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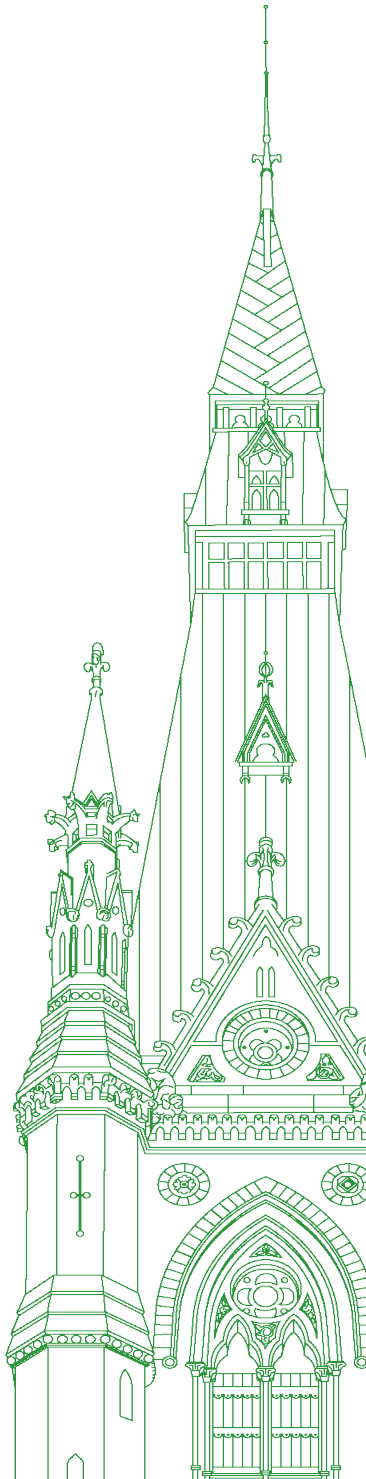

Chair: Mr. Sean Casey

Standing Committee on Health

Thursday, April 11, 2024

● (1110)

[*English*]

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

Welcome to meeting number 109 of the House of Commons Standing Committee on Health.

I would give a friendly reminder to everyone to ensure that you put you earpiece a bit of a distance from the microphone so that it doesn't cause feedback and potential injury.

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

Before I welcome our witnesses, I want to provide this trigger warning. We will be discussing experiences related to violence and assault. This may be triggering to viewers with similar experiences. If you feel distressed or if you need help, please advise the clerk.

I would like to now welcome our panel of witnesses. Appearing as an individual, we have Dr. Nichole Fairbrother, clinical associate professor, department of family practice at the University of British Columbia. On behalf of the Centre for Addiction and Mental Health, we have Dr. Liisa Galea, senior scientist and Treliving chair, women's mental health. Representing the Kawartha Sexual Assault Centre, we have Jocelyn Enright, coordinator, community engagement, communications and fundraising. On behalf of Persons Against Non-State Torture, we have Linda MacDonald, co-founder, and Jeanne Sarson, co-founder.

Welcome to all of our witnesses. You'll have five minutes for your opening statements.

We'll begin with Dr. Fairbrother.

Dr. Nichole Fairbrother (Clinical Associate Professor, Department of Family Practice, University of British Columbia, As an Individual): Good morning. Thank you very much.

I'm aware from colleagues that women's mental health encompasses a broad range of conditions that others have already spoken about this week, so in my five minutes I'm going to focus on my own areas of knowledge and expertise. I'm going to discuss with you two key topics in this area: postpartum thoughts of infant-related harm and their relationship with infant safety and mental health, and perinatal anxiety and anxiety-related conditions.

To begin, 99% of new parents report unwanted and intrusive thoughts of one's infant being harmed by accident, and over half of new parents report unwanted intrusive thoughts of harming their infant on purpose. This is not generally known, and understanding of this phenomenon is limited. This lack of knowledge has significant negative consequences for parents and their infants.

We now have superb data showing that, when unwanted and intrusive, thoughts of harming one's infant on purpose are not associated with an increased risk of violence toward the infant. They are, however, associated with significant distress and an increased risk of mental health difficulties, the most common of which are obsessive-compulsive disorder and depression.

Health care providers are understandably concerned when a parent discloses thoughts of harming their infant. However, a lack of knowledge in this area often results in unnecessary referrals to child protective services, monitoring for child abuse and, on occasion, child removal. These actions are necessary when there is a real risk to infant safety. However, when not necessary, these dramatic actions can have devastating consequences for parents and their infants.

In this area, I recommend that we develop and evaluate education for care providers to improve their knowledge and management of these disclosures of harm thoughts; that we seek to understand and mitigate the negative consequences of disclosures of postpartum harm thoughts by parents to care providers, in particular for indigenous parents; that we assess the effectiveness of education regarding postpartum harm thoughts in reducing their mental health consequences; and that we learn more about the experience of postpartum harm thoughts by fathers and parents of other genders.

With respect to anxiety and anxiety-related disorders, there are more than 10 such conditions. They disproportionately affect women, and, as a group, are the most prevalent of all mental health conditions. They are also associated with significant distress, life impairment and increased health care costs.

For convenience, I will refer to anxiety and its related conditions collectively as anxiety disorders.

Of pregnant and postpartum people, 21%, or one in five, suffer from one or more of these disorders. They are of particular importance during the perinatal period, because they also negatively impact infant and fetal development. For our health care system to respond effectively to people suffering from these conditions, we require accurate and effective screening, assessment and treatment.

Outside of reproduction, we have excellent psychosocial and medication treatments. Talk therapy—in particular cognitive behavioural therapy, CBT—is the treatment of choice for many of these conditions. CBT is typically as effective as medication at the conclusion of treatment and superior at follow-up and preventing relapse. However, publicly funded CBT is extremely limited; consequently, frequently only those with third party medical coverage, or the means to pay high out-of-pocket costs, are able to access treatment.

Among perinatal people, there is a high acceptability of screening, and talk therapy is strongly preferred to medication. Pregnant people especially need access to evidence-based talk therapy for their mental health due to concerns about the potential negative impact of psychotropic medications on the developing fetus.

My recommendations in this area are to increase research to identify accurate and reliable screening tools for perinatal anxiety disorders, to assess the impact of mental health screening on mental health outcomes for both perinatal depression and anxiety, to assess the effectiveness of CBT in perinatal populations and to identify low-cost ways of increasing CBT access for perinatal people in particular. Generally, I think increased funding specific to perinatal mental health would be very beneficial.

Thank you very much for your time.

● (1115)

The Chair: Thank you, Dr. Fairbrother.

Next, from the Centre for Addiction and Mental Health, is Dr. Liisa Galea.

Welcome to the committee. You have the floor.

Dr. Liisa Galea (Senior Scientist and Treliving Family Chair, Women's Mental Health, Centre for Addiction and Mental Health): Thank you, Mr. Chair, and honourable members.

I've been a professor for over 25 years, first at the University of British Columbia, and now at the Centre for Addiction and Mental Health and the University of Toronto. I'm also scientific lead of womenmind, which is at the Centre for Addiction and Mental Health, and the lead of the women's health research cluster, which has over 570 members in 29 countries worldwide. Both of these initiatives have common goals dedicated, in part, in closing the gender gap in science by putting the unique needs and experiences of girls and women at the forefront of mental health research.

As a neuroendocrinologist, my research is on how estrogens and stress influence female mental health across the lifespan from a biological perspective. My driving questions have been around why women are more likely to be diagnosed with depression and Alzheimer's disease compared to men. What is it about our brains that make us more susceptible to these disorders?

Indeed, we and others have found numerous molecular signatures in the brain that differ by sex and female-specific experiences, and underscore the vital importance of continuing this work, because one size does not fit all when it comes to mental health interventions.

Beyond understanding sex influence on disease, I have been studying how female-specific experiences, such as pregnancy, menopause and hormonal contraceptives, influence the brain. The time of greatest risk for first-time depression is during postpartum and in perimenopause. However, these female-specific experiences are rarely considered in the literature. How rare is that? We found that only 3% of neuroscience and psychiatry studies have examined women's health questions. Indeed, there were nine times more studies on males compared to females.

I'm a highly cited scientist, top 2% in the world and I have over 200 publications, but it has been very challenging to get the research funding to do work in this area. My experience is not unique. Many of us have had comments on our grants, saying to “add men” or “add males”. This is for grants that centre on pregnancy, placenta or female-specific cancers. We need women's health research; without the research, we can't tell our health care providers where to steer the boat as our research discoveries are our compass and map.

