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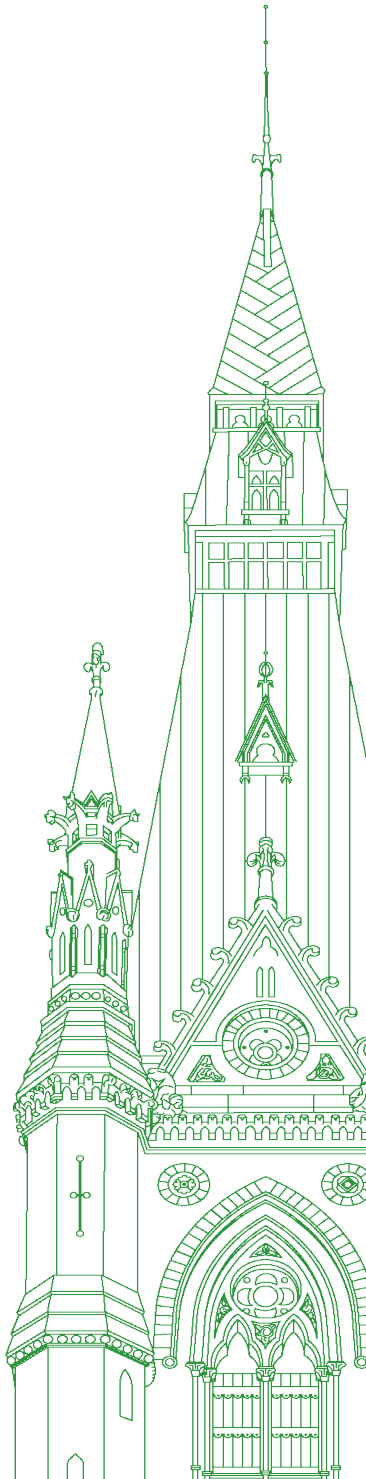

Chair: Mrs. Karen Vecchio

Standing Committee on the Status of Women

Thursday, October 20, 2022

● (1530)

[*English*]

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

Go ahead, Mr. Genuis.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Thank you, Madam Chair.

I'm going to take 30 seconds of folks' time. I want to give verbal notice of a motion. After I have given notice of the motion, there will be lots of time for people to see it, hear it and think about it. Hopefully, it will be discussed at a future meeting.

> That the committee report to the House that in its opinion the government should:
>
> (a) support the development of bystander awareness and intervention training, in collaboration with other levels of government, academia, and civil society organizations, as a key tool for combatting sexual harassment and violence, hate crimes, and other forms of criminal activity;
>
> (b) support the provision of bystander awareness and intervention training to federal workers; and
>
> (c) encourage all Canadians to avail themselves of opportunities to take bystander awareness and intervention training.

Thank you, Madam Chair.

The Chair: Excellent. Thank you so much.

I know it's verbal, so it's very important that we get that in writing, as well, to ensure that Andréanne Larouche will have it—it is in. We will make sure that there is a French version coming around and circulated for you. I will ask the clerk to make sure you get that motion, so that everybody has it in writing.

Are there any other questions or comments?

Thank you, Mr. Genuis.

Welcome to meeting number 34 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. You'll see online that we have some of our members on here today, as well as some of our witnesses.

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

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mike. Please mute it when you are not speaking. You will find interpretation on the Zoom app at the bottom of the screen. It says floor, English or French. Choose the one that works best for you. For everybody in the room, you have these handy earpieces. You can choose your language from French, English or the floor. The volume control is there, as well.

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

Before we welcome our witnesses, I would like to provide this trigger warning. This will be a difficult study. We will be discussing experiences related to mental health. This may be triggering to our viewers, members or staff with similar experiences. If you are feeling distressed or you need help, please advise our clerk.

I would now like to welcome all of our witnesses today. As I said, we have some here in front of us, as well as on Zoom.

From the Canadian Centre for Gender and Sexual Diversity, I would like to welcome Debbie Owusu-Akyeeah, executive director. We also have Jaime Sadgrove, manager of communications and advocacy.

From the Kawartha Sexual Assault Centre, we have Brittany McMillan, who is the executive director. Beside her is Jordanne McLaren, who is the manager of the client services and human trafficking response team.

[*Translation*]

Ms. Larouche, you have the floor.

Ms. Andréanne Larouche (Shefford, BQ): Madam Chair, I just want to make sure that we're hearing the witnesses. Have the pre-meeting sound checks been done?

The Chair: Yes, they have.

[*English*]

It was done prior to the committee meeting starting, so everybody has had their earphones checked.

From La Maison Hébergement RSSM, we have Véronique Couture, who is the executive director. Welcome, Véronique.

From the MEHRIT Centre, online, we have Stuart Shanker, distinguished research professor emeritus of philosophy and psychology at York University.

We also have, from Women of the Métis Nation-Les Femmes Michif Otipemisiwak, Melanie Omeniho.

I'm going to provide each organization with five minutes for their opening statements. If there are two from that organization, those five minutes are combined.

I'm going to pass it over first to Debbie and Jaime at the Canadian Centre for Gender and Sexual Diversity. Your five minutes start now.

Ms. Debbie Owusu-Akyeeah (Executive Director, Canadian Centre for Gender and Sexual Diversity): Hi, everyone. Thank you so much for inviting us today.

My name is Debbie Owusu-Akyeeah. I use she/her as pronouns. I'm the executive director of the CCGSD. Our organization is a national, youth-focused 2SLGBTQ+ organization headquartered here in Ottawa. We promote gender and sexual diversity in all its forms through the services of education and advocacy.

Our vision is a world without discrimination, especially for 2SLGBTQ+ youth, and to create a world where the human rights of 2SLGBTQ+ people would truly be respected. By recognizing the complexity of lives and experiences, our resources and our programming serve to empower marginalized queer, trans and indigenous youth and to provide the wider public with tools for building allyship with 2SLGBTQ+ communities.

As a leader in anti-oppression work, our goal is to promote healthy relationships and respect and dignity within and towards the 2SLGBTQ+ community. We specifically recognize that youth in our community have become disproportionately affected by bullying, violence and hate crimes in comparison with their cis heterosexual peers. We also recognize the effects that racism and colonialism have on queer Black, indigenous, and people of colour.

Our organization works specifically with queer and trans youth from urban and rural areas across Canada between the ages of 12 and 29. We mostly work within the middle school and high school context, as well as with young people who are marginalized due to many other forms of their identity.

From our evaluation work, we can safely say that a lot of the folks we work with also reflect a variety of different ages, gender identities, sexualities, abilities, races and ethnicities. I think what's key to mention is that about 60% of our participants happen to self-identify as female or as women or girls. Approximately 25% of the folks we work with are also racialized, Black or indigenous. We also work with folks—around 5% to 10% of our clients—who identify as trans or have trans lived experience. As well, about a fifth of the folks we work with note that they are living with a disability of some sort.

I mention all of this just to say that our work inherently addresses the mental health of diverse 2SLGBTQ+ young people, including young women and girls. It's important for us to look at the nuances of the experiences of young women and girls from the perspective of gender and sexual diversity.

In terms of what we do know, recently there was a study launched by Statistics Canada on bullying and victimization among young sexually and gender-diverse people in Canada. It shows that there are high levels of bullying against sexually and gender-diverse youth in Canada. That is having adverse effects on their mental health. These youth, who are more likely to be bullied, are also reporting high levels of suicidal ideation. They have a desire to skip school as a result. As to the levels of bullying they are dealing with, they are wide-ranging. They include being made fun of; name-calling; cyber-bullying, which speaks to the online hate that 2SLGBTQ+ people experience; being excluded from events; and rumours.

We know that the barriers and discrimination rooted in misogyny are only further compounded by that intersection of homophobia, biphobia and transphobia. It's also important to note that the bullying tactics we see among young people are highly gendered.

I want to note the report from our colleagues at Egale Canada entitled “Still in Every Class in Every School”. They look specifically at the context within school communities. Of the youth who were studied in the report, 11% of the cisgender and heterosexual respondents reported languishing mental health, as compared with 20% of those who are gay boys, bisexual boys or queer boys; 25% of the lesbian, gay and bisexual girls; and then 40% of the trans respondents. Conversely, cisgender lesbian, gay, bisexual and queer girls were more likely to experience some form of personal victimization through social media in comparison with their cisgender gay, bisexual and queer boy counterparts. This is happening of course online and in washrooms, change rooms and hallways. It's impacting their desire to participate in physical education, etc.

What's clear, and what I want to conclude with before we go to questions, is that there's a need for disaggregated data for this study.

● (1535)

We want to look at the specific impacts on the mental health challenges of young queer and trans girls and transfeminine people. There is a strong desire for Canadian context, especially with the increased amount of information coming from the States. We need to look at diversifying the data that speaks to transgender experiences and speaks to trans girls and transfeminine folks.

Lastly, we need to really focus on that knowledge mobilization piece so that educators and other adults know how best to address the needs of young queer and trans girls.

● (1540)

The Chair: Perfect. Thank you so much.

I'm now going to pass the floor over to Brittany and Jordanne from the Kawartha Sexual Assault Centre.

Go ahead, please, for five minutes.

Ms. Brittany McMillan (Executive Director, Kawartha Sexual Assault Centre): Thank you so much for inviting us today.

