebody out—we're actually there and we're holding them through until the next secured program for them. We would like to see more of that.

Ms. Michelle Jackson-Brown (Registered Social Worker, Royal Ottawa Health Care Group): Yes, I can speak to that. I worked on the psychiatric outreach team prior to my work on the women's mental health team. It was quite common that somebody would be referred at the age of 17 and then they would age out before they even qualified for the youth services program. What we need is bridging services so that as people are aging out at 17 years old, they are coming straight into a program at the age of 18.

The other issue is that the wait-lists are so long that people are waiting anywhere from three to six months for just a primary psychiatric consult, which is an issue. It's typically supposed to be a three-month caseload. I had to keep people on my own caseload for up to a year so that they could access services. We had people in our young women's shelter. Two years ago, I could get them connected to services within a month. It has now grown to two years in a young women's shelter.

To add to that piece, I should highlight that our women's mental health program has been entirely funded by philanthropic donations for the past 10 years, so we have to carve out of the mental health envelope of funding for our program. We rely in our program on peer support to expand our capacity. However, it would make a significant difference if we had targeted and earmarked funding specific to women's mental health care.

Ms. Jenna Sudds: Excellent. Thank you for that.

I noted that this was another one of the recommendations, ensuring protected funding specifically for women's mental health. The other one I wanted to touch on was a recommendation you made with respect to national standards. Can you speak to that?

Ms. Krystal-Jyl Thomas: There are some things that can be standardized. I understand that different provinces and territories may have different communities and different needs, so I don't want to take away from the fact that we do need to differentiate in different places, but there are some national standards that we could look to, again coming back to that protected funding, where we could have a national standard that there's so much funding for peer support going into Canada, and there's so much funding that's allotted to women and young girls.

Again, looking at peer-reviewed studies of what that would mean specifically, I'm not sure and I'm not prepared to answer that today, but I would like to see that we do have something along those lines that we're drawing from.

Ms. Michelle Jackson-Brown: I can add to that. The Canadian Perinatal Mental Health Collaborative, which some of you may be familiar with, released a report in May 2021, “Time for Action: Why Canada Needs a National Perinatal Mental Health Strategy Now More Than Ever”. It identifies that we should have universal screening, training and stepped care for perinatal mental health. I would recommend that report.

In addition, I think is also important having universal screening for gender-based violence. We don't currently have that. Again, that's where earmarked funding would make a difference. For example, on the psychiatric outreach team I was on, I did outreach into the shelters, but we did not have funding to do outreach into the violence against women shelters. That is a very important time in a woman's life to get in and to provide support. If they are at a shelter, that is a crisis situation and an opportunity for us to get them connected to the right supports and care.

One other thing I'd like to bring attention to is that the Mental Health Commission of Canada, in February 2022, released a report, “The Time is Now: Considerations for a National Psychotherapy Program”, which would also, I think, go a long way toward easing the burden of mental health care across this nation, providing access to free psychotherapy for anybody who is starting to demonstrate mental health concerns.

● (1600)

The Chair: Thank you so much, Michelle.

We're now going to pass it over to Andréanne for six minutes.

[*Translation*]

Ms. Andréanne Larouche (Shefford, BQ): Thank you very much, Madam Chair.

I would like to thank the witnesses who are here today to help us with our study.

Obviously, this is a topic that concerns everyone to varying degrees. We have all seen the stats on mental health during the pandemic. Mental health issues have really been exacerbated during this period. We will come back to this later.

I would like, however, to remind us all, as did Ms. Thomas, of the plight of women in Iran. Last week, our party, the Bloc Québécois, presented a motion at the House of Commons, which was unanimously passed and supports Iranian women in their fight for freedom and respect.

Sometimes, we get the impression that the fight is over. Some politicians are saying that the feminist cause and conflict between men and women are things of the past. This study shows that actually the opposite is true. There is still inequality between men and women.

My first question is for Mr. Charters.

Statistics show that there is a gap between the suicide rate of young men and that of young women, but that this gap is closing. Is that with you're seeing? How do you explain this phenomenon?

Mr. Owen Charters: Thank you for the question.

[*English*]

With regard to the data I was referring to, I didn't speak specifically to suicide rates. We do know that suicide rates, and I don't have the data for that specifically.... However, we do have the data that young women report at twice the rate of young men understanding their own mental health as being fair to poor—so not great—and obviously that leads to suicide rates.

I don't want to speculate on the rates, because there are many factors, unfortunately, that go into what I'll sadly call the effectiveness of taking one's life. While there are more attempts by females, males are more effective at actually going through with it. I don't have those numbers.

The challenge we see is that for young women, it isn't just the family pressures and the other pressures that we've seen in the pandemic; there is a social pressure that comes through that we see in clubs, which is also coming through in tools in the online space—social media. We've spoken about this before. The challenge of bullying and seeing greater social isolation does not go away when you leave school. That bully is available on your phone at three o'clock in the morning, and it's very easy for people to pile on.

When we've had to teach about gender-based violence and about dating safety, unfortunately what we're seeing is that a greater proportion of the burden is borne by many of these young females in social image, in body image and in what they're expected to display as a perfect image online, as one example.

We would say that's what's contributing to some degree, but I think my colleagues at the table would be able to add to that as well.

[*Translation*]

Ms. Andréanne Larouche: Mr. Charters, as you stated, we are seeing an increase in the number of intimate partner violence cases involving young women. Recently, I met the director of a CEGEP in my region, who confirmed that the number of requests for help from young women who experience intimate partner violence was on the rise. We know that intimate partner violence has an effect on women's mental health. They are clearly and directly connected. That is what the data seems to be showing, anyway, in a CEGEP in my riding. Do you have anything to add?

The other topic that I wanted to mention was something that you have already spoken of. I was asked to replace a colleague who sits on the Standing Committee on Public Safety and National Security when the committee was studying online hate. As you said, it is a problem that has been exacerbated by the pandemic, but it already existed before. Not only does social media put pressure on young women in terms of their image, and we know that they are spending more and more time cultivating that image, but we also know that they are receiving messages that are increasingly hateful and that the level of violence is growing. Obviously, this brings us to the issue of mental health. All these factors are directly linked.

What can the federal government do here? Is it time to legislate in order to fight online hate?

● (1605)

[*English*]

Mr. Owen Charters: That is a big question. I think counteracting that requires a societal response and an educational response.

We've talked about policy responses that are to help young Canadians better control.... First of all, it's to require permission to do what they do online to some degree. There is a lot of unsafe space online, and if there is better control of it—in terms of the work done by some of our social media corporations—to better enforce the “right to be forgotten” when a child gets to the age of majority, to be able to delete and reset.... We've seen that Facebook has attempted to do some of this, but I think the effectiveness is quite low, and regulation around it needs some teeth.

We've submitted a brief in the past that talks about how we protect young people in the world of social media to some degree. But I think that, broadly speaking, we're going to need to do more work to engage young people in programs like ours and Gordon's to build better social connections versus understanding that they can use this sort of Wild West of the Internet to spread hate.

The Chair: I'm now going to pass it over to Leah Gazan.

Leah, you have the floor for six minutes.

Ms. Leah Gazan (Winnipeg Centre, NDP): Thank you, Madam Chair.

My first question is for Gordon Matchett from the Take a Hike Foundation.

You identified, during your testimony, a number of young people who are questioning or exploring their gender identity, who they are, how they fit it and how they belong. You mentioned that the bullying and mental health struggles faced by trans youth especially—who are trying to live who they are and how they want to live their truth—are gruelling and even more pronounced.

The Canadian Mental Health Association indicates that LGBTQ youth face approximately 14 times more risk of suicide and substance abuse than their heterosexual peers. Can you expand a bit more on the kinds of support that some of the 2SLGBTQIA+ youth you serve are asking for?

Mr. Gordon Matchett: We're finding that many among the youth we're working with are really questioning their gender identity, and they need a safe place where they're able to explore that gender identity. What we're finding is that some days they may identify as male and other days they may choose to identify as female. They need that safe space where they're able to explore and find acceptance with their peers and the adults in the room.

