HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

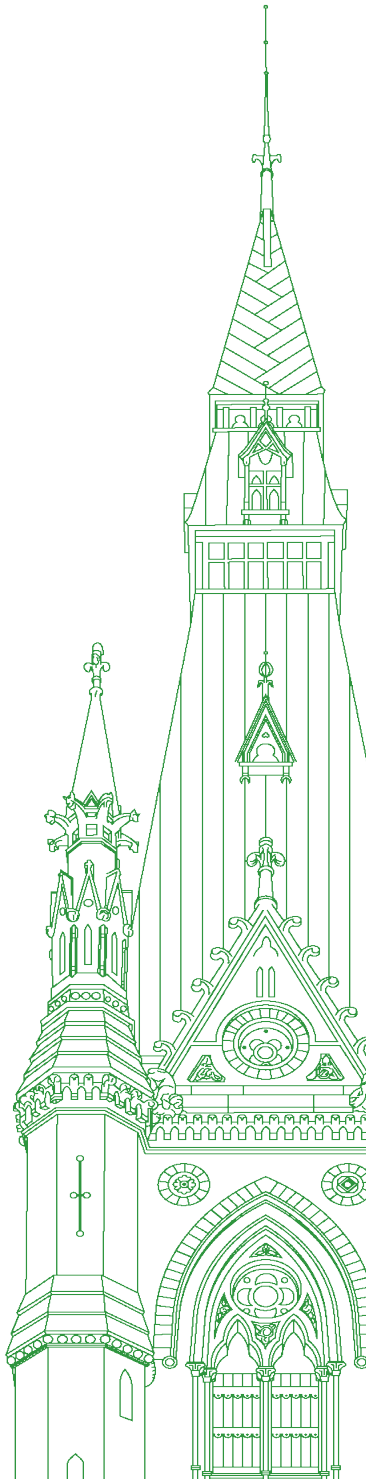
44th PARLIAMENT, 1st SESSION

Standing Committee on the Status of Women

EVIDENCE

NUMBER 033

Monday, October 17, 2022



Chair: Mrs. Karen Vecchio

Standing Committee on the Status of Women

Monday, October 17, 2022

● (1100)

[*English*]

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

Welcome to meeting number 33 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 the witnesses and members.

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mike, and please mute yourself when you are not speaking. There is interpretation for those on Zoom. You have the choice, at the bottom of your screen, of floor, English or French. Those of you in the room can use the earpiece. You also can choose floor, English or French.

For members in the room, if you wish to speak, please raise your hand. For members on Zoom, please use the "raise hand" function. The clerk and I will manage the speaking order as well as we can, and we appreciate your patience.

We are already halfway through the study on the mental health of young women and girls. It was previously agreed that the committee would undertake, as its fourth study, a study on human trafficking of women and girls and gender-diverse individuals for sexual exploitation in Canada. We're asking everybody to send in a prioritized witness list. The date for that is Friday, October 28. I see a nod there, so it looks as though everybody in the room knows that.

I remind everybody that we are welcoming our witnesses, and I would like to provide a trigger warning. This will be a difficult study. We will be discussing experiences related to mental health. This may be triggering to some viewers, members, or staff with similar experiences. If you feel you are distressed, please advise the clerk.

I would now like to welcome the witnesses we have with us today. We have, from ABRAR Trauma and Mental Health Services, Abrar Mechmechia.

Go ahead.

[*Translation*]

Ms. Andréanne Larouche (Shefford, BQ): Madam Chair, have all the witnesses participating by videoconference done a sound test to ensure they can be heard by the interpreters?

[*English*]

The Chair: Yes. Thank you very much.

We also have here today, as an individual, Tracie O. Afifi, professor. From the BC Children's Hospital, we have Jennifer Coelho, psychologist, provincial specialized eating disorders program. From the Canadian Mental Health Association-National, we have Sarah Kennell, national director, public policy. From the Mental Health Commission of Canada, we have Michel Rodrigue, president; Mary Bartram, director, policy; and Shaleen Jones, executive director, Eating Disorders Nova Scotia.

Each group will be given five minutes. If there's more than one who would like to speak, please divide that time. For the first five minutes, we will have Ms. Abrar Mechmechia.

Abrar, you have the floor for five minutes.

Ms. Abrar Mechmechia (Founder, Chief Executive Officer and Mental Health Counsellor, ABRAR Trauma and Mental Health Services): Good morning, Madam Chair and honourable committee members. Thank you so much for inviting me to speak today. It's such a great honour.

My name is Abrar Mechmechia. I am a Canadian Syrian mental health counsellor with expertise in working with trauma since 2014, back home and in Canada. I am currently leading an organization that is dedicated to providing affordable, trauma-informed, art-based and culturally sensitive trauma and mental health support for diverse newcomers and immigrants. Our services are carried out through professionals with lived experience and those who speak our clients' first language. Our main focus is usually women and youth.

I am speaking today from both my professional and personal experience, as a young woman dealing with layers of past trauma while striving to make a living and build a future with limited support. I'm not the only one out there.

As shared in our “Together Towards Recovery” report, during the pandemic my team led a national advocacy campaign focused on understanding the barriers to mental health support and services faced by marginalized youth. We undertook research to determine the impact of COVID on youth, especially those who come from under-represented communities. Of the 308 total research participants, the majority were female.

Our research showed that the primary barrier to accessing mental health support was inaccessibility. Many did not know where to seek long-term support. Even if they did, they were deterred by the unreasonably long waiting time. This relates to geographical and mostly financial inaccessibility of the service. Those who did get access often felt that it was generic. They did not feel that they were understood. They felt that the care provider lacked cultural competency, failing to understand their gender identity, their experience, the trauma they carried with them and the context.

One time I had a conversation with a young woman who told me her therapist said to her, “Well, if you would just try to loosen up, you could probably fit in or feel more included.” She was referring to her hijab and the way she dressed. It was really heartbreaking for me to hear that such a young woman, 17 or 18 years old, was facing that type of discrimination within the health sector.

Women, especially immigrant women, face a disproportionate amount of discrimination and racism on a daily basis, which leads to an increased prevalence of anxiety, depression, loss of esteem, body image problems, isolation, and the pressure to fit in and feel that they belong, all added to the layers of trauma they face, and yet there are very few services they can reach out to for help.

These findings informed our vision to provide culturally sensitive, trauma-informed services for marginalized populations, especially newcomer and immigrant women and girls. Throughout the last two years, besides our “In This Together” campaign, we have launched three projects focused on providing needs-based early intervention for newcomer and immigrant women.

For example, “Brave Space” was an early intervention support group that was created to support Muslim women after the Islamophobic attack that happened in London, Ontario. This project's goal was to support women who felt threatened after what happened. It was piloted in Hamilton, Ontario, with the support of community organizations like HCCI and SACHA, and Nrinder Nann, a city councillor. We hope to relaunch this project again with some support.

Another project was “Friends & Coffee”, our first virtual support group, 12 sessions, in partnership with the Syrian Canadian Foundation to support Arabic-speaking women throughout the early stages of the pandemic.

● (1105)

Lastly, there's our Dil Ba Dil project, which launched this month with the support of a lot of women, the Mental Health Commission of Canada—who are present today; thank you so much—and the Future Ready Initiative.

I think my time is nearly up.

What we hope to see is free, trauma-informed, culturally sensitive mental health support for marginalized women and young girls, especially newcomers and immigrants who have gone through a lot of trauma and still deal with discrimination every day. Canada is a country of immigrants, and we lack a lot of support that understands migration trauma and the marginalization experienced in total.

Thank you so much for giving me the time and the platform today to represent the many voices I'm carrying. It's such a responsibility.

Thank you so much for listening.

● (1110)

The Chair: Thank you very much. We are truly delighted to have you here today to be that voice.

I'm going to pass it over to Professor Tracie Afifi.

Tracie, you have five minutes. If you'd like to start now, you have the floor.

Dr. Tracie Afifi (Professor, As an Individual): My name is Dr. Tracie Afifi. I'm a professor at the University of Manitoba in community health sciences and also in psychiatry. I'm a tier 1 Canada research chair.

We know that mental health disorders among women and girls are prevalent in Canada. When someone begins to have mental health problems, it can significantly reduce one's well-being and quality of life. Mental health problems can persist across the lifespan, as well as create a substantial burden on society. Over time, mental health problems can worsen and lead to mental disorders, substance use problems, thinking about suicide, and attempting suicide. Mental disorders can be hard to treat, and wait times for treatment can be long. Overall, access to mental health care in Canada is limited and often inequitable.

If we want to make large gains in improving mental health among women and girls in Canada, we need to focus on prevention and understanding the role that violence plays on poor mental health. Violence prevention is critical for improving mental health in Canada among women and girls.

For some children, their first exposures to violence is in the home. We don't have good Canadian data to tell us how many parents spank or hit their children. However, we do know that hitting children as a means of physical discipline is common. We also know that there is conclusive evidence across decades and thousands of studies that indicate that spanking is related to poor outcomes, including mental disorders, substance use problems, and thinking about and attempting suicide in childhood and across the lifespan. Children who are spanked are also more likely to experience severe physical abuse, sexual abuse, emotional abuse, and exposure to intimate partner violence.

Our team analyzed data from nationally representative samples of Canadian adults who retrospectively reported on their childhood experiences. We found that among women, 21% experienced physical abuse, 14% experienced sexual abuse, and 9% were exposed to intimate partner violence. Overall, 30% of women in Canada have experienced physical abuse, sexual abuse, and/or exposure to intimate partner violence.

Sex differences were noted, with women compared to men being less likely to be physically abused and more likely to be sexually abused and exposed to intimate partner violence. Gender-based violence is an important consideration when understanding the mental health of women and girls.