My name is Brittany McMillan. I'm the executive director at the Kawartha Sexual Assault Centre, which is one of the many sexual assault centres in Ontario. Our core funding comes from the provincial government through the Ministry of Children, Community and Social Services, also known as MCCSS. We're a small agency that receives just under $320,000 per year as our core funding model.

Jordanne is with me to help support with any questions that may be more clinical or client-specific. She is the manager of client services and also leads our human trafficking response team.

Today I will highlight the significant impact that sexual violence has on the mental health of women and girls. I will also discuss the need to mitigate such long-term mental health concerns for survivors and the need for more prevention and education in the field of sexual violence.

Women who have been sexually assaulted are more than twice as likely as male victims to develop post-traumatic stress disorder, with PTSD symptoms lasting up to four times longer than in males. According to the DSM-5, some of the highest rates of PTSD are found among survivors of rape, with rates ranging from one third to more than a half of rape survivors. PTSD is commonly associated with other mental health conditions, and is not the only mental health disorder that may develop after a sexual assault. Survivors may also develop conditions that include complex post-traumatic stress disorder, generalized anxiety disorder, major depressive disorder, eating disorders, obsessive-compulsive disorders and substance use disorders.

The risk for these related conditions may be greater for individuals who experienced a sexual assault at a younger age. Girls who were sexually abused in childhood are at an increased risk of being sexually assaulted as adolescents and adults, which further increases the risk of developing mental health disorders.

I want to note here that unfortunately we aren't funded to support people under the age of 16, leaving a huge gap in our services for young girls.

In 2021, approximately 19.24 million women were living in Canada. Across their lifetime, it is estimated that one in three women and girls will experience sexual violence at least once. We believe that because of low reporting, these statistics do not reflect the reality. This means that at least 6.41 million women and girls in Canada will experience sexual violence. It's also important to note that the population in our catchment area is about 320,000 people.

It is not just the numbers that are increasing. Many professionals in our field are anecdotally reporting that the intensity of sexual assaults is increasing, including an increase in physical injuries and strangulations. At the same time, it is important that we are clear that these numbers are not just due to the pandemic. The rates of sexual violence against women and girls have long been staggering.

We have a recommended action plan. Women who are believed and not blamed, and who are offered support and treatment after a sexual assault, are less likely to develop long-term mental health impacts. Therapy, support groups and self-help strategies can help survivors cope with and heal from PTSD and other mental health symptoms.

The sexual assault centres across the province of Ontario, and surely throughout Canada, are very much underfunded. If more core funding was invested into these agencies, survivors of sexual violence would get better access to supports in a timely manner, which would prevent many instances of long-term mental health struggles.

Prevention and education also need to be a priority. In Ontario, many sexual assault centres have taken this role on with minimal funding, as we know that the impact is so valuable. If we can get to the young boys and teach them the core foundations around the issues surrounding sexual violence, consent, toxic masculinity and the patriarchy, we will see the rates of sexual violence go down. We are currently prioritizing this training to hockey associations in order for Canada's sport to be a safer space for everyone. We also need to prioritize male allyship programming.

● (1545)

In conclusion, I just want to say that we're change-makers. We get into this field because we want to make changes. The unfortunate reality is that we can't do that as well as we can with the limited funding we currently receive as a core funding model.

The Chair: Thank you so much.

I'm going to pass it to Véronique Couture from La Maison Hébergement RSSM.

There are five minutes for you, Véronique.

[*Translation*]

Ms. Véronique Couture (Executive Director, La Maison Hébergement RSSM): Good afternoon, everyone.

My name is Véronique Couture, and I'm the executive director of a community organization, a transitional housing facility in Granby, Quebec.

We provide transitional services to people coming from a prison, hospital or detox centre. Our clientele is mixed but is mostly women at the moment.

Our needs have obviously increased considerably because of the pandemic and a lack of services over the past two and a half years. Our biggest problem is a lack of regular funding, which means we don't have enough staff in the house. We are funded by the Government of Quebec's support program for community organizations. However, we need funding from elsewhere to help us move forward and go further in the services we provide.

It's very complicated to apply for grants and to be accountable. We are left with very few resources. Case workers can't do their job because they have too much office work to do, and they have to deal with endless requests, so we recommend that the funding come to us more quickly.

Personally, I came here with a lot of candour, and I feel like I'm not as prepared as the people around me. However, my requests are very real and urgent: women and girls need mental health care and in different areas, so the funds need to come in quickly.

We talked about sexual assault earlier. Ninety per cent of our clients have been sexually abused as children or youth. So we need to help these people become empowered in a way that they never were before. We need education in schools. We need people who know how to care for Canadian girls and women and guide them to the right places at the right time.

I'm making a heartfelt plea: we need many more resources to help these women and girls.

In closing, I'd like to talk about something a little more personal, as I deal with this situation every day with my eldest daughter, who isn't able to get help. I can tell you that services are lacking, not only because of a lack of funding, but also because of a lack of awareness and understanding in schools and universities.

[*English*]

The Chair: Thank you so much. I think you're going to find out we're all hearing the same thing, that there's just not enough. Thank you so much for being here.

We're going to turn it now online to Stuart Shanker.

Stuart, you have the floor for five minutes.

● (1550)

Dr. Stuart Shanker (Distinguished Research Professor Emeritus, Philosophy and Psychology, York University, The MEHRIT Centre): Thank you very much.

I can't help but feel that you must all be feeling a little bit overwhelmed by the absolutely frightening scope of the problems that we're facing with mental health of women and young girls today. I've been given the job of telling you—in five minutes—about an incredible neuroscientific revolution that we're going through. All I'm going to try to do is spark some curiosity, because this new understanding is giving us tools so that we can really reinforce all the messages that I've just heard, and that you've heard from your other witnesses.

I'm just going to talk about anxiety now, and essentially what we have learned, especially within the last three years. The numbers we're seeing are very difficult for us to tabulate. We know that it's far in excess of the 20% reported before the pandemic.

We know that anxiety is a warning system. It serves as a warning that the brain has detected an external threat, and that's not hard to figure out. We can certainly enumerate the threats that women are dealing with today. You just heard some very good examples.

It also serves as a warning system for internal threats, and that's what I'm going to talk about. An internal threat is something that's coming from very deep in the brain. It is coming from systems that lie beneath the threshold of awareness. Essentially what's happening is that these systems are in what's called homeostatic imbalance. Homeostatic imbalance produces things like depression, anxiety disorders, self-harm and so on.

There are three primary causes of these homeostatic imbalances.

The first one is simply excessive stress. Stress is a complicated issue, and I'll come back in one second to what a scientist means by stress. The second cause, and this is the big one during the pandemic, is maladaptive modes of dealing with that stress. Essentially, a maladaptive mode is something that gives you relief in the moment, but exacerbates the stress problem. The third cause is a lack of experiences that produce oxytocin. Oxytocin turns off the stress response.

What we see in all of the cases that you are hearing about are young women and girls who are in a state of being overstressed, something called “hypodopaminergic”. What does that mean? Stress is anything that requires the brain to burn energy to deal with that stress. It could be physical stress. It could be noise, crowds, too much light or not enough. It could be emotional stress. It could be cognitive stress. These are things that we talk about and explain.

The problem with excessive stress, such as we have seen over the course of the pandemic, is that it turns off dopamine. We need dopamine. These women need dopamine. Without it, when your dopamine levels are reduced, it causes withdrawal, as well as something called anhedonia. It causes lack of motivation—you can't go to school. It causes chronic anxiety and depression or dysthymia.

The question this raises for us is this: Given the unbelievable stresses that women and girls are under, what can we do to alleviate this? What can we do to put the brain in a state where it can benefit from the programs that you are hearing about? What we need is something that turns off the stress response.

● (1555)

I'll just explain this really quickly, because I can't keep track of five minutes. The problem that you have is that when there's a stressor, there are chemicals that go up to produce the energy to meet the stress. There's another set of chemicals that turn off the stress and get us back into balance. What we're seeing in anyone who is suffering from, let's say, anxiety disorder is that the two systems are out of whack, so what we have to figure out is how to get them back into balance. We can't do it by education. We can't do it—

The Chair: We are quite a few seconds over the five minutes. I know there is a lot more in that brain that we need to get out of there, but I'm going to have to turn it over to the next witness, and then we'll be sure to get back to you for questions. Thank you so much, Dr. Shanker.

I'm now going to turn it over to our final panellist today. We have Melanie, from the Women of the Métis Nation.

Melanie, you have five minutes.

Ms. Melanie Omeniho (President, Women of the Métis Nation - Les Femmes Michif Otipemisiwak): Thank you for the opportunity for Les Femmes Michif Otipemisiwak to speak to the committee today on experiences of mental health for Métis women, girls, two-spirit and gender-diverse people.

I'm speaking to you from the unceded, unsurrendered territory of the Algonquin Anishinabe people here in Ottawa, but I actually live in the Treaty 6 territory and the mother of the Métis land in Edmonton, Alberta.

Les Femmes Michif Otipemisiwak works to ensure that Métis women from across the motherland are safe, connected and empowered and have the capacity to create the conditions for healthy and vibrant communities throughout the Métis nation.

Métis women are the heart of the Métis nation, and we envision a world where they are able to live in safety and free from violence, enjoying the same standards of safety, security, justice, health and wellness afforded to others.

