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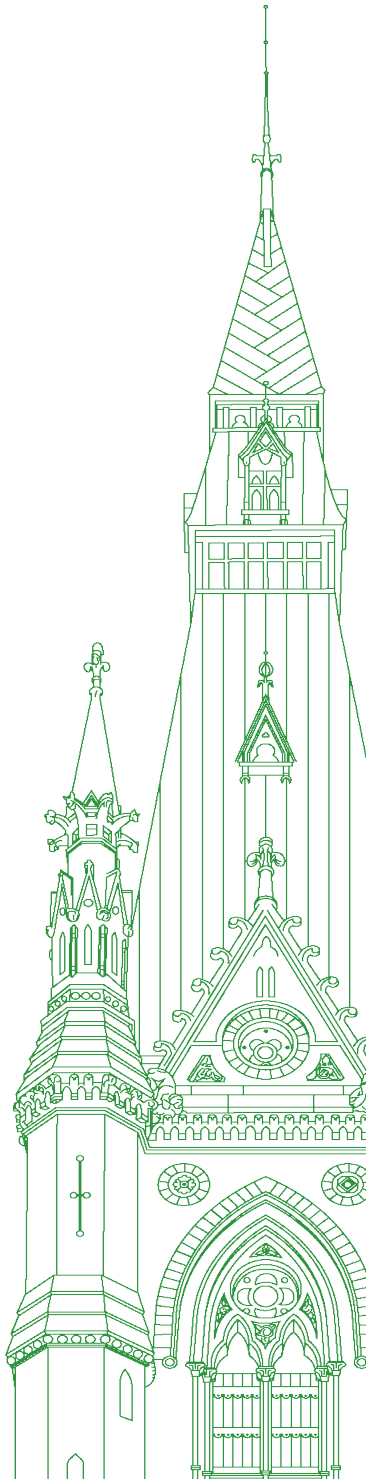

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, April 8, 2024

● (1535)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 108 of the House of Commons Standing Committee on Health.

This is just a quick safety reminder not to put earpieces next to the microphone, because it causes feedback and potential injury. In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Pursuant to Standing Order 108(2) and the motion adopted on May 16, 2022, the committee is resuming its study of women's health.

I'd like to welcome our panel of witnesses. We have with us today Dr. Catriona Hippman, postdoctoral research fellow, B.C. reproductive mental health program, B.C. Women's Hospital and Health Centre. By video conference, we have Dr. Ryan Van Lieshout, associate professor, department of psychiatry and behavioural neurosciences, McMaster University. Also by video conference, we have Dr. Simone Vigod, professor at the University of Toronto and head of the department of psychiatry at Women's College Hospital. From the Québec Alliance for Perinatal Mental Health, we have Dr. Tina Montreuil, associate professor and scientist for the Montreal antenatal well-being study.

Welcome to all of our witnesses. We're going to begin with opening statements of five minutes or less.

Dr. Hippman, we'll start with you. The floor is yours.

Dr. Catriona Hippman (Postdoctoral Research Fellow, BC Reproductive Mental Health Program, BC Women's Hospital and Health Centre, As an Individual): Thank you very much, and good afternoon.

Today, we are calling for an urgent revision of the Canadian task force guideline on perinatal depression screening. This guideline undermines decades of work by experts in B.C. and across Canada to promote universal standardized screening, and places the burden of advocating for their mental health on Canadian women at an incredibly vulnerable time in their lives. We can, and should, do better.

My name is Catriona Hippman, and I'm a post-doctoral research fellow with the B.C. reproductive mental health program, the University of British Columbia and the University of Calgary. I'm a Canadian Institutes of Health Research fellow and a Michael Smith Health Research BC fellow.

Perinatal depression is an important public health issue. It affects 10% to 15% of women, with even higher rates among marginalized groups, affecting almost half of immigrant and indigenous women. In light of this, it's unsurprising that suicide is a leading cause of maternal deaths in Canada.

Early identification is key to improved outcomes. When caught early through universal standardized screening, perinatal depression can be successfully treated, and negative downstream consequences for the child and the family can be prevented. Not only can we prevent disastrous outcomes for families with early identification, but we can also save costs for the health care system. A 2021 report by the Canadian Perinatal Mental Health Collaborative demonstrated that costs of $150,000 for each mother-baby dyad affected by perinatal depression and anxiety could be reduced to $5,000 per family with universal standardized screening.

Given this context, it is shocking that the Canadian Task Force on Preventive Health Care currently recommends against universal standardized screening for perinatal depression. This recommendation contradicts screening recommendations within Canada as well as worldwide, including in the U.S., the U.K. and Australia.

At the B.C. reproductive mental health program, we set the standard of care for British Columbia through clinical practice guidelines, resources and interdisciplinary education. We're a national leader in perinatal mental health care, providing over 5,000 direct patient care visits per year and indirect care for countless patients through a rapid consultation service to B.C. primary care providers. As determined by the reproductive mental health program, the standard of care in B.C. includes universal standardized screening for perinatal depression.

In contrast, the Canadian task force recommends that perinatal depression screening occur “as part of usual care”. This means that only patients flagged by their primary care provider will receive additional attention. This is simply not enough. A study in Alberta in 2021 documented that in “usual care”, approximately two-thirds of cases of perinatal depression were missed. This study estimated that 2,000 cases of postpartum depression could have been detected with universal standardized screening.

“Usual care” places the burden of advocating for their mental health on Canadian women. We know that our health care system is strained, and the reality is that under “usual care” conditions, it's the patients who need to bring perinatal depression to the attention of health care providers. What's more, “usual care” is inequitable care. Research has demonstrated that when perinatal depression screening is left to the discretion of the health care provider, racialized patients are less likely to get screened. White women are more likely to have their concerns taken seriously, and women with socio-economic privilege have the greatest capacity to advocate for their own care. This perpetuates health inequalities and further marginalizes Canada's most vulnerable.

You might think that we just don't like the conclusions that the task force reached, but it's more than that. Their conclusions are not justified. The systematic review on which the guideline was based identified a single randomized controlled trial, or RCT, which found that participants who had universal standardized screening had improved maternal mental health outcomes at six months postpartum. Further, the patient values and preferences studies conducted by the Canadian task force highlighted that participants felt the potential benefits of screening outweighed the potential risks. Participants characterized potential harms of screening as trivial. Our perspective aligns with that of the patients in this study, who felt that “risks of overdiagnosis or its resulting treatment were not considered critical in comparison with failure to diagnose depression”.

In summary, the task force prioritized concerns about speculative harms over documented benefits, the perspectives of patients and the opinions of experts.

We need to take the burden off Canadian women. Universal standardized screening promotes equitable access for all Canadians to have a mentally healthy pregnancy and postpartum. We need a Canadian task force guideline that prioritizes preventive health care.

● (1540)

Thank you.

The Chair: Thank you very much, Dr. Hippman.

Next, we're going to go to Dr. Montreuil with the Québec Alliance for Perinatal Mental Health.

Welcome to the committee. You have the floor for the next five minutes.

Dr. Tina Montreuil (Associate Professor and Scientist, Montreal Antenatal Well-Being Study, Québec Alliance for Perinatal Mental Health): Thank you.

I am an associate professor at McGill University, in the department of education and counselling psychology, as well as an associate member of the departments of pediatrics and psychiatry. I am also a scientist at the Research Institute of the McGill University Health Centre. As such, I bring together the perinatal mental health expertise and early childhood development. This is what I'm going to advocate for today.

I will add on to what my colleague mentioned.

The perinatal period is defined as the gestational period of pregnancy until 12 months postpartum. We know that perinatal mental health disorders, such as depression and anxiety, are among the most common complications of childbirth, affecting as much as 20% of pregnant and postpartum individuals. The rates of postpartum depression have doubled since the COVID-19 pandemic. This is from a source provided by Inspiring Healthy Futures, with the contribution of Health Canada and the Public Health Agency of Canada. The source estimates that the incidence of mental health issues among both women and men have increased by more than 10%.

These statistics are reported to affect an even greater number of women in marginalized and under-represented populations, such as IBPOC women, who are disproportionately affected by mental health issues and are most often missed in these reported studies. We're not specifically targeting these populations and, as such, it questions the generalizability of the findings that we often report.

More than 350,000 individuals become pregnant in Canada every year, which suggests that up to 105,000 Canadians may experience perinatal anxiety and mood disorders, making them the most common pregnancy complication. Pregnancy complications don't just have implications during pregnancy, such as gestational hypertension, pre-eclampsia or gestational diabetes, which have received recognition for their predictive roles in the incidence of more chronic disease later on in a woman's life. This is not the case, however, for mental health during that same critical period of women's health.

It was mentioned that maternal suicide is a leading cause of maternal death in high-income countries. Maternal depression and anxiety are associated with an increased risk of preterm birth, low birth weight and child social, emotional and behavioural difficulties. This is where my child expertise comes in. It's also known to basically continue to have a lifelong effect into adolescence and be associated with mental health issues in teenagers into adulthood.

Some causal analyses have been conducted in the United States, the United Kingdom and Australia. These are countries that are very comparable to the one that we are living in, Canada. They highlight the significant economic impact of untreated perinatal mood and anxiety disorders in Canada. Thus, many experts working in the area, such as us here today, do question the lack of early detection and appropriate treatment of maternal depression and anxiety, as well as its consideration as a public health priority.