Yet, although attention to the lack of equity in health research is improving, most of it is directed towards sex and gender differences in disease and health. We need to understand that specific research on women's health and female-specific variables across the lifespan is crucial for improved mental health outcomes.

Women's health research has been undervalued, understudied and underfunded. Not only do females and women have a unique physiology and experiences that impact their health differently from men, many women experience them differently at different times in their lives than men. Ignoring these differences, it becomes more difficult to accurately diagnose and treat these conditions.

Another large study found that for over 980 different disorders, women were diagnosed 3.7 years later than men for the very same disease. This was true for mental health disorders, Alzheimer's disease and more. A fundamental reason for these disparities is that most of our medical knowledge, including our diagnosis criteria, is based on the data and experiences of men.

This has led to the labelling of symptoms in women as atypical. This atypical label is seen across a wide variety of disorders, including depression, anxiety, bipolar disorder and autism. It's only atypical when you compare it to men. It's not atypical for the roughly 50% of our population. Words do matter. This atypical label likely contributes to the delay in diagnosis. We know that earlier diagnosis leads to earlier interventions and improved outcomes.

In another study we did, we examined over 8,000 Canadian grants across 11 years. We found that less than 6% of federal funding went towards women's health research. A recent World Economic Forum report suggested that we could save one trillion dollars a year worldwide if we invested in women's health research. The U.S. government is promising $12 billion for women's health research.

When funding for specific issues is protected, amazing discoveries are made. Consider the ALS ice bucket challenge that raised $115 million for ALS 10 years ago. This investment has more than doubled the number of researchers and publications, and increased the number of clinical trials 10 times, such that now we have at least four new approved treatments.

I recommend a concerted national investment in women's health research as this is necessary for improving women's mental health outcomes. Only when society values women's health factors, and pays more attention, will we be able to realize the promise of precision medicine.

● (1120)

Thank you.

The Chair: Thank you, Dr. Galea.

Next, from the Kawartha Sexual Assault Centre, we have Jocelyn Enright.

Welcome to the committee. You have the floor.

Ms. Jocelyn Enright (Coordinator, Community Engagement, Communications, and Fundraising, Kawartha Sexual Assault Centre): Thank you.

It's an honour to present today to the standing committee to speak on the health of women and girls.

My name is Jocelyn. My pronouns are she/her. I work at a small sexual assault centre in Peterborough, Ontario that receives around $340,000 in core funding from the provincial government under the Ministry of Children, Community and Social Services.

I will share that our centre does support survivors of any gender; however, I am going to focus on our supports for women and girls today.

I would like to highlight the significant impact that sexual violence has on the health of women and girls, including trans women and all other women members of the 2SLGBTQIA+ community. I will discuss the need to mitigate long-term mental health concerns for survivors, the need for more preventative measures and the need for more core funding to accomplish these goals.

Women survivors of sexual assault are more than twice as likely as male survivors to develop post-traumatic stress disorder, PTSD, with symptoms lasting up to four times longer than males, even when controlling for the extent of trauma exposure and the type of sexual assault experienced.

According to the DSM-5, some of the highest rates of PTSD are found among rape survivors, with rates ranging from one third to over one half. Symptoms include re-experiencing the traumatic event through flashbacks and nightmares, avoiding reminders of the traumatic event, startling easily and experiencing negative thoughts and beliefs that impact daily living.

PTSD is commonly associated with many other health and mental health disorders and is not the only mental health condition that may develop after sexual assault. Survivors may also develop generalized anxiety disorder, major depressive disorder, suicidal ideation, self-harm behaviours, chronic pain and chronic health conditions, eating disorders and body dysmorphia, obsessive-compulsive disorder and dependence on substances as a means of coping.

Many women may also receive diagnoses of personality disorders like borderline personality disorder after experiencing trauma, disorders that carry heavy stigma and may lead many programs to deem their cases too complex. Researchers suggest that there is an overdiagnosis of personality disorders in women who have been sexually assaulted particularly and advocate for diagnoses of complex PTSD instead.

The risk for these related mental health conditions may be greater for individuals who experience sexual assault at a younger age. Early trauma can cause disruptions of neurotransmitters and negatively impact brain development. Trauma changes the connections and wiring in the brain and may influence our ability to process and regulate emotions later on, symptoms often associated with said personality disorders.

Complex PTSD is often seen in women who have experienced multiple sexual traumas or experienced sexual trauma early in childhood. Girls who experience childhood sexual abuse, CSA, are at an increased risk of being sexually assaulted in adolescence and as adults, further increasing their risk of developing further mental health disorders.

It is important to note that unfortunately our centre is not funded to serve clients under age 16. This leaves a significant gap in services for girls. Where do we send them if they don't have money for private therapy or we don't have other agencies in our area that specialize in supporting sexual assault survivors? We have many folks come to our door as adults who are looking for support for their experiences of childhood sexual assault specifically. Imagine how much more we could do for these survivors if they could access our services and supports immediately after experiencing childhood sexual assault. Imagine the ease that would have on all health resources down the line if we could mitigate that trauma rewiring before it becomes ingrained and mitigate the development of all of those other mental health disorders. Imagine if we treated complex PTSD in women and girls instead of labelling them with stigma later in life.

Our agency services four large counties around Peterborough, and 2021 census data estimates around 336,864 residents are in our catchment area. Even just looking at women and girls alone, that's a lot of people, and I'll note that our core funding supports pay for one management role, one admin role, one prevention educator and one counsellor.

Women who are believed and not blamed and offered trauma-informed support after a sexual assault are less likely to develop these long-term mental health impacts. The sexual assault centres across Ontario and elsewhere in Canada are extremely underfunded. If more core funding was invested into these agencies, survivors of sexual violence would get better access to supports in a timely manner, which would prevent many instances of these long-term disorders.

Prevention education also needs to be prioritized. In Ontario a lot of sexual assault centres cannot take on this role for lack of capacity and funding or take this role on with limited funding. If we can teach young boys early about the core foundations of sexual violence, consent, masculinity and their patriarchy, we will see rates of sexual violence decrease over time.

Right now our funding provides us with the bare minimum to provide band-aid solutions to women, often long after the harm has taken place, and neglects the power of prevention in creating lasting change.

● (1125)

We work tirelessly to make the world as safe a place as possible for women and girls, but the reality is that we are dramatically underfunded to do so. Providing additional core funding to sexual assault centres will have a great impact on the future of women and girls, and on their health and mental health. The federal government can play a role in this by advocating to the provincial government for additional funding, and it can look to federally funded programs like Public Safety's end gender-based violence plan to help support that core funding.

Thank you.

The Chair: Thank you, Ms. Enright.

Next up is Persons Against Non-State Torture.

Welcome.

Ms. Linda MacDonald (Co-Founder, Persons Against Non-State Torture): Thank you.

I'm Linda MacDonald and this is Jeanne Sarson. We are from Persons Against Non-State Torture and members of the National Council of Women of Canada. We are retired public health nurses and grassroots feminist activists.

For 31 years, we have supported women in Canada who have been subjected to torture by non-state actors—non-state torture. This started with one woman in our community in Nova Scotia. We proudly bring these women's voices. Many have endured non-state torture from infancy onward, and they have all endured grave discrimination.

Non-state torture is torture that occurs in the domestic or private sphere in relationships perpetrated within families and in human trafficking, prostitution, pornographic exploitation, and violent groups and gangs. It is dismissed as socio-cultural, traditional or religious acts or norms, and it can be committed through migration, displacement and humanitarian unrest.

Non-state actors, as defined by the UN Security Council, are any individuals or entities “not acting under the lawful authority” of the state.

Acts of non-state torture are intentional and can include mental or physical severe pain and suffering through electric shocking, water torture, forced drugging, group or gang rapes, beatings, whippings, cutting, burning, forced impregnation and abortions. Because Canada's Criminal Code lacks a law against non-state torture, women are invisiblized, pathologized and mislabelled as mentally ill. Their normal response to non-state torture is seen as a disorder, and discrimination prevents them from receiving the proper mental health care they need to heal with dignity from such serious crimes and human rights violations.

A simple example is Sara, a survivor of non-state torture getting blood work done at our local hospital. Seeing blood tubes in the elevator, she got triggered and fell to the floor. The hospital staff misunderstood her response. They placed her on a stretcher with raised side rails and she was watched by a uniformed commissioner, who stopped her from escaping. After eight hours, she called us to the hospital and we helped settle her. If the staff had understood that this is a normal response to the terror of seeing her own blood, this eight-hour ordeal could have been prevented.

Using our own victimization- and traumatization-informed model of care, we have been successful in helping women heal from non-state torture.

● (1130)

Ms. Jeanne Sarson (Co-Founder, Persons Against Non-State Torture): I will continue and I will offer evidence-based and victim-centred research.