We further analyzed the data and found that individuals who experienced physical abuse, sexual abuse, and exposure to intimate partner violence were more likely to have depression, bipolar disorder, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, phobias, attention deficit disorder, eating disorders, alcohol abuse and dependence, drug abuse or dependence, thinking about suicide and also attempting suicide.

Importantly, other research has shown that those who experience violence in childhood are also more likely to experience violence in intimate partner relationships in adolescence and adulthood. For some, violence may also continue across generations when children who were abused in childhood grow up, become parents, and continue the same patterns with their own children.

We know that violence is not the only reason why people develop mental disorders. Genetics, environment, and other experiences are important contributors to mental disorders. However, our research team hypothesized that childhood adversity played an important role in understanding who was more likely to have a mental disorder.

To test this hypothesis, our team used data from the United States and computed statistical models that were designed to estimate what proportion of mental disorders and suicidal behaviours in the general population could be attributed to experiencing child abuse. In other words, the statistical modelling estimated how much mental disorders and suicidal behaviour prevalence might be reduced in the general population if the child abuse did not occur.

What we found was that if physical abuse, sexual abuse, and exposure to intimate partner violence could be eliminated, then it is estimated that mental disorders among women might be reduced by approximately 22%-32% in the general population. Suicidal thoughts may be reduced by approximately 16% among women, and suicide attempts among women may be reduced by about 50% in the general population. Even if we couldn't prevent all child abuse, making gains to reduce child abuse would likely correspond with dramatic increases in the reduction of mental disorders in Canada over time.

● (1115)

Of course, we can't focus on prevention alone. We also need to invest in evidence-based treatments for mental disorders, substance use problems, and suicidal thoughts and attempts. We need to reduce wait times for care and provide better access to treatment for all Canadians. An improved and targeted combined intervention and prevention approach is needed.

If we want significant improvements in mental health, we need to work towards reducing all types of childhood violence, including spanking. Preventing childhood violence is difficult but possible, and it is critical for better mental health outcomes among women and girls in Canada.

Thank you.

The Chair: Thank you so much.

I would like to introduce to you Jennifer Coelho, psychologist, provincial specialized eating disorders program, BC Children's Hospital.

Jennifer, you have the floor for five minutes.

Dr. Jennifer Coelho (Psychologist, Provincial Specialized Eating Disorders Program, BC Children's Hospital): Thank you so much, Madam Chair and committee members, for inviting me here today.

I'm coming here from Vancouver, which is the traditional unceded territory of the Musqueam, Squamish and Tsleil-Waututh people. In addition to representing the BC Children's Hospital eating disorders program, I am the president-elect of the Eating Disorders Association of Canada.

Back in 2014, the Standing Committee on the Status of Women published a report on eating disorders in girls and women in Canada, which references the services for eating disorders being in a state of crisis. The pandemic has really exacerbated this crisis and created a perfect storm of factors that has led to increased presentations of new eating disorder diagnoses across Canada, as well as internationally.

We know that biological and genetic factors interact with psychosocial challenges in the development of eating disorders. The psychosocial challenges in the context of the pandemic—including disruptions to daily routine, decreased opportunities for physical activity and increased social media use—are thought to be contributing to the surge in eating disorders.

In terms of the details of the surge, a report published by the Canadian Institute for Health Information reported that hospitalizations for young girls and women with eating disorders between the ages of 10 and 17 years increased by nearly 60% during the pandemic. Data from different Canadian eating disorders programs report similar or even larger increases.

Although the study is currently focused on mental health in girls and women, I want to highlight that eating disorders are diagnosed in people of all genders, all racial and ethnic groups, all body shapes and weight, and all socio-economic backgrounds. Eating disorders are a health crisis that can be fatal and, in fact, have one of the highest mortality rates of all mental health diagnoses. Because of that, intervention is really critical to prevent lifelong fatal consequences.

People with eating disorders experience a lot of barriers in accessing services. These barriers can include exclusion criteria for referrals or challenges in finding health care professionals who offer services for some eating disorder diagnoses. For example, services for an eating disorder called avoidant restrictive food intake disorder, also known as ARFID, which is a newly emerged eating disorder diagnosis, vary depending on where an individual lives, and typically are focused on pediatric services. Individuals with ARFID may present in a variety of mental health settings outside of specialized eating disorder services. Research from our group has demonstrated that health care professionals, particularly those who do not specialize in eating disorders, report very low confidence in providing clinical care for individuals with ARFID.

In looking for a path forward, we can look to our international colleagues who have developed innovative service models that can be adapted for a Canadian context. For example, Australia has created a national institute for research, translation and clinical excellence in eating disorders. In 2021, it released a national research and translation strategy for eating disorders. I would argue that the development of these national resources has contributed to innovative service models, including models that have focused on early intervention.

Similarly, in the U.K. there's a new intervention known as the first episode rapid early intervention for eating disorders model, or FREED, which focuses on rapid response to referrals with benchmarks for service provision, including telephone screening within 48 hours of referral and assessment in less than two weeks of referral.

As the committee looks for pathways forward, I want to highlight the existence of the “Canadian Eating Disorders Strategy”, which was published in 2019. It's a 10-year strategy outlining 50 recommendations for improving outcomes for individuals with eating disorders. These recommendations remain relevant today. They were developed in collaboration with the four national Canadian eating disorders organizations together with input from stakeholders.

Thank you so much.

● (1120)

The Chair: Thank you for your intervention.

We'll now go to the Canadian Mental Health Association. We have with us today Sarah Kennell, national director, public policy.

Sarah, you have five minutes.

Ms. Sarah Kennell (National Director, Public Policy, Canadian Mental Health Association-National): Thank you very much, Madam Chair.

Good morning, esteemed colleagues.

The Canadian Mental Health Association is the most established and extensive community mental health organization in Canada, providing advocacy, programs, supports and resources that prevent mental health problems and illnesses and that support recovery. We reach 330 communities in every province and the Yukon, engage 11,000 volunteers and employ over 7,000 staff.

Age and gender are major determinants in accessing mental health supports. According to Mental Health Research Canada, women under 25 are overrepresented among those with anxiety, stress and depression, and are less likely to seek out mental health supports, citing an inability to pay or not having enough insurance to cover them as barriers.

In the past 10 years, suicide rates among women have overtaken men in the 10- to 14-year age range. Girls are six times more likely to develop general anxiety disorder than boys, and there is a marked increase in the incidence of major depressive episodes among girls over the age of 13, compared to boys.

Structural inequalities in our mental health system exacerbate these gender-based inequalities. Canada's universal health system isn't universal at all. For services to be covered, they must be deemed medically necessary under the Canada Health Act. Mental health and substance use health services delivered outside of hospitals and by physicians are not considered medically necessary. This means that services like counselling, psychotherapy and substance use health treatments, for example, fall outside of our public health system, leaving people to rely on limited insurance benefits or to have to pay out of pocket to get the care they need.

Many turn to not-for-profit organizations to access these services. Long wait-lists, geographic barriers, system navigation issues, cost-prohibitive care and lack of access to community-based supports compound and intersect along gender and age lines.

From speaking with young women with lived experience of mental illness and the frontline mental health care providers who support them, we know that young women and girls face particular challenges navigating the system. They can feel a lack of agency and powerlessness, and that recovery depends on the privilege of income and time. Speaking to interactions with the acute care system as young women, they describe needing to be in crisis or sick enough to get the care they need, and being left to navigate the system by themselves, without access to community-based supports once discharged.

Power dynamics rooted in patriarchy perpetuate harmful gender stereotypes that permeate the mental health care system. When seeking mental health supports, young women can be perceived as "overdramatic", resulting in barriers in access to care. One woman spoke about the gendered ways in which physicians can impose judgment and pressure to adhere to treatment plans, saying specifically that they promoted medication over therapy-based treatments, despite concerns raised about risks associated with such medications, including suicidal ideation. Speaking specifically about eating disorder treatments, we heard about young women being released from treatment if they were non-compliant or if they failed to meet treatment goals.

On the issue of suicide among young women and gender-based stigma, research suggests that they're "attention-seeking" or "manipulative" and not taken seriously. Current responses to suicidality often fail young women by not creating the supportive environments to truly meet their needs when they are seeking help.

Upstream mental health promotion initiatives delivered by community-based organizations—like social and emotional learning, mental health literacy and comprehensive sexuality education—lead to healthier relationships, reduced bullying and improved self-esteem by addressing toxic masculinity and harmful gender stereotypes. These programs critically meet the most vulnerable in our communities and yield strong returns on investment. Connection, wraparound supports, follow-up and gender-sensitive and age-appropriate care are equally important.

The existing supply of such programs cannot meet the rising demand, but the federal government can help. Most critically, the federal government can create the promised Canada mental health transfer. CMHA is calling for the equivalent of 12% of provincial and territorial health expenditures—or $5.3 billion expensed annually—with 50% earmarked for community-based services, accompanied by a Canada mental health and substance use health act to bring permanency and accountability to the transfer.

● (1125)

Bringing an intersectional, gendered lens to mental health helps us better understand the different needs of women, girls, trans women and non-binary people and how best to respond to those needs. Left unaddressed, mental health issues experienced at a young age can turn into more serious mental health issues later in life.

As a country, we've failed to invest in mental health and substance use health, and it shows. CMHA looks to this committee for support in making mental health a priority now.

Thank you.

The Chair: Thank you so much.

Finally, from the Mental Health Commission of Canada, we have president and chief executive officer Michel Rodrigue.

Go ahead. You have the floor for five minutes.

[*Translation*]

Mr. Michel Rodrigue (President and Chief Executive Officer, Mental Health Commission of Canada): Thank you again for your time on this critical issue. I'm honoured to be able to appear before you to discuss such an important subject, the mental health of young women and girls.