Unlike other gestational conditions affecting the pregnant person, mental health issues remain the most underdiagnosed. To just give a little representation or equivalent, according to Diabetes Canada, gestational diabetes affects one in 10 women—we said that mental health issues affect about 20% of women. One in every 632 births would result in a baby with potential complications such as Down's syndrome. This, again, is according to Health Canada data. This data alone has sufficed over the years to understand the need to conduct and maintain systematic nuchal translucency and gestational diabetes screenings as part of routine prenatal care. Despite what we know of the incidence of mental health issues and the fact that they affect both the woman's health and the child in terms of intergenerational transmission, we do not have the same type of screening when it comes to mental health issues during pregnancy. It's not part of our prenatal care, unlike some of the countries that I mentioned before, which are developed countries like ours.

That being said, given the high prevalence and adverse consequences of perinatal mood and anxiety disorders, several countries have now recommended—as has been mentioned before and will be mentioned again—the need for routine screening for prenatal anxiety, depression and other mental health issues during the course of pregnancy. The failure to identify these risk factors of adverse perinatal mental health outcomes can have negative consequences for the mother, as I mentioned, but also for the child.

● (1545)

Using an existent evidence-based model stemming from the London School of Economics, we've been able to conduct this same type of economic impact calculator with the Montreal antenatal well-being study that I represent. The economic impact tool was necessary to determine the economic cost of perinatal health mood disorders and also enable us to make these estimations throughout every province. We are now upscaling this tool to include cost-effectiveness of interventions and referral interventions in the Canadian context.

The first phase of our economic impact calculator has produced an estimate that a lack of routine screening in Canada would lead to a cost of about $6.7 billion per year in Canada. The cost of perinatal mental health illnesses in Canada is associated with about $46,000 per birth for deliveries, and about 70% of these are accountable to the child. The child would basically go on to develop such adverse effects and outcomes as poor cognitive functioning, which is also impacting their future development.

The evidence speaks for itself. The benefit to the mother or pregnant person can be achieved via preventative care during the prenatal phase. Not only can this present as a benefit to the woman during pregnancy; it could also play a critical role in early detection and prevention of other postpartum diseases, as I've mentioned, such as breast cancer, cervical cancer, cardiovascular disease, diabetes and osteoporosis.

Using a precision health framework—

● (1550)

The Chair: Dr. Montreuil, can I get you to wrap it up? You'll have lots of time to expand on this during questions.

Dr. Tina Montreuil: Absolutely.

We've already been able to address that it's a benefit to the woman during the pregnancy but also postpartum. As a benefit to the child, targeting perinatal mental health issues is optimal for their development, and it contributes to society from a human capital standpoint.

Thank you.

The Chair: Thank you very much, Dr. Montreuil.

Colleagues, we are having some technical difficulties with the connection to our online participants. We will suspend to get those resolved before we invite them to present their statements.

The meeting is suspended, hopefully for just a short few minutes.

● (1550)

_____(Pause)_____

● (1550)

The Chair: I call the meeting back to order.

As you can tell by the length of the suspension, we have some highly trained professionals here in the IT support team for committees. It appears we're back in business. I hope I didn't jinx it.

Dr. Van Lieshout, welcome to the committee. You have the floor for the next five minutes.

Oh, no. We can't hear you, Doctor.

Dr. Ryan Van Lieshout (Associate Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, As an Individual): Is this better? Can you hear me now?

● (1555)

The Clerk of the Committee (Mr. Patrick Williams): We're good to go. Thank you very much.

The Chair: Thank you very much. Thanks for your patience.

Dr. Van Lieshout, you have the floor.

Dr. Ryan Van Lieshout: Thank you again.

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

I'm a psychiatrist and a clinician scientist who works with individuals struggling with their mental health during pregnancy and the first postpartum year, and whose research focuses on developing scalable psychotherapies for those with perinatal mental health problems. We also aim to optimize the delivery of these treatments to maximize their impact on offspring brain development. The primary goal of my work is to disrupt the intergenerational transmission of psychiatric problems from parents to their children.

My clinical expertise led to my invitation to co-author Canada's national practice guidelines for the treatment of perinatal psychiatric problems and Public Health Ontario's perinatal mental health tool kit. Throughout my career, I have seen the devastating effects that mental health problems occurring during pregnancy and the postpartum period have on children and families, and I have committed my work to reducing their impact.

As the other experts suggested today, perinatal mental health problems affect up to one in five women, but the disproportionate effects of the COVID-19 pandemic on mothers led these rates to increase to one in three. As previously mentioned, each case of postpartum depression alone is associated with costs of up to $150,000 over the lifespan, two-thirds of which is attributable to offspring.

Even though effective treatments can help both mothers and their children, as few as one in 10 pregnant and postpartum persons are able to access evidence-based care in this country. There are many barriers to the receipt of timely perinatal mental health care in Canada. One of the most significant of these is the current absence of coordinated care pathways that identify sufferers and match the right person to the right treatment at the right time. Second, since most individuals with perinatal mental health problems will respond to psychotherapy, talking therapies and/or medications, another significant challenge is the relatively limited knowledge possessed by frontline physicians about the safety of these medications during pregnancy and lactation. Finally, the profound lack of access to evidence-based psychotherapies, driven primarily by a lack of health care providers trained to provide them, prevents us from meeting our goal of becoming the best country in the world to raise a child.

However, there are many reasons for hope. A group of Canadian clinician scientists, of which Dr. Vigod and I are members, is working with the Canadian Network for Mood and Anxiety Treatments to prepare national practice guidelines for perinatal mental health problems, which can be used to help educate frontline providers and guide the creation and application of Canadian-specific care pathways. These structured care pathways—integrated systems that involve the detection of mental health problems, direct patients to the right resources at the right time, and provide treatment and follow-up—need to be tailored for the Canadian context and implemented.

Once these pathways are created, they will enable us to use evidence-based psychotherapies, developed and tested right here in Canada, to optimize treatment. However, there exists a substantial shortage of trained mental health care professionals required to deliver these interventions. To address this, our group has developed and tested several effective, scalable psychotherapeutic interventions that can be delivered by a variety of individuals, including public health nurses, with no previous psychiatric training or even individuals who have recovered from psychiatric problems themselves, also known as recovered peers.

These treatments can serve as both initial and more intensive steps in care models. For example, our one-day cognitive behavioural therapy-based workshop for postpartum depression can effectively treat up to 30 individuals at a time and be delivered online or in person by public health nurses or recovered peers. Our nine-week group cognitive behavioural therapy intervention has also proven effective, and its delivery has already been successfully task-shifted to recovered peers and public health nurses with limited to no previous psychiatric training. These have already been scaled up and are in use in Canada, Europe and the United States.

As Dr. Montreuil pointed out, we know that when mothers get these treatments, they help not only them but their offspring as well. Perinatal mental disorders are among the most common adverse childhood experiences. The research by our group and others has shown that treating mothers with postpartum depression leads to clinically meaningful improvements in mother-infant relationships, infant brain development and emotion regulatory capacity, and even the mental health of the older children in the home. This is in keeping with research from around the world that suggests that for every dollar invested in early childhood interventions, society reaps a $7 return.

Perinatal mental health problems in Canada can be prevented, detected and treated, and we already have the know-how to support mothers and disrupt the intergenerational transmission of mental disorders in families. The federal government can help by working together with experts to create Canadian-specific care pathways, scale the perinatal mental health workforce to meet the needs of mothers, and work together with the provinces to implement these systems. Such developments will enable our Canadian-made discoveries to improve the health and lives of all Canadians.

● (1600)

The Chair: Thank you, Dr. Van Lieshout.

Finally, we have Dr. Simone Vigod from the University of Toronto and the Women's College Hospital.

Welcome to the committee. You have the floor.

Dr. Simone Vigod (Professor, University of Toronto, and Head, Department of Psychiatry, Women's College Hospital, As an Individual): Thank you to the chair and the committee for inviting me to present today on the topic of the mental health of women.

By way of introduction, as you've heard, I am a psychiatrist. I'm the head of the department of psychiatry at Women's College Hospital in Toronto, where I also hold a research chair in women's mental health. I am also a professor of psychiatry in the Temerty Faculty of Medicine at the University of Toronto. For the past 15 years, my clinical practice and research have focused on women's mental health.

What I wanted to talk to you about today is how and why I believe that the mental health of women is a major public health issue for you to consider.

From menarche—the time when people get their periods—to menopause, women are two to three times more likely to develop common mental health problems such as depression and anxiety than their male counterparts. Mental health problems in women, of course, affect their well-being and productivity. Because women are often caregivers of all others in their sphere, when they are unwell, this can also negatively impact their children and families.

When I talk to my students, partners and the community about this, I usually say there are issues of mental health that are unique to women. You've heard about some of those today, including pregnancy, of course. Then, there are issues that disproportionately or differently affect women. Biologically, there are unique considerations. For example, mood problems that fluctuate with the menstrual cycle might require different treatments or different medication regimens. We've heard quite a bit about pregnancy already today. I would add that treatment decisions in pregnancy, and when someone's breastfeeding, require us to think about the potential for impact on a baby. Also, even the way women absorb and metabolize medications, they do this more slowly than men, so a dose of a medication, for example, that was established for an often larger or heavier man in the clinical trials might lead to toxic side effects.

Of the issues that disproportionately affect women's mental health, one of the biggest is physical, emotional and sexual abuse and assault, which is much more common in girls and women. You probably know that trauma changes the brain. It increases the risk for depression, anxiety and post-traumatic stress disorder substantially. In fact, we now know that more than 50% of women with mental illness report having experienced prior trauma.

Women are also at elevated risk of poverty, isolation after immigration, and stress due to caregiving, among other factors, which can not only increase their risk for illness, but also increase the barriers to their receiving care.

I thought I would tell you a bit about how our department of psychiatry at the University of Toronto at Women's College Hospital has addressed this. Dr. Van Lieshout works in a very similar program at McMaster University. We are one of the University of Toronto's main academic health sciences centres, and we've really taken these considerations to heart.