Compared to non-indigenous people in Canada, indigenous people experience mental health issues at disproportionate rates, often with greater severity of symptoms. Indigenous people, including survivors of the residential school systems and their descendants, experience higher rates of depression, anxiety, post-traumatic stress, substance abuse and behaviours related to suicide.

Yesterday, we were reviewing some pre-COVID statistics from 2018 with our Métis Nation British Columbia governing committee on the state of mental health in Métis youth in British Columbia. In the study, 47% of female Métis youth reported that they were experiencing anxiety—and this is all pre-COVID—35% of Métis youth reported experiencing depression, and 31% of female Métis youth reported serious consideration of suicide.

These statistics are alarming, and given the impact of the pandemic on mental health, we anticipate that the same mental health issues for Métis youth have even increased and been further exacerbated. We know that long-term COVID research is being done as to the effects on the mental health of our people, and many of our people have suffered from COVID.

Especially in the context of MMIWG, Métis women, girls, two-spirit and gender-diverse people have experienced severe forms of abuse, trauma and personal violence. Call to action number 19 from the Truth and Reconciliation Commission called upon the government to close the gap in health outcomes between aboriginal and non-aboriginal communities, including suicide, mental health and addiction. The National Inquiry into Missing and Murdered Indigenous Women and Girls also found a need for increased funding and support for holistic services and programming in areas including trauma, addictions, treatment, and mental health services.

It's important to note that for many indigenous people, mental and emotional well-being is also tied to social, cultural, spiritual, environmental and political well-being. Health is a holistic concept. It encompasses the well-being of ourselves, our families, our communities, and our nation. In this way, the mental health of our women, girls, and gender-diverse people is intimately interwoven and connected to the well-being of our families and our communities.

For Métis communities, the social determinants of health are not just social; they are political and historical. They are structural determinants of health. The impacts of colonialism, such as the intergenerational trauma of residential schools, the sixties scoop and other issues, have ripped people from their culture and the culture that presents our path to healing.

In working with Métis survivors of trauma, violence, abuse and neglect, we know that connection to culture and community strengthens opportunities for healing. Working with elders, spending time on the land, harvesting medicines, weaving and beading are all activities where culture itself becomes mental health care.

Understanding the importance of culture and identity is a necessary step in decolonizing mental health care. Beyond a pan-indigenous approach, incorporating Métis values such as kinship ties, faith, spirituality, storytelling and traditional knowledge in trauma-informed care is needed to truly support healing in our communities.

● (1600)

To this end, LFMO has developed "Weaving Miskotahâ", with 62 calls to *miskotahâ*, which means "change" in our language. In this report, we identified the need for a Métis nation healing and wellness resources foundation, to provide immediate and long-term supports to women, survivors and families, as well as the need for system navigators to work with Métis women, girls and 2SLGBTQQIA people and their families, and—

The Chair: Melanie, I'm going to have to cut you off. We've once again gone a little bit over, but we'll make sure we have lots of questions so that we can get to those, as well.

We'll now start our first round of questioning. Each questioner will get six minutes. I'm going to start with Michelle Ferreri.

Michelle, you have six minutes.

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

This is going to be, maybe, one of the greatest tests I've ever had. I'm going to try to interview Dr. Stuart Shanker. I am so excited. We have hours and hours to squeeze into six minutes. Dr. Shanker, I believe we can do this.

Dr. Shanker has personally transformed my life and my children's lives. I can tell you, with certainty, that this man knows exactly what we need to do on a child mental health level, as well as an adult mental health level. His research is proven and it works, but it is not a quick fix—nothing is.

Dr. Shanker, I truly believe that if we want to help our children, we have to help the people who deal with our children. Otherwise, we will just keep passing over our own stress—what you were talking about in much of your testimony.

One of the things you speak of is that calm begets calm. If the people who are supposed to care for our children.... This study we are looking at, particularly in FEWO, is about factors contributing to the mental health of our youth and young girls, and how we can help and support that. If calm begets calm, if the people who are supposed to be the calm are not calm and don't have the tools to learn, what impact will that have on our children? How do we get them to be calm?

Dr. Stuart Shanker: There are two really important points in what Michelle just said. The first one is that we do know, from studies we've done, that anyone who's working with children, teens and young adults today is extremely stressed. What we have found at all of the institutes we run is that we have to start off the first day dealing with their mental health needs, particularly as we work on something called self-regulation.

Michelle's second question is, why is that so important? The reason is this: One recent discovery in neuroscience is that we have a brain-to-brain connection with kids. It's a wireless connection. It goes from our limbic system to their limbic system. What the child hears is what our limbic system is feeling. If I am irritated, anxious, angry or hyper-aroused, that message is communicated to the kid. If I am calm, if I am myself regulated, that message is communicated to the kid. It's called the interbrain and it is truly a game-changer in our understanding of why it doesn't matter so much what we say, what words we use; it's the messages our brain is sending. It sends these through eye gaze, through tone of voice and so on.

Is that a good enough answer, Michelle?

Ms. Michelle Ferreri: It is. I know; I've watched it work. I understand. It changed my life, as I said.

We have $4.5 billion dedicated right now, under the Minister of Mental Health, that is supposed to be allocated to mental health.

Dr. Shanker, you have the framework, the research, the data in place of self-regulation to teach inside schools, to teach to teachers, to teach to coaches, to teach everyone who is dealing with our children, including all of our witnesses, to teach these frontline workers how to self-regulate. Of that $4.5 billion, if some of it were allocated to you for a framework that we need for a mental health strategy to help our people cope and have mental health wellness, would you be able to implement it?

● (1605)

Dr. Stuart Shanker: Again, it's a great question. What Michelle is pointing to is the fact that our numbers are so overwhelming that we need to be thinking in terms of a universal approach. That's why she's itemized things like schools, or any organizations or parenting groups.

What we have to do is develop methods that empower the child or empower the teen, methods for recognizing when they're overstressed, how to reduce that stress, how they can turn off that disparity I was talking about, the stress response, how they can experience calm, which is a forgotten thing these days, and finally, how they can restore it.

Can it be done? Yes, we've seen it can be done. Can you turn around a child's trajectory? You can change every single kid's trajectory, but to do it is a step-by-step process. They have to get back into homeostasis. They have to get back into that balanced brain state. Yes, we could teach this through our public resources. In fact, that's what we're doing right now, and it works.

Ms. Michelle Ferreri: It certainly does, and I think frontline workers need your self-regulation as much as our children do because if we both don't have that, it's not going to work.

I would love it if you could touch on what I know you didn't get a chance to say in your testimony, what you need to do. We have about 40 seconds left.

Dr. Shanker, I'm going to give you the floor if you want to take it.

Dr. Stuart Shanker: If I was going to give you one single message, it would be this. I've done this now my entire adult life. I've seen thousands and thousands of kids. I have never seen a bad kid. There isn't such a thing. If a kid is overstressed, it's a warning sign for us. This kid needs help, and we have to give it. That's why you guys have met together in this committee.

Ms. Michelle Ferreri: I couldn't agree more. There is no such thing as a bad child. Why do we see the behaviour, and why now? Words from my very good friend, Dr. Stuart Shanker....

Thank you.

The Chair: Thank you so much.

We're now going to pass it over to Emmanuella, who is online.

Emmanuella, you have the floor for six minutes.

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

I'd like to thank all of our witnesses for the incredible testimony they are providing us with today.

Dr. Shanker, I will get back to you because I have a very strong interest in psychology, so I would like to hear more, but before I get to you, I would like to ask some of our other witnesses a couple of questions on the work they are doing and—

The Chair: Emmanuella, I'm going to just say that I have messed up.

I just want everybody to know that both Jaime and Debbie must leave at the one-hour time, so if there are questions for them—I'm going to give your time back, Emmanuella—let's make sure we get them in this hour. I am so sorry that slipped my mind.

Go ahead, Emmanuella.

Ms. Emmanuella Lambropoulos: All right, thank you.

My first question will go to Debbie.

You mentioned that the biggest issue right now is gender and that people who have a different sexual or gender identity experience a much higher impact on mental health. They have other experiences of mental health. I am wondering if you can give us a day in the life of somebody who works in your shoes.

What is it, exactly, that differs in their experiences? Of course, bullying plays a really big role, as you mentioned. Can you tell us how desperate the need is for us to really take a look at the differences and to fund them appropriately?

Ms. Debbie Owusu-Akyeeah: Absolutely. That's a great question. Thank you.

In terms of a day in the life—and, of course, I'm contextualizing it for young LGBTQ girls, considering they're the main cohort we work with—for young people to deal with the everyday stressors of their lives, for those who are at a critical period of their development where they are developing a sense of self and are figuring out who they are in terms of their attraction or their gender expression, we know that we still live in a society where homophobia and transphobia exist and that it's still taught in institutions, including within the education field.

Despite the efforts to centre human rights, a lot of that stigma still exists within our communities, so what ends up happening is that, whether it's peer-to-peer, young people weaponize that against their colleagues. A lot of shame still exists for young people, despite seeing other—I'll use Jaime and me as examples—adults who are not that much older than they are who are proud of who they are and their identities. There's still a lot of push-back, and that push-back is driving a lot of issues for these young folks.