That's not always true in classrooms. Here in B.C. we're very fortunate that there is a very fertile ground with programs like SOGI 1 2 3—sexual orientation and gender identity—that's swept through the B.C. school system and is providing that safe space. Here at Take a Hike, we have our counsellors who are able to work with those youth to go deeper and help them explore.

Ms. Leah Gazan: Thank you so much.

My next question is for Owen Charters from the Boys and Girls Club.

Since the pandemic, what are some of the biggest challenges in terms of mental health that you find with young women and girls that could potentially be impacting their long-term mental health, things like burnout, depression and anxiety? One of the things we've been talking about is the impact of the climate emergency on the mental health of young people.

You also spoke about frontline workers. I was an ECE. I was a teacher, actually, and I was a youth care worker early on. There were still dinosaurs and palm trees. It was a long time ago.

What are some of the greatest issues that you see young people expressing feeling stressed about or that are impacting mental health?

Mr. Owen Charters: The answer to that question is interesting, because before the pandemic we did a survey of our youth to ask what issues were most impacting them and what they were concerned about. We talked about poverty and employment, which all came up to the very top. The topmost one at the time was, in fact, mental health. It's a reinforcing circle.

Some of the things you talked about are in fact what we hear from our youth on the reasons why. Before the pandemic, climate change, employment and academic success were contributing significantly to that, as well as what I just talked about earlier about the impact of social media.

Because of the pandemic, we've heard about social isolation and the breakdown of the connectivity, especially for young people. We all need it, but when you are going through the formative, transitional stages of your life, you need that social glue. That was ripped away from them, in some cases for two years, through lockdowns or their inability to connect except through screens, which we've all told them they shouldn't be on in the first place.

On top of that, they are now seeing the impact of an economy that is making their life more expensive or making their families' lives more expensive. They are seeing employment precarity for both themselves and their families. They're seeing that the ability to put food on the table is creating great stress at home.

Now, I think the climate change challenge has come back for them as they witness the impacts of hurricanes and a very hot summer. We know that was causing what I would call an outsized level of distress. It's a shocking level of distress for a lot of young people when they raise it in terms of its actual impact on their mental health.

● (1610)

Ms. Leah Gazan: When they talk about stress around the climate emergency, is there anything specific that they point to? Is there a fear of not being able to live a full life? What is the impact?

Mr. Owen Charters: Again, this is anecdotal. What I've heard are issues like they won't be able to have a family because there won't be a world to have that family in, or the inability to do anything meaningful to change the course of this or to see meaningful change being made on their behalf. It's about feeling helpless in the face of a crisis, which I think is the same in a pandemic. Feeling helpless in the face of a crisis is probably the greatest anxiety that any of us can experience.

Ms. Leah Gazan: Thank you so much.

I have 40 seconds. I had a question, but I want you to have time to answer.

Maybe I'll bring it over to Ms. Thomas. Is there anything in terms of building on the climate emergency in particular?

Ms. Krystal-Jyl Thomas: I was nodding along.

That's what I hear a lot as well from young people. We don't have super young children, but we have youth. A lot of them are questioning whether they're going to have the ability to have children and whether it's going to be a world that will be sustainable for them to have that. Young girls are feeling that now. They're already feeling that they have to make tough choices because of the trajectory that we're on with the climate emergency.

Ms. Leah Gazan: Is there anything we can do to—

The Chair: Actually, we're done. We'll leave that question for your next round, Leah.

I'm now going to pass it over to Dominique.

You have five minutes.

[*Translation*]

Mrs. Dominique Vien (Bellechasse—Les Etchemins—Lévis, CPC): Thank you very much, Madam Chair.

I am going to speak in French very slowly, given that I am going to ask an extremely difficult question.

A joint committee on medical assistance in dying, which includes senators and members of Parliament, has been set up. We are reviewing the act, which states that in 2023, a person requesting medical assistance in dying may be granted access in cases where mental illness is the sole underlying condition.

Moreover, we have also been asked to look at the issue of mature minors. That is the one million dollar question. I know that you do not necessarily have a ready answer, but you're here before me now and I am a member of this committee, so I'm asking you. I do not have a personal opinion on the subject, but I was a member of the Quebec Government and at that time, I voted in favour of medical assistance in dying.

It is important that you are here with us today. If you could give us your opinion on the subject, I would be most grateful. Indeed, we need to hear all opinions in order to make the most informed decision.

[*English*]

The Chair: Who would like to start?

Go for it, Owen.

[*Translation*]

Mrs. Dominique Vien: I choose you, Mr. Charters. You have the floor, but rest assured, this is not a trap.

[*English*]

Mr. Owen Charters: I'm not qualified to answer that and I'm not sure what the answer should be.

We are very much in the business of addressing what I think of as the frontline mental health crisis and giving every young person the opportunities they deserve and need. I don't think I could answer your question directly at all in terms of understanding what I think is the ultimate question, unfortunately, of what mental health supports could or might be.

In our case, we're seeing a lot of optimism. If we can do the programs that we do well, I think we can intervene early. That makes an enormous difference at those young ages. It's not going to be the solution for the rest of their lives, but I think it makes an enormous difference.

● (1615)

[*Translation*]

Mrs. Dominique Vien: Thank you very much, Mr. Charters.

I would ask you and your organization to think about this issue. We would be most grateful if you could send us your thoughts.

Ms. Thomas and Ms. Jackson-Brown, what is your opinion, as practitioners?

[*English*]

Ms. Krystal-Jyl Thomas: That is a loaded question.

In the last year, I haven't worked frontline due to burnout in the pandemic. I left the front line, but 15 years prior to that, I did work frontline on an assertive community treatment team, so I worked with people who were incredibly unwell. This is something that comes up often—dying by suicide, whether that's under MAID or under your own duress and your own hand. It's something I've had a lot of experience with.

Is it my opinion that people should die? I don't really have one on that, but I would support MAID services, with a caveat. What I would like to see is more preventative measures for our mental health services now so that people don't have to get to that point then. Drop the mike.

Voices: Oh, oh!

Ms. Krystal-Jyl Thomas: That's really what I think it is. If we don't want to face those tough questions down the line, then we need to start investing in preventative services now.

Ms. Michelle Jackson-Brown: It's absolutely about prevention, because the earlier we can intervene.... Like K-J, I was on an ACT team. The earlier we can intervene, the less likely it is that people are going to have significant, serious and persistent mental illness over the course of their lifetime.

Each time somebody experiences an episode or a bout of psychosis, their baseline drops, and we don't know if we can get them back up to where they were functioning before, so the earlier we can intervene, the better their long-term outcomes.

In addition, when we look at that, we're looking at the distress of the experience by the person. If we can have services in place that reduce that distress and give them quality of life, that's what we need to look at—the mental health supports and services that are going to support somebody with their quality of life.

At the end of the day, the person has the choice to decide what they need for their quality of life, so, with the same caveat as K-J, I would support MAID services, but we do need those mental health supports and services in place, both on an early intervention basis and on a long-term care and support basis.

Ms. Krystal-Jyl Thomas: This goes back to what we were saying earlier, and what Owen was saying. The burnout that's happening among our frontline workers is only increasing. That means wait-lists are getting longer and longer. Again, people are on these wait-lists waiting for services, and by the time they get them the problem has just been exacerbated so much more.

The Chair: Thank you so much.

Anita Vandenbeld, we're now moving it over to you for five minutes.

Ms. Anita Vandenbeld (Ottawa West—Nepean, Lib.): Thank you very much.

I also want to acknowledge the Royal Ottawa. You are not in my riding, but your parking lot is the riding boundary, so I consider you mine. Frankly, a lot of the people who live in my riding, people I know and family members, have availed themselves of the supports and the help that you provide. It is life-saving help. I think everybody in Ottawa can attest to somebody they know whose life was transformed because of the Royal Ottawa, so I want to thank you for everything you do.