Our department comprises clinical programming as follows. First, a reproductive life stages program for women who experience mental illness related to the menstrual cycle around the time of pregnancy is very important, as you've heard today, as well as around the time of perimenopause. Second, we have programs that cater to women from at-risk populations, including immigrants, refugees, indigenous women and women experiencing addiction. Third, we have a trauma therapy program for women who've experienced emotional, physical and sexual trauma and now are experiencing complications of mental illness.

Within these programs, because we're a university hospital centre, we're dedicated to expanding knowledge beyond our walls, via research and education. We study causes of illness, such as in our Canada-wide study of postpartum depression genetics. We identify novel treatments, as well as how best to use existing ones. For example, we're using non-invasive neural stimulation to treat depression in pregnancy for women who are worried about using anti-depressant medications. Also, we just received funding from the Canadian Institutes of Health Research to look at ADHD medications in pregnancy, because this is dramatically increasing in use among women. We also, as you've heard today, develop and test innovative models of care to improve access in the pregnancy period, but also to expand access to trauma-focused therapies.

Finally, we train clinical providers across all disciplines—not just psychiatrists, but also social workers, psychologists, midwives and people in multiple other areas of medicine that are related to ours, such as endocrinologists and gynecologists—so that those who are new providers and those who have been in practice for many years can help to better treat the 50% of their patients who are women.

● (1605)

However, as you've heard from my colleagues today, while we're making excellent progress, the goal of having all women with mental illness in Canada receive timely, effective mental health care has not quite yet been achieved.

I believe some great impact on a national level would be to invest in the following concrete, actionable priorities in women's mental health. First, I would recommend a mental health awareness campaign about women's mental health, to empower women to know what they can and should expect about their mental health and from their treatment. The second is to really champion the education and training opportunities in women's mental health, such as those that we, Dr. Van Lieshout's team and others have developed across the country. The third is to increase the targeted research opportunities to both improve the experience of care for women with mental illness today and to develop prevention and cures for the women of the future.

Given the large number of Canadian women affected by mental illness, even small gains in meeting the mental health needs of women across their lifespan have the potential to lead to a large positive impact on the health of all people in our communities.

Thank you.

The Chair: Thank you, Dr. Vigod.

We're going to begin with rounds of questions, starting with the Conservatives.

Mrs. Vecchio, go ahead, please, for six minutes.

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Thank you to all of the different witnesses today for bringing their professional opinions and work to this.

I'm going to start off very simply. We know that one in five Canadians doesn't have a family physician. I believe this would probably be one of the biggest challenges. I see that most of you are in the academic field, but perhaps you can share with me what you know about this. If you don't have a family doctor when you're pregnant, what do you do? It's important to have these task force guidelines, but if there's not somebody monitoring them all the time, what do we do in that situation?

I want to pass it over to Dr. Hippman.

Could you share with me some of your thoughts on that?

Dr. Catriona Hippman: Yes, that is a really important issue.

In British Columbia, you can also directly access midwifery care. I think the perinatal period represents a little bit of a unique moment in a woman's life where there's a greater chance that she would be able to connect with a family doctor. I've heard anecdotal stories of people being able to get a family doctor when they are pregnant. I think that's somewhat optimistic for being able to have that continuous care.

I'd also suggest that it could be beneficial to consider more of the self-screening and self-care options that exist. For example, I know of research in Alberta where a study has basically instituted a program online that empowers women to do screening for themselves. Then it can also connect them with online self-help, like self-care or self-directed cognitive behavioural therapy and that kind of thing. We can kind of let them do it.

Mrs. Karen Vecchio: Wonderful, I really appreciate that.

Hearing the testimony today, when we talk about perinatal care and postpartum depression, I've always thought only about hormones, but many of you have talked about the environment as well. We know that trauma adds to the environment. When we're looking at the hormones.... Actually, I'm going to pass this over to Dr. Van Lieshout, because he talked about the medications.

As a mom of five, that's very important to me. Going through depression, going through anything...watching what you're eating and watching what you're drinking so you ensure your child is safe.

Can you share with me what they're currently using when it comes to helping maybe with the hormonal....or what things are safe?

Dr. Ryan Van Lieshout: That's a great question. Thank you for asking.

As I mentioned, under Dr. Vigod's leadership, we're currently preparing the latest version of the clinical practice guidelines for the treatment of a range of mental health problems during pregnancy and the postpartum period. When we reviewed the literature carefully again, it appears that there's a relative lack of knowledge among a lot of professionals about the relative risks and benefits.

People often hear horror stories about things like this or read things online, but the vast majority of the medicines used to treat depression and anxiety have a relatively good safety record. It's not that every person who has a mental health problem should be prescribed a medication, but it's really important that those who are already taking it, as well as their health care providers, are aware of the relative benefits and risks of these treatments. It's important that people who are thinking about taking them don't just automatically turn them down because of things they're uncertain about or their health care providers are uncertain about.

We're so happy to have this opportunity to update these guidelines and disseminate this information to all the frontline care providers we work with, who are doing such excellent work with the women, mothers, pregnant persons and birthing parents.

● (1610)

Mrs. Karen Vecchio: Thanks so much.

I heard many of you also speak about peer-to-peer...and a variety of different things we can do. That counselling piece, I think, is so important. If you're looking across Canada, for someone to get into counselling if they have had a child, what kind of time frame is there for waiting to have either peer-to-peer counselling or a counselling session with a group or one-on-one? Could you tell me what the timelines are for someone to access a physician on this issue?

Dr. Catriona Hippman: In British Columbia, for example, there's the Pacific Post Partum Support Society, which provides support by phone or by text message. A person who is experiencing postpartum depression can connect with a peer who is on the other end of the line. The hours are not 24-7, but it's very accessible.

In terms of more formal counselling, that would depend on how much money you have to access it privately. If you can afford it, then you can get it almost right away. If you need to go through the public system, that can take six or eight months. It depends.

Dr. Tina Montreuil: I think the lack of Canadian guidelines when it comes to screening and providing care has led—across Quebec, for example—to very different types of programs being delivered based on the institution. For example, at Sainte-Justine hospital, where I happen to work, they have a stepped care approach. We have a chief OBGYN over there who is very much attuned to the reality that we've depicted today. Therefore, for all women being seen at that institution, there is a screening and referral process in place.

You were also talking about self-care. There will be a project called Grande Ourse, which is really intended for psychoeducation—for example, connecting women with various resources across the province, one of which is the Québec Alliance for Perinatal Mental Health. Another well-known resource is Réseau des Centres de Ressources Périnatales du Québec, under the guidance of Marie-Claude Dufour. There are already initiatives there to allow women to be connected, whereas if you look at other institutions, you will not find that.

I think that points to the fact that even when there are the best of intentions to provide care, because there are no clear guidelines in terms of what to do, there are discrepancies not just among provinces, but even within provinces and institutions themselves.

The Chair: Thank you, Dr. Montreuil.

[*Translation*]

Mrs. Brière now has the floor for six minutes.

[*English*]

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Mr. Chair.

Thank you to all of our witnesses for being with us this afternoon.

[*Translation*]

Ms. Montreuil, my first question is quite simple. What time frame does the perinatal period cover?

Dr. Tina Montreuil: As I said at the start, it starts at conception and lasts until about 12 months after delivery, or roughly until the child's first birthday.

Mrs. Élisabeth Brière: Okay.

Did you want to wrap up your remarks, or had you already finished?

Dr. Tina Montreuil: I have results regarding what I said earlier. We have already carried out the work. In Quebec, an ongoing pilot project funded by the Canadian Institutes of Health Research seeks to provide an online intervention to improve emotional regulation and shed light on many of the changes that occur during pregnancy.

We aren't just talking about biological and physiological changes, which are already part of prenatal care. We're also talking about the whole psychological component, which is often overlooked. We're working extensively with peer support workers in the province. The postpartum bible contains 300 to 400 pages on the baby and baby care, but only two or three pages on postpartum mental health.

I want to point out something. Right from the start of the postpartum period, we recommend, for example, following the protocol for checking car seats to ensure that babies are transported safely and correctly home. There's also a protocol for shaken baby syndrome. I agree with these routine practices. However, when it comes to child abuse, we know that the parent's mental health is the precursor. In that case, when checking the baby's seat and the risk of the mother or father potentially harming the baby, why aren't we also addressing the precursor, or how the parent is coping with the new situation of living with a baby? The transition to parenthood isn't the same for everyone. This must be taken into account.

At the start, most people are still wondering about the available resources, and how they can access them. Many resources are available to parents right now. However, we still need to work on integrating these resources into health care communities. I also believe that, even in this day and age, we can inform parents about the resources available, and still wonder why they aren't accessing them. The stigma aspect is a major issue.

As Ms. Hippman said, pregnancy is an opportunity to build relationships with the health care system, so that we can better prevent issues within families.

● (1615)

Mrs. Élisabeth Brière: Thank you. You answered a number of my questions, which opens the door to other questions.

Could training be included in prenatal courses?

Dr. Tina Montreuil: I believe so. Absolutely.

We also have a pilot project in Quebec. This project is funded by the Fondation de la recherche pédiatrique, or pediatric research foundation—formerly the Fondation des étoiles—and by the CHU Sainte-Justine. The project is the ECHO program, an online telementoring program.

We heard today about why people feel unable to carry out screening. We heard that treatment in general already includes a mental health component. However, we know that this isn't the case. Studies show this. The reason is that professionals, who are generally equipped to deal with a number of situations, don't feel equipped to really screen for mental health issues. Like other programs in Canada, this telementoring program helps to bring our health care professionals—midwives, doctors, nurses and social workers—up to speed with the tools needed.

When people are equipped, they feel better able to carry out screening. We know that investing a bit of money in training through this pilot project will enhance our health care system with the people already on the ground. We still need to hire more people for this, or to reorganize our resources. However, we can plan certain measures by establishing guidelines for doing so.