The Mental Health Commission of Canada leads the development and dissemination of innovative programs and tools to support the mental health and well-being of Canadians.

[*English*]

With regard to your committee's study, the commission's researchers have noted a gender paradox, where men are more likely to die by suicide; however, women are more likely to attempt suicide. For us, there is a clear opportunity to support women and girls early on in their lives, so that they have the tools they need for mental well-being during their entire lives.

In 2023, the commission will be embarking on a suicide prevention effort among women and girls. We would be pleased to come back to this committee to share some of the findings.

I am also happy to see ABRAR Trauma here today. The MHCC was pleased to recently partner with them on Dil Ba Dil, a program for Afghan newcomer women.

I would now turn to my colleague, Dr. Mary Bartram. As well, we have Shaleen Jones online, who is a member of the commission's Hallway Group. It's composed of people with lived and living experience of mental illness. She is also the executive director of Eating Disorders Nova Scotia.

I'll pass it over to you, Mary.

[*Translation*]

Dr. Mary Bartram (Director, Policy, Mental Health Commission of Canada): Thank you, Mr. Rodrigue.

Good morning, everyone.

[*English*]

I am pleased to be here to provide a bit more information about the Mental Health Commission of Canada's research and programming.

Findings from our COVID polling with the Canadian Centre on Substance Use and Addiction were very clear and concerning. Mental health and substance use concerns were greater for youth overall and differed significantly by gender. We'll table a more detailed report soon, but here are a few highlights.

Half of young women aged 16 to 24 and one-third of young men reported moderate or severe anxiety symptoms. Again, that's half of young women and a third of young men over the course of the pandemic.

When it comes to substance use health, two in five young women who use cannabis reported problematic use, as well as three in five young men. These impacts are compounded for youth who identify as 2SLGBTQ+, report low incomes and are from ethno-racialized communities.

The MHCC is developing a lens for mental health policy and programming that integrates sex and gender, as well as intersectionality, anti-racism and decolonization, to name a few. Again, we would be pleased to come back to share more with this committee as that work develops, as it may be of interest.

We also have several programs that are making a difference for young people, including young women and girls. For example, over the past year, over 800 teenage girls participated in our Headstrong anti-stigma summits. We also offer training on mental health first aid supporting youth, and we work with campuses across the country to adopt and implement the national standard for mental health and well-being for post-secondary students.

I am pleased now to turn things over to Shaleen Jones, who will speak more on an important mental health priority, which is eating disorders.

Thank you.

● (1130)

Ms. Shaleen Jones (Executive Director, Eating Disorders Nova Scotia, Mental Health Commission of Canada): Thank you all so much for inviting us here to speak about this really important issue.

I want to echo what we've heard from a lot of the panellists. I am a survivor of an eating disorder, and we know that eating disorders are complex, common, serious illnesses with the highest mortality rate of many mental illnesses. In the mental health community, we've been calling the alarm on eating disorders for 20 years, and we are in a grave situation. Indeed, this is a crisis point. We know that, with rapid access to early intervention, treatment and support, people can and do go on to lead fulfilling lives and are able to fully recover from this illness, but too many are denied the opportunity to recover.

I want to call upon all aspects of our community to enable several recommendations, again, streaming from the work done by the national eating disorders groups. We need rapid access to low-barrier support, including peer support, support for families, training for clinicians and training on early intervention for primary health care providers, and finally, funding for community-based organizations, which are picking up an incredible burden supporting folks with eating disorders.

Here at my organization, Eating Disorders Nova Scotia, we have been providing peer support to folks of Nova Scotia for the past 20 years. We're now extending this across Canada because the demand is so great.

I look forward to working more on this issue collectively with you all. Thank you.

The Chair: Thank you very much, Shaleen. Thank you very much for being here and supporting what we're doing.

We are going to our rounds of questions. To start our first round, each questioner gets six minutes. I'm going to pass it over to Michelle Ferreri for the first six minutes.

Michelle, the floor is yours.

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

Thank you to all of our witnesses. It's nice to see some familiar faces here.

If I may, I'm going to address this question to two groups, so I'll give one person a chance to think about it. The other person will have to answer it right off the hop.

Sarah, may I call you Sarah?

Michel, may I call you Michel?

I'll start with you, Sarah. I think we've made great strides in convincing people not to be afraid to ask for help, so now we have a lot of people who have overcome that hump and they're ready to ask for help, in particular children or parents of children. They're ready to access help. They take that brave, courageous step, and then there's nothing there for them when they do ask.

What is the number one thing we can do as a federal government to close that gap in access to treatment for mental health supports?

Ms. Sarah Kennell: I couldn't agree more. We've done much great work on raising awareness, breaking down stigma and addressing the discrimination associated with mental illness and substance use health, but the challenge really is in where you go for help. We shouldn't have a country where, in order to get the help you need, you need to be in crisis. Crisis means going to hospitals to get the care you need. We need to have more cost-effective and community-based care.

The role of the federal government is, in my opinion, in directing resources to provinces and territories to fund community-based organizations. That's that out-of-hospital care that people rely on in community. It's culturally appropriate. It's trauma-informed. It's age- and gender-sensitive. It's integrated youth hubs, for example. Really, it's about ensuring that we're allocating those federal dollars, both through the health funding that is transferred to provinces and territories, and through direct investment through grants and contributions from federal departments to those community-based organizations doing that work.

Ms. Michelle Ferreri: Thank you so much.

Michel, do you want to add to that?

Mr. Michel Rodrigue: Sure, thank you for that.

I will readily say that it's complex, but a couple of things really come to the forefront. The first is still the need to continue on prevention, and part of that is making sure that, in elementary school and secondary school, people learn how to speak about mental health and mental illness. Mental health literacy is so key.

Ms. Michelle Ferreri: May I add to that? That was one of my next questions. Do you think mental health first aid should be readily available to everyone who is working with children—caregivers, coaches, etc.—as well as age-appropriate mental health first aid for young children in the education system?

Mr. Michel Rodrigue: I very much think so. I think it's time for that to be pervasive throughout our workplaces for whoever works with children and teenagers, and it's time to create safe post-secondary campuses.

Ms. Michelle Ferreri: I'm a big ambassador of mental health first aid.

My next question for you, Michel, if you don't mind, is about the tax on psychotherapists. For people who may not be familiar with this, right now there is a tax that psychotherapy is getting that other service providers like psychiatrists are not.

Have you had an answer from Finance Canada as of yet as to why psychotherapists are being taxed and other providers are not?

● (1135)

Dr. Mary Bartram: I'll take this one. Thank you.

The whole issue around the regulation of psychotherapists is a priority in Canada. We have five provinces that are regulating psychotherapy or counselling therapy. The issue of tax is tied to the regulatory status of psychotherapists. If we can complete the regulation of psychotherapy across the country, I think this issue will work itself through to be on par with other types of health care providers.

I can add as well that the issue of a need for a national mental health and substance use health workforce strategy that addresses this among a range of other issues, as part of the prioritization of the health workforce right now, is another area where the federal government could have a role to play in making sure that the focus on the health workforce includes a variety of issues related to the mental health and substance use health workforce as well.

Ms. Michelle Ferreri: Do you know what the holdup is on why the regulation hasn't happened for psychotherapy?

Dr. Mary Bartram: Again, these are complex issues that get played out at the provincial level in terms of whether it advances or not. Most provinces have pre-regulatory bodies in place, so a federal push might be something that could be of assistance in getting those processes over the hump.

Ms. Michelle Ferreri: I know I don't have a lot of time left, and this is a very loaded question. I'm going to drive it to you, Sarah, because you addressed it a little bit in my first question. What needs to be changed in the Canada Health Act in order to make mental health care accessible to everyone?

Ms. Sarah Kennell: Thank you.

A reopening of the act and a clarification on the list of medically necessary services would go a long way to ensuring that the services that are now left out of the system are integrated. I mentioned counselling, psychotherapy, substance use health treatment—the services that we now rely on insurance or paying out of pocket for.

That is one avenue. An alternate avenue is to create a parallel Canada mental health transfer and an accompanying act that would create dedicated funding for those services that fall outside the system.

Ms. Michelle Ferreri: A dedicated $4.5 billion was promised by the federal government to mental health transfers. Where is that?

Ms. Sarah Kennell: That would be a question for Minister Bennett.

The Chair: Thank you so much. We will get back to you.

I'm now going to pass it over to Sonia Sidhu.

Sonia, you have the floor for six minutes.

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

Thank you to all the witnesses for their insightful testimony.

Ms. Coelho, we know that eating disorder admissions are on the rise in the ER. What do you think is the role of social media around that? Do you think social media has also had an impact there?

Dr. Jennifer Coelho: As we're hearing some of my fellow witnesses highlight today, it's complex. When we talk about the perfect storm of eating disorders, the increased use of social media is one factor that has been highlighted. At the same time, we know that social media in and of itself does not cause eating disorders.

I think what's challenging is that we're also in a context of what is known as "normative discontent". I think a lot of girls, young women, boys, and transgender and non-binary individuals have challenges with body image and may be trying to change their body image. It may not go to the point of an eating disorder. I think some of the witnesses were highlighting the importance of prevention in mental health. Body image is a factor of well-being that fits within that. I think that's where some of the main concerns around the impact of social media also lie, not only in clinically diagnosable eating disorders.

Ms. Sonia Sidhu: Thank you.

Professor Afifi, my colleague just raised the issue of education in terms of helping with mental health. When parents are open with their children about mental health, parents can support their kids, but there's also the educational side. How can we fill that gap?

● (1140)

Dr. Tracie Afifi: Thank you.