We are not alone in identifying and understanding the mental health differences between non-state torture and assault or abuse victimizations. Our research questionnaire asked citizens whether 48 violent behaviours were indicative of assault, abuse or non-state torture, if many or all were inflicted on one person.

Of 776 respondents, 723 or 93% were Canadian, 680 or 88% were female respondents, 89 or 12% were male, seven didn't answer or said “other”, 7% were from other countries and 8% came via our website or regular mail.

This questionnaire also asked, “If you were forced to choose between being a victim of abuse/assault or a victim of torture, which would you choose?”

Some 680, or 88%, chose assault or abuse, explaining that non-state torture was more life-threatening, more dehumanizing, more painful and more difficult to heal from and that they were disbelieved. Some 6% were undecided or did not answer and 6% chose non-state torture.

As two women explained, that's all they knew. One woman said that she was brought into a child sex-trafficking ring by her father when she was around the age of four. She said that most of what she was put through in this ring she considers to be torture and that she is still having powerful flashbacks, which include body memories of this torture.

The other woman said that she was definitely tortured. She said that she uses this term to help health care professionals and others understand her childhood and not minimize it.

Our three recommendations are to criminalize torture perpetrated by non-state actors as a torture crime; to recognize non-state torture victimization-traumatization informed care; and that education on violence against women must include non-state torture victimization.

Women cannot mentally heal when social-political injustice dehumanizes them as persons with no legal right to truth-tell, when they are not treated with dignity, when they are disbelieved and when they are not protected from non-state torture.

Thank you for your time.

The Chair: Thank you.

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

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

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

Thank you, to all the witnesses. I commend you. Your work is so important. I applaud you.

I am going to start with Linda and Jeanne.

I have to tell you, if you haven't read their book, don't read it at night before you go to bed. I'm going to quote a few things because I want to get to the torture part. I think this non-state and state torture is not fair.

I am going to start with a quote on page 15 of your book.

Sara said that there's “'no hope for people like me.'”

On page 27 is a quote from Sara, who said that her “'father was using her for his friends' and her aunt was 'making her sleep with her son and making them do things while she watched.'” She said, “'dogs were used.'”

On page 33, it states that in 1991, “the world did not acknowledge such dehumanizing brutality as non-State torture, as a form of violence being inflicted on girls and women within family relationships.”

It continues on to say, “Sara feared she would Self-harm if she could not” get out. She kept repeating, “'Get it out. Get it out'... [which] meant all the crimes perpetrated against her. She said, 'I know they didn't want me to die because I was their commodity.'”

I could go on and on. There are many quotes that really touched me when I read through a lot of information in your book.

One thing that really shocked me was when she said, “'big people, adults! Ministers, gov't worker, cops, pilots...basement orgies like other people having parties or Tupperware, etc.,' and of being 'taken way back in woods and tortured and raped continuously.'”

The study we're conducting today is on women's mental health, so let me ask you this: If a woman has suffered horrible atrocities at the hands of a family member, a spouse or a stranger and the Canadian legal system does not acknowledge that what she has been put through is torture, what would that do to a woman's mental health?

For example, gang rape has been acknowledged by the United Nations as torture, but the Canadian Criminal Code does not.

What happens to the woman's mental health when she finally has the courage to step up and name her torturer and the legal system says, “No, you didn't experience torture”?

I'll leave it to Linda or Jeanne to answer, please.

● (1135)

Ms. Jeanne Sarson: What happens to them? Well, when Sara came to us in 1993, Linda and I had no idea that torture happened in families. What we learned is that they survive by disassociation. Sara did not know she was a human being. When we said to her, “Sara, you're a human being,” she said that nobody ever told her that. She thought she was an “it”. That's how she explained herself as a human being: as an “it”.

When trying to heal, some women, Sara included, would often want to hold our hands. Sara would say that she could not feel any sensation. This is because, in order to survive, they have to cut off their senses. They cut off their sense of smell. They cut off their physical sense, and they cut off their visual sense. I was sitting outdoors with Sara one day in the fall, and all of a sudden she said, “Look at the trees; they're turning colour.” She said that she had only seen in black and white. We see that over and over again.

When you reference the issue to get out, it was the fact that the torture memories were so heavy. If they're not listened to, they don't know what else to do. As other people have said here, they start cutting, and they're self-drugging. They have difficulty with the food they eat. Sara was also taught by her parents to, if you will, die by suicide. When she was a little girl, they used to put her—and this is her telling—in the hallway and teach her how to cut her wrists if she ever told.

When we met her, she was almost 30 years old. She was a professional, had a professional job and was still living two lives. People seem to not understand that. However, we know that, in domestic violence, women go to work and then go home and get beaten. She was a professional. She went to work. She went home and even at almost 30 was still being tortured, was still being trafficked and still did not understand that what she was living was violence.

What we have to understand is that it takes time for them to understand what they've been going through. She was a baby, and the torture started then.

Mrs. Anna Roberts: I just want to say one thing because I know I don't have a lot of time.

There was a quote on page 43 that read, “I have lived my life doing what others wanted me to do with the hope they might love me or come to care for me even a little.” I want to thank you, Jeanne and Linda, for saving her because reading this book has taught me a lot. Non-state torture and torture are very similar. How can a country like Canada not look at this as torture? This woman who you were able to save today was tortured.

Go ahead, Linda.

Ms. Linda MacDonald: What I want to do is explain how Sara and all the women feel because there's no law in our country.

It's one thing to be dehumanized by your family or traffickers, or in prostitution or pornography. However, it's another to be dehumanized by your country. They are told by their country that.... Sara endured 20,000 rapes by the age of 20. If we want to call that assault in our country, that is a grave injustice to her. It reinforces that she's an “it” and that nobody will ever believe her. How do we say that women in conflict who are gang-raped were tortured but that in our country for Sara, who was gang-raped, or for women who were gang-raped after a hockey game, it's assault and not torture? The injustice is that we're telling them that they're not as important. It's a form of discrimination that they live with every day.

● (1140)

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

Ms. Sidhu, you have six minutes, please.

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

Thank you to all the witnesses. Hats off to you for the work you are doing for all women, and keep up the good work. Thank you for your insightful testimony.

Dr. Galea, in your testimony, you talked about women being behind. There are nine times more studies on men than on women. What barriers are you seeing? What are the recommendations that you can provide to us today on how we can help in this matter?

Dr. Liisa Galea: I think my personal opinion and recommendation is to have protected ring-fenced funding for women's health in general, and for the research, because when you protect the funding for research in a specific area, multidisciplinary researchers will write the grants and do the research in that particular area. If we leave it open to saying.... Right now in the federal grants, there's a lot of attention paid to sex- and gender-based analysis, which is fantastic and laudatory, and they'll tell you that 90% of their grants are doing this, but they've analyzed a mandatory box that we all have to fill out.

We actually analyzed what they said they were going to do, and that's when we found that only.... If you exclude female breast cancer, I think it's 4.4% of federal grants that are going towards women's health questions. I can't tell you all of it. I can just tell you my experience: that it is very undervalued. Part of the reason why I wanted to start the women's health cluster was to empower researchers to do this kind of work. I have heard from women's health researchers that they don't want to call themselves “women's health researchers”, because they feel it's undervalued.

As I said, I get questions. One of the things we do in my lab is postpartum depression research, and I've been told multiple times in trying to publish it or trying to get grants that this isn't important research, even though we know that in a person's lifetime it is the time of greatest risk to develop depression.

I think ring-fenced funding, like ALS and the ice bucket challenge.... Another one is HIV/AIDS. There was lots of money, which the Canadian government gave worldwide, and it went from a death sentence to people being able to live with the infection now.

That's the solution to me. That's our compass and map.

Ms. Sonia Sidhu: There is one other point I want to mention. You said that 3.7 years later a diagnosis is seen.

Dr. Liisa Galea: Yes.

Ms. Sonia Sidhu: Is this again something on the lack of data or lack of the research funding or a different diagnosis? What is it?

Dr. Liisa Galea: I think that's a really fantastic question. I think it's all those things. There are going to be things on the biological side of things. There are going to be things on the social side of things as well. We talk about the "D's" and the "U's": the denial, the dismissal, the delay, the diagnosis, and the understudied, the undervalued and the underfunded. A number of diseases and disorders do manifest differently, right? That's where we get that "atypical" label from.

Also, in another big one, there was a story just recently about a woman in her forties having a heart attack. They didn't recognize the symptoms, because one of the major symptoms is that they don't feel well. You've probably seen the stories: They go to the ER and they get prescribed anti-depressants. I think that's a big part of it. We don't recognize that the symptoms can be quite different, and that likely means that the manifestation brain-wise or body-wise is also quite different and requires different types of treatments. It's unfortunate.