Mrs. Élisabeth Brière: Do you think that interdisciplinary work is key?

Dr. Tina Montreuil: It's a key component. In 2022, we carried out an activity with the Alliance québécoise pour la santé mentale périnatale, or Quebec alliance for perinatal mental health. We recently had the chance to share our results at an event organized by the Daymark Foundation, which brought together Canadian policy-makers.

We spoke with a number of target individuals who can affect mental health, particularly women's health in Quebec. We identified three major obstacles. One obstacle is the integration of resources. There are already resources, but their interconnectedness poses an issue. Efforts are duplicated and work is done in silos.

We must first acknowledge that perinatal mental health is a public health issue. We must then determine how to reorganize and integrate many of the players involved. We also saw this at the Daymark Foundation event. It was demonstrated that a number of key community players could be better integrated into the health care system to ease the burden of this transition. We must assess the existing resources and determine how to combine them to make this feasible and achievable.

● (1620)

Mrs. Élisabeth Brière: Thank you, Ms. Montreuil.

The Chair: Thank you, Mrs. Brière and Ms. Montreuil.

I'll now give the floor to Ms. Bérubé for six minutes.

Ms. Sylvie Bérubé (Abitibi—Baie-James—Nunavik—Eeyou, BQ): Thank you, Mr. Chair.

I want to thank the witnesses for being here today, and for their valuable expertise.

Ms. Montreuil, you spoke earlier about marginalized women. What are the health outcomes for marginalized women before and after childbirth?

Dr. Tina Montreuil: We know, for example, that a number of issues affect marginalized women. I spoke about pre-eclampsia or other types of inflammatory diagnoses that affect marginalized women in different proportions to the rest of the population. Sometimes, we look at these types of statistics and think that this proportion isn't very significant compared with other types of statistics.

However, we must also consider that these women are under-represented. As researchers, we all know this. When we ask women to participate, we generally try hard to reach out to under-represented people. This still poses a hurdle. The issue of trust in our motives still arises when we carry out these types of studies.

Unless we specifically focus on these people, many of our studies don't provide representative results. We can benefit from working with communities and community partners, because they have already built relationships. In our indigenous populations and in the populations of Black women with whom we often work, these women are already integrated into many of the community resources. To ensure more representative results, it would be much better to work more with these community organizations, which have already established a bond of trust.

I'm providing this common example because of time constraints. However, it's something to consider. I think that we should also support the work of the Canadian task force on preventive health care, while funding more research that specifically focuses on these women.

Implementation science projects are expensive. They involve not only a community of researchers, but also practitioners accustomed to often conducting research. We must work with people who have lived experience in the community and who aren't experts in the field. We need funds to carry out proper studies, not just observational studies, which are limited in terms of positioning.

Ms. Sylvie Bérubé: I have another question for you. I come from the constituency of Abitibi—Baie-James—Nunavik—Eeyou. Our area is considered remote. We're well aware that many women experience post-partum, child loss, and so on. We know that the CHU Sainte-Justine is there. However, the process in remote regions is complicated. As a result, these women often don't necessarily have the tools available to cope.

As a researcher, what's your perspective on monitoring in Quebec?

Dr. Tina Montreuil: First, when we work with the women who contact us through the alliance, we can see that much more remains to be done in terms of post-partum follow-up care.

We recently recorded a podcast with a woman who said that post-partum follow-up care for the mother doesn't exist. During the post-partum period, her child had 10 follow-up visits with the pediatrician. Yet, at every meeting with the pediatrician, the mother was, as she put it, dying inside. She really wanted someone to ask her how she was doing, but the question never came up. She considered broaching the topic, then changed her mind. She thought that she would be deemed a bad mother for focusing on herself rather than on her child.

All this to say that the issue isn't straightforward. Having already worked in various areas, such as Gaspésie, I can see that we have plenty to do in terms of the first level of intervention. Research and clinical studies show that we must give people access to resources, while providing these resources with a type of seal of approval from the province.

For example, I'm involved in creating an initiative that will be implemented in Quebec in the coming months. Basically, when we provide a service, we give it a type of departmental seal of approval. At every prenatal visit, right from the start, we bring up the fact that services are available to women should they experience any difficulties during their pregnancy. We can then combine this, for example, with the ECHO telementoring model.

I haven't yet brought up other studies that we carried out and another initiative that we implemented to give people an additional tool. This tool involves Internet access, but also a follow-up with a mentor such as a nurse or a social worker for people who found the first level of intervention too basic and insufficient and who needed something more.

If necessary, we can then refer some people to psychiatric services. By providing the services at the first two levels of intervention, we can probably solve many problems. We have seen this in school settings. I work a great deal on level 3 interventions. With level 1 and 2 interventions, we can address about 70% of cases that would otherwise require a psychiatric consultation. The leaves us with 30% of people who will actually need to see a psychiatrist. This will automatically lighten the workload of these specialists.

When I talked about reorganization, this was also a factor to some extent. We must look closely at all the cases currently referred to level 3 to see whether these people could receive care at levels 1 and 2. This would lighten the load on the health care system, while meeting the needs of the more isolated communities that you referred to.

● (1625)

The Chair: You still have 20 seconds, if you wish, Ms. Bérubé.

Ms. Sylvie Bérubé: Ms. Hippman, can you describe how pregnancy loss or infertility affects a person's mental health?

The Chair: Please keep your answer brief.

[*English*]

Dr. Catriona Hippman: All right.

Well, it can be very difficult. I don't know the exact rates of depression, but they're high. Infertility can be incredibly stressful and can lead to anxiety and depression. In loss, it can be difficult to tease apart postpartum grief reaction versus postpartum depression, but it's important not to dismiss postpartum depression, assume that it is grief and not have good support for people in that context too.

The Chair: Thank you, Dr. Hippman.

Thank you, Madame Bérubé.

Next is Ms. Idlout, please, for six minutes.

Ms. Lori Idlout (Nunavut, NDP): *Qujannamiik, Iksivautaq*. Thank you, Chair.

It's a pleasure to be here. Thank you to all the witnesses for all their expert testimony. I think I will be asking Catriona Hippman most of my questions. The reason I kind of struggle to ask general questions is that all the witnesses come from very different institutions and different parts of Canada.

I'm interested in hearing about the standardized screening that you recommend, but before I get to that kind of questioning, I want to ask specifically about indigenous women. How long has it been known, would you say, that indigenous women are more vulnerable to mental health issues?

Dr. Catriona Hippman: I feel like we need to continue to expand our attention in that area. I do see that there is more research happening and more attention being paid to support mental health for the indigenous community, but it's still early days. There's such a problem with the lack of trust, as has been mentioned and as I'm sure you're all aware, in terms of someone actually being able to feel comfortable self-identifying as indigenous.

There's a program now at BC Women's Hospital. We have a system in place to connect indigenous patients with an indigenous peer support worker and an elder, but they need to feel comfortable identifying as indigenous. Given what we know about racism in the health care system and all of the discrimination and the negative, harmful impacts that can have, it's understandable if indigenous people don't feel comfortable sharing that they are indigenous or coming to the health care system at all.

It's a big issue, but we are working to find ways to build that trust with the community and trying to find a way to meet their mental health care needs in the perinatal period.

● (1630)

Ms. Lori Idlout: At the risk of asking you to generalize, which I'm not, what are some of the issues? What are some of the realities that make indigenous women more vulnerable to mental health issues?

Dr. Catriona Hippman: One thing, off the top of my mind, is the histories of intergenerational and personal trauma. Pregnancy is a time when trauma can really come to the surface in ways that people don't expect. You grapple with identity shifts and it connects to your ancestors and generations going forward. It's a really sensitive time, and I think it's not adequately appreciated or supported.

It's wonderful to hear from Dr. Vigod about the stream of support for trauma-informed care in their programs. Generally speaking, I don't think that's a strong element of our health care system. There needs to be support for people going through pregnancy to pay attention to and provide care for their trauma, which they may need to process if it is triggered.

Ms. Lori Idlout: In terms of moving toward making recommendations about standardizing screening, how would you ensure that it incorporates the need to reflect and understand what indigenous women may have gone through so that we include those struggles in some form of standardized screening?

Dr. Catriona Hippman: It's such an important issue to think about. There's a history of removing children from indigenous families, which is just so tragic. That has been seen as part of the perinatal health care system as well and has manifested in a practice known as birth alerts for indigenous women. After the birth, they would be seen by a child and family development worker and there was a higher risk that their child would be removed. That practice has ended, but relatively recently, I think, in 2019. There's still that history and a very valid fear that if an indigenous person comes to the system with a pregnancy, their child is going to be taken away from them. To add to that, if they're asked if they are experiencing depression or some other mental illness, that's more ammunition for taking away their child.

I can understand that being a really sensitive problem. We need to have more tailored screening approaches for indigenous communities so that they do not feel threatened, and embed that within a system from which they can receive culturally sensitive and trauma-informed support.

The Chair: Thank you, Dr. Hippman.

Thank you, Ms. Idlout.

Next we have Mrs. Roberts, please, for five minutes.

Mrs. Anna Roberts (King—Vaughan, CPC): Thank you very much, Mr. Chair.

Thank you to the witnesses.

I'm going to go back to a question that my colleague Karen brought up, and that's the family doctors and the lack of them.

Last Wednesday, there was an announcement made in Ontario—I'm from Ontario, by the way—that the Ontario government is going to provide $9 million to York University to build a medical school right next door to Cortellucci Vaughan Hospital, specifically for family physicians. I see that you heard about it. It is quite interesting. If I look at the stats in Ontario, I see that 2.3 million people do not have family doctors, and in 2026, four million people will be without family doctors. That's one in four people—and that's just in Ontario. Here's the kicker, though. The school will not be built and finished for occupancy until 2028, and then I think it's another four years....