Aside from the peer-to-peer model side, I do think it's important to note—and I think Dr. Shanker has mentioned this—that adults play a key role, and sometimes adults are the bullies who are driving these mental health stressors for young folks, whether it's parents who are not affirming, whether it's not seeing yourself reflected in course curricula, or whether it's coordinated approaches and rhetoric to ensure that young trans folks are excluded from doing other things that their peers are doing.

These things still exist. It's cultural. The work that we do is long-term cultural change, trying to centre and normalize the diversity that exists in our communities. What is critical about the work we do is that not only do folks, again, get to see possibility models, but they also get to hear their experiences be centred.

It's not just our work. LGBTQ organizations across the country are doing this. By virtue of existing, they are providing mental health supports and wellness supports in combatting the isolation that those young kids might experience in school by giving them a safe haven outside of a school context, so funding.... I will stress that LGBTQ organizations are super underfunded. We've seen some really exciting commitments recently, but it's not enough, and we need to see this stuff be core and last long.

Our work is super crucial for giving young people a sense of belonging to ensure that the challenges they are dealing with are being met.

Jaime, do you want to add anything?

● (1610)

Ms. Jaime Sadgrove (Manager, Communications and Advocacy, Canadian Centre for Gender and Sexual Diversity): Yes, sure.

There is one thing I'd add. Debbie mentioned that adults play a role and are sometimes the bullies. I think something that's important to note is the role that service providers play. The work we do is to provide community-focused services, but our staff aren't clinical. That's the case at most 2SLGBTQ+ services.

We know, from the survey included in the 2SLGBTQI+ action plan that was published at the end of this summer, that less than 20% of mental health care providers are providing services that are specific to 2SLGBTQI+. For queer and trans youth, if you're going to get mental health care and the service provider who's supposed to be giving you that care doesn't understand your lived experience or your identity, it's an additional hurdle where you're having to educate this person who's supposed to be giving you care. Especially if you're a youth who carries compounding identities—maybe you're from a racialized community, or you're Black or indigenous—that's a real challenge and a real barrier to accessing mental health care.

Ms. Emmanuella Lambropoulos: Thank you.

I guess, Jaime, you just helped us lead to my next question. I know that Debbie also mentioned knowledge mobilization so that adults know how to respond to our youth. Do you have any recommendations as to how we can make that knowledge mobilization happen? What are some of the ways that we can educate educators so that they're better aware of certain issues when they're dealing with kids from so many different backgrounds, in every sense of the word?

Ms. Jaime Sadgrove: Yes, absolutely.

We actually have a program that started earlier this year called “Not Just The Tip”. It's funded by Health Canada and it's a pilot project for a “train the trainer” model for comprehensive sex education. Essentially, our staff are going to go to cities in Canada and train sexual health educators in how to provide queer- and trans-inclusive sexual health education. I think a model like that could be really effective in terms of educating health care providers and teachers on how to provide compassionate and informed services to queer and trans youth.

It's something that's scalable as well. Rather than having to have staff all over the country, having people who can go to train trainers, who can then provide those services and pay it forward, I think is something that would be scalable in a really meaningful way.

The Chair: Perfect. Thank you so much.

We're now going to pass the floor over to Andréanne.

Andréanne, you have six minutes.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

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

It's interesting to talk about cross-identity factors with Mr. Sadgrove and Ms. Owusu-Akyeeah and Ms. Omeniho, and violence with Mrs. McMillan, Ms. McLaren and Dr. Shanker. It's interesting to hear the different concerns around mental health.

Ms. Couture, you made a heartfelt plea. For the reasons you mentioned, you work from home, and you are the mother of a young girl with mental health issues.

Over the course of this study, we've heard from several witnesses about the importance of stable and adequate funding for organizations such as yours, which work on the ground and are on the front lines of helping people with a variety of mental health issues.

Do you think that the unanimously requested increase in federal health transfers to Quebec and the other provinces and territories could be one solution? You mentioned a lack of financial resources.

● (1615)

Ms. Véronique Couture: Yes, that could be a solution. However, funding must be provided quickly and on a recurring and consistent basis.

Ms. Andréanne Larouche: That's precisely what health transfers do. The federal government would commit to stable, recurring, predictable and significantly increased transfers. You want this kind of recurring and stable funding.

The federal government is increasingly interfering in Quebec's jurisdictions. It sets up project-based programs, which isn't what organizations like yours are asking for. Stable, recurring funding is provided by the Quebec and provincial governments, which have the necessary skills and are much closer to what is happening on the ground.

Can the imposition of conditions and the project-based approach lead to duplication of services? Wouldn't it be better to transfer the money to Quebec's ministry of health and social services, which could then distribute it to organizations such as yours through its support program for community organizations?

Ms. Véronique Couture: Yes, in Quebec, the funds should be redistributed through this program. It needs to be simple and easy to access, so that we don't have to hire someone or ask someone to be dedicated only to this task. Project-based funding complicates things. We want the funds to support the overall mission of the organization or group receiving the funds.

Ms. Andréanne Larouche: You've been in the community and on the ground for a long time, and you've been saying this for several years. So you're well aware of the programs that are already available to you from the Government of Quebec. You discuss this with them, and they wait to receive funds to finance several projects.

The federal government talks about imposing conditions on health transfers. Yet it's the department that has the expertise, and you're working with them now, right?

Ms. Véronique Couture: That's right, with the Quebec ministry of health and social services.

Ms. Andréanne Larouche: Specialized organizations like yours are being told that the ministry is waiting for funding, is that correct?

Ms. Véronique Couture: Yes. Right now, we're working off of an agreement that is from 2015, and the funds aren't coming in. We're receiving negligible increases.

Ms. Andréanne Larouche: You also mentioned bureaucratic overload. What do you think of the idea of another level of government setting conditions and standards?

Ms. Véronique Couture: It would require doing the same work twice. We want to simplify the work, only have to do it once, and receive our funding. Project-based funding, on the other hand, requires a lot of ad hoc work that requires us to do the same thing again and again.

● (1620)

Ms. Andréanne Larouche: I'll move on to something else.

You said that you were seeing an increase in mental health issues on the ground. Could you tell us more about that?

Ms. Véronique Couture: Yes, absolutely.

These problems have been exacerbated since the pandemic began. Right now, there are 38 people in need on my waiting list. I can't help them because I don't have enough case workers or rooms, and because I can't afford to hire more case workers or expand the space.

Our case workers give really a lot for very little.

Our organization has never had a waiting list, actually. The list has been growing for about a year and a half. People live on the street or end up in prison for committing crimes. That happens a lot.

Ms. Andréanne Larouche: Do you—

[*English*]

The Chair: Thank you so much. We're at our time. We'll be sure to get back to you, Andréanne.

I'm now going to turn it back online to Leah.

Leah, you have six minutes.

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

Thank you to all the witnesses.

I'm joining you from unceded Algonquin territory, but from home today, which is new.

My first question is for Debbie or Jaime.

I want to ask you about the mental health of a particular segment of the 2SLGBTQIA+ community: the trans community. We know that trans youth face a much higher risk and higher rates of mental crises than other youth. For example, from the Ontario chapter of the Canadian Mental Health Association, we know that LGBTQ youth face 14 times the risk of suicide—you indicated suicide rates before—and substance abuse of heterosexual peers, and from an Ontario-based study, we know that 77% of trans youth who responded to that study had seriously considered suicide and 45% had attempted suicide. It also found that trans youth and those who had experienced physical or sexual assault were found to be at the greatest risk.

I mean, to share that these statistics are not alarming or upsetting is a complete understatement and, clearly, is indicative of a failure to respond to people of diverse identities and experiences. I think it also demonstrates that we are not properly supporting 2SLGBTQIA+ youth and, in particular, trans and gender-diverse youth.

Can you expand on what more we need to do to support queer and trans young people? I know you spoke about disaggregated data. I certainly agree with you. Just on the ground, if we could turn the key tomorrow, what would some of those supports look like?

Ms. Jaime Sadgrove: I can start, and then I'll pass it to Debbie.

I think the disaggregated data, which you mentioned, is one of the most important things. We just don't have information on a federal level about where the need is for trans and gender-diverse communities. For example, the 2019 health standing committee report on LGBTQIA2 health has data specifically on the experiences of LGB people, but there are no axes of analysis about how that breaks out when compared to gender identity. While you're right, Ms. Gazan, that research has been done on provincial levels, we haven't had that data on a federal level yet.

The training for service providers is another big piece, and building on what some of other witnesses have said, I think funding is a really big part of it. Most of the organizations across the country that provide services to LGBTQIA+ people are funded on a project basis, so there's no ability to grow that kind of core capacity.

When you're thinking about marginalized communities, the clinical support is a really important aspect. The other piece is being able to connect with people who share your experience. When you think about pride centres or queer and trans community centres, they're really providing life-saving support. I think, especially in rural areas or more remote areas or in provinces that don't have big cities and that have municipally funded pride centres, that funding is a really core need.

Ms. Leah Gazan: I'm going to have to move on to my next question just because I have a limited amount of time. I'll ask this one of Debbie, because I know that she is leaving in the next hour.

We know that LGBTQ rates of becoming unsheltered or of homelessness are much higher. I know the government isn't doing enough to address this, especially the many youth who are often kicked out of their houses or abandoned by family after coming out. To your knowledge, what kinds of supports do you know of that are currently effective?

