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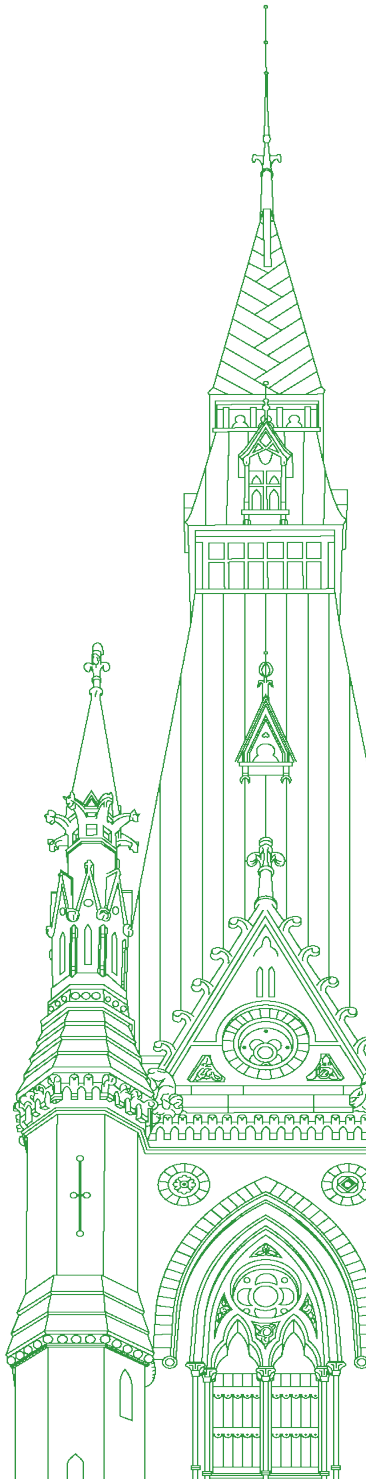

Chair: Mrs. Karen Vecchio

Standing Committee on the Status of Women

Thursday, October 6, 2022

● (1540)

[*English*]

The Chair (Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC)): Good afternoon, everybody. I'm calling this meeting to order.

Welcome to meeting number 32 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 of 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 our 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 your mike when you're not speaking.

For interpretation for those on Zoom, you have the choice at the bottom of your screen of floor, English or French. For those in the room, you can use your earpiece and select your desired channel.

I will remind you that all comments should be addressed through the chair.

For members in the room, if you wish to speak, please raise your hand. For members on Zoom, please use the "raise hand" function.

I'm going to remind people that we do have all of our witnesses on Zoom today. They should all be showing up shortly.

If I start to interrupt you, witnesses, I'm going to ask if you could wind it down within 15 seconds.

This is a bit of a trigger warning. As we all know, this study is very difficult. We will be discussing experiences related to mental health that will be triggering to viewers, members or staff with similar experiences. If you feel distressed or if you need help, please advise the clerk.

I would now like to welcome our witnesses for today's meeting. As I said, everyone will be on the screen.

On the panel, we have, as an individual, Dr. April Elliott, adolescent pediatrician, and Dr. Ryan Van Lieshout, associate professor, McMaster University, and he too is here as an individual. From the Kids Help Phone, we have Alisa Simon, executive vice-president and chief youth officer, E-mental health strategy, and from Klinic Community Health, we have Karla Andrich, counsellor.

Each of you will be provided five minutes for your organization's presentation.

I'm going to give the floor to Dr. April Elliott for five minutes.

Dr. April S. Elliott (Adolescent Paediatrician, As an Individual): Hello, and thank you for inviting me to participate today.

For those of you who haven't met me, my name is April Elliott. I'm a devoted mother of two youths. My profession of 21 years has been as an adolescent pediatrician and founder and head of adolescent medicine at the Alberta Children's Hospital in Calgary, Alberta. I'm also a certified executive coach trained at the University of Berkeley, and I work with physicians to support their burnout and proactively support their career development. I also coach parents to be more successful in their parenting interactions with youth.

As a frontline clinician, I have witnessed a dramatic increase in morbidity and mental health decline in youth from 2001 to the present. The availability of developmentally appropriate resources has not kept up to the rise.

As we all know, the 2020 UNICEF report card shows that Canada is shamefully lower than other rich countries in providing healthy childhoods. Of comparator countries, concerning physical health, Canada dropped to 30th of 38, and for mental health, to 31st of 38.

There are myriad topics related to youth health. This brief statement will discuss concerns related to the mental health of young women and girls, more specifically eating disorders, as this is my area of expertise and it was drastically impacted over the last two and a half years.

In March 2021, I published a paper with Professor Deborah Christie, "A year supporting youth within a pandemic: A shared reflection", in the Journal of Clinical Child Psychology and Psychiatry.

We summarized the impact of the COVID mitigations, school closures and the mental health impact on young people in the U.K. and Canada. The data began to emerge that the pandemic was causing a range of harms to children, including feeling isolated and lonely; suffering from sleep problems, anxiety and depression; and reduced physical activity.

Charities reported increased demand for counselling, with many young people talking about how lonely they felt. Calls to kids helplines increased fourfold from 2019 to 2020. There was also a risk in harm for those living with emotional, physical and sexual abuse.

Many colleagues worldwide described an “explosion” in eating disorders.

With regard to eating disorders, the prevalence of anorexia nervosa in adolescent females is 0.3% to 0.7%, with an incidence estimated at eight per 100,000. To put this in perspective, this compares to a minimum incidence of 1.54 per 100,000 per year of type 2 diabetes in Canadian youth.

Anorexia nervosa is a complex bio-psychosocial disorder that interacts with pediatrics and mental health. It is an illness that can be debilitating for patients and their families. The majority are young girls and women.

Eating disorders are common and are life threatening. Anorexia nervosa has the highest mortality rate of any psychiatric disorder. Mortality is as high as 5% to 7%; some report as high as 18%. With these significant medical and psychiatric consequences, an individual is 10 times more likely to die than their healthy peers are.

Globally we have seen unprecedented numbers of hospitalizations related to new and severe cases. Patients are severely malnourished, with increased medical complications.

The COVID pandemic is a common precipitating factor noted by patients and families. They note school closures, loss of sports, and not being with peers. A recently published Canadian pediatric surveillance program supports this.

These are my recommendations:

One, it is very costly to treat in a hospital setting, so early recognition and treatment by primary care physicians is essential. This education needs to be mandatory in medical schools.

Two is increased resources for timely referral and access to trained and qualified health care providers in delivering evidence-based outpatient treatment modalities for eating disorders.

Let's suppose a young person needs hospitalization for a moderate to severe eating disorder. In that case, they need specialized units or staff on generalized units with integrated training carrying out these guidelines. These are few and far between, and many Canadian cities do not have them. The Alberta Children's Hospital has a catchment area of 2.5 million and has no specialized eating disorder in-patient unit.

With regard to general mental health for youth, I would recommend providing more support for young people. It was already significantly stretched. We must prioritize teachers, school mental health and increased resources. We need to focus on this COVID generation.

Parity of esteem for mental health alongside physical health care is an absolute priority. Health care has a long history of not integrating mental and physical health. There must be significant investment in ensuring timely mental health access for appropriate mental health care where the young person lives in cities or rural settings.

● (1545)

Finally, in addition to bolstering the investment in mental health programs for children and youth, we mustn't forget we need to ensure there is support in place to strengthen and champion increased human and financial resources for health care practitioners in these areas, who are also on the brink of immeasurable burnout.

Thank you.

The Chair: Thank you very much.

We're going to move to Dr. Ryan Van Lieshout.

Ryan, you have five minutes.

Dr. Ryan Van Lieshout (Perinatal Psychiatrist and Associate Professor, McMaster University, As an Individual): Thank you, Madam Chair.

Good afternoon. I'm Dr. Ryan Van Lieshout, the Canada research chair in perinatal mental health and Albert Einstein/Irving Zucker chair in neuroscience at McMaster University.

I'm a member of the Royal Society of Canada and a perinatal psychiatrist whose research focuses on developing scalable psychotherapeutic interventions for those with perinatal depression and anxiety, and optimizing their impact on offspring brain development. The primary goal of my work is to disrupt the intergenerational transmission of psychopathology from parents to their children in Canada and around the world.

My clinical expertise led me to be invited to lead the development of Canada’s national practice guidelines for the treatment of perinatal depression and Public Health Ontario’s perinatal mental health tool kit for public health units. Throughout my career I have seen the devastating effects that mental health problems occurring during pregnancy and the postpartum period can have on children and families, and have committed my career to preventing these.

Perinatal mental health problems affect up to one in five mothers and birthing parents, rates that increased to one in three during the COVID-19 pandemic. Every case of postpartum depression alone is associated with costs of up to $125,000 over the lifespan, or $2.5 billion for each single year of births in Canada. The offspring of mothers with postpartum depression are up to five times more likely to develop a clinically significant behavioural problem, and up to four times more likely to develop depression in their lifetimes. Even though effective treatments can help both mothers and their children, as few as one in 10 pregnant and postpartum persons are able to access evidence-based care in Canada.

There are many barriers to the receipt of timely perinatal mental health care in this country. In addition to time, child care, travel and a lack of providers, most individuals prefer talking therapies or psychotherapy over medications, particularly during pregnancy and lactation. Even though Canada is a world leader in the development of scalable psychotherapeutic interventions for perinatal mental health problems, there is still a lack of providers, national quality standards, stepped care models and coordination.