Of those 3,000 studies, we also looked to see, did they analyze by sex or gender...? First of all, there was very little work on gender in general in the journals we looked at: It was 3% of studies—

Ms. Sonia Sidhu: Thank you.

We've heard that with the way perinatal classes are structured right now mental health is often overlooked or not talked about. Can you tell us how the training for future parents could be improved?

● (1145)

Dr. Nichole Fairbrother: Could you just clarify your question, please?

Ms. Sonia Sidhu: In the perinatal classes and how they are structured right now, mental health is often overlooked or not talked about. How could the training for our future parents be improved for these classes? Or is there anything missing from these classes? You can talk about that.

Dr. Nichole Fairbrother: I'd like you to go first, Dr. Galea. I can finish up, but I think you probably know a bit more about perinatal classes than I do.

Dr. Liisa Galea: I don't know about the perinatal classes, but I can tell you, because I did this little analysis very recently, that we looked at the books that are written. I'm sure that you might have heard about this on Monday as well. So much attention is paid to the pregnant person and, once the baby is out, all the attention moves to the baby. Very little attention goes to the birthing parent, and that's a problem.

Another problem is that mental health is still such a stigma in our country, but one in two of us will experience mental health issues in our lifetime. This means that either us or someone we love dearly is going to go through that.

I never understand this stigma. We have to break it up with a conversation. We have to make it clear that it's okay to talk about mental illness. Obviously, there are repercussions for talking about it when you're pregnant, but it's a very susceptible time. There are a lot of biological signatures during the postpartum period that match what happens during pregnancy, so it makes sense that this would be a very particularly vulnerable time.

Dr. Nichole Fairbrother: Certainly, one of the things that we notice within the area of perinatal health is that there is so much focus on the infant, which obviously is terribly important, but the focus on the infant sometimes comes across in such a way that a woman, the birthing parent, is no more than a vehicle to producing a healthy child. The woman, herself, is not perceived as having authentic and independent needs separate from the needs of the child. Mental health is a really great example of that, because we're so focused on infant development.

For example, it would be very difficult, I think, to get a lot of attention for mental health difficulties of the birthing parent, the mother, if there were no implications for fetal development, because there's such an orientation around the infant. When you talk about prenatal education around mental health, this is one of the issues for me, personally, because this is my area of work.

When we talk about postpartum harm thoughts, most parents, most pregnant people, have no idea that this can happen to them. Part of the reason for that is once it does, they're terrified to tell anyone in case somebody reacts in such a way as to take their child away. They think they're demonic. We've had people come to us in the lab saying they tried to give their baby up for adoption, because they were so afraid of these thoughts, or they became suicidal, because they were afraid of these thoughts.

Had they received education prenatally around these mental health concerns, even tip sheets or fact sheets, it would have made a difference to them going into this experience, and kind of knowing what's coming.

The Chair: Thank you, Dr. Fairbrother.

[*Translation*]

Now it's over to Ms. Larouche for six minutes.

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

I'm not sure where to start. This hits me like a ton of bricks. Your accounts touch me deeply, Ms. Enright, Ms. Sarson, Ms. MacDonald, Ms. Galea and Ms. Fairbrother. Thank you very much for that.

It's true that there is a lot of stigma, and that obviously leads us back to our lived experiences. In my own family, there are people living with mental health issues, with depression. They are probably going to need medication and monitoring their entire lives to keep them from going off the rails.

The Chair: Excuse me, Ms. Larouche. I hesitate to interrupt you, but there is no interpretation on Zoom, if I understand correctly.

We'll stop the clock until we get this resolved.

● (1145)

_____(Pause)_____

● (1155)

[*English*]

The Chair: I call the meeting back to order. I understand that our technical problems have resolved, so thank you again to the IT professionals for making that happen.

[*Translation*]

Ms. Larouche, thank you for your patience.

You have five minutes.

Ms. Andréanne Larouche: Thank you, Mr. Chair.

As Ms. Galea mentioned, one in two people will experience mental health issues in their lifetime. If someone is not affected directly, it will be a person close to them, so I want to acknowledge the work of the witnesses. Unfortunately, I've experienced suicide in my own family, and as the mother of a two-year-old daughter, I am worried for her.

I want to acknowledge the work of organizations back home. I would like to thank Oasis santé mentale Granby et région, which does exceptional work with families. Every year, I make a point of going to their fundraising brunch to support them. It's taking place at the end of the month. Also, the Centre de prévention du suicide Haute-Yamaska Brome-Missisquoi is celebrating its 40th anniversary this year.

I began my career as an MP in 2019 with a speech that commemorated the 30-year anniversary of the Polytechnique massacre, an act caused by misogyny, the hatred of women. I have also been a member of the Standing Committee on the Status of Women since February 2019. Every time this committee does a study, we see how women are affected in different and disproportionate ways. I find it hard to understand.

Ms. Fairbrother, you talked about the matter of indigenous women. The Standing Committee on the Status of Women is currently studying the creation of a red dress alert system in Canada. You talked about how indigenous parents experience mental health differently.

Could you tell us more about that?

Dr. Nichole Fairbrother: Sure. I'm sorry, but I will answer in English. I hope that's okay.

[*English*]

I cannot speak about all of the various mental health conditions that may affect people who are pregnant or postpartum. I also acknowledge with deep humility that as a white colonial settler person, I have to tread carefully in this area. I can't speak with authority on some things.

However, I think that when we talk about phenomena such as postpartum harm thoughts, which is a core area of my research, if I were an indigenous parent in Canada, I could not imagine ever disclosing that to anyone. We know from talking to white mothers that this is a hard thing to talk about, and there's a lot of secrecy around it. I can only imagine that, for an indigenous parent, with our history of child removals in Canada specific to indigenous parents, this would be near impossible. What that means is that if one is having that kind of experience, there will be hesitation to talk about it.

I do think that hesitation to disclose mental health difficulties very likely encompasses a broad range of mental health problems because of fear of consequences, authority figures and the health care system in general.

Recently I had an email from someone who reached out to me, because they had been experiencing thoughts of harm related to their infant. She shared with me that, at the hospital, there was quite a warm and cordial response initially. There was some discussion, and her family physician had sent her to emergency because, she was told that would be the quickest way for her to then get sent to reproductive mental health services.

Just for context, I'll tell you that she puts blonde highlights in her hair, as does her mom, so that people don't immediately know she's indigenous, because that makes her feel safer. That's just to show how much thinking goes into who you are as a person.

Once she disclosed her indigenous ancestry, she said that immediately reactions changed. She was left alone in a room for a period of time. The consequence of this was that she didn't have any contact with mental health services. She was referred to child protective services. Her whole family had to move for a period of two to three months so that they could be monitored for potential child abuse, because they couldn't provide that monitoring in her own city.

I am now in contact with various health authorities and working to provide some education and training around this, because this was so traumatic for this person.

I think that, while this example is specific to harm thoughts, a really big area of non-disclosure, there are similar things happening with respect to other mental health conditions.

● (1200)

[*Translation*]

The Chair: Thank you, Ms. Larouche. That's all the time you have.

[*English*]

Ms. Gazan, please go ahead. You have six minutes.

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

My first question is for Dr. Fairbrother.

You spoke about the apprehension of children potentially resulting in greater levels of depression in mothers. One of the things we're still dealing with in Manitoba, for example, to build on what Madam Larouche spoke about, is birth alerts, particularly for parents who have histories with child welfare; if there are concerns, their files are opened immediately, even before anything happens. We still have kids being apprehended from hospitals without allowing the parents the chance to be able to parent.

Can you speak to this? We know, as the research is very clear, that among women whose children are apprehended, there's a drastic decline in mental health, and it becomes harder for them to parent in terms of consequences of mental health issues like addiction or trauma.

Dr. Nichole Fairbrother: I'm also going to invite Liisa to pitch in if there's anything she might want to add.

My knowledge of child apprehensions is limited to my own area of research on postpartum harm thoughts. However, I think one of the things we have underappreciated is the attachment trauma that happens when a mother is separated from her infant. We have lived with the assumption that, even for children, moving a child from an unhealthy situation to a healthy situation is only a good thing. When we have a close attachment relationship with somebody, being taken away from that person is traumatic; it's traumatic for children and traumatic for parents, and it will very likely result in fallout in terms of mental health difficulties.

First of all, I think the problem we're having is, in many ways, obviously linked to systemic racism and the history of indigenous people in Canada. However, there are also the issues of threshold and process. Our threshold is set at a level that assumes removal will not be damaging, and that it will only be helpful. Consequently, we're setting the bar in the wrong location.