I agree with being able to focus on prevention, as was mentioned here already. We want to make sure that when children are having difficulties, the sooner they have access to care, the better. Again, repeating what other people have said, we don't want to wait for anyone—children or adults—to be in crisis before they get care, so it's about education in terms of how they can talk about their mental health and also giving them resources, both to the parent and to the child.

The parent and child have to be a unit to help the child. We can't just focus on giving skills to the child. The parent may also need skills in order to be able to handle even their own stress and concerns, perhaps, and then to also be a support for their child.

We need to make sure that access to care is early. We can't wait until a child is 12 years old or an adult of 18. We need to be starting really early. Then, when people have concerns with mental health and reach out, those services need to be in place across the country in all locations, because when you have an issue with mental health and you're told that you need to wait six months or 12 months, that's the worst news you can possibly hear, as a parent or as a child. When you need help, you need help now.

We need to be able to make sure that when people are asking for help those services are in place for everyone in the country.

Ms. Sonia Sidhu: Thank you.

I want to go back to Dr. Coelho.

We know that the pandemic has created a demand for virtual care delivery for eating disorders too. Is virtual delivery a factor when it comes to eating disorders? I just wanted to know that.

Dr. Jennifer Coelho: There was a Canadian consensus panel that put out guidelines for treatment of pediatric eating disorders, and then last year there was an addendum. There was an analysis of virtual care for eating disorders with recommendations that there is emerging evidence to support this approach.

In fact, although there are challenges in some rural and remote areas in terms of Internet access, it may be an approach that allows more equitable access for individuals, because the eating disorders programs in Canada tend to be based in urban and suburban situations geographically.

Many programs are using this with great success, and there's emerging evidence about virtual approaches.

Ms. Sonia Sidhu: Thank you.

My next question is for Ms. Mechmechia.

You talked about racialized women and how they can get mental health services. We heard about some barriers to that, and we heard from Ms. Kennell about community-based programs. Where is that gap and how can the federal government improve that gap? Both of you can comment if you want.

Ms. Abrar Mechmechia: Thank you so much for your question.

Just to clarify, do you mean the gap in how the federal government can give funding to community-based resources or services to support racialized women and marginalized populations and young girls?

Ms. Sonia Sidhu: The first part is about how the community organizations can help newcomers or racialized women.

Ms. Abrar Mechmechia: That's a great question.

It's about supporting them with early intervention and mental health support that is catered towards the trauma they have and the culture they come from, for example, especially now that we are open to a variety of cultures like Syrian, Afghan, Middle Eastern, etc.

First is providing that type of support. The other thing is creating more safe spaces. The first support would be providing early intervention and peer support—

The Chair: Abrar, you're going to have to get back to that answer, because we're quite a few seconds over time. We will come back to you.

I'm going to turn the floor over to Andréanne.

Andréanne, you have the floor for six minutes.

[*Translation*]

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

Thank you very much to the witnesses who are here this morning.

If I understood correctly, the guidelines are prevention, in other words, proactive work, and awareness, especially with young girls and children.

Since the 1970s, Quebec has been a pioneer in prevention and is proud of its community-based model. Social pediatrics has developed significantly, and there are centres throughout the province.

I had a call this morning from the Centre de pédiatrie sociale en communauté Main dans la main, which is currently getting ready for its annual charity drive, scheduled for December. The centre is required to raise funds to finance all the services it offers. I would like to remind you that these workers do prevention work with the most disadvantaged families, where there is violence, and they do an exceptional job.

I also had a discussion this summer with a suicide prevention centre in my riding. This centre already has a prevention program in the workplace and in different locations, and it does mental health and suicide prevention. The people I spoke to told me about the labour problem they're facing, and they can't afford to pay the staff adequately.

These are some examples of projects and programs for which the Government of Quebec would like to provide more funding in order to help these community groups even more. In Quebec, this is done through the ministry of health and through transfers.

Ms. Kennell, you talked about the importance of having the means to provide financial resources to organizations. Beyond what is being done in our health care system, the entire community network works on the ground every day to do prevention and, often, to respond to emergency situations, filling in the gaps for people who don't know where to go.

So I'd like to come back to the importance of these transfers. As I said, there are already projects in place. Can you talk about the importance of avoiding the duplication that occurs when the federal government tries to impose conditions when programs are already in place? Could you also tell us more about the importance of financial resources?

● (1145)

Ms. Sarah Kennell: Thank you very much, Ms. Larouche.

[*English*]

I agree completely. I think it's about scaling up and supporting existing initiatives that we know are evidence-based and that we know get the results we want to see.

I will comment on two things. One is the salary equity issue.

[*Translation*]

Pay equity is really an extreme priority across Canada. Social workers aren't paid enough.

[*English*]

We have to create pay equity across our acute and non-acute hospital-based and non-hospital-based health care settings.

The other issue we are experiencing is that not only are our frontline mental health care workers who are working in the community working at a reduced salary; they're also experiencing higher levels of burnout and stress. They are leaving the profession, often going to the private sector, and leaving community-based organizations without the adequate staffing needed to sustain scaling up and bring sustainability to their programming.

When it comes to the Canada mental health transfer, as I said, we need to see 50% earmarked for community-based care. We know that investments are already going to hospitals and physicians through the Canada Health Act. The Canada mental health transfer has the opportunity to redirect resources to the sector, which has been starved of resources for decades now. That's a problem created by the Canada Health Act.

By creating a Canada mental health transfer, we can see an influx of resources to these organizations.

[*Translation*]

As you mentioned, Ms. Larouche, these organizations need money and resources to adequately support their prevention programs.

Ms. Andréanne Larouche: That's interesting.

Ms. Kennell, when we asked you what was going on with the $4.5 billion of the original Canada mental health transfer investment, you told us to ask Minister Bennett.

Personally, when I hear about transfers and conditions, I often hear that funding is provided on a project-by-project basis, under certain threats. What community organizations, Quebec and the provinces are asking for is stable, permanent and predictable funding.

The $4.5 billion is fine, but it's more like a one-time, project-based amount. It isn't consistent with the demands of community groups on the ground and of Quebec, who want to plan for long-term funding for their health care system and to know what portion of the funding is earmarked for mental health.

I'd like to know more about the importance of stable, recurring and predictable transfers and their substantial increase. At the moment, federal health transfers are barely equivalent to 21% of the total costs of the system, whereas we want them to be 35%. We've heard several figures this morning. How important do you think it is to reinvest massively in the health system?

● (1150)

Ms. Sarah Kennell: I'd like to clarify that it's a permanent transfer, not a one-time transfer for five years. We hope it will begin next year, in the 2023 budget.

[*English*]

We want to create a parallel track of funding, because we're seeing organizations having to apply for short-term grants, often pilot projects, that prevent them from being able to build sustainability, retain staff, recruit staff, and pay them adequately. Rather than seeing community-based mental health as a charity that's offered by small donations here and there, we really want to institutionalize the system. We see it as part of our health care system—which mental health is.

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

We're now going to pass it over to Leah Gazan, for six minutes.

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

My first question is for Abrar Mechmechia.

You spoke a bit about one of the barriers being the cultural competency of the therapists providing care. You gave an example of the Islamophobic attacks that happened in Ontario, and the impact on mental health.

My riding of Winnipeg Centre is rich with diversity, but I would agree with you that we lack appropriate care, culturally competent care, particularly for newcomer youth and adult women, who have often experienced things like war trauma.

I want you to speak to that, but because I don't have a lot of time, I also want you to speak about art therapy. We have a program called Artbeat, which provides internships for people who are experiencing mental health issues.

Could you speak to the importance of art as a therapy?

Ms. Abrar Mechmechia: To comment on the first part, it's amazing that Winnipeg has diverse backgrounds and is doing great in terms of having more variety and culturally sensitive supports. In order to add to that, we need to have community-based organizations, as mentioned by Sarah, that provide early intervention and safe spaces for newcomer women and immigrants. They need to understand the trauma that these newcomers bring, speak their language, and be from their culture.

When you don't have the words, art is a great way to express yourself, and a great way to heal. We did find art therapy to be super effective when I used to work back home with war survivors, and currently. I have led many art therapy workshops with newcomer immigrants. Those who lead the art sessions are also from the same culture. Especially with a language barrier, art could be a really good alternative to give them the space to express their trauma and feelings.

Ms. Leah Gazan: Thank you so much.

My next question is for Mary Bartram.

You spoke a bit about consumption. Our party, the NDP, put forward a bill regarding a health-based approach to substance use. It was defeated, unfortunately.

The British Columbia Centre on Substance Abuse said:

> As well, we must end racism and sexism against Indigenous women, girls and two-spirited people as described in the Report of the Murdered and Missing Indigenous Women and Girls. In 2020, women accounted for 32 percent of toxic drug deaths amongst First Nations people in BC, twice the rate of the general population.

Another article stated, “The coroners service in British Columbia says more females are dying from illicit drug use.” I'm sharing this because I find that as elected officials, instead of taking a public health approach to toxic drug supply use, which is impacting certain groups more prominently than others....

Why is it important to take a health-based approach to consumption, rather than an approach based on stigma?

● (1155)

Dr. Mary Bartram: Absolutely, we need health-based approaches to the issues around deaths from toxic drug supplies and to the mental health and substance use impacts of the pandemic more broadly as well, which, as you know, has been closely intersecting with some of the issues you raised.

Again, a health-based approach with a focus on prevention, social determinants, reducing risk factors, adequate funding for equitable access to quality care that's culturally competent, and the importance of having the right capacity in the system to respond to those emerging needs.... All of those pieces are very much part of a health-based approach and very important.