However, there are many reasons for hope. Stepped care pathways, those that match individuals to the right treatment at the right time, could substantially increase the number of women receiving effective treatment, as can the application of scalable Canadian-made interventions and the task-sharing of psychotherapy delivery with non-physician health care professionals like social workers, psychologists, occupational therapists, and individuals who recovered from postpartum depression and anxiety, often referred to as recovered peers.

Our research group alone has developed and tested several effective scalable interventions that can be delivered by health care professionals or recovered peers, and it can serve as both initial and later more intensive steps in stepped care models. For example, our one-day cognitive behavioural therapy-based workshop for postpartum depression can effectively treat up to 30 individuals at a time and be delivered online or in person by health care professionals or recovered peers. Our longer nine-week group cognitive behavioural therapy intervention has also proven effective for those with higher symptom severity, and its delivery has already been successfully task shifted to recovered peers and public health nurses with limited to no previous psychiatric training. These scalable group interventions have proven effective being delivered in person or online, and a half a dozen public health units in Ontario, including those in Niagara and Prince Edward County, are now being trained to deliver them to mothers living in the community.

We and others have also shown that treating mothers not only benefits them, but their entire family. Up to 70% of the costs associated with perinatal mental disorders are due to their downstream effects on daughters and sons. Recent research by our group has shown that treating mothers with postpartum depression leads to clinically meaningful improvements in mother-infant interactions, infant brain development and emotion regulatory capacity, and even the mental health of older children in the home. This is in keeping with research from around the world that suggests for every dollar invested in early childhood interventions, society reaps a seven-dollar return.

Perinatal mental health problems in Canada can be prevented, detected and treated, and we already have the know-how to support mothers and disrupt the intergenerational transmission of mental disorders in families. The federal government can help by working together with experts to create national quality standards and to develop Canadian-specific stepped care pathways that can support the training of professionals and lay people in the delivery of treatments. Such developments will enable our Canadian-made discoveries to be scaled to improve the lives of women, girls, and all Canadians.

I look forward to working together with you to help make Canada the best country in the world to be a woman or girl.

Thank you.

● (1550)

The Chair: Thank you very much, Doctor.

We're now going to move to Kids Help Phone.

Alisa Simon, you have the floor for five minutes.

Ms. Alisa Simon (Executive Vice-President and Chief Youth Officer, E-mental Health Strategy, Kids Help Phone): Thank you so much to Madam Chair, members and staff of the Standing Committee on the Status of Women.

I am thrilled to be here today. My name is Alisa Simon and I am with Kids Help Phone.

For over 33 years, Kids Help Phone has been on the front lines hearing from young people from coast to coast to coast and from every single province. We hear from young people starting from about the age of five and we have no upper age limit. Young people come as long as they want and use our stepped care model to find the kinds of services and supports they need.

We have always been a critical part of the mental health infrastructure and system for young people, but since COVID, that need has exponentially grown. In fact, since the beginning of COVID, Kids Help Phone has supported young people over 12 million times, which is a significant increase from 2019 when we supported young people about 1.9 million times.

Of the young people who reach out to us at Kids Help Phone, 74% identify as female. They reach out about every challenge a young person experiences, from bullying, depression, anxiety and relationship issues to suicide.

Although we hear from young girls and women across the age spectrum, 46% of our users are in the age range of 14 to 17, which is a particularly important time in the development of young girls. We see that the challenges they're facing change over time, which makes sense for anyone who is around young girls and young women.

Not surprisingly, younger girls come to us in very high numbers about bullying and relationship challenges. In fact, girls aged five to 13 are 120% more likely to talk about bullying and cyber-bullying. That is quite detrimental to the well-being of young girls. We know that it can lead to anxiety, poor body image and lowered school performance.

It is also worth noting that younger girls are more likely to reach out to us about eating disorder and body image challenges. In fact, girls aged five to 13 are 34% more likely to reach out about those challenges.

As girls age, their challenges change. We see, for example, that 18- to 24-year-olds are more likely to come to talk about anxiety and stress. Interestingly, over the course of COVID, young women aged 25 and older have been coming 60% more often to talk about grief, which I think makes sense given so many of the losses we have all gone through over the course of the pandemic.

Perhaps most sobering is our data on suicide. Over the last five years, we have seen a significant increase in young people reaching out to talk about suicidality. In fact, about 23% of all girls and young women who connect with Kids Help Phone are reaching out about suicide. Of girls aged 14 to 17 who connect with us, 45% are talking about suicide. Perhaps even more surprising is that 21% of girls aged five to 13 talk about suicide. I think that is quite shocking to many people, as we don't anticipate that younger girls are even thinking about issues around suicide.

The good news I want to make sure I leave people with is that we are able to help the vast majority of young people who reach out to us. We are able to form a safety plan with them. Only about 2% of our contacts of people talking about suicide require an emergency referral.

I also feel it's really important to focus on equity-deserving populations, such as indigenous, Black and 2SLGBTQ+ people and newcomers. We know their experience in Canada and their experiences around social determinants of health are not the same. We know from our data that they are all struggling with one thing in common, which is isolation and feeling disconnected from others like them.

Social isolation can lead to a lot of negative outcomes and it seems particularly prevalent for equity-deserving populations. One reason we started our peer support service last year was specifically so that young people can connect to others.

Our data also demonstrates, for example, the incredible impact of racism and discrimination on young people from equity-deserving populations. After the murder of George Floyd in 2020, we found that young people who reached out and discussed racism were more distressed than any other service user, except for those who feared harm in their own home. They were more likely than any other service user to discuss suicide.

In closing, I have three recommendations.

We need to focus on equity-deserving populations and the specific needs they have.

● (1555)

We need more in school supports at every age along the spectrum to not only talk about mental health, but equally important, to talk about seeking help, what it means to not feel good and why reaching out is important. Kids Help Phone has been doing this in middle schools for many years, and just launched a high school program. Next year we will be launching an elementary school program.

The Chair: You have about 15 more seconds.

Ms. Alisa Simon: The last thing is that we have to continue to ensure that we are making investments in evidence-informed, non-duplicative services, so that we are ensuring that young girls and women can access high-quality services regardless of where they live in Canada,

I will end my comments here. Thank you so much.

The Chair: Thank you so much. I'm sure we'll get back to more comments from you as we go through today.

Finally, from Klinic Community Health, we have Karla Andrich.

Karla, I'll pass the floor to you for five minutes.

Ms. Karla Andrich (Counselor, Klinic Community Health): Good afternoon, honourable members and fellow witnesses.

Thank you for the opportunity to speak today. My name is Karla Andrich and my pronouns are she/her.

I am joining you today from the Treaty One territory, which is the traditional territory of the Anishinabe, Nêhiyawak, Oji-Cree, Dakota and Dene peoples, and the heart of the Métis Nation.

My personal relationship to those treaties is that I am a descendant of settlers. My great-grandparents and great-great-grandparents built their generational wealth from land that was never ceded. I carry the benefit of that wealth and also the responsibility to work toward justice and decolonization.

I am a counsellor at Klinic Community Health, an agency in Winnipeg, Manitoba. We've been in operation for about 50 years. We promote health and quality of life for people of every age, background, ethnicity, ability, gender identity and socio-economic circumstance.

I'll be speaking today through the lens of my work, providing one-on-one trauma counselling with survivors of sexualized violence, the vast majority of whom are women, girls, and gender minorities, with the acknowledgement that indigenous and 2SLGBTQIA+ folks are disproportionately targeted by those who perpetuate sexualized harm.

I hope to bring your attention to three main points today: the harm that systemic sexualized violence perpetuates; the need for trauma-informed care within systems; and the need for greater funding.

Sexualized violence is a web of daily microaggressions, systemic inequalities and acts of overt interpersonal violence, which include sexual assault, sexual harassment, gendered discrimination, and also the backlash that women, girls and gender minorities face when they speak out. It is also an integral part of colonial harm. Indigenous women, girls and two-spirit folks are disproportionately represented among the people that we see at the hospital through our advocacy work.

I have personally sat with so many indigenous folks at the Health Sciences Centre here in Winnipeg, from mature women, matriarchs of their families, to girls just 12 and 13 years old. So many of them tell me that this is just a reality in their families, that their mothers, grandmothers, aunts, cousins and siblings have all experienced some form of sexualized harm.

Contributing to this is the systemic lack of trauma-informed care in the justice system, the medical system and other supports, such as EIA, colleges of physicians, and other peripheral systems that survivors may engage with. My first counselling job was at the University of Manitoba, and it broke my heart seeing the profound impact that experiencing this harm had on my clients.

Finally and crucially, access to counselling is underfunded. Many survivors can't afford private therapy to help them recover from their traumatic experiences and spend months to years waiting for care at agencies like Klinic. This translates to months and years of greatly diminished quality of life, lost opportunities, lost jobs, education, relationships and contributions to their communities.

My suggestions for action today are that it is imperative we value the lives, futures and happiness of women, girls and gender minorities as equal to those of men and boys. We need to more deeply commit to implementing the 94 calls to action put forth by the Truth and Reconciliation Commission, especially calls to action 21 through 24, and 41. Trauma-informed training should become mandatory for any person or agency which provides care, reviews complaints or enforces laws or policies around sexualized harm. Finally, we need to greatly increase funding for survivors to access free counselling, legal support, system navigation support and advocacy.

My team at Klinic consists of just two full-time and two part-time counsellors. We have a coordinator. We have a few part-time advocates. We have volunteers of whom we ask too much, because the need is so great.

Essentially, we need more money. Every agency that provides this kind of care needs more money. We are stretched thin and constantly are trying to balance the needs of our crisis program, which intervenes for people in the immediate aftermath of a sexual assault, and our counselling program, which provides ongoing therapy and public education.