What I hear, though, is that while it is extremely transformative once people get in, getting in is the problem. You mentioned referrals. I think all of us know that, too often, when the person is presenting at emergency in a crisis—especially young women, young girls—that is their first entry point into that system. As you mentioned, by that time.... I've heard this consistently, and I think we're going to hear a lot of this. Prevention, early intervention, preventative care, that is really when it is needed, not at the point....

I can say that I had a family member who struggled for years until they got to the Royal. That was the first time when it just completely changed the situation in our family. I am somebody who is fairly empowered. I can navigate systems. I'm persistent. This family member had an advocate, and too many people don't. As I've said to others in my family, I can't even imagine what happens, especially to teens and young women, if you don't have that advocate who's just going to keep fighting for you to get the services.

I wonder if you can comment. I'll start with the Royal Ottawa, but I'll turn it over to the Boys and Girls Club. By the way, I could go on as well about the Boys and Girls Club's Ron Kolbus Clubhouse and the work you do.

How do we get past this situation where it is at the point of crisis that people actually get the help?

● (1620)

Ms. Krystal-Jyl Thomas: Unfortunately, I would put a caveat on that as well: Sometimes, even when people are in crisis, they still do not get the help. You mentioned that we have advocates. If somebody has an advocate, they may be able to navigate the system. I'm not going to go into my personal situation, but I had a personal situation this year. It was a women's health issue, and I could not navigate the system—and I run a women's mental health clinic. I was left for three months. So, it doesn't matter if you have an advocate or not. The system is very difficult to navigate.

I think that having some kind of standardized community meetings where we come together and learn about different organizations and what's actually available in our community could be really helpful. I hear of services that are underutilized because we know about the popular top-funded ones. They have wait-lists that are a mile long, and then we have other services that are underutilized.

I think if we started to have conversations and actually knew what was out there, what is available to us, that could make it easier to access that.

I don't know if Michelle wants to add anything.

Ms. Michelle Jackson-Brown: Yes, just to add to that, a huge, significant issue right now is access to primary care providers and family physicians. Again, I was working.... I'm doing outreach in the shelters. Our psychiatric outreach team is a team of 10 staff—seven nurses and three social workers—and we have psychiatrists we consult with. We were able to go into the shelters and allow people to get psychiatric assessments right away without a family provider. However, to access the majority of our services at the Royal, you need a family physician, and you need somebody who's going to be willing to follow you up. Accessing a walk-in clinic is not going to be adequate; you need a primary care provider.

Where we've had good success is with nurse practitioners who are trained; there are great community health centres and family health care teams. Then, also, we need to educate our family physicians and ensure that it's in the medical syllabus that substance use and mental health care are a standard part of the training so they feel competent when they're providing that care.

One of the things we've looked at with our perinatal health care programming at the Ottawa Hospital is a program where we can provide psychiatric consultation directly to primary care providers. If primary care providers are empowered to provide mental health care, people may not need to come to places like the Royal, and we can reduce wait times. That's the other piece.

If you're looking at mild to moderate mental illness, you can be supported and symptoms can be ameliorated with peer support and with psychotherapy. If we can have access to free psychotherapy, which we do not currently have on a national level, that could go a long way. The Ontario structured psychotherapy program has been wildly successful.

I have one last piece: The regional, coordinated access through AccessMHA has also been wildly successful.

The Chair: I'm going to be a pain in the butt. I'm going to throw a little chair's prerogative, if you don't mind. I see Gordon there with his hand up. He would like to answer this question, so, everybody, count Gordon's answer as part of my time that I don't get in the first place.

Go for it, Gordon.

Mr. Gordon Matchett: Thank you so much.

Take a Hike operates in partnership with public schools, and public schools have a very unique and interesting view into the lives of the youth they serve. What we find is that schools are full of caring adults who are really looking out for the mental health of young women and girls and all the youth they serve.

What I'm seeing in Ontario, as well as here in B.C. and also in my conversations with folks in the territories, is that they are building systems to be able to ensure that the youth are getting this care. They're able to identify them, but what the kids are saying is that they want to have the help available in school. That's where a program like Take a Hike is so important for the youth, because we're able to offer them a year's worth of a caring and safe environment. They're there all day, every day. They're not able to fall between the cracks, because we know who the kids are and we're able to follow up with them.

I'd encourage the committee to really think about how we can partner with school districts in providing this support. They're the ones who know the kids better. They don't know them as well as their parents do, but they're the ones who know them the best in the community.

● (1625)

The Chair: Thank you so much.

Thanks, everybody, for letting me take over.

Now I'm going to pass it over to Andréanne for two and a half minutes.

[*Translation*]

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

Ms. Thomas, in your presentation, you spoke about delays and the federal government's obligations. Every minute counts when a person is in crisis, and every delay has an impact.

You said that health falls under Quebec's and the provinces' jurisdiction, but you also stated that the federal government has responsibilities in this area.

How we establish what falls under Quebec's and the provinces' jurisdiction and what the federal government's powers are?

You also spoke about delays. Were you talking about delays in transferring money to organizations who are working in the community? What did you mean exactly?

[*English*]

Ms. Krystal-Jyl Thomas: I think I can expand on what the delays do, which you captured briefly there. When our experiences are invalidated by appealing court rulings and things like that, this prolongs when the money is going to go, which prolongs when it's going to make its way into communities and into organizations to start to make frontline differences. It also reinforces stigmas and stereotypes about people.

I think we can do much better than that here in Canada, at the provincial and federal levels. When we know there are problematic issues, let's take responsibility and work together with our communities, consulting on what changes need to happen and how we can make them. I think consulting the front line, not just the workers but the people who are being affected by the issues, is how we can start to make real shifts with the help of our government.

Ms. Michelle Jackson-Brown: I can just add to that by bringing back the attention to the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls. When we're talking about some of these delays, we're talking about court rulings and court processes that are delaying things. One of the highlights of the recommendations was asking for a federally coordinated cross-jurisdictional national plan to address some of these issues so that hopefully we aren't encountering issues with court proceedings.

On the other piece, too, when we talk about what the federal government can do, we can look at the health and social transfers and whether we can earmark some of that funding specifically for women's mental health care and research.

The Chair: Thank you very much. You had your two and a half minutes. We'll get back to you.

We're now going to pass it over to Leah for two and a half minutes.

Ms. Leah Gazan: Thanks so much, Madam Chair. You're just great at what you do.

We're not all the same. We have intersecting identities. You brought up missing and murdered indigenous women and girls. We have the National Day for Truth and Reconciliation. For me, this is a difficult day, and tomorrow will be as well.

We have young people, women, Black, indigenous, people of colour, people with disabilities, people who identify as belonging to gender or sexual minority groups. Is there enough specialized mental health care to really reflect the diversity?

Ms. Krystal-Jyl Thomas: We're not even close.

One of the barriers I see constantly is language. In the program we run, we don't have enough funding to even offer services in French, which is part of our national languages; never mind if you speak Somali. Language is such a barrier if you want to engage.

I see Gordon nodding as well. I don't know if that's an issue he runs into in B.C. as well, but language is probably the first thing that I see. I would love to see more courses offered to offer versatile language—and not just so that white people can speak other languages. Let's make sure that people who are representing those needing the assistance are being trained and having opportunities to go to school and get the education they need, and are certainly capable of, to engage and be part of their community in a helpful way.

● (1630)

Ms. Michelle Jackson-Brown: I'm just going to add to that. We also need culturally responsive care. We need ongoing opportunities for the education of frontline health care providers and frontline service workers to ensure that we're providing culturally responsive care.

In addition, in terms of a gender diversity clinic, for example, we do have one in Ottawa at CHEO. We don't have something similar yet at the adult level. People have to come to Ottawa for that support and service. I was working with children who were involved in the children's care system, like CAS, who actually had to come from rural areas to Ottawa to get that service. We need to find ways, whether it's through virtual care or outreach, to get to those outlying rural areas.