Ms. Leah Gazan: I ask that because, in Manitoba, we recently got a first-of-its-kind peer support van. We don't even have safe consumption sites in Manitoba. Even a peer support van was difficult because of stigma. Because of the fact that people who are suffering from addictions are so stigmatized, there seems to be this idea that they don't even deserve support when they're using.

Would a federal response to this overdose crisis, rooted in mental health, often mental health and trauma, be helpful?

Dr. Mary Bartram: I think the federal government is working on several fronts around substance use stigma and around the overdose crisis, but we see that this crisis is still impacting the country in a very deep and profound way, so I think more is always helpful.

Ms. Leah Gazan: Would decriminalization—

The Chair: We'll get back to you, Leah. We'll give you some more time.

We're now going to go to our next round, and it's going to be five minutes each.

I'd like to turn the floor over to Anna Roberts.

Welcome, Anna, to FEWO.

Mrs. Anna Roberts (King—Vaughan, CPC): Thank you very much. It's a pleasure to be here.

Thank you, everyone.

My first question is for Ms. Jones, on eating disorders.

I recently met with some young children who were bullied at school because of their shape, size, whatever. I approached the teachers on education, on how we are educating young students because, let's face it, the younger they are, if they develop a certain skill or they develop a certain—and I shouldn't say this—nasty attitude, it will continue with them for the rest of their lives. How can we improve education at that level?

Ms. Shaleen Jones: That's a great question.

I think you've hit upon something really important here, which is that we have to look at young people in the context in which they lead their lives. While it's important to do health promotion in the schools, early intervention for eating disorders and work around body image, it's also important to recognize that they are surrounded by adults. We also bring our own prejudices around weight, shape and size and our own judgments around what is healthy.

I think really looking at systems and how we address weight stigma and healthism within systems that are surrounding our young people is essential.

Mrs. Anna Roberts: Thank you for that.

I'm new to this committee. I understand that the government has promised $4.5 billion to assist with mental health disorders.

We've just gone through the worst two and a half-plus years with COVID, when a lot of young children became depressed. A lot of them developed eating disorders because they were bored. They couldn't get out, and they couldn't see their friends. They couldn't move on. I'm trying to understand why we're so slow in acting to ensure that we have taken aggressive procedures or aggressive manners to help in that area. What do you think we need to do better?

Ms. Shaleen Jones: That's the million-dollar question. In the 2014 report on eating disorders of women and girls, one of the witnesses said that if eating disorders were an illness that affected men like prostate cancer, there would be an eating disorders clinic on every street corner. I think it's valuable for us to take a gender equity lens to this issue and know that it impacts predominantly women and girls. Although, of course, it has impacted men and boys as well, it's seen as an illness that impacts girls and women, and it is seen as a feminine behaviour that stems from looking at Instagram too much and just not loving our bodies enough.

We've reduced it to an individual problem that girls just need to grow out of, snap out of and eat a sandwich. We've heard all of this. These are such complicated, metabolically and biologically driven, complex illnesses. I think we have been delaying taking action because of the lack of a gender equity lens to approaching eating disorders and because they are very complex. There isn't a one-size-fits-all solution to this.

● (1200)

Mrs. Anna Roberts: Thank you for that.

For my last question for you....

We talk about young children. We talk about the stats and generally this eating disorder is among young children. I recently met with a seniors group. I wasn't surprised to hear that some of these seniors—I don't know if you would refer to it as an eating disorder—given the cost of inflation, have had to reduce, let's say, their healthy meals to make sure they have enough money at the end of the month to support themselves.

Is there a program or do we have any stats on older individuals? In a lot of the homes, for a lot of the women—let's be honest, women outlive men; no offence to the men, but we all know the stats that this is the case—their pension or whatever is reduced once the spouse has passed on.

Are there any programs or do we have any numbers to find out about that?

Ms. Shaleen Jones: Yes, absolutely we can follow up with numbers on that. We know that eating disorders generally tend to start in adolescence, but for a variety of reasons, including lack of access to treatment, people still have them in mid-life and late life.

This isn't an illness that appears in adolescence and then disappears when they hit a magic number. We have a lot of folks within Canada who are currently adults and seniors and are still struggling with an eating disorder. We're also seeing disproportionate numbers of folks who are food-insecure and facing eating disorders.

Again, they're really complicated issues, but often they're connected to tremendous distress and lack of food availability.

The Chair: Thank you so much, Shaleen.

We're now going to turn it over to Jenna Sudds, who is onscreen.

Jenna, you have the floor for five minutes.

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

Good afternoon, everyone. My sincere thanks to all of the witnesses who have joined us today for their testimony and also for the incredibly important work they do each and every day.

My first question is for Ms. Mechmechia.

I know that one project you have under way—I believe it's called "Brave Space"—is helping to support Muslim women in particular after recent Islamophobic incidents in our country. I'm wondering if you can speak to us a bit about the impacts of Islamophobia on mental health for young women in the community.

Second, I'm thinking about world events that we're seeing, such as the tragic death of Mahsa Amini and this outcry and championing of women's rights in other parts of the world. I'm wondering if you can speak to that as well.

Thank you.

Ms. Abrar Mechmechia: Thank you so much, Jenna, for your question.

When we speak about the impact of Islamophobia, on a daily basis you face discrimination and racism. That absolutely leads to you feeling.... First, you're afraid to walk on the street. The participants we had at the pilot reported not feeling safe going out alone at night, not feeling safe being on the bus by themselves or needing to inform, for example, their friend or spouse that they're at this location. Especially after the incident, I personally did not allow my mom to go for a walk by herself because she wears a niqab. I was not going to risk it.

Feeling afraid and scared absolutely leads to feeling depressed and having a high level of anxiety and probably PTSD because it's trauma that leads to.... You're witnessing the trauma.

Anyway, there's also feeling slighted because there's not much support and you're feeling that you're being targeted.

I can speak a lot about the impact on mental health that women go through, especially after witnessing things like what's happening to other women in Iran, for example. I was having conversations with an Iranian girl and some of the professionals on the team just a couple of days ago. I was just checking on how they are feeling. They feel devastated. They wonder what support.... Also, the people who live in Canada and have families here don't know whom to turn to for support, to talk about their experiences and to explore that devastating feeling that they're going through.

When we did the pilot, we did four sessions. Now we have expanded it to eight sessions and we have applied to Islamic Relief for more support. Women wanted to be trained in self-defence techniques and that was surprising. It's not just the mental aspect. They don't feel safe even in Canada.

I don't know if I have more time to talk, but thank you so much for your question. I hope I gave you some insights.

● (1205)

Ms. Jenna Sudds: Yes. Thank you very much. I'm glad to hear that Brave Space is continuing.

Mr. Rodrigue, we've heard a bit today about some of the tools that are being used, the electronic tools, if you will, for mental health resources. Can you speak to whether these are being well received among youth? I ask that because I think part of the problem, as we've heard, is children gravitating toward technology and spending a lot of time on social media. I then posit, as a mother as well, whether, when a child is struggling with mental health issues, receiving health resources via Zoom or other electronic means is welcomed and effective.

Mr. Michel Rodrigue: Yes, it is welcomed. It is an efficient way to provide service when and where it's needed. It is as effective as face-to-face counselling, for instance. It is really part of that tool kit that we need to roll out. We need to prepare and support service providers, because they are not magically trained to provide that support.

Yes, text-based, Internet-based and phone-based ways are all very effective. For some, it's actually easier to interact, because they don't need to go into an office. There isn't that daunting element.

The Chair: Awesome. Thank you so much.

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

Andréanne, you have the floor for two and a half minutes.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

Dr. Afifi, you talked in your opening remarks about the importance and impact of family violence on mental health issues, as well as the importance of prevention in reducing violence that some women and some families may experience. As we know, it isn't just women who are affected, but children, too.

Quebec produced a report titled "Rebuilding Trust", which contains over 100 recommendations to specifically target intimate partner violence and the forms of violence that necessarily have an impact on families.

I'm also thinking about the whole issue of investing in groups that take in women who are victims of violence.

I spoke earlier about the fact that there is sometimes an attempt to complicate things or that there may be duplication of services. During the pandemic, transfers were made to shelters for abused women. It is important to invest more in these community groups that are working on the ground, and quickly, because they need resources to take in these women. There is a link between these financial resources and the help that can be given to women who are victims of violence.

Dr. Afifi, did you hear my question?

[*English*]

Dr. Tracie Afifi: Yes. I heard more of a statement than a question. Are you asking if these funds are helpful in reducing violence?

[*Translation*]

Ms. Andréanne Larouche: What I mean is that there are, for instance, community groups on the ground working on projects to take in more women, but the federal government has tried to impose conditions on its transfers. However, the Government of Quebec already had an agreement with these groups and wanted the money to be transferred to them as quickly as possible.

Trying to impose conditions or standards sometimes creates duplication of service or slows down transfers. Increasing support for these groups that help women is crucial because it has a direct link to mental health.

● (1210)

[*English*]

The Chair: We had only two and a half minutes there, so we don't have time for that answer.

Andréanne, if you want to hold on to that, we can come back to that when it's your turn again.

I will pass the floor over to Leah Gazan for her two and a half minutes.

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

My question is for Sarah Kennell.

Going back to my last question, Manitoba is talking about the peer support, and that was an issue. In Manitoba, we've had more people die of overdose in the past year than I've ever seen. I think it's over 500, which is a lot for a city the size of Winnipeg.

Would decriminalization assist? I say this because my thinking is that people, if they feel they're going to get in trouble for getting help, for being open about issues.... Would decriminalization assist individuals to get help? I say that in regard to women, because in the B.C. study, the BC Coroners Service says that more females are dying from illicit drug use. It says that while men have historically accounted for nearly 80% of fatalities, more than 26% of those who died in April were female, continuing a trend that began earlier this year.