We are constantly stealing from Peter to pay Paul. Ultimately, it's the survivors who suffer. Money is how we as a society indicate how important a particular issue is to us. Canada needs to invest in our women, girls and gender minorities.

At Klinic, we deeply appreciate the money that has come to Manitoba recently to help bolster our crisis services. It would be very helpful to also get money to support the other half of our advocacy and counselling work, which is for ongoing support for people, as these kinds of experiences take time, effort, and support to recover from.

Thank you very much for your time today.

● (1600)

The Chair: Thank you very much for those words, Karla.

We'll go to our first round of questioning. Each party will be provided six minutes. We'll be starting this off today with Michelle Ferreri for six minutes.

Michelle, you have the floor.

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

Thank you to our witnesses. It's great information that I'm sure will help in our journey here to get better resources, but better understanding and knowledge of contributing factors in youth mental health.

Dr. Elliott, that was great testimony. There's really a lot of information to unpack there. I'm curious to know if there's any data collected between developing an eating disorder and the consumption and use of social media.

Dr. April S. Elliott: There definitely is. I think many of my colleagues will agree as well that it's very challenging, because eating disorders are multifactorial. To be able to pull out all the confounding issues surrounding that gets very challenging. I am going to be preparing a brief to be submitted, and I will specifically look for something like that and add that to the brief.

As I said, it's very challenging because of all the confounding factors. We do know that depression and anxiety have increased exponentially since the introduction of the smart phone, and eating disorders are an anxiety-based illness, so there is a correlation there for sure.

Ms. Michelle Ferreri: Yes, it's very challenging when you have concurrent situations going on, but as a mom, and as parents, I think we can see what the consumption of social media and media in general does to our children when we look at anxiety and burdening our kids with adult problems, and then how that impacts their developing brains.

The data is going to be very powerful as we move forward, because this generation is in a completely different world than we were or any generation has ever been.

Dr. Van Lieshout, thank you for your presentation. I was really struck by one thing you said. It was about how you're focused on prevention.

Do you have a key on how we prevent postpartum illnesses, on how we prevent illnesses that develop into full-blown disorders?

● (1605)

Dr. Ryan Van Lieshout: Prevention is an integral part of the package of improving the perinatal mental health of pregnant persons, birthing parents, mothers and women. Three years ago, just before the pandemic, the United States preventive services task force recommended that all individuals who are at increased risk for developing postpartum depression be provided access to effective treatments. These treatments are not widely available generally, and they are, in their current packaging, a bit tricky to use, because a lot of pregnant people are still working outside of the home and existing treatment packages are 12 to 18 weeks long and require weekly attendance.

While prevention in higher-risk groups is likely to be helpful to prevent postpartum depression, anxiety and other common perinatal mental health problems, there's still a lot of room for innovation. A number of groups across the country are engaging in this, me included. We know who is at higher risk. We can identify them. We can support them. I think that part of any kind of national perinatal mental health strategy should involve a focus on prevention and for a variety of reasons: to prevent illness but also to substantially reduce costs financially.

Ms. Michelle Ferreri: You made some really great arguments around the cost savings when we invest. I think that's a really powerful stat.

If I may, I'll turn to Alisa Simon.

Alisa, one of the things that a lot of Canadians struggle with when they're looking at charities is making sure when they donate to a charity that the money is going directly to the charity. There are a lot of administrative costs or maybe there's a bureaucracy. Do you feel right now that the funding model is best set up to go directly to the resources you need to help kids?

Ms. Alisa Simon: That's a great question.

All of us in the charitable sector really appreciate funding that is undesignated, which allows us to use it in the ways we most need.

In order to be successful and build scalable solutions, you have to have a funding model that takes in government support, corporate support and donations. By doing that, you're able to, hopefully, bring together a model that allows you to pay for things that may be a bit less exciting. You have to pay for payroll and IT. Those administrative costs are real. However, what many donors want to pay for are the things they can see directly: a product being developed, or something that's directly going to young people.

The reality is that we have to be supporting charities to understand how to build a robust way to support themselves. Looking at all those different ways: government, corporate and philanthropic. Not all charities have the ability to do that, based on their fundraising staff or whether they even have fundraising staff to do that.

At Kids Help Phone, our ability to scale to meet COVID was partly due to shifting our funding model to accept more government funding, for example. We are incredibly thankful to partner with the federal government in so many initiatives. Without that, we would not have been able to scale to meet the huge demand that came in as a result of COVID.

The Chair: Thank you so much.

We're going to turn the floor over to Anita Vandenbeld.

Anita, you have six minutes.

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

Thank you, all, for your testimony. I have a question for each of you. In six minutes, I'll try to be quick.

My first question is for Dr. Elliott.

You've done a lot of work in burnout among practitioners, among nurses. The federal government has allocated $50 million for PTSD and trauma among frontline and essential workers impacted by COVID. I just made an announcement in my riding about long-term care workers.

I wonder if you could give us some advice about the best way to target and deliver that kind of funding.

Dr. April S. Elliott: First of all, I think the feedback and the study show that burnout comes from feeling a lack of influence or control in a scenario. I think, in the context in which we've been living for the last two and a half years, we've all been very uncertain. Often, if people have more control in their jobs, we see a reduction in burnout.

You don't want to look at programs that are just coming in to talk about wellness, but ones that are actually looking at the root—the values people have—and can work in that way. Well-being has many factors: financial, relationship, emotional and physical. Investing in programs that look at all those factors, not just a yoga class or something that people need to do around resilience.... There's much more than that.

● (1610)

Ms. Anita Vandenbeld: My next question is for Ms. Simon with Kids Help Phone.

Regarding what you said about equity-deserving—by the way, I love the term "equity-deserving"—groups, in particular, I want to ask you about newcomer children.

I know there was funding set aside by the federal government through Immigration for 100 languages to be accessible through Kids Help Phone. Particularly when we're seeing Afghan and Ukrainian refugees who have trauma.... How is that going? What is the impact of that?

Ms. Alisa Simon: Yes, up until a year ago, Kids Help Phone offered all our services in English and French. Because of a partnership with the federal government, we've been able to add Mandarin and Arabic. With the recent war in Ukraine, we've added Ukrainian and Russian. We also want to recognize that we have many immigrants, newcomers and refugees from Afghanistan, so we also offer Pashto and Dari. We are getting ready, right now, to trial two indigenous languages. We are moving quite quickly to provide more and more services to young people who speak other languages. We are on track to provide all our services in over 100 languages next year.

Our evaluations are finding that, in order to do this work, you have to first begin with deep relationships within communities. It is important that we are talking to the settlement and refugee organizations—any place where these refugees and newcomers are spending their time. The first thing is to build that relationship and trust, so they even know to come to us. Once they come to us...it's doing the ongoing evaluations we've been doing. Are we having good impact? Are we seeing reductions in distress? Are we seeing satisfaction levels?

Thus far, our numbers have been small. The output and evaluations have been quite strong in demonstrating that, when they do reach out, they are getting services in ways they've never been able to access before.

Ms. Anita Vandenbeld: My next question is for Ms. Andrich.

I'm picking up on something you said. You mentioned that sometimes young girls are waiting years before they can get help. We've been hearing, it seems, a trend in some of the hearings we've had about how, rather than prevention, the entry point is the ER, but even if they get to the ER, what happens is they may see a psychiatrist and they may get medicated, but then there's no follow-up if they don't have a family doctor. They don't even know what to do, if they're on medication, to get it renewed or monitored. The fact is that asking for help—and I think we heard this previously—isn't enough. What happens if you ask for help and the help isn't there or it takes years to get?

I want to direct that to Ms. Andrich, although I imagine the rest of you might have something to say about that as well.

Ms. Karla Andrich: Thanks so much for that question.

I think one of the things that many survivors struggle with when they come forward is the stigma of having experienced sexualized violence. Our program attends hospitals, but, of course, we have to be asked to come. There is a fairly good follow-through between folks we have seen at hospital and folks who use our crisis lines. There is a bit of a disconnect, I think, between those numbers and the demographics with respect to who comes to ongoing counselling, which I think speaks to sort of what Alisa was talking about in terms of engagement with community and knowing that the services are there so someone can even think about reaching out to them.

I think it goes back to money for engagement, as even Dr. Van Lieshout was talking about, in terms of preventive care. That is also about public education and building relationships with communities and having the funding to run programs like that and the ability to—given our own knowledge of what is needed on the ground floor, at the sort of boots-on-the-field level—direct money to where those things are going to make the most impact.

● (1615)

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

We're going to turn the questioning over for six minutes to Andréanne Larouche.

Andréanne, you have six minutes.

[*Translation*]

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

I want to thank the witnesses for being with us today.

In spite of their difficult experiences, they have solutions to offer. I thank them very much for their contribution to this study of the Standing Committee on the Status of Women. We are pleased that they took the time to participate. Their input is very valuable.

I said it at the beginning of the week and will repeat it now, because this is an important week: it is the week of the mental health awareness campaign of the network known as *Réseau avant de craquer*, and it is also Mental Illness Awareness Week. This year, the theme is that behind every face is a history... and in front of every person is a solution. Constructive action is needed to move forward.

This year, in response to the pandemic that affected the entire population, the campaign focused on people of all ages who are helping someone with a mental health problem by showing them it is possible to remain balanced while also being part of the solution. This is important; it is crucial.

I'm not sure who should take my first question, because I think all the witnesses could answer. I will direct it to Ms. Simon, from the Kids Help Phone.

Ms. Simon, the Kids Help Phone is a frontline resource for individuals with mental health problems. Your website provides a variety of interesting information.

As you indicated in your presentation, there has been a sharp increase in the use of your services since the start of the pandemic.