My second part just brings up some statistics. For example, according to Stats Canada, prior to the pandemic, LGBTQ2+ Canadians—at 27%—were twice as likely as their non-LGBTQ2+ counterparts—at 13%—to have experienced some kind of homelessness or housing insecurity in their lifetime. We know this is a crisis. I know it's a crisis, certainly, for many young people in my riding. What programs available right now, that you know of, are effective, and how are programs that are currently available not meeting the needs?

I'll give that to Debbie.

● (1625)

Ms. Debbie Owusu-Akyeeah: That's a great question. I think it's twofold.

There are the existing shelter services, which have a long way to go in being affirming of LGBTQ people. That is a huge gap that we're continuing to see. I have a history of working within the women's shelter sector myself, and I know that there are still some ongoing challenges in building capacity to ensure that those spaces are safe for not only queer people but also, I would say, transgender folks in particular.

I have more research on this and actually a study that I helped contribute to, which I'd gladly share later on so that folks can access that. There's definitely that support work. I actually think the LGBTQ sector and the shelter sector can be doing a lot of work together to address that.

Second, I would say that, with regard to family violence prevention, there is a lot of work that needs to happen in working with parents and caregivers around preventative work to support their young people so that these young folks are not ending up on the street. More work on that would be really crucial—and funding that, as well.

The Chair: Excellent. Thank you so much.

We're now going to start our second round. It's five minutes for the Conservatives and the Liberals, and two and a half minutes for the Bloc and the NDP. I'm going to turn over the first five minutes to Dominique Vien.

Dominique, go ahead.

[*Translation*]

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

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

Dr. Shanker, the motion talks about factors that affect the mental health of young women and makes them vulnerable. Could you tell us which factors you think are involved?

[*English*]

Dr. Stuart Shanker: Forgive me for answering in English. I couldn't find my translation button.

Both Debbie and Jaime have identified something very important. We know the data tells us that these pride centres have this beneficial effect. As neuroscientists, we're always asking why. Here, the "why" is that.... It's something that I was thinking of before when I was talking to Michelle. What we need to do is turn off the stress response.

The human brain can't really do it on its own. We are wired for social engagement. It gets turned off by human contact. That's our primary. One of the reasons we've seen this universal rise during the pandemic is that teens and young women have been deprived of what their brain needs, which is social contact, that intimacy that turns off the stress response.

The problem is compounded by the fact that, in the present culture, they are searching for what.... It's called dopamine hooks. You can get a shot of dopamine from social media. What that does is keep you going, but it does nothing to turn off the stress response. On the contrary, for the reasons that were explained to you first thing today, they are exposed to messages that greatly exacerbate their stress load.

The last point I want to make is that—

● (1630)

[*Translation*]

Mrs. Dominique Vien: Unfortunately, I have to interrupt you because we don't have enough time, Dr. Shanker.

Thank you for your answer, but I would now like you to tell me about a social phenomenon that began five years ago, the #MeToo movement.

What do you think about it? Do you feel that women's liberation has had a positive effect on the mental health of young girls and women in general? I'm talking about women in particular, but it can also be men.

[*English*]

Dr. Stuart Shanker: The problem they have is that, in isolation, they cannot reduce their stress, and here is a very interesting phenomenon. When stress is very high, it shuts down our self-awareness. It shuts down our feelings. Now we have the compound problem that they're feeling anxious but they don't even know it until the problem bursts. What we have to do in order to address what you're discussing, in order to empower them, is.... They have to learn how to recognize when they are, or are becoming, overstressed and what they can do to reduce that stress load, which will trigger oxytocin, not dopamine. Then, what we see in all of these problems—

[*Translation*]

Mrs. Dominique Vien: Thank you, Dr. Shanker.

Mrs. McMillan, I'd like to ask you the same question. Have you seen that the #MeToo movement has had a positive effect on women's mental health?

[*English*]

Dr. Stuart Shanker: I'm sorry. I don't understand.

The Chair: The question is for Brittany, so it's okay, Dr. Shanker.

Dr. Stuart Shanker: That's why I didn't understand. I haven't done that.

Ms. Brittany McMillan: Yes, I think there are two folds to the #MeToo movement. One would be that women feel empowered. We can now come out and say that we're survivors of sexual violence. However, the other thing to think about is how triggering it is for individuals to hear about everyone's experiences with regard to sexual violence. Although we want people to feel empowered to come forward and to get the support they need, I think there is some trauma that is created within each.... Because it's so public, it becomes quite traumatic for individuals who have experienced something similar or for them to just know that there is such a risk. Every day, women are faced with the risk of being sexually assaulted, and that just came more to light with the #MeToo movement and, similarly, right now with Hockey Canada.

The Chair: Thank you so much.

We're now going to move back online to Jenna Sudds.

Jenna, you have the floor for five minutes.

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

Thank you to all of the witnesses for being here today, and of course for the incredible work you do every day in our communities.

I just want to confirm—I can't see on the screen—that Debbie and Jaime are still in the room.

The Chair: They're in the room, yes.

Ms. Jenna Sudds: Okay, that's perfect. I was hoping I'd catch them before they left. I'm going to direct my questions to either of them or both of them.

In your opening statement, you mentioned the mental health impacts on 2SLGBTQIA+ individuals, girls and women. I'm wondering if you can elaborate and share with us what some of the impacts are and what difference there is in providing a supportive and accepting environment.

Ms. Debbie Owusu-Akyeeah: Yes. It's a really good question. You want to know what the differences are in providing a supportive environment. I just want to clarify the question, if that's okay.

Ms. Jenna Sudds: Yes.

Ms. Debbie Owusu-Akyeeah: Okay.

What we've seen—of course, I could provide some additional information after this—is the gender component of it. What girls are experiencing, of course, is compounded by the intersection of misogyny or trans misogyny, and then the bullying that's directed based on their gender or sexual orientation. To this day, the majority of the supports for LGBTQ people tend to be centred on cisgender male experiences, which means that the additional nuance of being affirming is lost, still. It causes those additional stresses. That's what we're seeing.

There is some more information that I'd gladly share after this.

● (1635)

Ms. Jenna Sudds: That's incredible. Yes, thank you. That would be very helpful, I think, for the committee.

There's another area I want to ask some questions on, and again this is for either Jaime or Debbie. Recently, in some of the work I've been doing as parliamentary secretary, I've had the opportunity to visit both Pride Fredericton and Yukon Pride. In those conversations, I heard about how important gender-affirming care is for the mental health of trans and non-binary youth—something as simple but as important as gender-affirming care and gender-affirming gear and how those can contribute to gender euphoria for an individual.

I'm wondering what other challenges you can share or point to that trans and non-binary young people face and that impact their mental health, and what we can do better to support them.

Ms. Jaime Sadgrove: That's a really good question.

Talking about gender-affirming care and gender-affirming gear is really interesting and really important. I think one challenge is that over the last few years we've seen a real rise in misinformation and disinformation about what gender-affirming care is and means, especially as it relates to gender-affirming care for people who are under 18.

There's this idea that youth are maybe coming out as trans and immediately accessing gender-affirming care that's irreversible, which is not true. First of all, the reality is that the waiting lists for gender-affirming care in this country are very long and are getting longer. That goes for gender-affirming care at children's hospitals, in youth clinics and for adults. I think there's a lack of understanding that sometimes gender-affirming care can be having support and changing the gender marker on your passport or on your driver's licence, or having support in a legal name change. It's not health care per se, but it's still something that impacts your mental health, not having to see a name or a gender marker that could be difficult.

Going back to what I was talking about before with regard to mental health care, it's having access to providers who understand what it means to be gender-affirming so that youth aren't coming out and then either having to do research online or having to advocate for themselves to providers, who maybe have an outdated understanding of what it means to be trans.

Ms. Jenna Sudds: That's incredible. Thank you for that. That's very helpful.

The Chair: You have 10 more seconds.

Ms. Jenna Sudds: Okay. Thank you.

As I said, I appreciate the insights and everyone's being here today. Thank you.

The Chair: Thank you so much.

We're now moving to two and a half minutes with Andréanne Larouche.

Andréanne, you have the floor.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

Ms. Couture, we ended our conversation by talking about the increase in mental health cases observed during the pandemic. According to the Canadian Institute for Health Information, hospitalizations for eating disorders among young women jumped by more than 50% during the COVID-19 pandemic.

In addition, the pandemic has led to an increased presence of young people on social media. Do you think that the online hate and hypersexualization that this increased presence has caused could have an impact on the mental health of girls and women?

Ms. Véronique Couture: Yes, absolutely. Our organization is currently helping a young woman who has been completely devastated by social media.

We have to raise awareness on the social media used by young people. Messages have to be quick and free of advertising. The companies and people who provide our youth access to social media should be better regulated.

Ms. Andréanne Larouche: If I understand correctly, you believe that the federal government should legislate to set guidelines for online hate. There should be such legislation.

Ms. Véronique Couture: Yes, it's necessary. There is clear evidence every day of the damage done to women and girls by social media.

● (1640)

Ms. Andréanne Larouche: We do need legislation on online hate content.

I'd like to come full circle on funding, which was discussed a lot in my first round. Can rising prices, inflation and the risk of recession be bad reasons for governments to shy away from investing more in health, including mental health? Is it appropriate to make budget cuts in this area?

Ms. Véronique Couture: On the contrary, we should move forward quickly.