We're so far behind with family doctors. I know that we Conservatives have a really good plan with our blue seal plan to bring doctors in. In listening to you, I know it's important that we identify these issues so that we can protect women.

In 2018, there were 8.3 maternal deaths per 100,000. It looks like it has doubled in the past 10 years. It is something that is really important, if we're going to stand up for women.

I don't know, but I guess I'm just not normal, because I lost five kids. I think what helped me was my faith and my family and the support system I had around me, which helped me get through it. When I did get pregnant, they made me stay in bed. I think that was worse than anything else, because I'm not the type of person who likes to sit still.

Do you think that those support systems, because of COVID—I know you mentioned COVID—just fell by the wayside?

I'll leave it open to anyone who would like to speak to that.

● (1635)

Dr. Simone Vigod: I can start a little bit, if you'd like.

Mrs. Anna Roberts: Great. Thank you.

Dr. Simone Vigod: As a psychiatrist, I have lots of colleagues who are family physicians, many of whom refer to me. The thing about having a family physician, especially when we're thinking about women, is that a family physician follows you throughout your whole lifetime. They know you. They know if something isn't your baseline, if something is off. They're watching things.

If we're saying that 20% or more of women across Canada have a mental health issue.... That's like saying that all of the cardiologists would manage high blood pressure. The truth is that the family physicians are likely the first line of defence for mental health issues, and it's the family practices, like the teams, where that first basic counselling starts.

One thing that was really interesting is that we did a model of care for perinatal mental health where women didn't need to go through their family doctors to come in. When they first came in, we did that stepped care that we talked about. We sent them for peer support. We got them psychological treatments in the community, which they didn't even need to see a doctor for. A small proportion might have actually needed medications, or something more, so we were able to have somebody like me, who knows about all the drugs in pregnancy and everything, go through some quick phone calls with the family doctors to figure out what the patients needed. Patients trust their family doctors. Out of the 50 people we put through our initial pilot, only two had to eventually come and see me.

Family doctors know when there's something that isn't quite right with their patient. It's almost like when a parent knows there is something not quite right with their child. The importance of primary care as the backbone and as the infrastructure of our health system, I think, can't be understated.

Mrs. Anna Roberts: One of the other things we have to do, when our own Canadian citizens leave to get their education elsewhere, is ensure that when they come back, we have them ready to be family doctors. I think we need to improve that. I really believe our blue seal program will help with that.

I agree with you that the family doctor probably knows you better than anyone else. That's the only way we're going to prevent these types of situations and deaths from happening. I'm glad you agree with that.

The Chair: Thank you, Mrs. Roberts.

Mrs. Anna Roberts: I wasn't finished.

Voices: Oh, oh!

The Chair: I'm afraid you were.

Mr. Jowhari, you have five minutes, please.

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair.

Thank you to the witnesses for their testimony today.

Dr. Vigod, I'll direct most of my questions to you. As you know, in May 2023 the Government of Canada announced funding for three projects related to maternal mental health, one of which was Health Canada's funding of about $372,000 to Women's College Hospital to develop national clinician guidelines for perinatal mood disorders. How did this funding help Women's College Hospital advance the development of national clinician guidelines or perhaps support other initiatives in support of maternal mental health?

● (1640)

Dr. Simone Vigod: Sure. It's my pleasure.

Dr. Van Lieshout actually referred to these guidelines. This is a partnership between Women's College Hospital and an organization called CANMAT, the Canadian Network for Mood and Anxiety Treatments, which has been doing the guidelines for depression and bipolar disorder and the treatments that the evidence suggests we should be recommending. What we did with those guidelines, which I'm co-leading with Dr. Benicio Frey from McMaster University, is develop a group of scientists from across the country who had expertise in this area. We also worked on developing panels of experts who would help us. Actually, Dr. Montreuil is on one of those panels, and Dr. Hippman will likely be asked to talk with us as well. We have panels of research experts. We have panels of care experts, such as OBs and midwives and psychiatrists who do clinical work. We also have panels of persons with lived experience, in addition to two persons with lived experience on the committee.

So far we've done the evidence review. We started with 12,000 reviews of evidence that we systematically went through. What we do is classify that evidence and determine what evidence is there, for example, for various therapies or various medications. We are at the point where, at a meeting on March 1, we brought all of the people together from across Canada who were writing the guidelines, to start putting forward the recommendations. This week, we have our first writing draft together. We are hoping that by early June we will have everything out to our partners, and by early fall we'll actually have a publication.

We'll also be developing a guide especially for persons with lived experience and patients and their family members. We'll do that in co-development with persons with lived experience and their family members. We'll also have a reference guide for providers. The whole idea here—and Dr. Montreuil spoke to this—is that we need to have some guidance so that we can develop standards. This also has to do with the issue of how we identify disorders. What are these disorders? Whom are we supposed to be looking at? How are we supposed to provide treatment? People will know what they should be receiving, and then in each province we can actually measure whether we are living up to the standard of care. Only once you measure can you then improve.

That's where we're at. It has really been a privilege to be able to have some of that support, especially for the library services evidence review. I have to tell you that it's more work than I ever imagined. I have to give kudos to Dr. Van Lieshout, who's been reviewing all the medications that we need to use. I think the hours he has spent number in the three digits, I'm sure.

So that's what we're doing.

Mr. Majid Jowhari: Thank you. That was a very comprehensive update.

Dr. Simone Vigod: I'm sorry if I took too long.

Mr. Majid Jowhari: No, that was great. I was hoping you'd get into some of the timelines. I thank you for that.

I have only about 30 seconds left, and I'm going to be a bit partisan here. Can you talk about the importance of developing the national clinician guidelines to treat perinatal and reproductive mental health, as opposed to allowing provinces to create their own approach for the care and screening? You touched on that a bit, but in your view, what role do you feel the provinces should play?

Thank you.

Dr. Simone Vigod: As we know, health care services are organized by province. What we should be able to do with these guidelines is say, this is the recommendation for treatment, and these treatments are all available in Canada. I'm talking about therapies and medications and how quickly someone should be seen, etc.

That might allow, for example—although this won't be under my control—for the Standards Council of Canada to say, “Okay, so you've done these treatment guidelines. Now what are the standards that need to be met?” Then, working in partnership with the provinces, they may be met in very different ways. Within Ontario, we've just been funded to take five different hospitals to work together to actually start to meet some preliminary standards on our own. Different provinces may do it differently.

● (1645)

The Chair: Thank you, Dr. Vigod.

[*Translation*]

Ms. Bérubé, you may go ahead for two and a half minutes.

Ms. Sylvie Bérubé: Thank you, Mr. Chair.

Ms. Hippman, how do mental health disorders such as depression and anxiety influence a person's decision to have children and parenthood?

[*English*]

Dr. Catriona Hippman: I'm sorry. It was a little quiet there with the translation.

Your question was about how mental health conditions can impact parents when they desire to get pregnant and then as they're parenting.

I have one story that comes to my mind. I worked as a psychiatric genetic counsellor for a while. I saw a woman who has bipolar disorder and who was very aware of all the risks involved in getting pregnant. She was very concerned about her own mental health, knowing that there is a higher risk for postpartum psychosis, for example, when you have bipolar disorder.

She was saying that she really wanted to be a parent but was worried about the pregnancy piece. She also saw that she might be disadvantaged in out-of-country adoption and that they wouldn't allow it with the medications she was taking. Within the country, she wondered if somebody would choose to make an adoption plan with her, knowing her history. She was also worried about the risk of passing on the genetic vulnerability of bipolar disorder to children.

We talked about it a lot. In the end, I wrote a letter in support of her having fertility treatments and having a donor egg. She felt better about removing some of that increased genetic vulnerability to pass that along. Then she had a really strong support team, with psychiatrists and other allied health professionals to support her. She did very well in postpartum.

I think it depends. This was a very well-informed woman. Others maybe don't have the same kind of insight, awareness and connections. Therefore, it would be really good to have additional supports in that area.

It can impact your capacity to engage in parenting, obviously. If you're experiencing depression, for example, everything is harder, but parenting is one of those things that are harder.

The Chair: Thank you, Dr. Hippman.

Next is Ms. Idlout, please, for two and a half minutes.

Ms. Lori Idlout: Thank you.

I'll be asking my questions of Dr. Van Lieshout.

I'm very curious about the recovered peers you were mentioning. What are some of the protective factors that these individuals would have had to be able to become recovered peers?

Dr. Ryan Van Lieshout: Thank you.

All we required was that they had recovered and had been recovered for more than a year. Then we asked them a few questions just about their openness to different treatment approaches. What we wanted, when we were selecting people who were going to work with mothers who were struggling, was openness to everyone's experiences and different treatment choices, so that those participants could feel good about that.

One of the singular joys of my career has been working with these peers. They are remarkable women—remarkably strong, bright and committed.

One thing we found—when they were trained and when they delivered the therapy and supervised each other in delivering the therapy to make the program sort of self-sufficient—is that they found that engaging in the helping work helped them solidify and complete their own journey and recovery from depression. Some people were worried that they would get worse, but treating or helping others actually led them to feeling stronger and more recovered.

● (1650)

Ms. Lori Idlout: Could you give us a better sense of the context of these recovered peers? How many were considered recovered peers, and what is the possible expandability of using individuals such as recovered peers?

Dr. Ryan Van Lieshout: They ranged very widely in age. Some had just recovered. Some were in their early twenties, and some were in their fifties, having had their reproductive journeys 30 years ago. We weren't very particular when we were selecting. We were interested in people from all walks of life and all experiences, so we were really inclusive when we selected them. They came from all walks of life, spiritual orientations, things like that.