Can you tell us more about this increase? What changes in behaviour have you noted in women and young girls who have used your service over the past two or three years?

[*English*]

Ms. Alisa Simon: Yes, we have seen really significant increases in the volume of young people coming to us, and also in the ways they are coming. We continue to see very high volumes on our phone line, but we are the only 24-7 texting service in Canada, so we have also continued to see very high volumes in young people texting us.

Just as before the pandemic, our busiest times are when everything else is closed, so into the overnight hours we are very busy with young people who are reaching out. They are often reaching out with more serious and significant issues, particularly suicide. If you imagine a young girl where everyone in the family is asleep and they can't sleep, that is the moment they pick up whatever device they have and reach out to us.

Certainly at the beginning of the pandemic we saw large increases in young people reaching out about abuse and neglect. Again, everything was closed. The places that are often reporting abuse and neglect, like schools, were not able to do that, so young people were coming directly to Kids Help Phone.

Over the course of the pandemic, body issues—as was brought up earlier—and eating disorders came up in really high numbers, as did isolation and anxiety. Young people were increasingly talking to us about the challenges of missing out—missing out on graduation, on sports, on all of those things that they were used to, or they had been looking forward to.

As we have continued through COVID and things feel like they may be getting back to a little more normal—young people are often back in school now, face-to-face—we continue to see high levels of anxiety as young people are trying to figure out what the new normal is. Can you go to school with your mask or not? Are you able to hang out with your friends? When do you stay home?

Like many of us, young people are still navigating this new world. It's not back to normal. It is a new normal, and we don't know exactly what that is yet. As we, as adults, are anxious about that, certainly the young girls and young women in our lives are as well.

We continue to see a new normal in terms of volume, but in terms of the issues, there are some new things, again, around missing out and anxiety, but a lot of the challenges are the same as we saw prepandemic in terms of suicide, depression, anxiety and relationship issues.

● (1620)

[*Translation*]

Ms. Andréanne Larouche: What you say is interesting, Ms. Simon. You offer a service by text. Technology can help young people stay in touch. Coincidentally, young people are also connected to their mobile devices 24/7.

You talked about stigmatization and body image issues. I think texting can help young people as much as it can harm them. In the middle of the night, for instance, a young girl can be in bed comparing herself to other young girls on social networks. Moreover, the number of cases of online assistance has increased.

How can these social networks, these spaces, influence the mental health of young girls? What protections could we implement? What could the Government of Canada do to make social media safer spaces, with much less online hatred?

[*English*]

Ms. Alisa Simon: You bring up such an important point. It's something that we've talked about for years as it relates to cyberbullying.

Often, as a parent or a caregiver, your first response when a young person in your life is being cyber-bullied is to take away their device, or to say that they can no longer go on social media, yet social media is a double-edged sword. On the one hand, it provides incredible connection for young people. It allows them to feel less alone. We think about the trans youth who is living in rural Canada who finally, through something like our peer support service, is able to connect with other trans youth. It allows young people to reach out to services like ours. On the other hand, there is a tremendous amount of data about the danger and difficulty of social media, particularly for young girls.

I think—

The Chair: Ms. Simon, I know you're going to give some really amazing information, but I do need to go to my next questioner. However, I'm hoping that we can get all of that information as well.

I'm now going to pass it over to Niki Ashton, who is online.

Niki, you have six minutes.

Ms. Niki Ashton (Churchill—Keewatinook Aski, NDP): Thank you, and thank you to our witnesses today.

One of the themes this committee has been hearing over the past few meetings has been the impact of sexual violence, gender-based violence and the lasting impact and trauma it has on women and girls who are survivors of this violence. One of the previous witnesses at this committee said that we will not be able to improve the mental health of young women and girls if we don't deal with sexual violence.

Ms. Andrich from Klinic touched on this. I'm wondering if Ms. Andrich and then Ms. Simon could talk about the lasting impact of sexual violence and what their thoughts are on the need to act to end sexual violence in our country.

Ms. Karla Andrich: Thank you so much for that question.

I think one thing that sometimes is not well understood is the systemic nature of gendered and sexualized violence. It's not simply interpersonal acts of physical violence. It's also the water that we swim in every day. It's the way in which women and girls are depicted in the media. It's the way that we speak about gender roles. The kind of bullying that happens is often gender-based as well. I think when it comes to fighting the impact of those things, it is more about a systemic approach.

Part of what we do at Klinic is to offer public educational training to school districts and schools. We have visited classes at medical schools, massage therapy schools and things like that. I think those kinds of programs could also be very helpfully extended into elementary and middle schools and high schools as well. I know that there are lots of programs where people come in and talk about consent and all those sorts of things. That should really be emphasized when it comes to fighting the systemic impact of sexualized violence.

Ms. Niki Ashton: Thank you for that.

I'm wondering, Ms. Simon, if you have anything to add on your end.

Ms. Alisa Simon: Yes. About 5% of our contacts for girls from age five to about 16 are specifically about sexual violence. I think one of the big things, which was just being spoken about, is around that education, particularly for younger girls, to even have the name that it was sexual violence, that it was wrong. It's quite difficult, particularly when we talk about what we were discussing earlier around social media, where we are often inundated with images as young women. It's very hard to understand where violence begins and ends and where the sexualization of young girls begins and ends.

I think we need to continue to look at investing around taking off the online sexual images of girls. Certainly Europe and some other countries have really invested in that. We need to ensure that girls and young women who are being victimized online have a way to stop that victimization. We need education so that girls understand what their boundaries are and the ability to say no, and understand that help-seeking is critical. You don't just keep that in. You actually reach out and talk to somebody. We know that talking to anybody, any safe and caring adult, is going to help that young person, whether it's Kids Help Phone, whether it's a parent or whether it's a friend's parent.

It's talking about help-seeking and then making sure that we have the right laws on the books to allow girls to adequately address this. Whether it is taking down an image, whether it is moving forward with removing somebody's licence or bringing a court case or whatever it is, we need to make sure that the legal system stands behind girls who are experiencing sexual violence.

● (1625)

Ms. Niki Ashton: Thank you.

Of course, we know that poverty has a detrimental impact on physical and mental health.

Ms. Andrich, you talked about working with communities that are on the margins, in particular indigenous communities, many of whom struggle in poverty here in our province. One of the things we've heard about from other witnesses is the importance of taking poverty seriously when we're talking about the mental health of children.

My colleague Leah Gazan, who is the usual member on this committee, has put forward legislation around a guaranteed livable basic income and the need to take concrete action to eliminate poverty in our country. I'm wondering if you think we should be looking at these kinds of measures as a way of also supporting the mental health of young women and young people in our country.

Ms. Karla Andrich: Absolutely I think so. As I said earlier, money is how we talk about what's important to us as a society, and money is often the key out of situations in which women and girls find themselves in danger. If everybody had the option of moving out and away from people who are dangerous to them, if everybody had the option of not working at a job that was dangerous to them, and if everybody had the option of that kind of freedom and the ability to support themselves, I think we'd see a lot of people in a lot better situations, absolutely.

The Chair: Ms. Ashton, you have 25 seconds left.

Ms. Niki Ashton: Okay.

I don't think I have time for an answer, but I want to share my appreciation for all the witnesses. I look forward to some more time for questioning.

Thank you.

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

We're going to begin our second round. I'm going to pass it over to Shelby Kramp-Neuman.

Shelby, you have five minutes.

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

Thank you to the witnesses.

To start with disclosure, I'm the mom of two teenage girls, so this very much hits home for me. Our teenage girls are overwhelmed. Parents are overwhelmed. There are teachers who are overwhelmed. There are a lot of people in a dark spot right now.

Raising teenagers in 2022 is an entirely different experience from the one my parents had raising me in the eighties and nineties. Social media didn't exist. Talking about mental illness didn't happen. COVID hadn't happened. Eating disorders weren't trending. Bullying has always happened, but it's been taken to a whole new level. It's out of control. In some cases, teenagers are now even contributing to families' finances, because the cost of everything is outrageous. The pressure is extremely real. It's almost like it's the perfect storm.

I would like to pose my first question to Dr. Elliott.

I'd like to dive into the punitive damages that our young girls and youth in general are experiencing as a result of COVID. They're missing out on graduations. They're missing out on sports. They're talking about isolation.

Where do you think we can find additional accountability? What can we do differently? What can the government do differently next time, if there's another pandemic?

● (1630)

Dr. April S. Elliott: Thank you very much for that question.

I have to take a breath, because I have a lot of professional thoughts about this, but I also have a lot of personal thoughts about this.

Children were at the absolute lowest risk of impact from the disease, yet they were the ones who suffered the most. We wrote an evidence-based letter back in February 2021 to say that children should be returning to sports, that they were safe to do so and that we were very much supportive of kids being in school and doing their sports. Still, I saw in many jurisdictions that kids were limited.

This can never happen again. These restrictions and mitigations, we see now—parents will tell us; youth will tell us and the evidence is telling us—were related to isolation, lack of control, and an inability to meet their developmental milestones. With that, I would say this can never happen in this way again.

We can't undo what's happened, but going forward, I hope we use the evidence from families, from youth and from the evidence in the literature to never have these lockdowns again.

Mrs. Shelby Kramp-Neuman: Thank you for that.

Continuously we have heard that we need to increase resources, that we need more support, that we need to address the people who are help-seeking, that we need more in-school support and that we need to increase spending. We have continuously heard this from our witnesses.

My last question is posed to Ms. Andrich.

Which barriers, if any, might young women and girls in Canada face from accessing specialized and specific mental health supports and services? I know we have the telephone helpline, but with regard to the Internet, what can the government do?