Ms. Andréanne Larouche: So, in your opinion, the economic crisis shouldn't be used to justify disinvestment in health, but rather to maintain investments in health despite the economic crisis.

Ms. Véronique Couture: Absolutely.

[*English*]

The Chair: Excellent. Thank you so much.

Now we'll go online for two and a half minutes with Leah Gazan.

Leah, go ahead.

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

Because they're leaving, I have another question for Debbie and—

The Chair: Debbie and Jaime are out of the room. They're gone. Sorry.

Ms. Leah Gazan: Oh, I missed them. That's okay.

I'll move on to the testimony from the Kawartha Sexual Assault Centre.

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

Can you share your perspective on this?

Ms. Brittany McMillan: Yes.

Similar to what Debbie and Jaime stated, we need to educate people on the effects of misogyny and the patriarchy, making sure that those things are kind of at the forefront because, again, when we look at it, every single person is affected by sexual violence. If we're living with the fear of sexual violence or if we're living with the trauma as a survivor of sexual violence, we really need to get to the core and the root of the problem, which is the violence itself being perpetrated.

Ms. Leah Gazan: Just following up on this question.... We know that we need education, but going back, we also know that women or gender-diverse people who have experienced violence—there's been a lot of research on it—have lasting post-traumatic stress disorder that impacts their daily lives. Do you think there is enough support for women or gender-diverse individuals who have gotten out of violence to recover from the post-traumatic stress that it often causes?

Ms. Brittany McMillan: Absolutely not. If we look at just the sexual assault centres in Ontario, many of our centres haven't seen an increase in funding since the 1990s. With the #MeToo movement, for example, we saw rates of people requesting our services heighten, but we haven't been able to figure out a way to manage our wait-lists without increased funding.

We were a core service that was asked not to have a wait-list, but that's not a reality. Across Ontario—and, I'm sure, the country—that is a challenge.

The Chair: Thank you so much.

We're now going to start our third round, for five minutes, starting off with Anna Roberts.

Mrs. Anna Roberts (King—Vaughan, CPC): Thank you, Madam Chair.

Wow, I'm learning so much today. I have a couple of questions. I'm going to start with Brittany or Jordanne.

How many people do you serve?

Ms. Brittany McMillan: Right now, with the way we're funded, out of our core funding, that includes only four staff. I can pay only four staff under the core model. However, with a bunch of grants we chase—we are always asking for money and doing all these things—we have more than that.

Right now we have three full-time counsellors—one of them is funded with core funding. They serve about 30 clients each round, who get about 12 to 14 rounds of service, counselling sessions. Then we have two part-time counsellors, who serve Trent University, the university that is in Peterborough, as well as Fleming College. In a year, we probably see close to 200 people.

● (1645)

Mrs. Anna Roberts: You do this on a $300,000 budget.

Ms. Brittany McMillan: Yes.

Mrs. Anna Roberts: We need to learn how you do that, because that's really incredible. Congratulations to both of you. That's amazing.

I want to also ask Dr. Shanker something. Is he still there?

The Chair: Yes, he's there.

Mrs. Anna Roberts: Dr. Shanker, I know you spoke to Michelle. You mentioned calming. I found that very interesting. I did some research on PTSD with veterans and on how service dogs or therapy dogs really help with PTSD. Do you have any studies on how service or therapy dogs, whatever you want to refer to them as, help with the same situation with young women and victims of sexual assault?

Dr. Stuart Shanker: You're exactly right. My older son is on the spectrum. The very first thing we did was get him a service dog. We now know that what the dog does is trigger oxytocin. Oxytocin shuts down the stress response.

The problem with PTSD is that the victim has what's called a kindled or heightened stress reactivity, so all kinds of things send them into hyperarousal. It's not just a simple fix—"Let's go get a Lab"—although, as the owner of a Lab, I can attest to their incredible benefits for calming an autistic kid. There are all kinds of ways. It's really a case that, for these women and kids, we want to give them as many different ways of triggering the oxytocin as we possibly can.

It's a great question.

Mrs. Anna Roberts: One thing I also learned was that having a service dog helped reduce the medication they required for PTSD. It also helped them.... As we know, they are costly to train, but the advantage at the end of it is the money we're saving, both on health care and on prescriptions, and the benefit to the individual of not having to absorb all these medications when they have a service dog or therapy dog.

One example that was given to me was that of a veteran who was on suicide watch. He would have horrible nightmares about what happened. The dogs were able to wake him up and calm him down. Do you think that would be beneficial?

Dr. Stuart Shanker: You've done your homework, Anna.

What the medication does is suppress the physical symptoms of an anxiety attack. It slows the heart. It slows galvanic responses. It does nothing to stop the mental side. It does nothing to stop the stress itself. The dog does.

Here what we find is that the wonderful therapists, who have been talked about today, are triggering that calming system. Let me just generalize. We are seeing a generation now, a generation of teens and young adults, of both sexes, who do not know what calmness is.

Mrs. Anna Roberts: I have 10 seconds.

Thank you very much.

Dr. Stuart Shanker: We need more dogs.

The Chair: Yes, and to my dog, Benson, hello. He's probably out there watching right now. He keeps me calm.

We're now going to pass it over to Sonia for five minutes.

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

Thank you to all the witnesses for joining us and giving us valuable testimony.

My first question is for Ms. McMillan. You said we need more education. Also, you talked about PTSD. What is an effective way to prevent sexual violence? Can you elaborate on that?

Ms. Brittany McMillan: A big focus that we have at the centre is prevention education. Again, there are sort of two parts to our services. One is providing counselling services and case management to survivors. The other is prevention education. Really, we do things like bystander intervention and we talk about what consent actually means. We're really getting into the school systems and things like that to be able to provide that service.

● (1650)

Ms. Sonia Sidhu: Do you think the online violence or bullying is also a risk factor? How are you preventing that?

Ms. Brittany McMillan: Yes, it's certainly a risk factor. We see many clients who come to us because of sexual assault that was perpetrated on them through social media or through texting photos and things like that. It's certainly a huge concern, and as we as a community get more technology, it continues to be a concern.

Ms. Sonia Sidhu: Dr. Shanker, or any of the other witnesses, can you elaborate on that and offer us any insight or recommendations as to how we can prevent that and protect our young girls?

Dr. Stuart Shanker: One of the questions we have to be asking is why these young or older males are doing it. One of the problems we see is, again, that there is a system very deep inside the brain. It's called a seeking system, and when it becomes aggressive, it's called predatory aggression, and it can be triggered by what Brittany was just saying. When that is triggered, it shuts down self-awareness. It shuts down thinking. What happens is that all of the things we've taught them, all of the lessons about the harm, go out the window. They don't process them in the moment.

What we have to do is figure out...and we actually know how to do this. Michelle was hinting at this at the start. They have to learn to recognize in themselves when they are shutting down and why they are shutting down so that we can bring their empathy back online, because empathy shuts down completely. They do not see their victim as a human being. They see them as prey. This is the scariest part of it.

Ms. Sonia Sidhu: Dr. Shanker, you talked about emotional stress and how that turns off dopamine, but how can we balance that dopamine? There's a lack of motivation in youth. How can we elevate that motivation? Does psychotherapy help?

Dr. Stuart Shanker: Of course it does, but the problem is that, as data coming out of the U.S. tells us, at least 50% of adolescents are having these problems, and it's probably considerably more, so we need to be thinking in terms of a universal model. Our problem is that they are living at a time when they are turning to things like social media or video games, and what these do is give them a shot of dopamine, but they do nothing to turn off their stress. And so, they get more and more stressed, and then—guess what—now we have a serious issue like suicide on our hands.

There was somebody today who made this wonderful point. I think it was Jaime. These parents and providers, we have to educate them. What are the signs that your kid is overstressed? What are the things they're doing to deal with that stress? As a parent or a provider, you shouldn't add to their stress by thinking that all they need is to be pushed and that if we push them, then their motivation will come back online. It is not a case of pushing. It is a case of reducing the stress so that they can get to calm.

I don't know if that answers your question, because it's a really tough question.

Ms. Sonia Sidhu: Yes, it does. Thank you very much for all the work you're doing on the ground.

Thank you.

The Chair: Fantastic.

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

[*Translation*]

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

Mrs. McMillan, I was one of the MPs on the Standing Committee on Canadian Heritage to question Hockey Canada representatives about the sexual assault allegations. They have since resigned, and that's fine; their lack of empathy and real commitment to culture change was striking in their opening remarks.

You yourself talked about hockey and these assaults. Now that Hockey Canada representatives have left, what is being done? Where do we start to demonstrate the importance of taking action, to bring about a real cultural shift in toxic masculinity and the lack of empathy around violence against women in all sports, not just in hockey?

● (1655)

[*English*]

Ms. Brittany McMillan: That's a great question. Thank you.

I think the biggest piece is prevention education at a really young age. Right now, for example, we at the centre are getting to minor hockey associations to start that training right at the age of six. We're also working with coaches and parents to talk about those issues around toxic masculinity and the dangers of it. We're doing a lot of work that way. Unfortunately, there aren't funds for that. We're just responding to the crisis, knowing that we can prevent a bunch of future sexual assaults from happening.

We do work closely with our OHL teams; I just want to highlight that. The Ontario Hockey League has taken many steps ahead of these allegations, so I think that's also important to note, but it is.... It's getting to the kids, the coaches and the parents at a really young age because we do put hockey players and other athletes on a pedestal. We need to make sure that they're not just great players but that they're also great off the ice.