The other piece is ensuring that we're working with the community. There are lots of folks who are already out on the ground doing this work. There are indigenous-led communities like Akausivik and Wabano. We partner with the Ottawa Black Mental Health Coalition to identify the agencies and organizations that are already on the ground doing this work. That's what we need to continue to do.

The Chair: Perfect. Thank you so much.

We're now going to go to our next round of five minutes. Actually, it's back to six minutes. I apologize.

Ms. Michelle Ferreri, you have the floor for six minutes.

Ms. Michelle Ferreri: Thank you, Madam Chair.

Thank you so much for the great information coming out of here from all of you.

Thanks to my colleague for bringing up a conversation that I wish we could do a whole other committee on when we talk about investing in preventing mental health issues. If we're going to be honest about preventing mental health issues, where are we putting that money? Where are we putting that education piece into it?

I'm going to go back to you, Mr. Charters.

I want to delve a little bit deeper, if we can, because we have a bit more time to do this, talking about the burden of the adult problems that are being transferred to the children and they are carrying this over.

When we look at this study in particular, we're looking at factors contributing to mental health issues experienced by young women and girls, including, but not limited to, eating disorders, addiction, depression, anxiety and suicide. I hear from kids. They will say that they didn't want to tell their parents they wanted to take hockey or they didn't tell their parents they wanted to do dance because they know they don't have enough money.

What do you think about that as a major factor? Where would that fall in what you're seeing in the Boys and Girls Clubs?

Mr. Owen Charters: Do you mean as a major factor in terms of the mental health challenge they have from that?

Ms. Michelle Ferreri: I mean the anxiety of worrying about adult problems, like money at home and financial stress.

Mr. Owen Charters: I don't know where it fits, but it's a big factor.

The reason I don't know is that we haven't asked the question specifically of what they think about that. Too often, kids who come from underprivileged homes or homes where there's a single parent take on a burden that is like that of an adult at a very young age. They worry about those adult issues. They may not always let their parents know, because part of being a responsible member of that family is not to let that burden fester on the other members of the family. We see that as part of single-parent families especially or families where the parents are dysfunctional. Of course that comes into clubs.

What our clubs do is try to take on those opportunities for those kids where the family can't provide it. We often hear—in fact, in London, at the club, at an event I was at—a family say that the club was the missing father in their family. It provided the balance those kids needed and couldn't otherwise access.

I think we don't understand how significant that is. There was a movie at TIFF called *Scarborough*. It came out a year ago, I think. It's well worth watching. It's not the real-life stories; it's a dramatized version, but it's the real stories of what our clubs see, of kids who take on the burdens of their parents, who are working through real challenges in their life, from putting food on the table to securing employment.

You talked about regulating emotion. There is the challenge of dealing with a parent who cannot regulate their emotion, and the kid becomes the antidote to that or takes on those challenges. I think those are pretty scary elements that live on in adulthood one way or another.

Ms. Michelle Ferreri: I would add that when we say “poverty”, I think what used to be low income has now become the middle class. It's not even just lower-income families anymore. This has become an everyday Canadian problem. People often write to me saying, “I make $100,000. That's a lot of money and I still can't make....” It used to be paycheque to paycheque, but now it's 10 days before paycheque.

That is trickling down to our kids. It's this anxiety, this worry, this fear, this burden and the long-term impacts of what's going to happen from COVID. Because the parents didn't have the tools in their tool belt to regulate their emotions, the stress comes onto the children and, bing, bang, boom, you have a domino effect. We're going to be seeing the impacts of this for decades, in my opinion.

We look at abandonment and coping mechanisms, or maladaptive coping mechanisms, for parents who just can't manage that stress. There's social media. We talk about kids being exposed to social media, but what about the parents who are on their phones trying to manage and self-regulate because they can? That's what we would call a maladaptive coping mechanism.

I would love your feedback. Maybe I'll throw it over to Michelle or Krystal-Jyl.

When I see what my kids do.... I think of myself, too, when I watch the news over and over again and how it starts to impact our mental state because it's negative. What do you think the impact of the media is on children?

● (1635)

Ms. Krystal-Jyl Thomas: It's definitely negative. Owen, you said this earlier—the bullies can now be there at 3 a.m. on your phone, and that can be for parents or children. Also, on algorithms, once we start looking at certain things, our phones will now reinforce those beliefs for us over and over. If you're looking at sad or depressing things, that's what's going to start to feed to you all the time. I think algorithms are a big part of the problem.

I have no idea what laws look like around that, or how we regulate things like that, but if the federal government does, I would love for them to pay attention to that.

You were mentioning that families now need a dual income. You both need to be working full time. That's now more time away from children. Children are isolating, so now they're spending more time on their phones, where those bullies are, to try to get that connection. It really is a continuous, self-perpetuating problem.

One of the things I think about—which I know is getting a little away from your question of social media but would be really beneficial—is peer support for families. Peer support for families is an avenue where we can actually look at equipping parents and children to understand what's happening. We talked about mental health first aid earlier. If you teach that to a child and they come home and say, “Listen, I'm depressed,” that can be really traumatizing for a parent, but if you teach the parents what that means as well, you can start to build community and relationship within the homes.

I tried to talk fast.

The Chair: It's all good. I know about talking fast.

Sonia, I'm going to pass it over to you for six minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Madam Chair.

Thank you to all the witnesses for your valuable input, and thank you for the work you are doing in the communities.

My first question is for Mr. Gordon Matchett.

You talked about school. I think school plays a big role when it comes to mental health promotion. BGC Canada can also provide valuable information. Do you think there are some approaches that teachers can take in the schools to prioritize mental health and wellness? What is a successful model? My colleague talked about social media literacy. If the teacher can teach about.... Cyber-bullying is also prevalent. How can we stop that disinformation? Can you talk about that?

Mr. Gordon Matchett: Yes, schools are a phenomenal place to provide that early intervention and prevention support for vulnerable youth.

I'm thinking about many of the programs that we see here in B.C., and we're seeing it right across the country and throughout North America, in fact. They're teaching social and emotional learning. There is an overwhelming amount of evidence showing that programs that focus on the social and emotional well-being of our youth produce wonderful effects, not only in their grades—we see about 17% increase in youth's grades when they participate in social and emotional learning—but in equipping them with resiliency so that, as they face mental health challenges, they are able to bounce back from them.

I'm also impressed by programs like Stan Kutcher's teen mental health literacy, which teaches youth as well as adults how to understand what mental health issues are and what they're not. Kids get nervous over tests. It's not anxiety; it's just being nervous over tests. It's really helping us to tease apart what is what.

We're also seeing that schools are a very important place to be able to go deeper with youth. As I said, schools are starting to look at ways in which they can look for youth who are having mental health concerns. We partner with school districts purposefully because we know that they know the youth. They know who's not accessing services, and they know who can benefit from them. We rely on them to help us identify those youth and bring them into the program that we serve together.

I would really encourage the committee to think about the place where youth spend most of their time, which is school, how we can help support them when they're there, and how we can support programs like Take a Hike that operate in schools.

I know that schools are not a federal mandate, but when we look at mental health that happens in the schools, that's where the kids want it. That's where they want to be able to get that help. They don't want to have to go somewhere else. They want it to be normalized. They don't want to have the stigma.

● (1640)

Mr. Owen Charters: I think everything Gordon said is absolutely true. I'm impressed with what I see in schools. I'd also add that we're adding new burdens into an under-resourced sector. I come from a family of teachers. There has always been the challenge of what else they need to do in the day, aside from deliver on the curriculum. Administrators are challenged to provide what they see as increasing connections to social services that are stretched.

I think the school is a wonderful place to do some of that work, and I think we need these wraparound supports. My answer to an earlier question about access is that the social safety net seems to be quite frayed. I think it was fraying before the pandemic, and it is increasingly frayed. School is part of that, as well as the health care system, as well as the social services that clubs, for example, provide. There are lots of families and kids, unfortunately, falling through the gaps. They're falling through the gaps at schools because of that under-resourcing. It's happening now because of staffing challenges in social services, and because of a lack of financial capacity.