There is a really big supply of people who've recovered from postpartum depression, unfortunately, because it means they've gone through it in the first place. But if one in five has gone through something like this, we have a really large supply of recovered peers who could help fill the gap that exists in terms of getting people treatment in a timely way.

The Chair: Thank you, Dr. Van Lieshout and Ms. Idlout.

Next is Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thanks, Chair.

Just give me a minute, if you would, witnesses, to indulge in some committee business.

I'd like to give notice of the following motion.

That, given

> The Minister of Mental Health and Addictions has asserted that there is “no evidence of widespread diversion”, and yet the Health Canada data released today shows that police seizures of government-issued hydromorphone (Dilaudid) in British Columbia have increased fourfold, or 300%, since the implementation of “safe supply,” from less than 100 seizures per year to 408 seizures in 2023;
>
> The Prince George RCMP reported the seizure of “thousands” of safe supply pills in an illegal drug bust of 10,000 individual prescription pills last month, and police in Campbell River, B.C. have reported the seizure of 3,500 diverted safe supply pills on the territory of the We Wai Kai Nation;
>
> The chief of the We Wai Kai Nation has harshly criticized the so-called “safe supply” experiment;
>
> 3,656 people in British Columbia have received government-issued hydromorphone because of this dangerous experiment; and
>
> There have been reports of diverted safe-supply drugs being sold in schools;
>
> The committee call the following witnesses: the Minister of Mental Health and Addictions and Health Canada officials for no less than two hours; RCMP Commissioner Michael Duheme; Assistant Commissioner John Brewer of RCMP “E” Division.

That's the end of my statement. Thank you for indulging me. I appreciate that.

Dr. Hippman, when we first start talking about this, I'm wondering if we might make clear to all Canadians out there listening the difference that the Canadian Task Force on Preventive Health Care...the change in the recommendation, because I think maybe a lot of us here know what happened but we need to explain to Canadians in the easiest way what this really means. I don't want people to miss out on the difference this change will make to Canadian women out there.

Dr. Catriona Hippman: Sure. Are you talking about the task force recommendation that came out in 2022?

Mr. Stephen Ellis: Yes, sorry, Doctor. Thank you.

Dr. Catriona Hippman: That's okay.

When that was released, it was actually consistent with the previous task force recommendation, which was focused more generally on depression in women or in adults, and it was still recommending against tool-based screening—so, using a questionnaire, basically, and suggesting that a conversation with your doctor would be better.

The change that we saw at the B.C. reproductive mental health program was that when the recommendation was released, we heard informally from OBGYN colleagues or family doctors who would say, "So I don't need to worry about screening anymore." Even though that wasn't technically what the task force recommendation was, what was heard, generally speaking, by the maternity care community was that screening for perinatal depression was not recommended.

● (1655)

Mr. Stephen Ellis: So in essence, Dr. Hippman, realistically.... I think we've heard very clearly from all of our witnesses today that this perinatal period is a unique time in life, obviously, for many reasons, but it also presents an opportunity to screen for mental illness and difficulties that can affect the pregnant woman and the child subsequently, of course, and the relationships there.

Just to be clear, for people listening, the unintended consequence of this recommendation was that screening is not being done. Am I clear on that?

Dr. Catriona Hippman: Yes.

Mr. Stephen Ellis: The recommendation now...what would you like to see differently? Do you want to return to tool-based screening? Often, medicine is about a relationship, of course. It makes it much easier if you've known the person, but as we know, many people don't have access to a family doctor. If you had all the money, the $4.5 billion of the untransferred Canada mental health money, what would you do differently?

Dr. Catriona Hippman: What a dream.

Just on a very small scale, it would be great to have universal standardized screening recommended. What I mean by that is to have a clear message sent to all primary care providers that this is important and that there's nuance in how you do it. If you use the gold standard globally—that's called the Edinburgh postnatal depression scale—you can use it, but you can make it part of a conversation. It doesn't have to be handing someone a piece of paper, so you can incorporate that into your regular practice. However, the strong message is, "Ask people about their mental health to see whether there's depression there."

Then, if I had the additional latitude and money, it would be wonderful to see some of these other recommendations you heard today, in terms of having more of a national strategy for perinatal mental health that would enable additional training and capacity for health care providers to know how to best support people and how to connect them to all of the amazing supports that are out there but that, as we heard, are not necessarily connected.

The Chair: You have 30 seconds.

Mr. Stephen Ellis: Thank you, Chair.

I guess the question that remains.... When we look at this, we know that 25% or maybe one-third of Canadians have issues with their mental health generally. I think today we heard very clearly that pregnant women have, perhaps, more issues, and almost half of people now have unmet health care needs.

Maybe I will give a shout-out to the Canadian Association of Occupational Therapists. I met with them today, and I think they would be ideally suited to provide part of this care. Is that a fair statement?

Dr. Catriona Hippman: I think that would be great, yes. It would be fantastic.

I'd also love to see a role for psychiatric genetic counsellors to support that.

Mr. Stephen Ellis: Thank you, Doctor.

The Chair: Thank you, Dr. Hippman and Dr. Ellis.

Next we have Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): We're all a very sophisticated bunch here. I'm surprised no one has asked some really dumb questions, so leave it to me. I'm not a "common-sense Conservative" like the members over there, so I lack that.

Voices: Oh, oh!

Mr. Marcus Powlowski: I would have thought that, as I recall from medical school, the big issue around perinatal depression is that there is a societal expectation that people are happy. The husband, or whoever the father is, thinks that the mother should be happy. The siblings figure they should be happy. Their parents think they should be happy, and they're not. I would have thought it's part and parcel of the whole problem that there is this expectation. You're supposed to be happy, and perhaps there's some shame and unwillingness to talk about it because you're supposed to be happy.

With that, I have two questions. One is, why? How much of it is hormonal? I'm sure there are a large number of cases, because there's pre-existing depression, but how much of it is other things, like the situation the woman is in, if she is unhappy in the relationship or there's loss of freedom or lack of support? How much of it is situational? How much is hormonal? That's one question as to why. Then the second part of the question is, how much is that part and parcel of the whole problem of recognition and treatment, the fact that there is this expectation that you're supposed to be happy?

● (1700)

Dr. Tina Montreuil: We developed this program that I referred to before. It was inspired by mothers and babies and is evidence-based worldwide but stems from Palo Alto in the U.S. We adapted it to call it *Toi, Moi, Bébé*. One of the first couple of modules is really that. We made these kinds of cartoons, and we were addressing a lot of societal, universal golden rules of how people experience transition to parenthood.

It's not the same for everyone. I think a lot of the time there are these social standards that are sometimes perpetuated by what we see more actively in the media; therefore, I think this is very helpful. We've had people we've worked with test out the intervention at the very early stages in terms of feasibility and acceptability. That's one of the things they would point out. I felt so relieved to see a woman who was experiencing pregnancy in a positive light, where it was very challenging and it was not a joyful moment, but then there was also representation of me.

To get to your second question, until we know the why, there's nothing that prevents us from having these types of interventions available, because they do seem to help and they're easily accessible in our province, for example, online.

The other piece is that there are studies like ours, the Montreal antenatal well-being study, where we're looking for certain biomarkers, neural or endocrine. For sure there is something happening. We know that there are specific profiles of women who are more vulnerable; therefore, when we're talking here, it's more about women's health more generally. Preconception care, for example, brings about this opportunity, if we were to identify these biomarkers in combination with dialogue and picking up on certain things that are being mentioned by the pregnant people, to also have these more medical base biomarkers.

As a clinical psychologist, I see that people who are not expecting often neglect their well-being. We're all like that. We know what a healthy lifestyle is, but we don't necessarily live it.

Where pregnancy presents as an opportunity, for women but also men, is that, all of a sudden, I'm preparing to care not only for myself but also for my offspring. There's something that happens at the cognitive and motivational levels that people want to seek help for. Why not leverage this added motivation to get people to talk about mental health and how they can do a self-reflection at that moment to improve themselves, according to not a curative approach but a more preventative one?

We've already heard stats from Dr. Ryan Van Lieshout about the seven dollars for every dollar invested. This goes back to Dr. Heckman, who mentioned this in 2000. If we were to invest one dollar in prevention, it would save us seven dollars in terms of curative care later on.

This is what we need to keep in mind. There is an opportunity to use those motivational aspects to get people to want to get better.

Dr. Catriona Hippman: I don't know if there's any time for me to add a little bit.

Even before we have the biomarkers or anything like that in a blood test, even right now, as a genetic counsellor, I take family histories. You can tell a lot about risk based on what's happened in somebody's family. You can work with them. Part of genetic counselling is identifying risk, but it's also talking to people about things they can do to protect their mental health. There are ways that we've seen improvement in mental health for people after they've come for genetic counselling. There's a mix in terms of genetic and environmental vulnerability.

The Chair: Thank you, Dr. Hippman.

Next we're going to Dr. Kitchen for five minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you all for being here. It's greatly appreciated.

Ultimately, we're doing a study so we can hopefully ask Canadians how we are going to make it better for women. It's a challenge.

You all are researchers, and you've indicated that to us. I thank you for the research you do, because that helps practitioners. Some of us at this table have been practitioners, but at this point in our lives, we're politicians. Ultimately, how do we improve things for Canadians, especially when we're dealing with a health care system that is primarily a provincial issue? There's a huge challenge along those lines.

I know that throughout the conversation we've had today, in everything that has been talked about—postpartum and prepartum, etc.—it has been one year. I would argue that's not the case. I think people listening would say, “Oh, it's one year. I'm a year past giving birth, so I don't have to worry about it.”

Is there any evidence to suggest how long it could be, Dr. Montreuil?