Ms. Leah Gazan: I have a question about that. We know that the first two years are the most critical for developing an attachment to another person. Is there a connection between the removal of children and the potential for attachment disorders developing later on in life?

● (1205)

Dr. Nichole Fairbrother: I wish I knew the answer to that. If you were asking me to guess, I would say yes, but I can't speak with authority on that.

Dr. Liisa Galea: I would say the same thing. I don't know, but my guess would be...

Dr. Nichole Fairbrother: I don't know how many people in this room have children, but if you remember your child when they were one or one-and-a-half years of age—it's going to bring tears to my eyes—I think you will all remember the love and the intensity in that relationship. I think it is very hard to imagine there would have been no consequences.

Ms. Leah Gazan: I have a question about the fact that we always have to measure women's health against that of men. It's just so ridiculous. One of the things that I know many universities and polytechnics are pushing for is more funding for research in academic institutions. How is the lack of research funding provided to academic institutions impacting women's health?

Dr. Liisa Galea: It's having an enormous impact. We have so little of it in the first place. Let's be clear: Our funding levels have been low and they are declining in comparison to the G7 and G20; our health research funding is going in the opposite direction to that in many other countries. We have that against us.

We then also have this extreme lack of attention being paid to women's health factors, which were the subject of 6% of funding in 8,000 federally funded grants over 11 years. That's a pretty small piece of the pie; we need a larger pie in general.

I'll just say that a lot of our costs for research are funding people. The costs for Ph.D. students, research assistants and labs are all going up, so we can do less and less research with the money we have.

Ms. Leah Gazan: We often talk about violence within domestic relationships. We don't talk about violence against women who fall outside of domestic relationships. We know that, often, women will use substances to deal with the violence they're experiencing as a way of coping.

I've been pushing for more low-barrier spaces for women. Why is it critical to have low-barrier spaces, such as 24-7 spaces and shelter spaces, for women?

The Chair: Give a brief answer, if you could. We're out of time.

Dr. Liisa Galea: I'm going to speak to what I know. With concussions, we all think about sports injuries, football players and hockey players. It is more than a thousandfold more with interpartner violence from domestic violence with girls and women.

The Chair: Thank you.

We'll go to Ms. Vecchio, please, for five minutes.

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Thank you very much.

It's wonderful, having the opportunity to ask questions. I usually don't get that chance.

I have five minutes, so I'm going to make it really quick. Nichole and Liisa, I'll start with you.

I believe one of the ways to break the stigma is to talk about things like the menopause. To everybody, menopause, here we come—here I am.

What should we be warning my other colleagues about when we talk about mental health and all of those different things, such as the hormonal changes, as well as the lost time? I think of being here for the last nine years, and I think I've seen dips in things. When we're looking at lost wages, we know there is absolutely not enough done on menopause. Women are struggling, but we just keep plugging along, because that's what we know to do.

What are some of your recommendations when it comes to menopause and some studies that we should be doing? If we were to invest money into a later stage of a woman's cycle, what would you recommend?

Dr. Liisa Galea: Can we have more time? We know so little.

In fact, I was just listening to a podcast called “This Podcast Will Kill You.” The title of the podcast episode was, “Menopause is whatever you want it to be”. It made me both angry and happy to listen to it. They talked about all the different symptoms that occur during perimenopause, which is the two- to 10-year period prior to menopause, the cessation of menstrual cycles.

We just know so little about it. I think there's 0.5% of research on the female brain during the menopause, which is really low, so we don't really have a lot of information.

There are so many different symptoms that we can experience. Everybody thinks about hot flashes, but there are many more than that. I think that's why people drop out of the workforce. They don't realize what's happening. It's musculoskeletal. I'm now getting arthritis in my joints, and it's a menopause-related symptom.

Sometimes, people will say, “Well, it's just aging.” There's a bit of that, but think about the loss of ovarian hormones. In ovarian hormones, we have estrogen receptors and progesterone receptors. They're everywhere across our body. They're not just in the parts that we cover with a bikini; they're everywhere. It makes sense, then, that when we lose these hormones, we're going to experience many different kinds of symptoms.

We need research, research, research.

● (1210)

Mrs. Karen Vecchio: I know I want more, but I have two more questions that I need to get out, so I will go to Jocelyn before I get to Jeanne and Linda.

Jocelyn, we talk about coercive control. We know that 30% of women may show up, showing signs of abuse, such as bruises, but a lot of that other 70% is coercive control that is controlling an individual.

What do we need to do when it comes to coercive control? We know the impact is all mental. What can we do there?

Ms. Jocelyn Enright: Thank you. That's an excellent point.

Sometimes, we get caught up in looking at the physical symptoms of things. Unfortunately, I think we live in a society in Canada that follows a lot of the same guidelines of policing, so, “I need this hard evidence. I need to see it with my eyes in order to believe it happens.” Meanwhile, our centre, and all of the other sexual assault centres, are operating on the basis of, “If this is your experience and if these are the emotions you're feeling, that is the evidence I need to support you.”

A lot more work, even if it is in physical health spaces, needs to just be around how we can create a more trauma-informed space. How can we make sure that everybody who walks through the door feels as safe as possible, so that even if they don't show a physical sign of injury—they mention, “I'm not allowed to go here, because of this,” or, “My partner holds onto my phone”—we don't just ignore that? We know how to ask some more probing questions about that and provide space for them.

Mrs. Karen Vecchio: I'm leaving it to you, Jeanne and Linda, to talk about trauma. The first time I met you was during COVID. We talked about a young woman being tied to a radiator; I think that was one of the first stories you shared with me.

When we're looking at counselling, what is available? You can't even get into a counsellor for simple mental health issues, whether it is anxiety or.... I know anxiety is not simple. However, when we're talking about complex trauma from human trafficking, what is available? Who is educated to help with counselling? What do we have here in Canada to help save some of these young women from the mental torture they're going to continue to have for the rest of their lives?

What can we do?

Ms. Linda MacDonald: With regard to torture and human trafficking, the only place we know of that took on the model we created is the London Abused Women's Centre.

Other than that, we have emails. I answered an email this week from a woman whose daughter was tortured in trafficking. I had to tell her that, where she lives in Canada, there's no one I know of who can help—not in the way she needs.

I want to tell you some of the reasons why victimization- and trauma-informed care is so important. Things disappear. People stop being suicidal. They stop being triggered. They stop disassociating. They're able to sleep at night. They go off medication. They go off disability. They get a quality of life where they can have fun and joy, and just be free to be themselves.

I know it's hard to read at night, Anna, but the story is a good story. It's a positive story if we embrace their reality and know that, if they can heal from torture, they can heal from anything. It's the worst crime on the face of the earth. There's no place for them in this country yet, because we don't have the law. Of course, because we don't have a law, we don't have the care they need and deserve.

Mrs. Karen Vecchio: Thank you so much.

The Chair: Next, we have Dr. Hanley.

Go ahead, please, for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you so much, all of you, for being here.

I'm going to start with Ms. Enright.

You talked about not having funding for the under-16 age group at your centre. Could you briefly talk about what is available in your area for that age group—children and younger youth?

Ms. Jocelyn Enright: Unfortunately, there's not a lot.

I think the assumption is that, because we have a duty to report, the police and CAS are the appropriate services when somebody under 16 has been harmed. It's assumed that we call them and let them handle that. We know a lot of those scenarios, again, are incredibly harmful and come with a lot of stigma. People might not be treated in the right way.

Yes, of course I can call the police for something when it's somebody under 16. If they decide there's not enough evidence, I can't offer counselling. I'm stuck saying, “Here is a child and youth centre that has a one- or two-year wait-list, potentially.” I don't know if it's changed, but over COVID, in Peterborough, we were looking at at least two years for most of our child and youth service wait-list. I cannot guarantee the workers—who I am sure are wonderful at their jobs—have the specific training to work with survivors of sexual abuse, which often needs different ways of looking at it. We often can't use a particular modality without making some changes to make it more trauma-informed.

Unfortunately, those are our options right now. We're left in a position of not having a lot for people.

● (1215)

Mr. Brendan Hanley: Speaking of funding, you talked about where the federal government might have a role. I think part of it was engaging with the provincial government on core funding and boosting other sources of funding. A pre-budget announcement recently from Minister Saks was pretty good news: $500 million dedicated towards youth mental health.

Let's say you had a slice of that funding. Where would you put it in your community? Where would you go first? I know it may depend on how much, but let's say you had a chunk.