Ms. Karla Andrich: Thank you for asking that.

I think this is related to a lot of barriers people up north face, which is that the Internet is not a public utility like water or electricity. We are in an age of information. I think that being able to access the Internet is a human right, or it should be. It's one of the things that would help people access these services.

There is a question of geography, simply, when it comes to being able to talk with a counsellor or talk with advocates, or the things of that sort. That's definitely one of the things—

Mrs. Shelby Kramp-Neuman: I'd like to acknowledge that, because in Hastings—Lennox and Addington, rural Internet is a concern. I'm sure it is for many of my colleagues around the room.

Thank you for addressing that.

The Chair: Fantastic. Thank you so much, Shelby.

Jenna, believe it or not, you're going to get your full five minutes today. I'll pass the floor over to you.

Ms. Jenna Sudds (Kanata—Carleton, Lib.): Amazing. Thank you, Chair. It's my lucky day.

Thank you to all the witnesses, first of all, for the incredible work you all do, which is so important, and also for sharing your time and expertise with us today.

I'll add the caveat that I am also a mother of three teenage girls, so I live and breathe a lot of these struggles as well.

I echo one of my colleagues who was just saying how difficult COVID has been for parents and children, and young girls in particular. The provincial decisions when schools were closed were difficult decisions that we all lived through. One of the witnesses referred to the COVID generation, which I hadn't heard before. It is so accurate.

I'll direct my first question to Dr. Van Lieshout.

You had a few recommendations. One was around Canadian-specific stepped care pathways. I would appreciate if you could walk us through what you believe that should look like.

Dr. Ryan Van Lieshout: stepped care pathways are the systems by which we deliver and monitor psychiatric treatments so that the most effective and least resource-intensive treatments are applied at the right time.

In Canada, we have remarkable strength in perinatal mental health research, leadership and clinical work. There aren't many of us, but those of us who are here.... Well, my colleagues are great; I'm just okay.

When we're talking about a stepped care model, I think we'd be talking about starting with some quality standards around preconception information and prevention, as well as detection, assessment, intake and treatment. All of this would be, of course, measurement based.

We have lots of wonderful measures in the perinatal mental health space, like the Edinburgh postnatal depression scale and so forth. We'd be talking about trying to identify those individuals who require treatment and then identifying some low-intensity treatments that could be used by most.

There is a model within the Ontario structured psychotherapy program that could be used, whereby classes and self-directed psychotherapies.... CBT-based would usually be a low-intensity intervention. We would monitor responses to those interventions and determine if people needed more, if they had a poor treatment response, if the treatment wasn't good for them or if they didn't agree with it. Then we could move up to higher-intensity treatments, like individual or group-structured evidence-based psychotherapies, cognitive behavioural therapy, interpersonal psychotherapies and things like that. Then we go to medications and so forth.

● (1635)

Ms. Jenna Sudds: You also mentioned a national care standard. Is that a separate recommendation and if so, what does that look like?

Dr. Ryan Van Lieshout: I would see the national quality standards as setting the stage for the stepped care models. Quality standards across the care spectrum from detection through treatment could set standards for access, wait times and things like that. Once we have those quality standards in place, they could be used to identify human resource needs. They could be used to guide the coordination of different organizations that are already helping.

I sounded arrogant and obnoxious as a doctor there for a second when I said that we have lots of expertise. We have fantastic expertise and supports in community organizations around the country, but one of the struggles we have is the coordination of them. There are so many people doing so much good work, like peer organizations and community organizations. I think quality standards would set the stage for us to identify what we need and who we could coordinate with.

Those things would feed into those stepped care models and inform them so that we could decide which low-intensity treatments are the best that we can do in Canada at the present time. It would help us decide what determines whether people move up or down to lower-intensity or higher-intensity treatments.

Ms. Jenna Sudds: Incredible. Thank you so much.

I realize I don't have the time, but I wanted to go to Alisa Simon and dig a bit into one of her recommendations around in-school supports. I know the chair is not going to give me the extra time, unfortunately, but maybe one of my colleagues will pick it up.

Thank you.

The Chair: Jenna, you never know with me. I think I have cut you off for the last three months on your questions.

We will now go to Andréanne Larouche.

As a reminder, there are two and a half minutes for this round.

[*Translation*]

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

I would like to discuss an important matter that was mentioned in the opening remarks.

Ms. Andrich, you talked about the importance of the Truth and Reconciliation Commission and the 94 calls to action. There is clearly a link between mental health and the violence to which women can be subjected, especially sexual violence.

You mentioned calls to action 21 through 24 and 40.

Please tell us more about how these calls to action can help women and how they could be linked to mental health.

[*English*]

Ms. Karla Andrich: Thank you so much for that question.

Calls to action 21 through 24 are around our medical system and training around that. Call to action 41 is the one that directly addresses missing and murdered indigenous women, and the investigations around that. That is extremely important because part of the barrier—

The Chair: Excuse me, there is no interpretation. If you could hold on for a moment, I am going to reset the time so that Andréanne will be able to hear the answer.

Do we have interpretation now? Can you hear us, Andréanne? We're good. Okay.

If you want to begin that answer again, I will give you back that time. Go for it.

● (1640)

Ms. Karla Andrich: Thank you.

Calls to action 21 through 24 refer to training in the medical system and making sure there are indigenous folks represented as medical practitioners. Call to action 41 speaks to missing and murdered indigenous women, the investigation into that and the prevention of that in our society.

They're specifically important, I think, because part of the barriers to accessing help are the systemic injustices that indigenous people face in our communities. It would make a difference to have people who are aware of indigenous traditions, who have been educated as to the harm of colonization as the ones facing the indigenous people when they first go to seek help. I think it will make a huge difference to the retention of people, accessing services and the efficacy of those services as well, if people believe they are understood and seen.

[*Translation*]

Ms. Andréanne Larouche: If I understand correctly, you think this report is important. It is crucial, in fact. There is a direct link with mental health, particularly in indigenous communities.

I could draw the same parallel with LGBTQ+ communities, since they are also subject to various prejudices. Do you have anything to add in that regard?

[*English*]

The Chair: Excellent. We won't have time for that, but when we come back to Andréanne, I'm sure we will have time.

I'm going to pass it over to Niki.

Niki, you have two and a half minutes.

Ms. Niki Ashton: First I would like to ask Ms. Andrich to expand on a point that she raised earlier about the lack of resources in what Klinic does.

Obviously, anyone who lives in Manitoba and works anywhere close to the field of trauma and mental health supports is aware of the important work that Klinic does for all of us, and I want to thank you for that. I'm wondering if you could tell us also clearly the kinds of resources that you would need to meet the need that you're dealing with.

Ms. Karla Andrich: It's probably payroll, as Alisa talked about earlier. Our wait-lists are hugely long, and we just don't have enough counsellors to take everybody on in a timely manner. Unfortunately, the pandemic has only made this worse. I know that in my program, the sexual assault crisis program, our wait-list almost doubled in terms of wait time between 2020 and the present day. So, yes, it is payroll—more people. We're all burning out.

Ms. Niki Ashton: Yes, for sure, and I appreciate your being very clear on that. Again, I want to underscore the life-saving work that you do here in Manitoba. Thank you.

My next question is for Dr. Van Lieshout around perinatal care.

I really appreciate the critical points you've raised. Here in northern Manitoba we have an added issue where a number of women have to leave their home community to give birth and are ripped away from their support network. In some cases it's quite recent. I'm thinking of Flin Flon, a major hub in our north, that had its entire obstetrics ward shut down, and hearing the harrowing stories about what moms from there were dealing with before they gave birth and certainly after as well. I'm also thinking of all of the indigenous women forced to leave their communities to give birth.

I'm wondering if we should be addressing that piece when we're talking about perinatal care.

Dr. Ryan Van Lieshout: Absolutely. One thing the pandemic showed us was the importance of supports, family supports, community supports, networks of support people, so when people are taken away to give birth to their children, it disrupts that. It disrupts the birth process. It disrupts the experience. It increases the likelihood the births will be traumatic or will be experienced as traumatic by people.

Absolutely that's an issue that is prominent among the clinical work that we do and something that hopefully we'll take into consideration. We're looking at quality standards around perinatal mental health if we get that far.

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

We'll be getting back to Niki, I'm sure. I'm going to pass it over to Dominique Vien.

Dominique, you have six minutes.

[*Translation*]

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

Thank you all for being here this afternoon. These conversations are very informative.

I will start with you, Dr. Van Lieshout.

You said we need to work to make Canada the best country in the world for our women and girls. I thinking everyone shares that wish.

You suggested that such well-being starts long before the baby is in the cradle.

I am concerned about women who suffer from postpartum depression. What are the potential negative effects for newborns when their mother suffers from postnatal depression?

How long does it affect the child? What effects have you observed?

● (1645)

Dr. Ryan Van Lieshout: Thank you.

[*English*]

Over the past few decades considerable evidence has accumulated to suggest that the risks associated with being born to an individual who struggles with postpartum depression are myriad. Children who are born into this setting are about three times as likely to experience a grade failure and significant school problems. They are four to five times as likely to develop clinically significant emotional and behavioural problems, and about four times as likely to develop depression in their lifetimes. These problems can begin as early as toddlerhood. The research that has followed individuals the longest suggests that this can persist well into adulthood.

Postpartum depression keeps individuals from becoming the parents they want to be. It disrupts the detachment bond. It makes it difficult for parents to respond in the ways they want to the cues of their children and it has a lifelong effect. The number I quoted earlier was from the United Kingdom. Each case of postpartum depression is associated with $125,000 in costs over the lifespan, 70% of which are due to these difficulties in offspring.