[*Translation*]

Ms. Andréanne Larouche: We really need to send a message of zero tolerance and transparency when these situations occur. Proper training allows us to recognize these situations and denounce them in order to send this message of zero tolerance and to make it clear that we don't want any more cases like these.

We know that there have been studies, especially academic ones, on how to create a culture change. Are there any that you're interested in? Would you like to turn to this research and these researchers who have looked at this issue of culture change?

[*English*]

Ms. Brittany McMillan: The prevention education team at our centre—and across most of the sexual assault centres—is always looking at current research and trying to implement those changes and be a part of some of those implementations. We're consistently looking for new ideas, for how we can make this better and for how we can effectively change a culture.

It's not just hockey. It's a society culture that we're trying to shift as well.

[*Translation*]

Ms. Andréanne Larouche: Absolutely.

Ms. Couture, in closing your opening remarks, you also talked about the importance of educating people about this and working proactively with young men and women. Would you like to add anything to that?

Ms. Véronique Couture: I sincerely believe that school faculty and officials should have training on mental health issues. I think there's a lack of education around this. Most of the time, mental health issues are lumped together, but I think everyone needs to learn more about it.

Ms. Andréanne Larouche: You talk about education, but there are also gaps in areas of federal jurisdiction, such as a lack of mental health education in federal penitentiaries.

Staff in these penitentiaries need to be trained on how to intervene, because they often have to deal with people who have mental health issues.

Ms. Véronique Couture: Services are indeed quite minimal in the prison system. There should be much more extensive and explicit training. I think it's necessary, because people—

[*English*]

The Chair: That's perfect. We're going to have to switch over to the next person.

I'm going to pass it over to Leah Gazan.

Leah, you have two and a half minutes. No, I'm sorry. You have five minutes. I'll give you five.

Ms. Leah Gazan: I was going to say that I'm watching the clock here. Thank you so much, Chair.

My question is for Dr. Shanker.

I'm interested in your analysis. When I was in university, my first course in psychology was taught by a neuropsychologist, so I certainly appreciate your perspective.

Here's my question for you. In your testimony, you talked about helping young people—or women and girls—with stress by taking away stress factors, and you mentioned, for example, parents, but we know that all situations aren't the same.

For example, you can look at social determinants of health and look at it more from a social psychology perspective in terms of things like intersecting identities and the impacts of colonization on indigenous people. We've heard much today about the impacts of bullying on the 2SLGBTQIA+ community, and I would say that it goes beyond bullying to things like mass murders, which we've actually witnessed, and the kind of stress that just living in the world places on those communities. There are also discrimination and ableist behaviours faced by disability communities.

These are just a couple of very brief examples that impact many young people—many young women and girls and diverse-gender people. I'm wondering if your research looked into intersecting factors that impact brain health and functioning.

● (1700)

Dr. Stuart Shanker: Leah, you had a good professor.

Yes, we do. We distinguish among three levels of the brain. We call them blue brain, red brain and grey brain. The red brain is the part below the surface, the part that has the limbic system—our emotions and things like that. All of those stresses that you're describing send these kids—or people of whatever age—into red brain. When they're in red brain, strong negative emotions are running the show.

We've heard today about these wonderful programs that are designed to get them back into blue brain, to calm down the red brain so they can begin to think. What we find—and this is really important—is that when someone is in red brain, they cannot choose. We can give them all the information that we—

Ms. Leah Gazan: Just going in there, we hear about things like blood memory, for example. We can talk about red brain. This is not a moment of behaviour. For example, if a parent is calm.... There are intergenerational layers of trauma. If we look at, for example, war veterans or women who have experienced violence, there are all sorts of triggers that set off stress factors that can't just be controlled. It goes beyond that. It's in the lived memory of our brain. I would say spirit, but it's our brain.

When you're talking about mitigating that, is part of the response then addressing those historical impacts or colonial impacts to assist people who go into crisis?

Dr. Stuart Shanker: Absolutely. We do an awful lot of work in the far north. The basic thing we've learned is that we cannot have this kind of individualistic focus. We can't look at the mind as this solitary thing. We're seeing entire communities that are in red brain. In fact, if we look south of the border, we're seeing an entire country that is in red brain.

What we have to do is figure out how we can precipitate this healing process. It cannot happen unless we restore calmness—unless we restore homeostasis—so that we can now begin to jointly problem-solve and address it.

Ms. Leah Gazan: Sure. Thank you so much. I would say that when we're talking about restoring calmness, that also includes addressing systemic racism.

Dr. Stuart Shanker: I agree.

Ms. Leah Gazan: I just want to move on to—

The Chair: You have 10 seconds.

Ms. Leah Gazan: Oh, shoot.

My next questions will be for Melanie Omeniho.

The Chair: Okay. Go right now. I'll give you your minute and half right now, Leah. Go, and then we'll come back.

We're just going to move you. Go for it.

Ms. Leah Gazan: You spoke about land-based healing. We have a term about that. I was wondering if you could explain that. We know that “one size fits all” doesn't work.

Can you expand on that?

● (1705)

Ms. Melanie Omeniho: Many of our communities have land-based learning opportunities for people to reconnect to who they were, their culture, their identity and their ability to work through many issues. There have been many programs and pilots that have been examples of bringing our youth back to being a connected part of our community and our society.

Ms. Leah Gazan: I was just saying, feeding off the last question, that it's like feeding our blood memory. It's resolving past traumas. Would you agree with that?

Ms. Melanie Omeniho: Absolutely. As a young child, I was very fortunate to have my community around me. I was able to connect with family and always have people who loved and showed support, caring and kindness. Our young people now are missing that, especially our young women. We need to bring them back to connect with the grandmothers and the grandfathers so that they can feel connected to society.

Ms. Leah Gazan: It's almost like a circle. You start understanding why you are the way you are today by understanding your lived history but also the lived history of the ones before you.

Ms. Melanie Omeniho: Absolutely.

Ms. Leah Gazan: Thank you so much.

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

We're now going to our next round. Leah, I'm dropping you from this round now.

For the next round, we're going to start off with four minutes for Michelle and Marc, and then with two and a half minutes for Andréanne and Annie.

We'll start with Michelle.

Michelle, go ahead for four minutes.

Ms. Michelle Ferreri: Thank you, Madam Chair. Thank you to everyone. We'll see what we can fit in four minutes here.

We are studying the mental health factors that are contributing to the decline of women. I know we have Brittany and Jordanne here from Kawartha Sexual Assault Centre. I'm going to try to do something in four minutes. Let's see if we can do this. I'm going to try to connect you to what Dr. Shanker is doing to see how that will actually help where we are going.

How is the frontline staff doing, Brittany, in managing the stress of caring for your clients?

Ms. Brittany McMillan: That's a great question. I think it's something that's so important.

If we think about the mental health of those of us who are the people serving the clients, that needs to be at the forefront. Unfortunately, with so much uncertainty in terms of budgets and things like that, people are always feeling at risk of losing their job. We've been asked to continue to provide this service based on our passion for helping people. But if we look at this as a systemic issue, people know that most people running these types of organizations are women and that we'll just do it out of the kindness of our hearts.

It is a systemic issue. We're drastically underpaid—from my role all the way to every frontline person there. We continue to do things with each other—we're a great team, and I'm hopeful that a lot of people have that support—but the reality is that it's really hard.

Ms. Michelle Ferreri: The irony is that you need the care provided to you that you are ultimately trying to provide to your clients.

Now I'm going to turn to Dr. Shanker. Brittany touched on one of the things we are fighting for so much right now, which is that every parent, every person in general, is bombarded with the stress of this new world of inflation and worrying about the affordability crisis. That goes for the not-for-profit sector as well. When they don't know where their funding is coming from, that creates stress.

Dr. Shanker, how do we help these frontline workers? If we do not help them, if we do not help our RCMP officers who are out there getting killed because they are doing the work of too many people, how are we going to help shift our society to get back to calm and to self-regulation?

Dr. Stuart Shanker: Let me just say to the committee that what Michelle is saying needs to be processed very carefully. This is important. Right now we are doing big projects with the armed forces. We do projects with hospitals, pediatricians and nurses, etc. They are burned out. They are overstressed. Parents are overstressed because of the stresses that their clients or their patients or their frontline workers are feeling.

What we need to start thinking of—and this is Michelle's point—is a universal approach. We as a healthy society need to figure out why this is happening and what we can do about it so that we maintain what has always been the heart of Canada, which is that we are a society that cares about every one of its members.

● (1710)

Ms. Michelle Ferreri: I love it when Dr. Shanker is able to tell people what my point is, because he's bang on. It's true, and I think if we don't have that national framework in place.... He's saying "universal", but I'm going to speak from a federal government perspective.

Dr. Shanker, with that framework, $4.5 billion has been allocated, as I said earlier. If we don't send this mental health transfer into a universal or national framework, what's going to be the destiny of Canada? Answer in five seconds. Good luck.

The Chair: You have 15 seconds to reply.

Dr. Stuart Shanker: I can do it in eight seconds. Just look south of the border, Michelle.

Ms. Michelle Ferreri: Yes. Well said.

The Chair: Thank you so much.

We're now going to pass it over to Marc Serré for four minutes.