We know that the rate of deaths among women and young women is going up. Would decriminalization help?

Ms. Sarah Kennell: Thank you for your question, Ms. Gazan.

Yes, we know that research demonstrates that the impact of the criminalization of substance use not only leads to deterring people—particularly marginalized, vulnerable people, including women, trans women and non-binary folks—from seeking care, but it also delays access to care and further pushes them underground, where they have fears of arrest, fears of criminalization and fears of child apprehension.

The system that surrounds criminalization actually has a ripple effect that is worse. CMHA is advocating for a nationwide approach to decriminalization to respond to that.

Ms. Leah Gazan: Would you say that stigma around addiction and drug use is in fact costing lives in terms of a failure of elected officials to support decriminalization in spite of the public health research?

Ms. Sarah Kennell: We know that taking a health-based approach leads to positive health outcomes, reduced arrests and reduced criminalization, which ultimately benefits society as a whole.

Ms. Leah Gazan: In fact, it's almost like a crime prevention strategy.

Ms. Sarah Kennell: A health-based approach reduces criminalization, yes.

The Chair: We're now going to pass it back to Michelle Ferreri.

Michelle, you're back to six minutes.

Ms. Michelle Ferreri: Thank you, Madam Chair.

Thank you, again, to our witnesses. Thank you for being here for this.

I'm curious if we can touch on.... I believe it was Ms. Jones. May I call you Shaleen? Today, ironically, Uber is making cannabis available for delivery in Toronto. I'm really curious about your thoughts on what the impact will be. I guess I will boldly ask you if you think cannabis should be as readily available in Canada as it is.

Ms. Shaleen Jones: Is this question for Shaleen Jones?

Ms. Michelle Ferreri: Who spoke about the cannabis? Was it Mary?

I'm sorry about that, Shaleen.

Go ahead, Mary.

Dr. Mary Bartram: Because of the Cannabis Act, there's a regulatory framework for making cannabis available under certain restrictions. The Cannabis Act is currently under review, which just opened up a few weeks back.

It's very difficult to know whether legalization has driven the increased rates of cannabis use among those who use that, as I mentioned earlier, or how much of that is part of the response to the stresses and distress during the pandemic, with the social isolation and that whole constellation of mental health and substance use impacts.

I think the answer to your question is going to be examined over the review of the Cannabis Act. We have a suite of research on the relationship between mental health and cannabis, which the Mental Health Commission has been funding for the past five years, so we look forward to bringing those findings into that conversation. It's not a direct answer, but nevertheless it's the one that I would give.

● (1215)

Ms. Michelle Ferreri: I think it's an important conversation to open up. There's a distinction, obviously, between recreational and pharmaceutical use, for sure, and I want to be clear on that. Where I'm going with this is.... We do have an increase in stress and maladaptive coping mechanisms, not just for adults but for children as well as they try to navigate the social stress that's been put on them. Now there is an affordability crisis, which we've heard from other witnesses is downloaded to the children.

Would you want to see research on what happens to those young people with developing brains who are turning to cannabis as a maladaptive coping mechanism because they don't have access to the support or healthy coping mechanisms that should be available when they need help or counselling?

Dr. Mary Bartram: I absolutely think, 100%, that children and young people who are experiencing mental health concerns should have access to high-quality treatment that's culturally competent and equitably funded, with low financial barriers.

The other parts of the question are packed with too many things to be able to give a resounding yes, but we need access to care for people across the lifespan. Intervention at an early age, such as making sure that kids, in particular, have access to those services and supports early on from a prevention perspective, is also incredibly important.

Ms. Michelle Ferreri: I'd love to see stats and data put forward on the impacts of the use for those who are turning to cannabis as a maladaptive coping mechanism, for that developing brain.

I'm going to turn to Jennifer from BC Children's Hospital. Do you have any stats on the mental health of the mothers of the young women you are treating?

Dr. Jennifer Coelho: When you say “stats”, do you mean in terms of their well-being generally?

Ms. Michelle Ferreri: Yes. Do you see a correlation between mothers who suffer from anxiety or depression or who are diagnosed with a mental illness and young women who are developing eating disorders?

Dr. Jennifer Coelho: What I really want to highlight is that we know that parents are actually the best resource for supporting their child. Parents are the ones who know their child best. Even parents who have their own mental health concerns, whether anxiety, depression, or their own eating disorder, can be the best support. In one of our evidence-based approaches.... Family-based treatments for eating disorders can be helpful regardless of what mental health concerns parents bring.

At the same time, we know that having a child with an eating disorder is very stressful. One of the factors that we talk about with families is the cliché that you need to put your own oxygen mask on in the plane before you can help a child. If a parent's mental health concerns are interfering with their own ability to function, of course this is going to have an impact on their ability to support their child with an eating disorder, and other children in the family as well. We know that siblings can also be impacted when there's an eating disorder in the house or when parents are not able to function well because of their mental health concerns.

Ms. Michelle Ferreri: Thank you so much.

The point I'm getting across is looking at investment in the mother. When we look at young women's mental health, we see that when we have a mentally healthy mom, there's a good chance of having a healthy child—that co-regulation.

I don't know how much time I have left. There's none. Then I won't even ask my question.

● (1220)

The Chair: Thank you so much.

I'm now going to Marc Serré for six minutes.

Marc, you have the floor.

[*Translation*]

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

Thank you very much to the witnesses. Five or six minutes isn't much time to ask questions.

Mr. Rodrigue, you talked about elementary and secondary schools, the importance of which was also emphasized by stakeholders in British Columbia. The federal government is in the process of negotiating a bilateral agreement with the province. There's also the $4.5 billion Canada mental health transfer that has already been mentioned.

What recommendations do you have for the federal government, given that elementary and secondary schools are under provincial jurisdiction? Since it's very important to look after young people, what role can the federal government play in working with the provinces to focus on young people?

Mr. Michel Rodrigue: Thank you for your question, Mr. Serré.

It's essential to have a clear picture of the federal government's role. As elected officials, you can put in place a dedicated mental health transfer, which is particularly important.

We know that the provinces have major problems in health care and that too often it's because of the stigma attached to mental health. When tough budget choices are made, mental health is left behind.

So I strongly recommend that dedicated transfers for mental health be put forward to allow provinces to determine the investments they deem most important. I hope that prevention in elementary and secondary schools, as well as at the post-secondary level, will be among those priorities.

Mr. Marc Serré: That's great, because today's meeting is about youth prevention. That will help us a lot.

Dr. Afifi, you said that wait times for violence prevention need to be reduced. You also mentioned the lack of data, using statistics from the U.S.

What are your recommendations for the federal government to enrich the conversations on this issue and to ensure that the money goes to evidence-based psychological treatments?

How can we ensure that we are using the right data to target the work that needs to be done in mental health, especially with youth?

[*English*]

Dr. Tracie Afifi: Thank you for the question.

We have a great opportunity to collect data in Canada through Statistics Canada, and we don't take advantage of that. We have a lot of health surveys that are in place. Some are focused on children and children's health. We could very easily be putting indicators of violence and adverse experiences that children could have into those surveys. We can do that for adult surveys as well. This isn't a new thing to suggest.

Statistics Canada has some measures in some studies, but they're very limited. Sometimes, when the study comes up to run again, those measures are often the first to be pulled out and it sometimes becomes a big conversation about why we need them in there.

We have the infrastructure in place to easily collect that data. We need to understand the importance of it and recognize that countries all over the world collect very high-quality data in a very safe way, so Canada is behind in this. We need to have more data in Canada, so that we can make evidence-based decisions with Canadian data.

Mr. Marc Serré: That's good. Thank you very much.

Sarah Kennell, thank you so much for the work you do. Pat MacDonald at the Sudbury Canadian Mental Health Association and her team in greater Sudbury also do amazing work.

You mentioned the 50% earmarked as a condition from the federal government to the provinces for community-based agencies. If we look at.... We talked about decriminalization. We're looking at B.C. We have an agreement with the province of B.C. In Sudbury, for example, there's a safe consumption site that was just put up. It was funded by the federal government and the city. The province did not want to fund it.

What happens when some provinces don't want to look at community-based agencies, some of the conditions or safe consumption sites? What recommendations do you have for the federal government to deal with this?

● (1225)

[*Translation*]

Ms. Sarah Kennell: Thank you for your question, Mr. Serré.

[*English*]

The reality is that there is community-based mental health and substance use health service delivery across the country right now. It's organizations like my colleague Abrar's that are creating service and meeting need because of the demand.

The challenge is that these organizations operate on shoestring budgets and don't often have reliable funding from their provincial or territorial governments that allows them to scale up and expand service delivery to meet that rising demand. It's demand, frankly, that was there prepandemic.

My recommendation to the federal government is to collaborate with provinces and territories to identify those best practices and the organizations that have strong track records, and to bring those organizations into provincial and territorial funding mechanisms, which are often there. We have great models in Ontario and British Columbia of funding for community-based care.

Regarding the issues of safe consumption and safe supply, these programs are popping up across the country. We know that there's peer support and there are buses in Winnipeg. There are great examples of work being done already. Police departments are great allies, as are paramedics. Ally with those organizations that are already doing the work. They're at the forefront.

The Chair: Excellent. Thank you so much, Sarah.

We'll move back now to Andréanne, for six minutes.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

I'll try to find some information in the preliminary notes, but I'd like more explanation.

Mr. Rodrigue, you talked about a gender paradox in suicide prevention. Could you elaborate on that? What is this paradox?

Dr. Bartram, you can respond as well, if you wish.

Mr. Michel Rodrigue: The reason for this paradox is complex to explain.