[*Translation*]

Mrs. Dominique Vien: Can we now more quickly and readily recognize those women? Is it more apparent than it was a few years ago?

I remember being like Superwoman was when my son was born. I should mention in passing that I am older than many of you.

That is my second question: can it be readily recognized?

It is clear that action is taken after the fact for women in that predicament. Is it easier to identify those women now?

[*English*]

Dr. Ryan Van Lieshout: I smiled when you asked your question, because we used to call the shower in our house Clark Kent's phone booth when our daughter was born. My wife would go up there, take a shower and come back out as superwoman.

We've had the tools to detect postpartum depression for some time. We know what questions family doctors and other primary care providers should ask. We have easy questionnaires that can be completed. Lots of people go undetected, but it's a little easier to detect because of the good work that people have done around awareness.

More people are aware. Reducing stigma has helped people come to ask for help. I think we've improved outcomes for mothers and families as a result of that, but there's still a general lack of awareness and we can still improve that and improve these pathways to increase the likelihood that these individuals will be detected so that we can treat them easier.

[*Translation*]

Mrs. Dominique Vien: The mothers, grandmothers and sisters watching can no doubt help a great deal.

Thank you, Dr. Van Lieshout.

Dr. Elliot, you talked about malnutrition. That is worrisome. I think that self-mutilation can be linked to malnutrition. I have noticed that clothing manufacturers are increasingly using ads that feature diverse bodies. This will be more positive. There will be more cultural diversity, and more body diversity as well.

Is this a good thing? Are we on the right path? The image depicted of a perfect girl or woman can be hard on the morale of young girls.

[*English*]

Dr. April S. Elliott: Thank you.

Those are a lot of ideas at once. I would say that eating disorders have increased exponentially. There are so many factors.

I will say that back in 2014 when I testified at status of women around eating disorders, at that time Spain had just announced that models could not have a BMI less than 18.5, and that was a law. That is a law. When we look at that and we look at the models who are out there, I'm not saying there's a direct correlation with eating disorders, but if that's the image young women see, that can contribute to eating disorders, but obviously, there are many other factors as well.

● (1650)

The Chair: Thanks very much. I know the time is up, but I just want to clarify.

You said it's the law in Spain that the body mass index must be.... It's the law?

Dr. April S. Elliott: Yes. It's the law. It's a law.

The Chair: Okay. Thank you.

We'll turn it over to Marc Serré.

Marc, you have six minutes.

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

[*Translation*]

Many thanks to all the witnesses for being here.

My questions pertain to national standards. We all know of course that health is a provincial matter, but I want to state clearly that the federal government also has a role to play. We have to find a way to work with the provinces and reach bilateral agreements, which are currently under negotiation. These agreements represent $4.5 million in funding over five years.

We heard from the Royal Ottawa Health Care Group a few weeks ago. You touched on that briefly today, namely, that the system has gaps and it is very difficult for parents and individuals to navigate through the system.

I am trying to get a better understanding of certain aspects, specifically services relating to community expansion, mental health, addictions, youth aged 10 to 25, and early intervention. I am not necessarily asking all four witnesses.

Dr. Van Lieshout, you also mentioned the lack of coordination among the various organizations. For example, I was in Sudbury with Minister Bennett for a round table discussion. The groups in attendance said there were about 6,000 organizations—an exaggeration—and very little coordination.

[*English*]

I'll start with Dr. Ryan Van Lieshout and then go to Dr. Elliott.

What can you inform this committee about on best practices, evidence-based, to finalize these bilateral agreements so that the money could flow with the provinces and the federal government? Maybe you could answer in a minute each.

Dr. Ryan Van Lieshout: It's an interesting conundrum to negotiate these agreements between the provincial and federal levels, but I do believe that the federal government's creating quality standards and discussing with the provincial governments their needs and what they can help with will be helpful. There are many community organizations doing great work. We once surveyed them, because we created an app to try to help people with postpartum depression, and there were so many doing such great work that's so diverse.

I think quality standards will help us to then say, “This is what we're going to do”, and we can inform the organizations and the provinces. Then people can get together under an umbrella to do the fantastic work that we know they do in isolation. We can get so much more efficiency out of it and probably save a great deal of money.

I'll turn it over to Dr. Elliott.

Mr. Marc Serré: Dr. Elliott and then Alisa Simon, please.

Dr. April S. Elliott: Thank you very much. I really appreciate the question.

We have to look at where the most expensive care is, and the most expensive care is in hospitals.

When we can work with community to make guidelines that include the amazing work they do, move things into community and partner with community agencies, such as for community beds, or beds where young people do not need to be in a clinical setting but maybe still need some high-level care, those are the places I think we need to start.

We need to have a national standard for that, so that each program in each province isn't developing their own standards, because it's costly. I think this is essential.

Ms. Alisa Simon: I'll quickly add two things.

One is that, while it is a provincial responsibility when we think about health care and mental health care, I think there is a critical role for the federal government to end inequities based on where you live and to end duplication in spending.

I actually don't know that we need a gigantic amount of more funding. We do need some more funding for mental health, more focus on mental health. However, we also need to be better at spending the dollars where the evidence shows it works and moving people from the most expensive services to potentially less costly services that will meet the needs.

We have to ensure that we are spending our money—and that's where we get to the stepped care model that Dr. Van Lieshout spoke about—in a way that makes sense to that end-user. Often that can be a lower cost, a lower step, on that stepped care model.

That does require national thinking. Otherwise, we set up many different, diverse provincial and territorial spends that all have costs, duplicate and aren't necessarily using the resources that already exist or the evidence that already exists.

● (1655)

Mr. Marc Serré: Thank you.

Alisa Simon, you also mentioned schools.

What kind of role could the federal government play with the provinces to try to get where the youth are, for delivering mental health services within schools? We've heard this several times from different witnesses, and I know you get several calls. What kinds of recommendations do you have along those lines?

The Chair: You have about 30 seconds.

Ms. Alisa Simon: Thank you.

I think one of the things would potentially be for the federal government to recommend programming within schools. There are examples in the U.K. Their helpline, Childline, is in every single classroom in the U.K.

Right now, with a program like what Kids Help Phone offers, or others, we have to go jurisdiction by jurisdiction or work with the ministry of education in that province or territory to try to get into schools.

We could have a much more streamlined approach from a recommendation by the federal government that every single young person, for example, is connected with Kids Help Phone three times through their education, or that every single young person receives education on help-seeking, stigma and mental health. Those kinds of recommendations could go very far down into ministries of education and be able to get these things into schools.

The Chair: Perfect.

Thank you so much. We're now going to Andréanne Larouche for six minutes.

Andréanne, you have the floor.

[*Translation*]

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

My question is for Dr. Van Lieshout.

Unlike my colleagues, I do not exactly feel like Superwoman right now. I am trying to balance my job with being a mother to an eight-month-old little girl. As I already said, I am even wondering if I can do a good job as a mother and also as an MP. So I understand the tremendous importance of mental health for young mothers.

I would like to get back to the fact that we all agree that we need more investments in mental health. Someone said that it might not be huge amounts, but we still need to invest. You said so earlier, as the community organizations did at our last meeting. They do outstanding frontline work with people grappling with mental health problems. They need help and funding, because of the massive growth in demand and in needs. One way to help these organizations is of course to recognize that they need more funding in order to hire more people and extend their hours of service.

Dr. Van Lieshout, how important is it to recognize that health transfers represent an investment in health and that the federal government is working to inject more money into the system to give our departments larger budgets? How can that help organizations on the ground respond to growing demand?

Dr. Ryan Van Lieshout: Thank you.

[*English*]

Congratulations on the birth of your eight-month-old. You seem to be doing an awfully impressive job as a mom and MP, but I will stop being ingratiating.

There are a lot of remarkable people doing remarkable work across sectors at the municipal level, at the provincial level and at the federal level. Public Health in Ontario does a lot around perinatal mental health, these community organizations, hospitals and so forth. I think part of the setting of quality standards by the federal government would be to implement the need for measurement-based care. Ms. Simon alluded to that.

It's important that we coordinate and collaborate together, but also measure what we're doing and assess how well we're doing. Organizations that are able to help us produce the best outcomes could be one way to determine how things are allocated and so forth.

A part of quality standards in the stepped care models, of course, is measurement. There are cheap scales available in the perinatal mental health space that can be used to benchmark and create standards and do those sorts of things.

I hope that answers the question you asked.

● (1700)

[*Translation*]

Ms. Andréanne Larouche: I think rapid investments are urgently needed. In that regard, I hear what you said about avoiding duplication and time wasted on these agreements.

Right now, the provinces and Quebec are all asking for a health transfer of up to 35%, precisely because they know there are projects within their borders that will never get off the ground owing to a lack of funding. So we also need to find a way to accelerate these transfers.

Let me turn to you now, Dr. Elliot. You are a pediatrician and work with adolescents. Having adolescents in my life, I know they are very worried about the environment; it is called eco-anxiety. We have not talked much about this in our study thus far. I would like to know the potential impact on the adolescents you work with.

The government must definitely address environmental issues. That might, among other things, provide some relief to these young people and address their concerns.

[*English*]

Dr. April S. Elliott: I want to go back to what a few people have discussed. Let's bring it back to the family, and let's bring it back to the schools and into the community.

One of the things that really is curious to me is why, after two and a half years of such significant increase in mental health concern—and we all spoke about it—school counsellors and psychologists have either been let go or are not deemed necessary. I heard several examples of this just in Calgary. We need that force in the resources in the schools.