● (1705)

Dr. Tina Montreuil: That's a very good question.

I'd say that, more and more, we develop protocols to be able to follow that. That's one of the things. If we were to have a continuum of care from preconception going forward, we'd be able to establish very strong causal models to address the question that you have. Unfortunately, we have a lot of cross-sectional studies at different time points, and we can kind of put these studies together.

One thing we know for sure, from some of the studies that we're conducting at RI-MUHC, is that, for example, in the case of anxiety starting perinatally, there is some sort of linkage with conditions that are inflammatory, which can then.... Once we get these women at their first pregnancy, if we follow them into their second pregnancy, it seems that, if you were to look at these two pregnancies in more than just a year, there are connections. For example, the mental health that remains unaddressed will also affect—

Mr. Robert Kitchen: Thank you. I appreciate that. I apologize for cutting you off. There are a number of questions, and I have such a short period of time.

Dr. Van Lieshout, you talked a little about lactation and concerns about medications and issues. How do we educate Canadian women to truly...? I know that when I was in practice, Dr. Google came into my office every day and said, “This is what I have.” In today's world, Dr. Google seems to know a lot more about what goes on in lactation than practitioners supposedly do. I'm just wondering how we combat that.

Dr. Ryan Van Lieshout: Yes, I'm familiar with Dr. Google and his credentials.

I think the first thing is that, when we put together these practice guidelines and we get the state-of-the-art and Canada together, and then we get that information out to the frontline practitioners so that they know this, when people seek a second opinion on Dr. Google and come and ask those questions, the practitioners will have that information handy and they can help those people make the best decisions possible. It's the same with midwives.

We look forward to doing that with the information we're pulling together now, and then I think we'll have to see how that goes. Maybe there's room for public health to get involved and start to talk about all of the real benefits and drawbacks of treatment versus not getting treatment. Unfortunately, Canada has a shortfall of psychotherapies; they're not available. Medicine is often a default option for a lot of people, and people just get no treatment as a result because of uncertainty about the safety.

Mr. Robert Kitchen: Thank you. I appreciate that as well.

Ultimately, I think that when we look at aspects of what we're dealing with, you brought up a point about.... I come from rural Saskatchewan. My colleague from the Bloc comes from rural Quebec, and my colleague from Nunavut comes from much farther. My riding, which I consider rural, is not even close to my colleague's from Nunavut. For my colleague beside me, who comes from a rural area in the London area, it's ultimately a half-hour drive, but it takes two or three hours for our constituents to get where they are going. Our female constituents are dealing with practitioners who come from various parts who have never lived in that area.

How do we educate those practitioners to make certain that that information for women is being put out during that time so that they know what to do? They drive three hours to go for a meeting and, as you said, Dr. Montreuil, the reality focuses on the baby as opposed to focusing on the mother. That is a big challenge, so how do we improve that?

Dr. Simone Vigod: Can I jump in? Is that okay?

Mr. Robert Kitchen: Certainly. Go ahead, please.

Dr. Simone Vigod: If you go on PubMed and you type in “antidepressants in pregnancy”, you'll get like 80 articles a year. It is practically impossible for practitioners to go through that. Then, when patients type it into the Internet, it's the same.

A number of years ago, we created an online patient decision aid that talks to people about what their condition is and all the different treatments. It provides the potential benefits of the medication and the potential safety risks. When we tested it, we found that for somebody who talked to me in my clinic—because I'm a provider and I do this kind of counselling all the time—the decision didn't give much more to them, but when we tested it with people across Canada who, for example, lived in rural Saskatchewan and other places, they really had a big improvement in their decision-making difficulty and felt it was so much easier to make a decision about whether to use the medications or not. Then we were funded—and we've had about 500 people all across Canada—to see not only whether it helps their decisions, but whether it helps them have better outcomes and less likelihood of having depression in the long term.

If you can take a few specialists and have a trustable brand with the evidence, there are really neat ways of getting it out to people. The family doctor can download the tool, and the patient can look at it. We have really good technological ways of getting that stuff out, but I think it's about making sure that the information is branded in a trustable way.

● (1710)

The Chair: Thank you, Dr. Vigod.

Next we have Ms. Thompson, please, for five minutes.

Ms. Joanne Thompson (St. John's East, Lib.): Thank you, Chair.

I'm so pleased to be here today. I'm not normally part of this committee, but what we're speaking about is very near and dear to my heart. In my riding of St. John's East, there is tremendous work happening. It's not, clearly, where we need to be, but this is something that I'm very aware of and certainly continue to worry about as a mother and a nurse, and now in this role as a politician.

Dr. Vigod, I will go to you, but this really could be asked of anyone in the room. Could you go back to stepped care and drill down just a little bit more? In the back-and-forth, I still feel there is not a real understanding of what stepped care is, and the role of multidisciplinary primary health care in enabling someone to begin the supportive treatments without having to see a family physician.

Could you break it down for me, please, in a simple, tangible way?

Dr. Simone Vigod: I can try, and then maybe my colleagues will help me with that a little bit.

The whole concept of stepped care is the idea that, if people have very mild symptoms, you want to be able to give them the least invasive treatments first and the ones that are most easily available. Then, you would want to add on another, higher step—something that takes more resources, takes more of their time, or maybe has more safety issues associated with it—only if they really needed it.

What we normally think of as step one of care for perinatal mental health is education, self-guided treatments, and public health nurses' supportive counselling. There is so much evidence, for example, for peer support—as we talked about today—as well as for protecting people's sleep and dealing with all sorts of social issues that are happening, and the support.

If those things don't work, then you'd want to move to the next step of care, which maybe involves formal psychotherapy, like cognitive behaviour therapy or interpersonal psychotherapy. If that doesn't work, you'd want to move up another step, maybe to medications. Then, if something is very severe, you might be talking about hospitalization or different kinds of more serious treatments.

You also have to remember that in stepped care, depending on someone's level of severity, you might give them the step one things, but also realize that they need step two. If somebody is very ill—let's say, suicidal—you would move them to step four right away. Stepped care really is about what step they need. Sometimes you can go up a little bit, but sometimes, if someone is really sick, you might start them at step three.

Does that help?

Ms. Joanne Thompson: Absolutely. Thank you.

This leads me to the conversation around public awareness, which really links into so much of the challenge and stigma of why women tend to hide how they're feeling in the perinatal period.

What would a public awareness campaign program look like?

● (1715)

Dr. Simone Vigod: We've talked a lot about perinatal mental health today. From my point of view, we should be talking about women's mental health across the lifespan and all of those different, unique issues, because they're all related to each other. For women to even know that, biologically, if they are more likely to have mood problems around the time of their period, they're probably more likely to have mood problems when they deliver a baby and around perimenopause.... It's all linked together. What are the things that are different? Women should know that they might metabolize medications differently.

Given how many people struggle with mental health issues, a public awareness campaign doesn't need to talk about mental illness or mental disorders necessarily, but it can talk about mental health issues across the reproductive lifespan, so people can understand what is par for the course and what should suggest that they might need a little more help. If they need a little more help, what are the things they can expect from their treatment?

That's actually where I would start. Of course, 80% of what I do clinically is perinatal. The others here can also talk about perinatal. You could think about very specific things, but that's actually where I would start. I think that if we had more awareness about women's mental health more broadly, when people get to the perinatal period, they would be more willing and more able to realize that they might be able to.... Some of the shame and stigma.... It might help with that.

That's my view. Others may have different ones.

The Chair: Thank you. That's your time.

[*Translation*]

We now go to Ms. Bérubé for two and a half minutes.

Ms. Sylvie Bérubé: Dr. Vigod, how do protective factors and risk factors for mental health change throughout women's lives, across different age groups, for instance, during menopause?

[*English*]

Dr. Simone Vigod: I was listening to the simultaneous translation. You asked about risk factors for mental health across a woman's life, and whether they change over menstruation, pregnancy, postpartum and menopause.

I think it is true that having a history of depression, a family history of depression or a mother or a sister who struggled with reproductive life events is a risk factor. Some women's brains are more sensitive to the hormonal shift. It's not necessarily a high or a low level of hormones but something about the shifting that some women's brains are more sensitive to, so that's a risk factor. Other risk factors are some of the things that I talked about. For example, early childhood trauma—physical, sexual or emotional abuse—is a major risk factor, and then there are other psychological and social risk factors, such as losses and transitions.

Related to the menstrual cycle, sometimes if people are in more stressful months, that will actually impact the premenstrual mood. We talked about the perinatal period. The biggest risk factor for perinatal depression is a lack of emotional and practical social support. Then, when you think about perimenopause, you're talking about transitions there as well—people are getting closer to ending careers, children are leaving the home—so there are really very similar risk factors and, I would argue, women-specific risk factors.

[*Translation*]

Ms. Sylvie Bérubé: What measures would you say the Government of Canada is taking to promote good mental health among women at different stages of their lives?

[*English*]

Dr. Simone Vigod: I will say again that the biggest thing we can do federally is to help women understand what they could face so that they know what they can expect from their mental health and from their treatment, and understand that there are some very specific things. There are different ways that we prescribe medication if somebody has trouble with their moods around the time of their period. Around the time of menopause, we get involved with reproductive endocrinologists and gynecologists, because we have to think about whether this should be hormone treatment or a different kind. I think awareness is important.

The second thing is, again, education. Approximately 50% of the people in the country are women, and yet it's not really in the core curriculum of training programs to talk about these women-specific things. Even when it comes to what dose of medication we should prescribe, we don't talk about how women absorb it more slowly, so it might fill up in their system higher and give them more side effects. We know these things, but we haven't.... The federal government could help us with integrating these things better as core components of curricular training.

Then, finally, we can always do more and more research that attends to sex and gender.

● (1720)

The Chair: Thank you, Dr. Vigod.