Dr. Bartram, do you want to respond?

[*English*]

Dr. Mary Bartram: Sure, I can speak to that.

The gender paradox in completed suicides and suicidal ideation is fairly well established. We know that women, young women and girls are more likely to experience symptoms of depression and anxiety, which are also closely connected to suicidal ideation. Gender socialization clearly has something to do with why women and girls are more likely to have these expressions of distress. Men and boys have tended historically, and we've seen through the pandemic as well, to express those types of things with a higher degree of problematic substance use, so we see those statistics come out over and over again.

Surprisingly, women have been more likely to express thoughts of suicide, and men tend to die by suicide. Access to means and knowledge about means are more concentrated among men than women. As Michel mentioned, the importance of better understanding of the experiences of women and girls is something on our agenda for next year. We just completed a study around men and mental health and suicide prevention. We want to extend that to look further into the issues related to women. We see gender roles playing a big part in all of this, as well as some of the issues that Sarah mentioned around how those shape people's agency in our society.

[*Translation*]

Ms. Andréanne Larouche: Thank you very much.

Dr. Coelho, you talked about Australia in your opening remarks. Are there any models in other countries that the committee could draw on in its work on mental health?

[*English*]

Dr. Jennifer Coelho: Absolutely, right now researchers in Canada look primarily to international colleagues. We know that eating disorders receive significantly less funding than many other mental health conditions, disproportionately in terms of the number of people who are affected, as well.

One factor that was highlighted in the eating disorder strategy is the existence of some costing reports, for example, that have been performed in the United States, Australia, and the United Kingdom. They are arguably part of what provided the impetus for some of the changes in service models in order to understand the economic impact of eating disorders and to then better plan services.

We don't yet have this type of study in Canada, although there are some national colleagues who have come together, receiving funding from the Canadian Institutes of Health Research in order to start informing about the economic impact of eating disorders.

● (1230)

[*Translation*]

Ms. Andréanne Larouche: Thank you very much.

Ms. Mechmechia, you talked about the hatred that some women experience and the pressure put on them on social media, which is a very difficult space for women because it puts additional pressure on them in terms of their self-image.

So it's important to legislate and address the issue of online hate. A federal bill on this issue is currently being studied. What could such legislation mean?

[*English*]

Ms. Abrar Mechmechia: A lot of work has been done to ask the federal government to move forward toward implementing any type of legislation to prevent hate speech, especially on Facebook, Instagram and Twitter. Yet, I don't think any action has taken place. Speaking about Bill 21, many bills in our legislation reinforce that type of hate globally and nationally, as well.

I don't know what else to add, but yes, we need action to be taken in terms of social media, and absolutely, in terms of our own legislation and work environments. We also need to have a more diverse presentation for the publishers we work with, especially at the policy-making level.

[*Translation*]

Ms. Andréanne Larouche: I just came from an international summit where this issue was discussed, and I offered my full support to the Iranian women who spoke out against their treatment. I would remind members that a woman was killed because she wasn't wearing her veil properly. It's horrible that this could still happen in 2022.

My time is up, but I'd like to again offer my full support to Iranian women in their fight for equality and freedom.

[*English*]

The Chair: Fantastic.

Leah, you have the floor for six minutes.

Ms. Leah Gazan: Thank you so much.

I want to very quickly follow up, and then I want to go to Sarah Kennell afterwards.

You made a very good point about Bill 21. What I've said is that it's about choice, about a woman's choice—what they want to wear and what they don't want to wear—and about taking the ability to choose. I ask that because I feel there is growing Islamophobia in the country. I certainly worry about the many women and young women in my riding who have experienced in Manitoba increased levels of Islamophobia.

Would you say that these kinds of debates about taking away a woman's right to choose what to put on her body and even reproductive rights, with the whole debate we're having about Roe v. Wade—I mean, it's the time—are impacting women's mental health?

Ms. Abrar Mechmechia: Absolutely they are, because we don't feel that we are in control of our choice. Regardless of what a woman wants to wear or doesn't want to wear, it is definitely her choice. I've been reading the news about Switzerland recently. I think they now fine you 10,000 euros or something if you wear this in public or at a workplace.

At the end of the day, it's a woman's choice. I think because we're still in a masculine society, we still have men making decisions on what a woman can and can't wear. I think that's the main reason behind it.

● (1235)

Ms. Leah Gazan: Yes. Thank you so much.

I want to talk about eating disorders. Jennifer Coelho made a statement, as did Shaleen Jones from the Mental Health Commission. One thing that we know contributes to body distortion is the hypersexualization of young women and girls. We know that's an issue. I'm hearing very clearly from the witnesses today that this is just part of the equation. I've heard very clearly that in care we need low-barrier support.

Sarah Kennell, you spoke about mental health supports in terms of income and time, and I would say geographical as well.

I'm wondering if the three of you could maybe speak about that low-barrier care and not just focusing on one element that might be a factor causing eating disorders, and then speak about access to care and what that low-barrier care looks like.

We'll start with you, Jennifer, and then we'll move quickly to Shaleen and then Sarah.

Thank you.

Dr. Jennifer Coelho: I've heard some of my fellow witnesses highlight options in terms of integrated youth hubs, which exist in provinces across Canada, although not in all provinces. I think one of the aims of the early intervention work I've highlighted of some of our international colleagues is to take the services outside of hospital-based services and try to bring them to community and primary care.

I will hand it over to my fellow witnesses.

Ms. Shaleen Jones: Thanks, Jennifer.

The issue of access is so critical. It's one that I'm really passionate about. The work we've done here in Nova Scotia has been exactly on that. It's been looking at removing barriers to access to care for folks with eating disorders. What we found to be working in our province is having a suite of low-barrier, low-intensity programs consistent with the sub-care model. Locally, we offer text-based chats; Zoom chats; peer support programs, including one-on-one mentoring; groups led by professionals; groups led by peer supporters; and clinical support from therapists and dieticians. We find this works really well in connecting with folks where they're at. They may not be ready to access a therapist, but we want to catch them where they're at. When they reach out for help, we want them to know that support is available. There's no wait-list. It's immediately accessible. No diagnosis is required.

We have really tried to remove barriers. We've had so much success with this here in Nova Scotia that we're now rolling out this peer support program nationally. Folks from across Canada can access a variety of peer support programs for that immediate and highly accessible support. We can then help them access more accelerated treatment should they need that.

Ms. Sarah Kennell: I would build on my colleague's comments by adding consideration around the social determinants of health. That's recognizing that, in order for us to access care, we also need income supports, reliable and safe housing, and food security. That's just to add that, often, mental health concerns and problematic substance use intersect when we don't have those needs met. In addition to ensuring that we have access to care, it's about providing those supports alongside it.

Ms. Leah Gazan: I'm happy to hear you say that. One of the things that I've pushed for is a guaranteed livable basic income, in addition to current and future government programs and support.

I've often said, especially around indigenous peoples and first nations communities, that we're often pathologized. When you don't provide proper housing, it's bad for mental health. When you don't have clean drinking water, it's bad for mental health. If you don't have a toilet, it's bad for mental health—

The Chair: We're done.

I have to watch Leah. She knows that with me, she can usually inch out another minute or two. We have to watch out.

We're now going to turn to our next round. We're going to do five minutes and five minutes, and then we'll go for two minutes and two minutes. We'll then come back for a question from Wayne Long and a final question from Michelle.

I'm going to pass it over to Anna.

Anna, you have the floor for five minutes.

Mrs. Anna Roberts: Thank you, Madam Chair.

My first question is for Abrar.

We all know that the IRGC is a terrorist group. I attended a rally recently, where I met a young woman from Iran. I mistook her daughter for her sister. I was very appalled by her story. She finally escaped Iran and came here with her daughter. She was 12 years old when she was forced into marriage. Her daughter was 12 years old. We have this young woman, who is 24, with a 12-year-old daughter. She managed to escape and come to Canada, and she is still dealing with mental health issues from that whole process.

Would you say that the $4.5 billion that was promised could help when we talk about culture and culture-based situations? Would you say that money could help this mother and child, whom I mistook for sisters?

● (1240)

Ms. Abrar Mechmechia: Absolutely it would, especially if it's an early intervention, such as upon their arrival. We can, at least, prevent them from escalating and ending up in the ER. That's the first thing: direct support.

The other thing is to have more training on cultural competency and cultural sensitivity for other care providers, because they are working on a daily basis with this population and with these communities. Having that training to be.... For example, a while ago, we provided training for Kids Help Phone, to train their counsellors on how to work with newcomer youth through a cultural sensitivity lens. That was a great step. We want to see it happening more with other care providers.

Mrs. Anna Roberts: Thank you for that.

I don't know if Jennifer or Tracie can help me with my next question.

Last December, with the help of our local communities, the youth corps decided to raise money for blankets, towels and equipment, and funds to go down to feed the homeless. This is a very shocking story, so I apologize up front to anyone who's going to be upset by my sharing this story with you. Although these types of events are rewarding, they're also very depressing. I came across a young boy who was 10 years old and living on the streets.

We talked about violence. Earlier, it was said that parents are the best resources for children. As much as I agree with that, I sometimes think that it's not always the case. This young boy was in several different foster homes and he kept escaping. The only way for him to survive was to sell drugs from the local drug dealer, so that he could afford the bare necessities of life. It was very sad for me to see that. He is addicted. He admitted it. He is addicted to the drugs of choice, but he had no choice.

How do we educate and help social workers to identify these situations, so that we don't continue to have 10-year-olds living on the street?

I don't know who wants to take that question.

Dr. Tracie Afifi: I can jump in really quickly.

Again, prevention of violence and adversity is key. If we could have prevented those early life experiences from happening, then this person may not have ended up trying to escape the foster care system.