That's something that I think as a society we're going to have to address one way or another. At some point, the bill will come due.

Ms. Sonia Sidhu: In the last meeting we heard from Jack.org that 16% of young women seek mental health support from a professional while 32% seek help just from friends. They just want to get some help. They don't want to go to the professionals. Why does this gap exist? How can we fill this gap?

This is for Ms. Thomas or Ms. Jackson-Brown.

Ms. Krystal-Jyl Thomas: I mentioned in my opening as well that peer support is a really underutilized service that we can tap into to fill a lot of these vacant positions. You talk about how some people don't want to go to that clinical piece. That can be a really intimidating space, especially for young people. Peer support can really bridge that gap when you have someone with lived experience who may be closer in age to the person and able to speak to them in a way that clinicians just aren't trained to, able to speak from the perspective of their own resilience and strength to have an opportunity to have a relationship with that person.

I think if we started to open up more peer support programs, going along with what you're saying, rather than putting this on top of teachers' responsibilities, maybe we could bring peer support workers into the schools and to people who are on wait-lists. If we had peer support workers who were connected with them as advocates while they were on wait-lists, this could really start to lift some of the burden off the frontline health care.

Michelle is a big advocate and a peer supporter, in case she would like to say anything to that.

Ms. Michelle Jackson-Brown: I would just add to that the combination of outreach and peer support and peer support training. Again, I used to do outreach into the youth shelters. Many of those youth were afraid to go and speak with their doctor about their mental health care. They were afraid to speak with their families about their mental health care. Oftentimes I was the first person they had ever spoken to about their mental health care.

It's also about being able to go into the schools. I hear from teachers that they just don't feel equipped to address mental health concerns if a student comes in and speaks with them. If we have social workers going out and doing outreach into the schools to provide education and training, then we can identify within those schools youth ambassadors who can lead peer support initiatives. I think this combination would make great headway toward ensuring that youth feel supported within their schools and among their peers—

● (1645)

The Chair: That's perfect. Thank you so much, Michelle.

You're all offering such good information. I'm sorry for cutting you off, but we're getting tight here.

Andréanne, go ahead for six minutes, please.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

I have some questions for the witnesses. Once again, your testimony today confirms that some cases are extremely sensitive and that it is obviously not easy to go and get help for many reasons. You personally have to overcome the first hurdle, which is to recognize that you have mental health issues.

Ms. Jackson-Brown, I would like to go back to what you said just before the end of my last question time. You spoke of health transfer payments. We can't possibly hope to provide better mental healthcare without getting more funding and more support for the system. Organizations are saying the same thing. In my riding, organizations receive funding from the Ministry of Health and Social Services. The ministry has direct links with the organizations that provide mental health services or help women who are victims of violence.

On a more practical note, can you please tell us more about the importance of health transfer payments. I would like to hear you speak about what the impact would be if our healthcare system had more funding. Whether the funding would be used for physical or mental healthcare, workers on the frontline or our institutions, our organizations need money to be able to respond to the increase in cases that you have spoken about today.

[*English*]

Ms. Michelle Jackson-Brown: When we're talking about transfers, I think the program is available if the funding is available. If we don't have funding that's earmarked, then that program isn't going to be developed.

For example, in Ontario we had funding for women's health research, which was drawn back. Then we lost funding to research those initiatives and programs. This was through the Women's College Hospital. There was $15,000 of funding available. That is no longer available. We need to have the funding earmarked to promote the development of women's mental health programming and mental health care specifically.

The other piece is ensuring that when we're providing education to our primary care providers, the curriculum includes education on mental health and substance use, so that primary care providers are feeling equipped to address these issues as they arise. It's also to provide them with the screening tools. When we're talking about a national strategy for prenatal mental health, we're talking about supporting primary care providers with universal screening and care pathways.

What we need to be doing is providing supports to our primary care providers to address these mental health concerns so they are not necessarily requiring further specialized psychiatric care.

I don't know if anybody else would like to add to that piece.

[*Translation*]

Ms. Andréanne Larouche: As you indicated today when we talked about workers on the frontline, we are referring to community organizations that are working on the frontline with people who are in crisis. We mustn't forget that they are also part of the healthcare system. They have been asking for better long-term funding for quite a while. It's a simple question of mathematics: in order to be able to provide more services, they need more resources, more money. We can see that our healthcare system has been underfunded for far too long. This is obvious not only in hospitals and doctors' offices, but also when we look at community organizations and workers on the frontline, who don't have the resources to increase and improve the services they provide. To my mind, this is a crucial aspect.

Furthermore, perhaps because we have just finished a study on intimate partner violence, we spoke a lot about the connection between being subjected to violence and mental health issues. That connection is real. You've mentioned the National Inquiry into Missing and Murdered Indigenous Women and Girls. As you said, tomorrow, September 30, will be the National Day of Truth and Reconciliation, a day of reflection. Solutions and measures have been proposed. When we look at delays, we also have to remember that funding is sometimes lacking.

Finally, there is also the issue of housing. We cannot hope to break women free of the cycle of violence if they don't have a place to live. We have seen delays in transfer payments for housing in Quebec. We need to invest massively in housing, because having a safe place to live will allow a woman to get out of a volatile situation and possibly rebuild her life. She can't do so if she is in direct contact with her aggressor 24 hours a day. We have to inject more funds and build social and community housing. We need to offer a safe place to live at a reasonable price. This will allow us to relieve the pressure on emergency women's shelters, where women are staying longer because they don't have a place to go afterwards, which means that the shelters for women are always full. It is a vicious cycle created by the lack of spaces and social and community housing for women.

I see you all nodding. If you feel like commenting on the link between health and housing, please do so.

● (1650)

[*English*]

Ms. Krystal-Jyl Thomas: I would agree with you. There isn't enough space, and women are not likely to leave or to be prepared to leave if they know they're not going to have a place to go.

I'm not sure if there was a specific question in there, but I would agree completely that we need to be looking at our housing crisis, because the housing crisis goes beyond just women.

Also, on the front line in mental health care we've seen our waitlists skyrocket, and the domestic violence situation has gotten much worse since the pandemic. I don't see that this is going to settle down now that we've reopened, because women are still being greatly impacted by the fallout of the pandemic, so—

The Chair: Perfect.

The mean chair got back up here.

I'm now going to pass it over to Leah for six minutes.

Ms. Leah Gazan: Thank you so much, Madam Chair.

I have another question for Royal Ottawa Health.

In your testimony, you spoke about police in mental health involvement. In the city of Winnipeg, we currently have a pilot project. It's called the ARCC program. It's an alternative response. It's in partnership with the Winnipeg Police Service and Shared Health's crisis response centre.

Here's the thing, though. In the city of Winnipeg, we have very fractured relationships between the indigenous community and the police services. Although I think it's well meaning, one of the issues I see—and I brought it up with one of the community police officers—is the fact that the initial response is still a police officer who assesses whether it's safe for the mental health worker to go along with the police officer. I feel like it's the same response. If they don't behave properly, they're in a mental health crisis and they get arrested. The problem is that people will be hesitant to reach out when there's a mental health crisis if it goes to the police rather than getting people who are actually qualified to deal with it.

I know you mentioned it. I don't know if you agree with me. It just seems like we can't police our way out of a mental health crisis. We need to invest in real mental health services with mental health specialists, action therapists and the like. Do you agree? Do you disagree? Why or why not?

Ms. Krystal-Jyl Thomas: I agree completely.

I'm not overly familiar with the ARCC program, but I used to work on a crisis team in Simcoe County. In the crisis house I worked in, I would be deployed to situations usually without, but sometimes with, police. I can say with certainty that when police were deployed with me, almost always a situation that did not need to be escalated was escalated. We can train specialists to attend frontline situations in a crisis emergency. If it's deemed unsafe, then perhaps police could be in a nearby vicinity.