Ms. Jocelyn Enright: I was told that our dream is for $700,000 more. That would be the bare minimum for us to have core funding to support who we're supporting and who we're missing. That's the huge thing. We could do as much as we could to create as safe a place as possible. I'm trying to provide my voice for that. We're missing a lot of people who are falling through the cracks.

Yes, I understand the need for all sorts of childhood mental health...but looking at all those different sections.... It's not just saying, “mental health”. Okay, we could mitigate a lot of those mental health things by putting the money into centres like ours. That's great. Let's do that. However, I think, a lot of times, we don't consider children who are coming from domestic abuse situations. It's not as simple as saying, “Leave the situation.”

“Well, can I go to a shelter if I have my children? Is the shelter low-barrier? What if I'm using substances to cope with that sort of stuff? What if my children are using substances to cope with it?" There's putting funding into that, as well. A lot of that could be getting people those basic necessities as they're leaving those situations.

Also, there are organizations people don't think of right away. We might think about putting it into mental health, but if it's put into different forms of things—into torture or into the work we're doing with sexual assault—chances are we might see decreases of further mental health disorders.

Mr. Brendan Hanley: Thank you.

I'm going to move to Dr. Galea. I have so many questions for you.

You talked about getting women's health studies published. Is it about the content? Is there any role in being a woman doing the research? Does that play into it at all, as a female researcher?

Dr. Liisa Galea: Yes, it does—100%. We tend to research what we are interested in, and we're interested in things that we've experienced.

I'll give you a really good example of this. I experienced nausea and vomiting very badly during pregnancy. I was told it was just in my head. I want to make it clear that I had a fantastic health care provider. They just hadn't had the schooling, because we don't have the research in knowing some of these things. She told me not to worry about it, that she could admit me to hospital, but it would go away. I just sucked it up, because that's what you do. My son is now 27 years old, so fast-forward 27 years, and we now know that there's a hormone called GDF15.

I'm sorry, but I've forgotten the name, but it was discovered by a woman in the States. She suffered very extreme nausea and vomiting during pregnancy, and actually ended up losing her baby. The other thing we were told was that it was fine and really safe—but actually not for some people. She was a geneticist. She started to look for a genetic factor for it and found this hormone. Now there are some putative treatments that we can use for people who have really severe nausea and vomiting during pregnancy.

When she told her lab that this was what she wanted to start studying, they laughed at her. She persevered, because this was an experience she had. She wanted to know what this meant and why it was happening.

Women scientists are more likely—the data is not 100%—to work on the issues that matter to them. It's important. As you probably know, like in many areas, we don't tend to move up the ladder as well.

● (1220)

The Chair: Thank you, Dr. Galea.

[*Translation*]

It is now Ms. Larouche's turn for two and a half minutes.

Ms. Andréanne Larouche: Thank you, Mr. Chair.

For this turn, I want to come back to Ms. Galea.

Again, I don't understand why there is such a difference in funding between research on women's health and diseases and research on men's health. The figures you gave are really alarming.

Can you go back to the reasons for this investment gap and tell us what more can be done?

You also mentioned that higher investments in research on women's health would lead to savings. You talked about a trillion dollars in savings, if I understood correctly. I would like you to come back to that figure and tell us which organization provided it.

[*English*]

Dr. Liisa Galea: I'll answer the last question first.

[*Translation*]

I'm sorry, my French isn't very good.

[*English*]

The $1 trillion worldwide that we could save if we achieved more knowledge in women's health research is from the World Economic Forum's report that was just released a month ago or so.

One of the major federal funding agencies is the Canadian Institutes for Health Research. They have something like 58 committees. They'll be on neuroscience, and biological and clinical aspects of aging. None of them is for women's health in particular. There is one on maternal and child health. I've tried to get funding through them. I can't get funding through them, because it's mostly on the child, as you might imagine.

There's another one called gender, sex and health, GSH. That's where I tend to get my funding. If you look on Twitter/X you'll see my pinned rant. I was really angry, because in that committee I put in a grant five times on looking at how pregnancy affects the aging brain, and they kept asking me to add males. Males don't get pregnant. I couldn't do the work that they wanted me to do. Also, there is a lack of research and publications in this area. There is this mistaken belief that girls, females and women are harder to study, because they're more hormonal. We have these menstrual-cycle phases, so we're more difficult to handle or interpret. However, just for a little bit of levity, human males have a 50% decline of testosterone that occurs daily. I have one little thing that I say: Given the monthly fluctuation in females and a daily fluctuation in males, who's more hormonal now?

There have been many studies done to show that there's no difference in variability within each sex. I can't tell you. I wish I knew the answer.

The Chair: Thank you. I interrupt with great reluctance.

We'll go to Ms. Gazan, please, for two and a half minutes.

Ms. Leah Gazan: I'm not sure if anybody can answer this, but I was really shocked. Two days ago there was a woman from Mexico who was denied a C-section in Edmonton until she came up with $5,000 to do so.

I've been really pushing for status for all for these kinds of reasons, safety factors for women.

You spoke a little bit about mental health. I'm wondering if perhaps Madame Enright, Dr. Fairbrother or Dr. Galea could answer how that places women's health at risk, a current, systemic racism within our system—I call it systemic racism.

Can somebody answer that?

Dr. Nichole Fairbrother: I can say just a little bit about that from my own experience.

I've had a number of conversations over the past 10 years with indigenous women who have spoken to me about mental health concerns. When I hear their stories of some of their experience within the health care system and within psychiatry, the feeling I have is surreal. I feel like they are reading from a recent news article describing the problem. It sounds like—and I don't mean this in the trivializing sense—a cliché.

What they're describing is what we've all received notification about or we've seen headlines talking about, and then they're telling me these stories that map on exactly to that, and it feels extraordinary to me.

I think I had the hope or the impression that, given that this has become better known, it would not still be happening, and clearly it is still a very serious and ongoing concern.

● (1225)

Ms. Leah Gazan: I appreciate that because, as I asked you on break, we know that forced sterilization of indigenous women continues to happen in this country. Discrimination is certainly not new in our health care system.

I was horrified. I just thought, “Oh my goodness, what she must have been going through when she was denied the ability to deliver a baby in a hospital”. How can this be allowed? Do you have any comments?

The Chair: Be very brief, if you can. We're out of time.

Ms. Jocelyn Enright: I'm not as well versed with the health care system, but certainly, we work with women all the time who discuss how they don't feel comfortable going to the hospital for anything related to any health issues because of the systemic discrimination they face.

It's being denied something that you think is just a basic human right in Canada, to be able to go in and have this procedure. It seems so simple, but it's not happening. We see a lot of the same with our survivors going in for anything related. As they soon as they identify as being a woman, as soon as they identify going through any sort of trauma or sexual violence, they are treated incredibly differently.

The Chair: Thank you.

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

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

I really appreciate all of the witnesses being here.

I'm going to focus some of my questions specifically to Dr. Fairbrother and Dr. Galea.

I shared with you before committee started that I am a mom to two little boys. Specifically on the perinatal mental health and the anxiety piece, that wasn't something I even knew existed.

When I had my first son, I didn't have any of those experiences. Very shortly after having my second son, I realized that my anxiety was crippling, out of control. I felt like there was something wrong, and he was born a month early. There was a lot of extra stress, so I just assumed that, clearly, I was anxious, and there was something to be anxious about.

It took finding some of your research that helped me realize, “Hey, wait. This is just a normal phenomena. This too shall pass. I am fine. It's all good.”

I share that because I didn't even know that it existed. I was wondering what recommendations you would have that we could put forward on improving this aspect.

Dr. Nichole Fairbrother: You're absolutely right.

Major depression and postpartum psychosis are probably the two mental health conditions that have received the most media attention, the most research, etc. They are the two conditions that people know the most about. Postpartum depression, as a major depressive disorder, affects approximately 6% of new moms, versus anxiety disorders, which affect 21%. All of the research and attention that have been given to depression and to psychosis are well deserved. That's lovely. However, we have not spent any amount of time really giving attention to these anxiety difficulties that are much more common.

A starting point is even just naming this. I will often speak to people who say they had postpartum. They don't even qualify what kind of postpartum. There's the assumption that it was depression. If you go into a physician's office and they start asking you about depression and you have some elevated symptoms of depression, it is quite possible the reason you're depressed is because you're suffering from an anxiety disorder that nobody's asked about and nobody has talked about, and yet you're being diagnosed with depression because a consequence of that disorder is depressed mood, but it's not on anyone's radar.

We need some increased public information about that so that people are more aware that it exists. Someone earlier spoke about prenatal education. Information about what that looks like is really important, as is additional dedicated research so we can learn more about this. It's important to look at whether people are informed and what we can do to ensure that new parents come into this with better information.