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

Thank you to all the witnesses. It's going to be a challenge to get in all of this in four minutes. I just want to follow through with what Michelle was just mentioning about the national framework. Right now negotiations are happening with the provincial governments and the federal government. Obviously, community-based services and mental health and addiction services focused on youth aged 10 to 25 are one of the priorities. Previously we heard witnesses from The Royal Mental Health in Ottawa indicate that the system is broken and hard to access.

Brittany McMillan, earlier you mentioned a gap and how you cannot serve girls under 16 years of age. Who is serving them? What's happening and what recommendations do you have for us to go back to the bilateral agreements to address this?

Ms. Brittany McMillan: That's a great question, and it's something that sits really heavily with all of us. We know we need to be serving those girls.

I will say that we do have a limited Public Safety grant, through the federal government, to focus a little bit more on human trafficking and sexual violence. With that piece, we do have some flexibility to help service girls under the age of 16. However, again, it's not in our core funding model.

It's such an issue. I really worry about the girls. I think at this point they're often told to pay for services or to get services, as the other team that left was saying, from those who aren't specialists in sexual violence. We're not entry-level counsellors, but we pay only entry-level wages, so we need to make sure those young girls are getting service that's trauma-informed but also specific to sexual violence training.

Mr. Marc Serré: Thank you for that.

Earlier you also mentioned clinical therapy versus home strategies. Can you expand a bit on some of the recommendations along the lines of the hospital or clinical aspect versus the organizational and home strategies? You alluded to that earlier.

Ms. Brittany McMillan: Yes. We work really closely with a lot of our community partners, so if people need counselling, they come to us or we refer out. Then we do a lot of meeting people where they're at. Jordanne specifically does a lot of accompaniment of individuals who are navigating the legal system, as well as those needing to go to the hospital because of STIs. There are things like that.

I think we're basically doing it all when it comes to sexual violence. Maybe MCCSS will be mad, but we can't follow the mandate or we wouldn't be able to sleep at night.

Mr. Marc Serré: Thank you.

Melanie Omeniho, you mentioned earlier land-based knowledge and traditional medicine, but can you expand a bit on the grandmothers' wisdom circle and how that could inform us, with some recommendations along those lines?

Ms. Melanie Omeniho: In our community, we have grandmothers. I know that people have a tendency to call them “elders”, but they really love to be called “grandmothers”, and they're the grandmothers who collectively work together.

When they come together in circle, they bring the young people with them and they pass on the tradition, knowledge and language of who we are. It's an important part of reconnecting people who are sometimes called “latchkey children”, who have been disconnected due to urban issues or due to the fact that we don't have the same kind of communities we used to have. We try to bring them back together, and the grandmothers work with them, counsel them and advise them.

● (1715)

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

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

[*Translation*]

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

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

Since these will be my last questions, I'll quickly turn to Ms. Couture, who hadn't quite finished what she was saying when I talked about the importance of providing mental health training, especially in the prison setting.

Do you have anything to say or add on this in 30 seconds?

Ms. Véronique Couture: I'll talk about what we're seeing in our organization. People come from a prison setting, but because there are no direct mental health services, they end up in the general population, where the problems are only half-treated, if at all.

When they come to us, they're even sicker. They need a lot of consultations with our case workers. Their stay with us lasts longer, because they need more time to regain enough independence, especially to move into an apartment. Normally, a stay with us lasts from three to six months. However, because of work that wasn't done beforehand while they were in prison, these people now need 18 to 24 months to achieve that independence.

Ms. Andréanne Larouche: Thank you for your testimony and commitment to the community, Ms. Couture.

Ms. Omeniho, you mentioned the recommendations that affect indigenous women and girls. If I've understood correctly, you talked about the importance of implementing these recommendations, which still hasn't been done, and how that might relate to the mental health of young indigenous women and girls.

[*English*]

Ms. Melanie Omeniho: Yes, it has been pushed back. The recommendations have been made for a very long time now. It's been three years since the reports from the inquiry in “Weaving Miskotahâ” have been out, and longer for those from the TRC. A lot of the commitments that were made have not been acted on, and that has significantly impacted young women and girls.

When one-third of our young women tell us that they have suicidal thoughts, it's a serious, traumatic issue in our communities. We need to work to make sure we can have healthy young women moving into the future who don't feel that they're not important or who don't have extreme anxiety and depression issues.

The Chair: Thank you so much.

I'm now going to turn it over to Annie for the last round of questions.

Go ahead, Annie, for two and a half minutes.

Ms. Annie Koutrakis (Vimy, Lib.): Thank you very much, Madam Chair, and thank you for giving me the opportunity to ask this question.

When I interview people for my staff, I always tell them they can have a one-minute elevator pitch to convince me why I should hire them, so here's the one-minute elevator pitch to the Government of Canada.

In what ways could the Government of Canada improve the effectiveness, availability and accessibility of mental health services for young women in Canada, and why?

The Chair: If you want to direct that to whoever you want to answer first, you have a minute and a half.

Ms. Annie Koutrakis: I would start with Dr. Shanker, and then if there's some time, any one of the other witnesses who would like to could chime in.

Thank you.

Dr. Stuart Shanker: I want the government to teach parents and educators what self-regulation is. I want them to teach it so that they do it for themselves, and so that they recognize the need for their kids, whatever their age, to learn how to self-regulate in healthy ways.

Ms. Brittany McMillan: In terms of what we could do specifically, it would be to invest some more dollars towards sexual assault supports, knowing that, statistically, the rates of sexual violence are significant.

[*Translation*]

Ms. Véronique Couture: I would say that we need to simplify and speed up access to funding so that we can meet our clients' needs more quickly.

[*English*]

Ms. Melanie Omeniho: For me, it's about trying to make sure that the resources we need get to the communities' program service providers who are providing mental health services to help our young people.

● (1720)

The Chair: That's perfect.

On behalf of the committee, I would really like to thank everybody for coming and bringing their testimony today. It's been very strong and very helpful.

As you're leaving, we are going to have about six to 10 minutes of committee business. We're not going in camera; we're just going to do it live. Our guests are more than welcome to leave right now if they wish to. I'm just going to go through some of our business right now.

Perhaps everybody can turn to their business for the day. I'm going to start with an Elections Canada document. As you were all informed by the clerk, Senator Donna Dasko has inquired about the possibility of accessing Elections Canada's written response following their appearance in June 2018.

Is it the will of the committee to share that response with the senator?

Some hon. members: Agreed.

The Chair: To the clerk, we will send off a favourable response to the senator.

Go ahead, Sonia.

Ms. Sonia Sidhu: Madam Chair, a response came in 2018. If all party members are willing, then we can share.

The Chair: That's fantastic. It looks as though we're all in favour. There should be no issues there. That's wonderful, so we will send that off.

On the next piece, a delegation of Armenian parliamentarians has asked to meet with the committee next week. We had initially looked at Thursday, October 17. They had asked for us to do it from 11:15 to 12:15. Unfortunately, that will not work because resources are not available to us.

The clerk has been working on this, but it's really up to the committee if we want to arrange an informal meeting. I'm going to ask the clerk, if she wants to take the mike. I'll be honest that I really get nervous about cancelling our meetings when it comes to mental health and wellness, because we're doing such incredible work.

I'm going to turn it over to the clerk. What are our options? We can do an informal meeting and have some food. What are you recommending?

The Clerk of the Committee (Ms. Alexie Labelle): Usually those kinds of meetings are considered informal meetings. The committee can decide to organize a lunch. I can go back to the organization to see if the date and time the committee would like to meet with them would work for them. It will always depend on the resources. I can make a request for the time that you decide upon. If the resources are not available, then it will be up to the whips to decide.

The Chair: That's perfect.

I guess the first question I have for you is whether you are interested in having an informal meeting with the parliamentarians from Armenia. Overall it looks as though we're good.

[*Translation*]

Ms. Andréanne Larouche: Madam Chair, even if this is an informal meeting, with a change in time slot, could we still request resources?

The Clerk: Actually, I had already requested resources for the proposed time slot, but that was denied. If the committee decides on another time slot, I will make the same request because I will have to get the resources approved again.

[*English*]

The Chair: That's fantastic. We are good to have an informal meeting.

Is it the will of the committee that the clerk be authorized to make the necessary hospitality arrangements for an informal meeting with the Armenian parliamentary delegation? We have to try, first of all, to get resources. That's very important, I know, for both Andréanne and Dominique specifically, so we can all be part of this. Is it the will of the committee that, if everything's a go, we go ahead and authorize the clerk to make the arrangements? Do I see support for that?

(Motion agreed to)

The Chair: We're going to go ahead, then. With your authorization, I will work with the clerk and we will find a date and time and try to find something that works for at least the greatest majority of us.

Finally, we will be meeting again next Monday, October 24, to resume the study of mental health of young women and girls.

Do I see adjournment for today's meeting?

Some hon. members: Agreed.

Ms. Leah Gazan: Sorry, I just have a question. We were given a motion. What is going to happen with that?

The Chair: That motion is just sitting there. It's been tabled. It's just sitting there among all of our other motions. When we come to discussing what we want to do for our next studies, it will be up to the membership of the committee how we want to move forward.

● (1725)

Ms. Leah Gazan: Oh, okay. I see. Thank you for the clarification.

The Chair: Today's meeting is adjourned.