Next we have Ms. Idlout, please, for two and a half minutes.

Ms. Lori Idlout: *Qujannamiik*. I'll direct my questions to Professor Vigod.

I represent 25 communities that are all fly-in, none of which can be driven to. Among the 25 communities, there's one hospital. Most of the communities have only nurse practitioners and a health centre. Most experience closures and will only open for emergency situations. Having understood some of these realities, I point out that there are too many risk factors for Nunavummiut, for women of Nunavut.

What are the investments that this federal government needs to make to increase protective factors so that Nunavut women can enjoy the same protective factors that other Canadian women experience?

Dr. Simone Vigod: You know, we speak a lot about the social and physical environment elements that underlie health. If people don't have the basics of what they need, then it's very difficult. Even in my practice in downtown Toronto, if somebody comes to me saying that she doesn't have enough food to feed her baby or that she doesn't have anyone to help her at all, I'm not going to make her better with therapy and an anti-depressant.

I would not pretend to have all the answers, but I think we're back down to what these risk factors are and how we ensure that people have the basics that they need in order to be able to build upon that and to have wellness.

Ms. Lori Idlout: Could you give an example of some of those basics? Would you agree that it's something like having a safe, comfortable home, having a place to do homework and having a place to take care of your mental health?

Dr. Simone Vigod: Absolutely.

The Chair: Thank you, Ms. Idlout.

Next is Mrs. Vecchio, please, for five minutes.

Mrs. Karen Vecchio: Thank you very much.

I am going to go back to Dr. Vigod.

You mentioned the online patient aid you have available so that we don't all go to Dr. Google. Is this something that's available to all women or just to people who are patients within your centre?

Dr. Simone Vigod: The idea is that it will be available across. We've actually finished the clinical trial now, so we're talking with the Quebec government about French translations, and we're talking now about how we can start getting it out sustainably. Hopefully, we will have it available pretty soon.

Mrs. Karen Vecchio: That's fantastic.

I come from the dental health field. We used to have patients come in all the time, and you would say, “That's a sinus infection.” I understand that dental is about one or two days of the entire curriculum.

When we're talking about mental health and specifically about women's mental health during this period of perinatal care, what type of training would a general practitioner have during those first few years of school?

Dr. Simone Vigod: You know, there is a little bit in the core curriculum in medical training. Dr. Montreuil might be able to talk about psychological training, and Dr. Hippman about genetic counsellor training. I would say that there is a paucity of hours, relative to the proportion of the population that is affected.

Mrs. Karen Vecchio: Dr. Hippman and Dr. Montreuil, go ahead.

Dr. Catriona Hippman: Agreed. I have worked to create some curricula for genetic counselling programs on perinatal mental health and mental health generally, but it's still something that is a very small number of hours.

● (1725)

Dr. Tina Montreuil: We're testing it with the ECHO program right now. It's six sessions, so we're looking at, say, 90 minutes. It's already possible to increase the level of knowledge, and it's not just knowledge; it's the know-how. Sometimes, it's just validation of some information that people have gathered themselves, but having it in the context of formal training is enough to empower people to feel better about what they're doing.

There are existing programs out there. We just need to look at what's been done. If we look at the ECHO program specifically for the perinatal mental health, for example, one session is on screening and referral and who can do the screening and referral. We're talking about more rural areas. We have a screening and referral protocol we're now testing with midwives, which has been shown to work really well, and we're thinking it could be adapted to other types of health care professionals.

I think there's a minimum, such as asking, “What is mental health? How do I detect it? What are the tools?" and those types of things. I think it's enough to just give people information.

One thing we're realizing as well is our own biases about mental health issues. We're looking at change with our screening and referral. We're looking at educating people on basic.... We have a three-hour training. We're able to show that just by giving a three-hour training, we're able to change the way people feel about mental health. I think that is a big piece we're often omitting. We're giving tools, but we're not looking at the beliefs that people hold about people who consult for mental health issues. If we're able to change the care workers' or care providers' views on mental health, we're able to improve the quality of care.

Mrs. Karen Vecchio: Perfect. Thank you so much.

Going from what Lori said, there are 25 fly-in communities. They need the services. Everybody needs these services to be available to them, but we also have connectivity issues in these types of places.

What are some of the things we can do between now and tomorrow? What can we do immediately to help make changes for those people who deserve this support?

Dr. Catriona Hippman: It's politically charged, but a universal basic income and having more financial stability would speak to food security and a lot of those basics that have that foundational wellness and can then enable additional insights.

Another thing is education. I think a lot of these things can be implemented now in terms of how you take care of yourself and how you promote your own mental health. That doesn't need anything additional, but you need to have the resources to feed yourself well.

Mrs. Karen Vecchio: Perfect.

I know my time is up. He's cutting me off now.

Thank you so much for coming today. This has been so useful. Thank you.

The Chair: Thank you, Mrs. Vecchio.

[*Translation*]

This is the last round.

We will go to Ms. Fortier for five minutes.

Hon. Mona Fortier (Ottawa—Vanier, Lib.): Thank you, Mr. Chair.

I, too, am standing in for someone on the committee today, and what a great meeting. It's bringing me back to my three and a half pregnancies—unfortunately, I had a miscarriage. I had the help of a midwife during my pregnancies. Mental health came up constantly during all my midwife appointments. Even when I had my miscarriage, my midwife kept calling to check on me. I think you really hit the nail on the head in terms of what's important. I had my children years ago, but the fact remains that this is an issue we have to keep thinking about. Thank you for sharing your ideas and recommendations.

Something you said struck me, your recommendation for a national strategy. I did a bit of research, and I came across an article in the January 2023 edition of the Journal of Obstetrics and Gynaecology Canada entitled “Perinatal Mental Illness: We Need to Act Now. Together.” The authors of the article refer to a national strategy and the fact that Australia and the United Kingdom each have one. Can you tell us what a national strategy would look like, and what other countries are doing? I think that would be helpful information for the committee.

Dr. Tina Montreuil: Yes, the United Kingdom and Australia have adopted national policies.

In my previous life, I did a lot of psychosis work. Now, when a first psychotic episode occurs, a lot of work is done through the Access Open Minds network, for instance. It's based on an Australian model and really seeks to connect medical stakeholders and community stakeholders to create readily accessible clinics.

We've discussed a number of things today, including access to care and doctor availability. In remote areas that don't have doctors, what do you do? I won't get too into the weeds, because my answer would be too long, but we can provide the committee with information after the meeting. In short, programs like this improve access to care and connect the various stakeholders in an integrative way.

I also want to point out something we learned: it wasn't enough to just raise awareness. Awareness raising is great, but in working with people with lived experience, I learned that psycho-education and awareness campaigns on their own weren't enough. I want to tell the committee something I'm concerned about as a psychologist: we do a lot of psycho-education, but it has to be followed up by meaningful intervention and possible next steps. Someone with lived experience whom I work with said that the lack of solutions in the face of constant education campaigns was beginning to have a pernicious effect. People are being told that it's normal and that things should be fine, but that likely won't work for the 30% of people who really aren't fine. Stronger measures are needed to deal with their situations.

● (1730)

Hon. Mona Fortier: I'd like to give the rest of my time to Ms. Hippman. I think she wanted to add something.

[*English*]

Dr. Catriona Hippman: Thank you so much for the question.

I think the Australian example is a good one to look to. There are similarities in terms of geographic distribution of the population, as well as the unique needs of the indigenous aboriginal populations in Australia. I think they are a really good example to learn from.

They've also done a really good job of having evaluations of the implementation of their initiatives, such as the Australian national perinatal depression initiative. They looked at the impact on hospitalizations for postpartum mental illness, and they showed a 50% reduction in psychiatric hospital admissions after they rolled out their screening and treatment pathways. That is huge.

I'm leading a research study right now with a group of lived experience advocates and advisers who have all experienced hospitalizations for postpartum mental illness in Canada. It is a really traumatic experience right now in Canada. There is no option to be co-admitted with your baby, so you will be separated. We're hoping to work towards recommendations for ways that we can do a better job of supporting people once they reach that level of need in that stepped care pathway.

It also really speaks to the value of trying to catch people early, get the foundational supports in place and ideally prevent the need to have hospitalization.

[*Translation*]

Hon. Mona Fortier: Thank you.

[*English*]

The Chair: Thank you, Dr. Hippman.

Colleagues, that's it for the rounds of questions. We're going to bid our witnesses goodbye, and then I have one question for you, so please don't run off.

To all of our witnesses, thank you so much for being here. The depth and breadth of the experience and credentials appearing before this committee never cease to amaze. Today's panel was a shining example of that. Thank you for being so patient in sharing your expertise with us. Be assured that it will be of significant value to us in our deliberations. If there are any matters that you wish to address to augment what you've already said, we are more than happy to receive written submissions. It will all be considered as we put together the report.

To all of you, thank you so much. You're welcome to stay, but you're free to leave.

For the rest of you, colleagues, the time has expired for the consideration of the Medicago documents that we had available for review, so we would like the direction of the committee to destroy those documents. Can we have a motion from the committee to do just that?

Is there anybody with any discussion or points of view on that?

● (1735)

Mr. Marcus Powlowski: I move to burn them.

Some hon. members: Oh, oh!

The Chair: If I may, I would like someone to move this motion:

> That the unredacted copies of the vaccine supply contract between the Government of Canada and Medicago Inc. dated November 13, 2020, submitted to the committee in response to the motion adopted by the committee on Friday, January 19, 2024, be immediately destroyed by the clerk following the adoption of this motion.

Does anyone care to move this motion?

Mr. Marcus Powlowski: I do.

The Chair: Is there any discussion?

(Motion agreed to)

The Chair: Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: The meeting is adjourned. Thank you.