Again, Michelle and I have worked on the front line for 15 years. I recall maybe three times when I had to have police come in with me to a situation. I remember this one time being in an apartment building and the officer saying to me, "I can't believe you go into these houses alone. We wouldn't even go in alone as officers. We would go in in twos." Yet, in 15 years—not to say it doesn't happen—I've never been harmed. I've never been in a situation that I couldn't de-escalate myself.

I did mention police. I think the primary first response would be if we could train people to go into frontline situations in which there's a mental health crisis. If there were safety issues, then police would be somewhere in the background. I also think that if we're going to continue to send police in, then we need much better mental health training for police.

● (1655)

Ms. Leah Gazan: My other observation—and then I want to move on quickly—is that often the response, as you've indicated, exacerbates the situation because the people who are being confronted have historically had very negative relationships with people in positions of authority. It's like a fight-or-flight response. Would you agree with that?

Ms. Krystal-Jyl Thomas: I would agree.

Ms. Michelle Jackson-Brown: Absolutely. In some cases, it can be retraumatizing for an individual.

Ms. Leah Gazan: In Winnipeg, we have something that has been named the "drunk tank". It's slang. People who are intoxicated are put in these cells with a hole in the ground. It's still there in Winnipeg, in my riding. Often, the people who are put in there are residential school survivors, kids aging out of care and sixties scoop adoptees. It's just exacerbating it. I want to put that on the record. I'm glad the new director of Main Street Project is a trailblazer and is changing that abusive, vile practice in our city as rapidly as he can.

You spoke about the social safety net. I put forward a bill in support of a guaranteed livable basic income. It's Bill C-223. We're talking about a financial crisis. My bill is being put forward in addition to current and future government programs in support. We've heard about financial stress, yet I find that nobody is really committed, and the political will is not there to deal with things at the front end. We know there's a direct correlation between violence and poverty.

Have you heard about a guaranteed livable basic income? Do you think that would assist families you serve in terms of supporting good mental health in the home?

Mr. Owen Charters: We know that there were pilots that ended early. They were interesting to watch. We were very curious about the outcomes of those in terms of the changes they might make in the lives of those families—especially how they impacted youth. I think we would still be interested in seeing how those go.

I think it's not a substitute for some of the social services that are still needed for those families. I think if the programs work well, that may remove some stresses, but just because you have the essentials on the table or in the fridge, that doesn't mean mental health supports are there on a day-to-day basis. While you take away those stresses, I think the other things.... We talk about the fact that "underprivileged" doesn't necessarily mean just in financial capacity. It refers to a wide breadth of challenges. A very well-to-do kid can be very underprivileged in terms of their access to the supports they need.

We're very curious. We'd like to see the outcomes of those. The pilots had started, and we'd love to see them continue, to understand what they could do.

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

We're now going to head back to our five-minute rounds.

I'm going to pass the floor over. I believe Dominique and Michelle are going to share their time.

Dominique, I'm passing it over to you.

[*Translation*]

Mrs. Dominique Vien: Thank you.

I have many questions, but Ms. Ferreri also has a great one for you, Mr. Charters. My question will be of interest to you, too, given that you are the director of a 120-year-old organization.

Do you think that people are experiencing more mental health issues nowadays? Does this impression stem from the fact that we are better at recognizing mental health issues and voicing them and less embarrassed about talking about them? It is because these issues are more and more prominent in the media? Is it because the problem is becoming more democratic, so to speak?

[*English*]

Mr. Owen Charters: It's absolutely beneficial that we're speaking about it. Earlier we were talking about Stuart Shanker and the regulation capacity. We're having this conversation with youth from the day they enter the clubs, because we need them to understand how to emotionally regulate. If they can understand and have those conversations and be comfortable with that language early on, they will do better in their outcomes with social interactions, academia and everything else.

I think their ability to have comfort with the terminology—not just the idea that there is this issue around mental health but specifically what it is, what it looks like, how you address it and what supports are there for you—makes an enormous difference. The fact that society is having these conversations—that there's the Bell Let's Talk Day and all kinds of conversations like these—really does help because it brings it to the fore and reduces some of the stigma. I say "some" because it's not entirely removed. We need to do a lot more work on this, but it really does help.

● (1700)

[*Translation*]

Mrs. Dominique Vien: There are even great athletes, some female, who have decided to withdraw from a competition because they are faced with situations that have an impact on their mental health.

I will share my time with Ms. Ferreri.

Madam Chair, how much time do I have left?

[*English*]

The Chair: You have three minutes and five seconds—actually, two minutes and 55 seconds.

[*Translation*]

Mrs. Dominique Vien: Okay.

I am going to give up the rest of time to my friend, Ms. Ferreri.

[*English*]

The Chair: Michelle, I will just let you know that you have two minutes and 45 seconds. I started the clock wrong.

Ms. Michelle Ferreri: Thank you, Madam Chair.

I just want to summarize, because I think this is the last time I get to chat, that we've established the economic stress and inflation and those kinds of things. What's interesting is that many of the services that are here today are also impacted by financial stress and a lack of financial security, of funding, which in turn creates a downflow and a downward spout to the clients they're serving, including young girls.

I'm curious as to whether you've met with the mental health minister. There has been $4.5 billion set aside for mental health. Are you getting any of that? Is there any talk about that?

Owen, I'll start with you.

Mr. Owen Charters: Yes. In fact, we met with the minister early in her mandate and had this conversation, including the push for mental health first aid, because we saw the need early on. I think we've seen some positive responses, some openness to this structure. Ultimately, we would like to see the funds flow faster. We could probably say that about all of government in general. In this case, we are dealing with a crisis. We need to see some of these responses. I know the consultation has been ongoing.

We need to see some supports in the community grow from the crisis they are in, as well. These mental health supports are struggling. We're struggling enormously with all kinds of capacity issues, including on this side.

Ms. Michelle Ferreri: Just to build on that, is it applying for the funding that is time-consuming? What is stopping it from being faster?

Mr. Owen Charters: At this point, I think we're looking for some of the structure of what it would be that we could actually apply for, in cases where we might fit. Other parts of the system may have access to some grants that don't apply to us, but we don't yet have a stream of funding that makes sense for the work we do or that we'd be eligible for.

Ms. Michelle Ferreri: Mr. Matchett, I think you talked about that. You said you didn't fit under the categories outlined so far to apply for funding. Is that correct?

Mr. Gordon Matchett: Exactly. We have had an opportunity to meet with the Minister of Mental Health and Addictions. Right now we're experiencing an incredible amount of support from the federal government, but we're concerned about the jurisdictional issues. Because we offer a mental health program that's embedded in schools, there's this concern about how that should be the mandate of the school system. The school system is very clear that mental health supports for vulnerable youth are above and beyond its mandate.

We keep getting bounced between provincial government ministries. When we go to the federal government, we go between ministries as well. We get bounced back to the provincial government. We get bounced to the school district. There is not a clear, direct path to funding for a unique and innovative program like Take a Hike.

The Chair: Thank you so much.

We're now going to pass the next five minutes to Marc Serré.

Marc, you have five minutes.

[*Translation*]

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

I am going to carry on the same topic as my colleague.

The federal health minister is holding round tables with his provincial and territorial counterparts right now. They are discussing the expansion of community services and services to help young people with addictions, meaning those aged between 10 and 25. Obviously, they are also talking about early intervention as a form of prevention.

[*English*]

Those are happening right now.

I heard earlier, Krystal-Jyl Thomas, that the system was hard to navigate. We also heard that the system is broken. I want to hear your comments on that. You mentioned psychiatry. You mentioned that donations—not even government—are funding the program. That's scary, to say the least.

● (1705)

There are also eating disorders. I have personal experience with youth up to 18, and then they go into the abyss, really, because there are no services.