Child welfare also requires huge reform in our country. It happens at the provincial level across our country. I do think we need a national approach to child welfare, because it is failing our children. Having better supports for social workers to be able to identify issues and support families to keep children intact with their families, supporting those families for better outcomes, is ideal. Really, we should think of foster care as the very last resort.

Dr. Jennifer Coelho: Maybe I can add to that. In the context of the past question, when I was referring to parents, I was referring to a question relating to mothers. In fact, family-based therapy considers all caregivers. That might be grandparents. That might be a strong individual in that person's life who is not a parent but is there as a support person. Family-based therapy can be effective with adults who are supporting a person but aren't necessarily a biological parent.

● (1245)

The Chair: Thank you.

I am just going to give Abrar a chance. I know she's been trying to answer this question.

Ms. Abrar Mechmechia: Since I work with lots of group homes, I wanted to add that, instead of just revisiting child welfare, we also need to listen to these kids. There is not much counselling and support in the school and also in the foster care homes. The first approach they take is medication. It's heartbreaking for children to be on medication for their mental disorders.

The Chair: Thank you so much.

I'm now going to turn it over, for the next five minutes, to Anita Vandenbeld.

Anita, you have the floor.

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

I have a couple of questions. My first question is for Ms. Kennell.

I'll pick up on something you said, and also on the fact that in all likelihood our recommendations from what we're studying here will inform the new Canada mental health transfer and how it should be structured in our negotiations with the provinces, which as you know are ongoing. You really focused on there already being transfers for acute care and that it really needs to be in the community.

You painted a very alarming picture of what happens to young girls navigating the system. They have to be “sick enough”. They present at emergency. They're treated, I think you said because of the toxic masculinity, as if they're attention-seeking, manipulative or overly dramatic, which we know is a gender stereotype. They're given medication and sent home, but there are no follow-ups. You mentioned some of the medication. There may be effects that might actually make their condition worse, but nobody is following up in terms of modifying that medication, especially if they don't have a family doctor. You're portraying a very alarming picture.

I would like a little bit more about that recommendation you made in terms of getting it out of acute care. We talked a lot in previous meetings about prevention. If the Canada mental health transfer is going to be focused on community care, how would you see that being structured? Also, how would that potentially interact with and benefit our other programs?

Ms. Sarah Kennell: Thank you very much for the question, Ms. Vandenbeld.

We know where the Canada health transfer goes. It goes from the federal coffers into provincial budgets, and it ultimately gets spent on services deemed medically necessary. Those are hospital-based care, psychiatrists who are in the community—but again, you need a referral to get to see a psychiatrist—and family doctors. We know, sadly, that family doctors don't have the time or the training to be delivering comprehensive mental health and substance use health supports.

We see opportunity with the Canada mental health transfer to direct resources into areas of the sector that have been underfunded yet, as we know, are so critically needed. It's those wraparound supports that help people transition out of hospital if they've been in crisis care through either an emergency department or a psychiatric ward. It's really about ensuring that they have the supports needed to advance along a recovery journey, whatever that looks like for them. It's not only the preventative upstream interventions that we see but also that long-term ongoing support for people dealing with mental illness and substance use health concerns throughout their life course. It's really about ensuring that people get the care they need, when they need it, wherever they are.

Ms. Anita Vandenbeld: I appreciate that. We'll note that for our recommendations. Thank you.

All of you mentioned a bit about the impact on people on the front line, workers who are often women.

I want to direct a question to the Mental Health Commission. Recently you were in my riding. Out of our $50 million for PTSD frontline and essential workers due to the trauma from the pandemic, we were able to get some funding for frontline long-term care workers.

Generally, you were talking about particular programs like The Working Mind, where you can modify programs that can then be replicated across the country to help frontline and essential workers, who, as Ms. Kennel and others have mentioned, are leaving the industry because of the trauma of this kind of work. Can you elaborate on how that funding is having an impact? What would you recommend going forward?

Dr. Mary Bartram: There are two prongs to this.

One is better support for the mental health of the health workforce, including PSWs and people who work in long-term care, and the importance of attending to moral injury and psychological support for the comprehensive health workforce.

Second, we need to pay attention to the mental health and substance use health workforce in and of itself to make sure that the critical role it has to play in improving access to high-quality care isn't overlooked in the very important focus on the mental health of the broader health workforce.

They are both very important. We can't improve equitable access to mental health services unless we have more people trained and able to provide those. That's where the need for that comprehensive mental health workforce strategy is so important.

● (1250)

The Chair: Thank you so much.

We're now going to change it up a bit because I'm going to provide an extra 90 seconds to the Bloc and the NDP and then come back for two minutes and two minutes. Then we'll be done.

Andréanne, you have the floor for 90 seconds, a minute and a half.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

Time is running out very quickly, but I'd like to come back to online hate and misinformation.

As I was saying, I just came from an international meeting where I was going to talk about equality in parliaments and the importance of improving the representation of women. As an elected official, I had decided to bring my young daughter and post on Facebook my conviction that it is possible to be a mother in politics. However, my Facebook status received comments that went so far as to tell me that bringing my daughter was just as criminal as the actions of some of the protesters, and that the location wasn't appropriate for a child. These comments were horrible.

If we want to talk about mental health, we have to recognize that legislation to combat online hate is essential. There are only 30 seconds left. Could each person take 10 seconds to talk about the critical importance of this issue in 2022?

Ms. Sarah Kennell: I can start, Ms. Larouche.

[*English*]

I'm sorry that happened to you. As women around the room, as politicians, you've all experienced this deeply and personally.

My contribution to the conversation would be to address the root cause, which is a lack of comprehensive sexuality education and mental health literacy starting in elementary school. We need to address toxic masculinity and harmful gender stereotypes from the beginning.

The Chair: Thank you very much.

I'll now pass it over to Leah.

Leah, you have the floor.

Ms. Leah Gazan: Thank you so much.

I'd like to go back to prevention.

I know that child welfare was mentioned. In Manitoba, for example, we know that 90% of kids in care are indigenous. We have long-term historical examples like the sixties scoop, with impacts on identity and the sense of belonging. Child welfare is not the answer.

Why is prevention so important in terms of keeping families together as a way to support positive mental health in young women and girls?

Dr. Tracie Afifi: Thank you for the question.

Yes, I agree with you. It's easier to prevent a problem than it is to solve the many issues that happen after people experience adversity such as trauma and racism. If we can try to prevent those things from happening in the first place, then we won't be having as many mental health problems to deal with.

We need to invest in prevention from the very beginning. We need to be able to support families in order for them to understand how to raise children without violence, which includes not spanking their children. We need to provide support for parents in terms of dealing with their own mental health, so they can be good supports for their children. If it can't be a parent, as mentioned before, research has shown that a supportive caregiver in someone's life makes a really big difference. It doesn't have to be a parent. It can be someone else in the family or another adult.

Preventing problems before they occur is very important.

The Chair: Thank you so much.

We're now going into our final couple of questions.

Michelle, you have two minutes, and then Anita will have two minutes.

Go ahead, Michelle.

Ms. Michelle Ferreri: We should have everything fixed by five o'clock today. It's fine. Two minutes is tons of time.

Thank you again.

Coming back to the point of this study of the factors contributing to the decrease of young women's mental health, I think we need to absolutely focus on that. I keep coming back to prevention being absolutely key, but at the same time we're not going to prevent those who are already halfway through that, so we almost have to have a two-pronged strategy.

I'm going to go back to Sarah, if that's okay.

If we are not taking care of these frontline workers and if we are not taking care of a mother who isn't aware of how to take care of her own mental health.... To me, that is the number one factor contributing to the success of a young child's mental health. It's the people around them, like the teachers, caregivers and coaches. If they are so exasperated by the stress of life or have never been taught the coping skills, what would the $4.5 billion do to help with that?

Where would you see the biggest improvements to help parents and caregivers help their children?

● (1255)

Ms. Sarah Kennell: I think when we invest in upstream interventions, in mental health promotion and mental illness prevention, we know the benefits are long-term. We know that supporting kids in school or post-secondary mental health first aid is all part of a continuum of supports we can provide that support people in achieving the best possible outcome from themselves.

I want to make the point that the investment on the table is not only money out, but money back in. When we invest in mental health and substance use health, it yields returns on the investment in relation to productivity, reduced acute care costs, reduced criminalization and reduced hospital stays.

Ms. Michelle Ferreri: I agree 100%.

The Chair: Thank you so much.

For the last two minutes, Anita, you have the floor.

Ms. Anita Vandenbeld: Thank you.

I saw you nodding when I asked the previous question about the mental health and addictions health care workers themselves. I will give the last minute for you to also answer that question.

Ms. Sarah Kennell: Thanks very much.

I would echo what my colleague, Mary Bartram, has said around a national mental health workforce strategy. We need to be looking now at the long term in terms of what supports need to be put in place to ensure that we're not only sustaining the workers we have right now—who are predominantly social workers in community—but also planning for the long term. Whether it's that transition to virtual care that is on the rise or group-based therapies, these are all new innovations that we're seeing emerge predominantly out of the pandemic.

What can we be doing from a salary perspective, from a workplace benefits perspective, from an institutional change perspective and on regulatory issues? What can we be doing holistically to ensure we're sustaining and then growing this workforce that's so critically needed?

The Chair: Thank you so much.

On behalf of the committee, I would really like to thank all of the witnesses here today. We have a very important study to do, so all of the information that you're bringing forward is very much appreciated.

I would just remind committee members that we need to have those human trafficking names in by the 28th. For anything else you may need, just contact us.

Everything looks good. Do I have a motion to adjourn? Thank you.

Today's meeting is adjourned.