● (1230)

Mrs. Laila Goodridge: Dr. Galea, go ahead.

Dr. Liisa Galea: I was writing down a whole bunch of things. Obviously, my big message here is research, research, research. We know so little about what happens to the maternal brain. As I said, there are a number of biological signatures that occur across pregnancy and postpartum. I would love to make some jokes, but I know I don't have time for them. Those signatures mirror what happens in a number of psychiatric disorders, including depression. I probably disagree with my colleague a little bit on the numbers, but that's not the point. The point is that it is a time of really great susceptibility, and we need to provide people with the tools they need to understand this.

There's a great new discovery that just came out of CAMH from Jeffrey Meyer. He's looked at some supplements and at evidence-based information on what's missing, what the biological signals are and how we can better serve people.

On psychosis, I would disagree. I don't think most people know that you can get thoughts, psychosis and schizophrenia-like symptoms after giving birth. Only about 1% of people will have that, but it's pretty significant.

Patricia Tomasi has a really great article. They did a big piece on her in Toronto Life if you want to take a look at it.

Mrs. Laila Goodridge: Thank you.

I appreciate it, and if you can table any of that extra information with the committee, that would be very useful.

I would like to move a motion that I have put on the Order Paper, and I think it's very timely, considering we're studying women's health. Mr. Chair, it is:

> That, pursuant to Standing Order 108(2), the committee undertake a two meeting study on breast cancer screening guidelines in Canada, including but not limited to, an examination of (a) current breast cancer screening guidelines, (b) Breast Cancer Canada’s recommendation to lower breast cancer screening guidelines to begin at age 40, (c) Breast Cancer Canada’s recommendation that Canadian guidelines for the screening, detection, and treatment for breast cancer be updated every two years, (d) best practices in treatment and options to improve health outcomes; that the committee report its findings and recommendations to the House; and that, pursuant to Standing Order 109, the committee request that the government table a comprehensive response to the report.

I am moving this in this space because April is cancer awareness month. I am also doing it for people like me. I lost my mom to breast cancer in 2010. She was 49 years old. I know that, had earlier breast cancer screening been available, I might have been able to talk to my mom when I was going through postpartum anxiety and see if that was something she had. However, I didn't have that resource.

As a direct result of these screening guidelines' not being in place, many women don't have this. I am doing this in honour of my mom and of all of the women who will benefit, as well as their families and society.

Mr. Chair, I will move my motion and I hope everyone will support it so we can get a study on this very important topic.

The Chair: Mrs. Goodridge, in spite of your personal connection and your passionate presentation of the motion, the motion is actually not in order because we are currently undertaking a study, and the motion calls for us to undertake a new study.

We can accept your motion as notice of a motion to be debated at a later date, unless there is unanimous consent to adopt the motion as is, which would thereby dispense with the need for notice but would also not allow for any debate.

Shall we take it as notice, or are you seeking unanimous consent?

Mrs. Laila Goodridge: I'd like to seek unanimous consent, Mr. Chair.

The Chair: Is there unanimous consent to move the motion?

Some hon. members: Agreed.

The Chair: I'm now advised that, because she has unanimous consent to move the motion, it is debatable. If anybody wants to speak on it, the floor is open.

Dr. Powlowski.

● (1235)

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I think we want to get back to the witnesses, so we support the motion.

The Chair: Are there any further interventions on the motion? No.

(Motion agreed to [*See Minutes of Proceedings*])

The Chair: Thank you, Mrs. Goodridge.

That also concludes your time and brings us to Dr. Powlowski for five minutes.

Mr. Marcus Powlowski: I'd like to ask all of you questions, but I'm going to concentrate on Dr. Fairbrother.

You cited that 50% of women had thoughts of harming their babies. Can you quickly give me some citations? What's the sample size?

Dr. Nichole Fairbrother: A number of different investigators have looked at this—Jonathan Abramowitz, in particular, and then me.

I focus specifically on harm thoughts. I have two publications on this. The first was about 100 people, and the second was about 400 people. The first time it was 49% who reported unwanted intrusive thoughts of hurting their babies on purpose. In the second iteration of somewhere between 400 and 700 people—I'd have to look at the exact numbers of who reported this—we had 54% report unwanted intrusive thoughts of hurting their babies on purpose.

We have, in both of those studies, looked at whether or not the people who reported these thoughts of hurting their babies on purpose were actually harming their infants, and whether or not that was happening more often in that group than in the group of people who did not report thoughts of hurting their babies on purpose. To date, we have found zero evidence, and the raw numbers would suggest that the people with those thoughts may—possibly, if we had a large enough sample—be slightly less likely to hurt their infants.

Mr. Marcus Powlowski: I would take it that this is very stressful for women who have these thoughts.

Is there evidence that this contributes to depression and anxiety in women? How much would that be alleviated by the fact that they could talk to somebody about it without having to worry about losing their children?

Dr. Nichole Fairbrother: It is very upsetting for some people. Some people are able to cope with those thoughts, but for a lot of people, that is very distressing.

What we know is that obsessive-compulsive disorder, which is the mental health condition most likely to arise as a result of these kinds of thoughts, may impact as many as 17% of postpartum people. That is not exclusive to the thoughts of hurting your baby on purpose but also encompasses thoughts that the baby may be harmed by accident.

As a first step, what we really want to know is this: If we educate people prenatally about these thoughts, how much of that will be mitigated? I think that's the most important first step because you may be able to get a long distance from just doing that. Those, then, are the people who are going to require some treatment postpartum.

Mr. Marcus Powlowski: I've worked a long time as a doctor, and I've delivered a lot of babies. However, my involvement in prenatal care has been blood pressure, protein in urine and those kinds of things, and it's mostly been in developing countries.

In Canada now, is this part of the discussion that most practitioners looking after pregnant women are having with mothers?

Dr. Nichole Fairbrother: No. It's not non-existent, but it is far from common. Many health care practitioners, unfortunately, know very little about these thoughts, and they are either not mentioned or not responded to, as if all thoughts of hurting one's baby on purpose are harbingers of child abuse, which is not the case.

Mr. Marcus Powlowski: I would have thought that these kinds of thoughts would be most stressful to people who, themselves, either experienced child abuse or had seen siblings experiencing child abuse. I want to get to the next part of the question, which is about differences as to how mothers are treated according to their race. I would think there is probably a higher incidence of intervention when indigenous women report such things.

I've worked in a lot of emergency rooms. I'm pretty sure that if you had an indigenous woman, routinely, the doctor would refer the case to child care services. It would depend on whether you have indigenous child care services, as we have in Thunder Bay. Other places don't. My guess is that if you're an indigenous woman who says that you're having these thoughts—especially if you, yourself, had a history of child abuse—your chances of having that kid taken away are really a lot higher, but is there evidence for that?

● (1240)

Dr. Nichole Fairbrother: My research lab is trying to move in that direction. As I think some of your colleagues in this room will really appreciate, as a white person, treading into that sphere is a little more complicated and requires a lot of collaboration with indigenous scholars. One of our next moves is to try to get some data on that. I think you're absolutely right; that's going to play out very differently, and child removal is almost inevitable with that, but that is anecdotal at this point, and I don't have the data yet for that.

Mr. Marcus Powlowski: I have a quick question. When the courts look at child custody, the best interests of the child come first, but certainly, we have heard today of the trauma to the mother of losing a child. When the courts establish that balance between the interests of the parent and the interests of the child, do you think they are generally doing that right? Second, does that balance change according to whether you're indigenous or non-indigenous?

Having said that, let me quickly say that as a medical practitioner, you see people who have a real drinking disorder coming to emergency all the time with high levels of alcohol. They are homeless. You tell them that they're killing themselves, and they say they know. You ask why, and often losing a child is, in my experience, one of the most common things you hear.

Do the courts get the balance right? I know this is very difficult for the courts, but is there a difference between indigenous and non-indigenous cases?

The Chair: Excuse me for one second. That was Dr. Powlowski's idea of a quick question, and he's well past time.

If you could answer much more succinctly than he posed the question, that would be helpful.

Dr. Nichole Fairbrother: I'll give it a try. I wish that I were more of an expert in this area. What I can say on this is that the trauma that a mother experiences when losing her child has heavy implications for the child. This is not just an either-or question. That mother-infant is a duo, and in some ways they exist as a unit, so what happens for the mother has implications for the child. Her ability to regain custody of her child diminishes as a consequence of that trauma, so no, I'm not sure we're getting it right.

The Chair: Thank you.

Dr. Kitchen, you have five minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair, and thank you all for being here.