I also think we need to take it back. I love the prenatal or the early childhood where we teach parents how to regulate their own emotions. They can have the highest IQ, but if you haven't learned emotional regulation, when the avalanche is coming you may start doing things that you wouldn't typically do. I think we need training at different areas—community, places of worship, within schools—where we help parents learn techniques such as mindfulness, emotional regulation. This will help them with many of those things to help adolescents. If you're not in a grounded environment, you cannot ground yourself.

My approach a lot of the time is to work with the parents to help the youth, to coach them to be in a better place and then to deal with the crises.

The Chair: Fantastic. Thank you so much.

We're going to pass it over to Niki.

Niki, you have six minutes.

Ms. Niki Ashton: Thank you.

My question is for Dr. Van Lieshout.

You talked about the impact of mental health being passed down from mothers to their children. For indigenous women and girls, we know that there's intergenerational trauma that transfers across generations, trauma that is caused by colonization, the impacts of residential schools, trauma caused by systemic racism, ongoing violence and genocide.

Could you talk a bit about any research that you're aware of, or that you have been involved in, that is focused on indigenous women and girls? How can we best support these communities whether it's in terms of the national standards you have talked about, or other measures when it comes to prenatal and postpartum care?

Dr. Ryan Van Lieshout: I actually live about 2,000 metres from the Six Nations reservation here in Caledonia, Ontario, so we've been fortunate enough to develop links with the Six Nations birthing centre and a group of local indigenous midwives to try to understand the unique struggles faced by first nations people here locally.

In addition, I do clinical work and have had the honour of working with first nations people from Ohsweken, Six Nations, Rama near Orillia and so forth. The stories are striking. As you point out, the intergenerational transmission of many things is quite striking.

We did a study during the COVID-19 pandemic working with the Six Nations midwives. We found a number of challenges that have been described by other members of the panel, such as access to health care and other things. What we also saw was remarkable strength and remarkable resilience among these individuals. We think, of course, it was within them as well, but also because they have this amazing birthing centre.

It's having first nations-specific supports, peers who have recovered.... We have to work together—no health for us without us. We have to work together to understand these unique challenges that are being faced, and develop tailored, unique strategies that meet those needs, whether they relate to intergenerational trauma, water security, food security, or things like that.

We've been doing that work. We're trying to help train the midwives. I'll be doing some training with the midwives soon. We look forward to continuing that partnership and understanding it better. I have great teachers, and I'm very lucky to have that.

I hope that helps with the question.

● (1705)

Ms. Niki Ashton: I really appreciate the experience you've shared. We can all agree that the work you're doing is very important, and hopefully, work that can be replicated in other centres with and for first nations and indigenous communities across the country.

I want to move to another topic. Ms. Simon, I'm not sure if you might have something to share on this.

We're hearing a lot more about young people who are extremely anxious and increasingly anxious about climate change. We've already seen the impacts of climate change on our communities. Personally, I represent communities that have been evacuated and have experienced long-term evacuations as a result of historic wildfires just in the last couple of years. We know that mental health issues have been further exacerbated.

I'm wondering, though, through your work with Kids Help Phone, what you are hearing from young people when it comes to what is termed as eco-anxiety, or anxiety around climate change.

Ms. Alisa Simon: That is such an important question.

It's interesting. We are not seeing young people name it eco-anxiety, or climate change anxiety right now. What we are seeing, certainly, when we experience any kind of disaster related to climate, whether it is wildfires or flooding, we see an increase in contacts from that area. We will continue to see young people reaching out about that as we continue to see those disasters occur.

It is part of our role at Kids Help Phone to start helping young people name that and think through what it means and what they can do. A lot of the work that we do is helping young people understand what they can control and what their role is. When it comes to climate change, young people have to understand they have a voice and that they can use it. Supporting young people to use that voice, whether it is writing letters or talking about the impact of climate change, is some of the work that we still have yet to do at Kids Help Phone.

I want to also connect that to some of the conversations we were talking about just a moment ago about indigenous people. Certainly, at Kids Help Phone we've done a lot of work with a distinctions-based approach for first nations, Métis and Inuit youth. We are seeing there are significant concerns from our indigenous young people around the climate, around what's happening to their communities and the planet we live on.

Being able to have those conversations.... We piloted last year, and have continued, where we trained indigenous volunteers for our texting line—that's our volunteer service—so that when young people text Métis, Inuit or first nations, we can try to connect them with a volunteer of the same background, so they can actually have those conversations about climate change or anything else that's concerning them with somebody who actually understands that background. That's been incredibly powerful.

● (1710)

The Chair: That's perfect.

Thank you so much for that.

For our next five minutes, we're now going to Michelle Ferreri.

Ms. Michelle Ferreri: Thank you, Madam Chair.

Thank you to all of our witnesses for answering some really great questions about how we do that bilateral funding and how we amalgamate mental health into our health care. I think we have made huge progress on that, quite frankly. People are now asking for help. However, when they do ask for help, there's nothing there to help them. There's a very huge health equity gap there.

Dr. Elliott, I might be your new biggest fan. I'm really enjoying your testimony and a lot of what you have to say. You touched on one area that I'm particularly interested in personally and very passionate about. That is the education piece of self-regulation—arming our children with the tools, because the toothpaste is out of the tube. We're not going to put social media away. We're not going to reverse and go backwards. This is where we are. Now we have to give our kids the right tools to manage their feelings, give them the language to manage their feelings, but also not confuse them—I think we also see this—into thinking they might have something they don't. They've seen this imposter syndrome as well, which is dangerous.

I'm curious as to what you think would be the return on investment when we look at investing. I'm going to name a doctor whom I adore, Dr. Stuart Shanker. I don't know if you are familiar with his work, Dr. Elliott, when we are looking at self-regulation and teaching children and teachers to recognize the why of their behaviour.

Why do we see it and why now, Dr. Elliott?

Dr. April S. Elliott: I'm really thrilled that you're aware of self-regulation and those topics.

Recently I did a program called Reset to Reconnect. It was with six families with adolescent boys. We did an initial kind of education. Then they went to it with their families, calling out their families on different things and setting their own plans for their families. After it was done, the feedback was that they recognized they had better sleep. They were more emotionally regulated. They were more connected to their family. They had more time to do other things that really social media and screens took away from them.

We're also seeing a really significant uptick in somatic symptom disorders, which involve someone's experiencing a physical presentation because of an underlying psychological event. For this, we have now seen on social media something called TikTok tics. When young people are watching a lot of TikTok, they start to get physical symptoms.

To go back to that, if we can teach parents early to regulate and teach young people to be in an environment of regulation, whether it's in schools, places of worship or other places, then everyone is going to have the same language and the same ability to take a breath before they respond. In so many situations, things are "figureoutable" if you're able to regulate.

Ms. Michelle Ferreri: It's Marie Forleo's saying, "figureoutable". I know it well. It's a good one.

I think we're really on the same page. I think what we haven't addressed, really, in this round is parents' inability to self-regulate, which is downloaded to the child. There is parents' use of maladaptive coping mechanisms such as looking at their screens, just basically tuning out and also scrolling. I think we need to give a name to this, because I actually do think it is comparable with, say, alcoholism or some kind of addiction, where you are tuning out so you don't have to deal with the stresses of life.

We have an affordability crisis. We have both parents working and not able to afford to put food on the table, who, at some point.... I have parents now writing to me. They make over a $100,000. That's a lot of money. Now they can't afford that because the cost of groceries and housing are through the roof.

My question, Dr. Elliott, is whether there is data—because that's ultimately what determines funding—on investing in giving parents the tools they need to self-regulate as well.

● (1715)

Dr. April S. Elliott: Maybe some are aware of the Palix Foundation in Calgary. It has done a lot of work on the Brain Story. There is a plethora of evidence on early childhood education and prenatal development. They're really helping individuals understand how the brain works, in a very simplistic way, so that everyone has the same language.

I think in Calgary, in Alberta, they have done a lot of work that way. I'm already seeing that when I work with my youth who are experiencing homelessness and with other communities, we're all using the same language to describe the young person. Someone is no longer a difficult youth; they are a youth with challenges. The language is important.

The Chair: That's awesome. Thank you so much. I absolutely agree.

We're going to pass it over to Emmanuella.

Emmanuella, you have five minutes.

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

I'd like to thank our witnesses for being with us today to answer a lot of our questions and for giving us so much great information.

On my first question, we heard at several of our meetings, including today's, that there is a lack of support and there just isn't enough help for the amount of help that is needed, whether that means trained therapists or people who are actually considered psychologists. There aren't enough of them around. Even if there were enough around, it's quite unaffordable for many Canadians.

What do you think our government—specifically, the federal government—can do to help make mental health care more accessible to Canadians across the country? I'm talking specifically about costs, but also about getting more people into this field and making sure that in the future we are more prepared to deal with this type of crisis.

Anyone can answer.

Ms. Karla Andrich: The first thing I can think of is making mental health care a part of our health care system.

Right now, if you want counselling, you go through your work EAP, or you go to a free agency, like Klinic, or you pay out of pocket. If you are looking at EAP, those sessions are very limited. Some people have as little as six, which is not a lot of time to work on any kind of mental health issue. At free agencies like mine, the wait-lists are quite long, and for private care, it's quite expensive.

Integrating mental health into our health care is definitely a piece of that puzzle.

Ms. Emmanuella Lambropoulos: Does anyone else want to chime in?

Dr. April S. Elliott: The Royal College of Physicians and Surgeons said quite a few years ago that all physicians should be educated in mental health and physical health: It doesn't matter if you're an orthopedic surgeon, a brain surgeon or a pediatrician. I was on a Royal College subcommittee, and I have yet to see this actually happening.