I want to ask a question. I'll start with the Royal Ottawa Health Care Group and then go around. Right now, we are negotiating with the provinces. What best practices or outcomes or results would you see that the federal...? You mentioned virtual care. We don't have much time, so could you give us three or four points on what is needed in a federal-provincial agreement? Should the federal government be funding in the next 12 months, until this agreement is done, directly to communities, bypassing the provinces? I just want to get a sense of the urgency today, and then how you negotiate that. If you were talking to the ministers of health, what would you tell them to look at for those high-level agreements?

Ms. Krystal-Jyl Thomas: I think I would start with requesting that there be protected funds going directly to services such as women's mental health. You already said it perfectly. It's kind of ridiculous that we're depending on charities to continue to—

Mr. Marc Serré: Big cities will get donations and rural areas will not get private donors.

Ms. Krystal-Jyl Thomas: Yes, absolutely.

As for whether virtual or in-person is better, that's interesting. I don't have any hard data to support it. If you had asked me prior to the pandemic, I would without a doubt have said in-person, but we've seen a really powerful impact with virtual care. If it comes down to the barriers of distance between rural communities, I think making sure we have good Internet connection in those places is somewhere to start.

I don't know if Michelle has something she might want to add to that piece.

Ms. Michelle Jackson-Brown: Yes. I would just reiterate that we should have funding specifically earmarked for mental health care and substance use. Within that, specifically for women's mental health care, we met with the minister and talked about having specific funding for perinatal mental health care, for example. We don't have that. We're drawing on reserves from other parts of the hospital for programs like that. Right now, for example, for perinatal mental health care, there's a six-month wait at the Ottawa Hospital, and by that point women don't qualify. From six months up to a year, they don't qualify for it anymore.

Again, with the virtual care, it's great if we can invest in that, but we should also be investing in the rural communities—having organizations that are, for example, indigenous-led and ensuring that we can provide the supports through virtual care from our hospital, as long as we have partner organizations on the ground.

Mr. Marc Serré: I think I have 30 seconds or so left. Can you provide to the committee a briefing on best practices, looking at the federal-provincial relationship in those agreements?

Mr. Matchett, the aspect of the shortage of human resources has been raised everywhere. When we look at training and retention, in which areas do you think the federal government and the provinces should be doing the most work?

Mr. Gordon Matchett: For Take a Hike, we look at recruiting registered clinical counsellors to be mental health clinicians in our programs. We really encourage the government to invest in training programs for those folks. We have a very difficult time recruiting clinicians.

I'm thinking about the attempt to recruit a clinician in Merritt right now. I'm sure you've all heard about Merritt with respect to fires and floods over the last year. We're looking to recruit a counsellor for Merritt, and we've heard so many people say, “You know, I just don't want to live in that community.” So we're looking to offer some incentives to people to live in the community. We really need to have some support to be able to offer additional dollars to people to provide those additional incentives.

The Chair: Thank you so much.

I'm now going to pass it over to Andréanne Larouche. You have five minutes.

[*Translation*]

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

Mr. Matchett, I am coming back to you because you touched upon the complex issue of jurisdiction.

Here is an example. In Quebec, we drew up a non-partisan plan to help women who are victims of intimate partner violence. The report is called *Rebâtir la confiance*, or “Rebuilding Confidence” in English. The Quebec Government drew up a plan to help women break free from violence, which can help with their mental health.

Organizations have been asking for funding. Mr. Matchett, you spoke about jurisdiction: this is at the heart of the issue. Ms. Thomas, you stated that organizations working on the frontline do not have enough funding. I just keep coming back to this idea about the importance of transfer payments and reinvesting in the healthcare system, without getting into a war on jurisdictional powers.

Quebec and the provinces are currently requesting health transfer payments. Quebec has community organizations who are ready to work on the frontline, but they need predictability. Bigger and regular transfer payments that can be invested in the healthcare system would allow organizations to provide services to their clients on a longer-term basis. As you said, one-time funding is not a good solution. Organizations need to be able to offer long-term projects that help women with mental health issues. It is important to have stable, regular and permanent transfer payments. The crisis caused by the pandemic has revealed the need to reinvest in our healthcare system. We are not yet out of the woods; the number of cases is still increasing. The pandemic crisis has revealed how fragile a lot of people are.

Mr. Matchett, could you please clear up the issue of jurisdiction? At the top, there's a federal state that is obligated to make transfer payments to Quebec and the provinces so that they can invest in health. That would simplify the transfer payments and support given to organizations. This is what we have done in Quebec. I would also like you to talk about the importance of funding organizations and of recognizing the work they do on the frontline.

Mr. Matchett, if you could talk about jurisdiction and then, because time is running out, come back to the importance of investing more in our community organizations that know exactly what to do to help people. Currently, depending on what will happen, the quickest way would be to have transfer payments. Quebec and the provinces already have plans in place. I know that in Quebec, community organizations have their plans all drawn up: they are ready and willing and just need funding to get going.

● (1710)

[*English*]

Mr. Gordon Matchett: I would agree. There are projects in British Columbia like Take a Hike that are ready, and they need funding right now. Take a Hike, for the last 22 years, has been funded almost entirely by philanthropy. Last year we received about $150,000 of non-COVID-related government funding.

This year, as we're starting to negotiate some funding with the federal government, there are concerns around how the province is supporting the Take a Hike program. Instead of asking charities to navigate the jurisdiction among provinces and territories and ministries, we need to have governments able to navigate those jurisdictions themselves.

Charities are small. We are a $4.5-million organization. We are doing all we can to provide services to youth, and what we need is the funding. We need to have those barriers removed, like having to figure out which jurisdiction to go to and then, when we do get funding, being asked, "Well, what does this other jurisdiction [*Technical difficulty—Editor*] need?"

Ms. Krystal-Jyl Thomas: Beyond the funding piece, I think when we're looking at women transferring out of a shelter or youth transferring into another care centre or somebody coming into an ER, something we see often is that only one thing gets addressed. If I walk into an ER with three bullet holes and you give me great care for one of those bullet holes and then you put me on a wait-list for the other two, I'm not going to fare very well. That's something we see.

We talk about parallel services or wraparound services. When we look at the five points of care that we need to address, we see that they're all addressed at the same time. We don't just focus on one while we exacerbate others. I think that would go hand in hand with funding.

The Chair: Fantastic. I'm now going to pass it over to Leah.

Leah, you have five minutes.

Ms. Leah Gazan: Thank you so much, Madam Chair.

My question is for Gordon Matchett.

You spoke about the difficulty in finding frontline mental health care providers, particularly in remote areas. I'm a long-time educator. Prior to being elected, I taught at the University of Winnipeg, in fact, and one of the things we focused on was training people to work right in community. For example, I was in education and we actually trained teachers from the community to teach in the community.

We know that people who are from communities are committed to staying there. Do you think that instead of piloting in specialists, it would be worthwhile...? For example, education on reserve actually does flow through the federal government. On-reserve and post-secondary programs also, for first nations people who qualify, fall under the federal government. Do you think it would be worthwhile to provide support for programs to train people who are from the community rather than shipping people into communities?

● (1715)

Mr. Gordon Matchett: Absolutely. I think it would be best to have a clinician who knows the community very well and who is able to respond to the needs based on their own lived experience of being in that community. If we're able to provide opportunities to give that training to those folks so they're then able to return to the community, I think that is the best way to do it, but that doesn't solve the issues right now.

A small not-for-profit like Take a Hike—again, we're less than $5 million—isn't able to take that three-to-five-year time horizon because we don't even have the commitment for three to five years' worth of funding for Merritt. We need to count on our donors to be able to support that, and our donors can't necessarily decide to provide that training for this counsellor. That is where we will need to have more substantial funding from government.

Ms. Leah Gazan: I've heard that from everybody, that government funding is certainly a critical issue and that we currently don't have a level of funding that addresses the severity of the mental health crisis we're experiencing across the country.

I notice that you are nodding, and I'm just wondering if you have anything to add to that.

Ms. Krystal-Jyl Thomas: Absolutely. If we can invest in training people within their communities, people who have experienced what life has been like in their community and have first-hand experience, that's going to be much more meaningful to human connection in the long run.

I know I've talked about it a lot, but I would come back to peer support. That is a way we can get people trained faster. They have the lived experience and they can be a first line of connection there. If we can have earmarked funding, as they do in the U.S., that goes towards peer support in our provinces and territories so we can build people up within their communities, I think that's going to have one of the greatest impacts we will see on people's mental health.

Ms. Leah Gazan: Go ahead.

Ms. Michelle Jackson-Brown: I just want to add to that the importance of having indigenous-led organizations within the communities. One of our psychiatrists, for example, was involved in a training program in which she trained a nurse practitioner who was already embedded in the indigenous community. She was able to partner with that nurse practitioner to provide mental health care. She was part of the community, providing care to that community, which is so much better.

I have worked with youth who have come down from Nunavut, where every four months a social worker was being flown in. They couldn't make a connection with a social worker because it was always a new person coming in. Having somebody who's already there, who is trained and whom we can partner with to provide support is going to be the best investment.

Ms. Leah Gazan: I know that the Boys and Girls Club does similar things in terms of youth actually being part of the Boys and Girls Club. I'm wondering if you could talk a little bit about that. I often end up working in the Boys and Girls Club. I know that in Winnipeg—I do brag about my community because I think we're the best riding in Canada, and I would debate with all of my colleagues around the table—we have a lot of organizations that in fact have that model. They bring in youth. They train youth and the youth actually become the leaders within the organization.

Can you please expand on that?

Mr. Owen Charters: Yes, absolutely. That's actually a big part of our model. We find that a lot of youth—two-thirds of our staff—who come through the clubs end up working in the clubs. We have 7,000 staff across the country, and two-thirds of them are youth, most of whom have come up through the club and go on to other careers in the community. We often hear from all sorts of organizations—retail, hospitality, etc.—that the people they hire from the club are some of the best employees they have.

These programs work in a multitude of ways.

Ms. Leah Gazan: Would you say that this kind of mentorship—

The Chair: Leah, that's awesome, but you've used your time.

Actually, what I'm going to do is just take a little prerogative after all of that. I'm going to pass it over to John. John has sat here graciously, and we've not allowed him to speak.

I'll give you the floor for three minutes—good questions only.

● (1720)

Mr. John Aldag (Cloverdale—Langley City, Lib.): Thank you so much. It's a real pleasure to be here.

I normally sit in the natural resources committee, so this has been quite a lovely change in tone and topic. Thank you for letting me be here this afternoon.

I actually have six thoughts, somewhat random thoughts, and some of these are fuelled by the fact that I have a wife who works as a doctor in a hospital in B.C. and who also deals with some of the issues discussed here today. We have three kids—two daughters and a son, between 16 and 21 years old—so we have a lot of discussions. When they asked what I was doing today, I said I was coming here. I was fascinated today.

So this is sort of an assemblage of thoughts that I'll put out there, and in the time that's left over, anything that you could offer on it would be great. You're also allowed to do up written briefs on anything, so maybe this will give some fuel for thought.

First is simply that in B.C. we've recently rolled out a model called the Foundry. It may not mean anything if you're not in B.C., but it's for youth community-driven programs. My community was the 13th one in B.C., and it's about having a place for youth in crisis to go to. It provides wraparound services. The doors have been open for only a month, but we're seeing great success. It's for kids who are in crisis, who are looking at identity issues, family issues and a lot of things related to instability and mental health issues, so they have a place to go and land. It's great, and I would love to know what else we have in Canada, in other provinces and territories, other jurisdictions. There could be a best practice that could be shared, and perhaps the federal government could help facilitate some of those best lessons.

Second is eating disorders. My daughter says that it seems as though half of the female population right now has an eating disorder and issues of body dysmorphia. This has been a societal problem, but do we understand it? Is it getting worse? What are the root causes and treatments? I think this is something that is really important, and we can't pretend that it's not happening in society.

Third, you spoke, Mr. Charters, about the right to be forgotten. In B.C. we have a couple of names that always come to mind, Reena Virk and Amanda Todd. Both of their lives were ended tragically through bullying and cyber-bullying. I'm really interested in what the federal government can do to help and whether we've gone far enough in working with other jurisdictions on bullying and cyber-bullying.

Fourth is this whole sense of helplessness and climate change. How do we give hope to our youth again? There is a sense of despair that I hear from youth in our community, and I think we need to do better as the adults in the room to get a sense of hope and a sense that they can help.

Fifth is toxic masculinity. My 16-year-old daughter texted me. Her question would be, why do men all have this thousand-times-overinflated ego and why do they think they are experts on everything? That doesn't help with self-esteem. The question is about toxic masculinity in society.

Finally, there is this whole question of causation, prevention and trajectory and where the best point to intervene is. How do we get ahead of mental health issues? Is it through advertising? Is it through stable communities and family situations?

There's a bunch of random thoughts. I'd love to get solutions.

The Chair: I'm just going to bring up that John is usually a chair, so he never gets to ask questions, and that's why he took three and a half minutes just for questioning.

John, I will provide two and a half minutes, or whatever we can do, because we have to get to business.

I'm going to throw it to you. When you see me start throwing my arms, that's when we have to stop. John had some very good questions, and I have to let those go through.

We'll start with the Royal.

Ms. Michelle Jackson-Brown: In terms of youth, I actually used to work at a youth drop-in, Operation Come Home, in Ottawa. Having federal funding available that organizations on the ground can apply for is so important. When I was working at that centre, it was a drop-in centre, but we received funding through the employment programming. However, in order to get the youth into the employment programming, we had to have the drop-in centre, which we supported through donations.

From there, we were able to get them into employment, back into education. We were able to provide case management supports and housing-based case management supports. Having that wraparound care is so important for early intervention, reconnecting youth with services and providing the supports that are going to support them in the long term to be successful and to reintegrate back with their families, into education and into employment.

The Youth Services Bureau in Ottawa is another great example of that. Beyond providing those wraparound services, they provide shelters and supported housing options. Investing in affordable housing for youth, specifically, is important, as well as the mental health services. It creates, again, a wraparound continuum of services that starts from supporting families with early intervention and continues to youth who have found themselves in shelters. It's that continuum of services, as well as providing those peer supports. Again, the Youth Services Bureau is able to go out into schools and into other organizations to provide training for youth ambassadors to create the peer support that keeps those youth involved and supports their shared mental health.

● (1725)

The Chair: I hate to do this, but I do not have time for the rest of the questions.

A voice: Way to go, John.

Voices: Oh, oh!

Mr. John Aldag: I'll leave now.

The Chair: If there's any information on those questions that were just asked that Take a Hike and the Boys and Girls Club can assist us with, this is exactly the type of stuff we're looking for.

On behalf of the committee, I would like to thank all of the witnesses for joining us today. We have about a minute and a half of committee business that I need to bring forward, so I will excuse you. You don't have to leave the room, because we are doing it in public. Everybody, make sure your microphones are off.

I'm going to turn now to an email we received earlier to do more with scheduling, and it has to do with both of the ministers. They have once again requested that they be on the panel for one hour together. That would mean that both Minister Bennett and Minister Ien would be appearing for one hour. It is against what our motion has actually indicated. We have requested one hour from each minister.

I just want to make sure that I'm coming back to the committee and that we're all still online. I just want to reconfirm our motion to ensure that, when we go back again, this is the request of the committee.

Is everyone in favour of staying with the current motion asking for two hours, one hour per minister?

Some hon. members: Agreed.

The Chair: Thank you, guys. That's how we do committee business.

John, take that home. That's how we do committee business.

Some hon. members: Oh, oh!

The Chair: To the clerk, if you could go back, we are requesting the two full hours, and it looks as though we are unanimous on that. I saw everybody's smiling face. That was great.

Seeing that there's no other business and we're all happy, I would like to adjourn today's meeting.

I'll see you on Monday.