We are seeing more and more physical presentations of psychological issues. People say, “I don't know what to do.” Other physicians, other people...they're very much physical versus mental health. It needs to be integrated. That education has to start in medical school. It has to start in nursing school. It has to start in all of the schools where health care is being trained. They're not separate. There's not a dualistic system. We come into a room with our brains and so we need to really support that from the education perspective.

Ms. Emmanuella Lambropoulos: This might be a little far-fetched, but you've raised it, so I'll go along with it and take further what you're saying. I've heard that there is a link between sexual assault and cancers—specifically, reproductive cancers. I'm wondering if this is something you've also read about in your research, if you've seen that and if what you're saying right now can also lend itself to that kind of work.

Dr. April S. Elliott: If someone has HPV, which they could have acquired with sexual assault, there is definitely a link to cervical cancer—

Ms. Emmanuella Lambropoulos: You don't think the trauma that somebody experiences in those areas can lead to psychological trauma that leads to physical manifestations in that space. No?

● (1720)

Dr. April S. Elliott: No. I actually believe that trauma raises the cortisol in one's body, and there are many illnesses that can come from having a trauma or specifically a sexual assault. I believe there is a connection, but I don't know the literature around this, and that would be something I would need to look at: the correlation of that. I definitely think that any time the body is stressed, they're more at risk for illness.

Ms. Emmanuella Lambropoulos: Thank you very much. I'm sorry if my questions were a bit all over the place. A lot of these topics hit very close to home, so it's very hard to actually concretize my thoughts.

The Chair: Thank you so much.

That's why we're a committee doing this all together. Let's continue with this great work we're doing, and we can ask these tough questions together.

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.

Dr. Elliot, you mentioned a law earlier that exists in Spain. Can you tell us a bit more about that law?

[*English*]

Dr. April S. Elliott: I'd have to go back to look at the year that they put this forward, but I know of a law in Spain that says models need to be a BMI of, I believe, 18.5 or higher, but they cannot be below that. It may be 18. It is a law, so absolutely no models can be below that.

The other thing they have, which is incredible, is sizing that is consistent. I don't know if you've ever gone into a store that's been open for 20 years, but the sizing is not consistent. In Spain, there's a law that says a 30 is a 30 and a 32 is a 32. There are no fours that are eights.

This has a huge impact on body image for young women and girls, so it's also a law in Spain.

[*Translation*]

Ms. Andréanne Larouche: Thank you very much.

Since the meeting is drawing to a close, I want to clarify a few things.

Ms. Simon, when we talked about digital tools, you said Europe had invested in this area. Can you give us some specific examples that we could draw on?

[*English*]

Ms. Alisa Simon: I think part of what we have seen, particularly over COVID, is people all across the world looking to e-mental health and digital health as a solution to their challenges. When we think about that stepped care model, digital health is fantastic for a lot of those lower acuity challenges, single-session counselling and things like that.

The thing that I think is worrisome is we have seen a flooding in the marketplace of for-profit companies within Canada, but even more so internationally. They're coming into our marketplace and offering digital services without a lot of efficacy or evaluated information behind them.

There's cost, so that we are creating a second tier of services that people can choose to pay for. When we talk about things like navigation, it is becoming incredibly difficult. Go to the Apple or Google store and put in “mental health”. You will see hundreds of apps, and that's just apps; that's not even talking about the other kinds of digital services.

I think we need standards for digital supports and to ensure that companies that are coming into Canada to provide digital services are able to demonstrate that there is efficacy and evaluation behind the products that they're offering to Canadians.

The Chair: Thank you so much, Ms. Simon.

We're going to move to Niki for two and a half minutes.

Ms. Niki Ashton: Thank you.

My first question is for Dr. Elliott.

You highlighted the fact that you work in Alberta. I really appreciate the insights you shared around working with girls and young women on eating disorders and anxiety disorders.

Similar to other questions that I've raised during this committee, is there any insight that you can bring in terms of the challenges particularly around anxiety disorders, but also eating disorders and working with indigenous communities?

Many indigenous communities face high food insecurity. The cost of a healthy and balanced diet is out of whack compared to in the rest of the country. Obviously, the resources are even fewer when it comes to mental health supports.

I'm wondering what insights you could share in working with indigenous young people, indigenous girls and women. Are there any concrete recommendations that you can make to our committee?

● (1725)

Dr. April S. Elliott: I've had the honour of working and developing a clinic with Wood's Homes, which is a not-for-profit in Alberta, and creating CATS clinic, the Calgary Adolescent Treatment Services. Very sadly and unfortunately, 30% of the youth who come are indigenous. I say that because only 3% of Canada is indigenous. I'm very saddened, because many of them are coming because they're anxious. They have experienced sexual assault or they've had other things that made them need to come to a clinic like ours.

However, the hopeful thing is that we have specialists in intergenerational trauma. We have people in the clinic who work with these youth and get them the right resources. I'm heartened that we have that available through Wood's Homes, but I'm very saddened that the percentage is still very high.

Ms. Niki Ashton: Thank you for sharing that.

I wonder if you would recommend that greater resources be dedicated to working with an obviously overrepresented community in this field.

Dr. April S. Elliott: Definitely. Marginalized communities, youth experiencing homelessness, indigenous or very diverse youth.... There's a lack of services. It isn't that they aren't there, but sometimes they're very nervous about asking for help. They do not want to go to big hospitals or other clinics, so we need specialized, accessible clinics for them, where they can feel there is no judgment.

The Chair: Thank you so much.

We're coming to our last round. What we're going to do—I'm so sorry, Jenna; I never do this for you, somehow—is pass it directly over to Sonia for her five minutes, so everybody has the opportunity to question our witnesses today. It's special treatment for the vice-chair. I'm sorry.

I'm passing it over to you, Sonia. You have five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Madam Chair, for being generous with me.

Thank you to all the witnesses for their very valuable input.

As the mother of twin daughters, I want to ask a question that comes back to eating disorders.

You said, Dr. Elliott, that eating disorders are increasing. What is the main reason for these disorders?

Dr. April S. Elliott: In general, eating disorders are multifactorial illnesses. There are genetic underpinnings and serotonin receptors, and there's an environmental context—social media and screen time have been alluded to as impacts on body image. It's an anxiety-based illness.

Over the last two and a half years, during COVID, we have seen our wait times go from one to two weeks for a specialized tertiary care program to 56 weeks in 2021. I think they're now down to about 40 weeks. The basis for this seems to be loss of control and isolation. Many youth would say that when the pandemic hit, they needed to focus on something and control something, so they controlled their food. Once you become malnourished, the brain becomes malnourished. You go into rigid patterns, and then, all of a sudden, you have a youth who is starving and having all the complications of malnutrition.

Again, it's multifactorial, but COVID and isolation had a significant impact on this population.

Ms. Sonia Sidhu: Do you have any research on celiac disease, where they cannot eat food because they're so scared that if they eat gluten, there can be a cost?

Dr. April S. Elliott: I think what you're speaking to is a diagnosis called ARFID, which is avoidant restrictive food intake disorder. We can see that coming. Someone does not have a body image issue, but they've had a choking event or severe abdominal pain from, perhaps, celiac or other illnesses. They can then become very fearful of eating and quite malnourished, as well. We need more funding in that area specifically. It's quite a crossover of GI specialties, pediatrics and psychiatry, and there's such a lack of knowledge in the community around it.

● (1730)

Ms. Sonia Sidhu: Thank you.

My next question is for Ms. Simon.

Ms. Simon, you said that, over the age of 25, they are more in grief. Do you think they have anxiety or are there other reasons for mental health issues? You also said that suicidal thoughts start at ages five to 13. Is that true?

Ms. Alisa Simon: As I mentioned, we hear from young people between the ages of five and 13 who are thinking or talking about suicide. Again, the important thing to me about that is, when a young person reaches out, we have this unbelievable moment to help them—the fact they are willing to talk about it.

It's scary for us as adults, and it is shocking to hear about young girls who are reaching out about suicide. As a parent to a young girl, I feel that. I also want to really drive home that the fact that they're talking about suicide is okay, because it allows us to have that moment to talk to them about hope, about resiliency, about inner strength, about being present in their own life and about what coping tools they have. So yes, we are hearing from young kids about suicide.

Your other question was about older women, 25 years and over. Certainly, we see those young women talking about anxiety, depression, relationship issues and all of those things. We don't diagnose at Kids Help Phone. We have done evaluations where we've asked young people to take a scale called the Achenbach to get a sense of whether they have diagnosable challenges. Certainly, we see large numbers of young people coming to us who do have diagnosable conditions, but we deal more with what the feelings are in that moment. The feelings that women 25 years and over bring to us are high levels of anxiety, lots of depression and lots of feelings of their life being out of control.

As I said, what we have noticed for particularly those older young adults is that they bring in challenges around grief and around loss. Around the pandemic, we think about post-secondary students who haven't been able to go. We think about people who haven't been able to see their families and who are feeling isolated. That has continued in this new reality.

I would say that young people reach out about every issue, and every issue at every age, but those are some of the differences we see as young people age.

The Chair: Awesome.

I would really like to thank the panellists today. Thanks so much to April, Ryan, Alisa and Karla. This has been a phenomenal panel. Thank you for participating. As indicated, if there's additional information that you would like to send in, we are accepting that until November 1.

Everybody, we'll now be adjourning our meeting. I would like to say thank you and wish all of you a happy Thanksgiving. It's time to go home, put up your feet and enjoy a turkey or something with your family. I hope everybody enjoys it.

Are we ready to adjourn? Okay.

Today's meeting is adjourned.