Today, when I first sat here, the chair announced at the beginning of the meeting a warning about what we would be experiencing today. He made that announcement for those watching and listening. I thought that it was the first time I had ever heard a warning being given out, yet it has been one of the most compelling meetings I have ever been at in my nine years, to hear about the experiences and the huge impact.

I have so many questions, but I will try to be as quick as I can.

I looked around the room, and I saw expressions on people's faces. What we heard was astonishing. I've lived in Afghanistan, Pakistan and Iran. I have been places where people have had their hands cut off, where there have been hangings, and what I heard today was more compelling to me than things I've ever heard. I appreciate it, and I thank you all for what you do. It's a huge area.

Ms. Enright, you brought up an issue about recognizing that it's the provincial government that provides your support, and that perhaps the federal government could at least show some discretion in the sense of advocating for that. You talked about four people who are helping your organization.

How many of them are actually making the diagnoses before the people come to you? Are they coming to you with a diagnosis or being referred to you by practitioners?

● (1245)

Ms. Jocelyn Enright: Basically, anybody can come through our door. They don't require a diagnosis of anything to receive our services.

However, anecdotally, many of our clients have been to other sorts of therapy and received different diagnoses. Then they come in. For some people, it's helpful to receive a diagnosis. However, for a lot of other people.... Women, especially, feel that, a lot of times, they go into the medical system and are told, “You have this disorder, so here's a pill and goodbye,” or, “Okay, you're being dramatic and hysterical”—the things we typically hear about women.

Then they come to our centre and talk through the trauma and realize that, yes, who wouldn't develop anxiety? Who wouldn't develop depression? Who wouldn't need some sort of substance to cope after going through something terrible? Am I not just acting the way any human being probably would towards this? Yes.

That's what we're seeing.

Mr. Robert Kitchen: Thank you.

I apologize for interrupting, but I have a short amount of time.

Dr. Galea and Dr. Fairbrother, your comments were tremendous, especially when you talked about depression versus anxiety.

I am a practitioner, and mental health is not my area of expertise. However, when I had patients come to me, I would always try to make those referrals, whatever the situation may be. You pointed out the fact that, a lot of times, women do not get the diagnoses they deserve and do not get the referrals. For example, cardiovascular disease is a leading cause...in women—more so than in men—and it's not recognized.

One thing I've pushed for quite a bit is how to educate practitioners. I know that, when I graduated, I knew everything. The reality is that, once you get out into various areas....

How do we educate them? Granted, we have a continuing education system that's supposed to be there, but how do we ensure this is actually happening?

Dr. Liisa Galea: I'm going to try to start.

As far as I'm aware—because I'm not a medical doctor, as you know—there is not much taught about women's health, specifically, in medical school. I think there's a morning for menopause and a week or so for pregnancy. I'm not sure, but I'm sure it's not necessarily about the mental health of pregnancy or those susceptible times. We absolutely need more education. To get the education, we still need that research. We still need that compass and map, and we need more specialties in this.

If you have perimenopausal symptoms like night sweats, you go to the gynecologist and get some hormone therapy if you're a good candidate for that. However, in my experience—anecdotally, but also through my expertise—they don't have all the information they need and that's because we just don't have the research on it.

If I can segue, another point I want to get in very quickly is about databases.

People say databases are great. We get millions of people we can look at. We've tried to do some of this work—looking at hormone therapy and how it might affect the brain, and different kinds of hormone therapy. That information isn't in the database. It will just say “hormones”.

Mr. Robert Kitchen: Thank you.

I apologize again, timewise.

One of the other aspects that I think gets missed is educating women to truly understand what could be there. That education needs to come from practitioners as well as through other means, like public health, etc., such that—

The Chair: Thank you.

Mr. Robert Kitchen: —women truly understand the potential of mental health issues.

The Chair: Thank you, Dr. Kitchen.

Mr. Jowhari, go ahead, please, for five minutes.

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

Thank you to our witnesses.

First of all, I sincerely apologize that I cannot be there in person, but thank you for being there.

I'm going to start with Dr. Fairbrother.

In your opening remarks, you talked about how approximately one in five women in Canada struggle with their perinatal mental health.

Can you kindly expand on the most significant challenges women in Canada face in accessing maternal mental health support, care and evidence-based treatment?

Dr. Nichole Fairbrother: I think it is absolutely the case that we're looking at 20% or more pregnant and postpartum people suffering from one or more mental health conditions during pregnancy and postpartum. A first step in care is adequate screening. For depression, we have great screening. For anxiety disorders, we have yet to identify appropriate tools. However, I'm very grateful to have a grant right now and we're working to change that particular situation.

When you look at pregnancy in particular, and a bit at postpartum with breastfeeding, perinatal people want access to talk therapy, because they are concerned about what it might mean to take medication while pregnant and how that may affect their developing infant. I would say that, right now, evidence-based talk therapy in Canada is funded in little, tiny corners here and there. I have an entire sheet in my lab for the little, tiny pieces people might be able to get after very long wait-lists. There isn't general access.

If I were to advocate for any subgroup of the population as deserving of access to evidence-based talk therapies, I think pregnant people qualify because of concerns about their infant.

● (1250)

Mr. Majid Jowhari: Thank you.

You also talked about evidence-based treatment and publicly funded CBT. What other types of evidence-based treatments are currently available in Canada? Also, how do we compare with any jurisdiction or international best practices, and how can we follow them?

That's for anybody.

Dr. Nichole Fairbrother: I will let Liisa respond to this portion of the question.

Dr. Liisa Galea: I'll say—and I believe you heard this on Monday—that we don't have a Canadian perinatal mental health strategy in Canada. That was voted against for some reason. Australia, the U.K. and the U.S. have one. I think having guidelines and a strategy for perinatal mental health would go a long way for health care practitioners, so that we have that information, and for the people who are pregnant, so that they have that information.

In terms of CBT, you're better to answer that one.

Dr. Nichole Fairbrother: Outside of reproduction, if you look at the data on treatments for anxiety and anxiety-related disorders, the strongest evidence is for cognitive behaviour therapy. Additionally, if we're talking about trauma-related cognitive behaviour therapy or therapies of that ilk, as well as mindfulness-based approaches, access is very limited.

Mr. Majid Jowhari: Yes. I think talking about access is a great point. You also talked about publicly funded CBT. Unless you have private insurance...it's not available publicly.

Can you comment on that?

Dr. Nichole Fairbrother: One of the reasons I started research in this area is because I feel very passionately about access to the highest level of health care. It is a very peculiar situation we're in, whereby the treatment of choice and the treatment that has the strongest evidence of effectiveness is generally not available.

If you're looking at access to medication for a mental health condition, you can probably secure that within a week. If you're looking for publicly funded talk therapy that's evidence-based, you're probably looking at a year or more.

Dr. Liisa Galea: At the Centre for Addiction and Mental Health, we have another womenmind-funded researcher named Daisy Singla. She just did a very huge study with Simone Vigod, whom you heard from on Monday, about talk therapy. They had some really great data showing that you can instruct another person, not necessarily a medical doctor or a formal health care practitioner, to do some of this talk therapy, and that works very well.

That's a very low-cost thing that Canada could adopt.

Dr. Nichole Fairbrother: I think dedicated research looking at that would be incredibly helpful.

The Chair: Thank you.

[*Translation*]

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

Ms. Andréanne Larouche: Thank you, Mr. Chair.

Since this is the last time I have the floor today, I will try to summarize everything that was said.

Ms. MacDonald, you talked a lot about trauma. You gave us the example of a woman being gang-raped after a hockey game. The Standing Committee on the Status of Women conducted a study and the main recommendation was to invest more money in research on women's health. Another mental health-related recommendation called for an independent inquiry that would shed light on the culture of misogyny and hatred of women in sport.

What do you think? How important is that recommendation? Why should it not be shelved?

● (1255)

[*English*]

Ms. Linda MacDonald: I think it would be a valuable recommendation, but I would like them to also understand that torture would be involved in the—

[*Translation*]

Ms. Andréanne Larouche: Mr. Chair, I'm not getting the interpretation.

[*English*]

The Chair: Is it working now? Okay.

[*Translation*]

Ms. Andréanne Larouche: I hope you stopped the clock, Mr. Chair.

The Chair: Yes, Ms. Larouche.

Go ahead, Ms. MacDonald.

[*English*]

Ms. Linda MacDonald: Thank you.

Yes, I think that would be very important, but I also think that in studying misogyny and violence in sports, we should expand our understanding of the type of violence to include torture—especially gang rape—because there are different goals with abuse versus torture with perpetrators.

With abuse, the goal is to control the woman. With torture, it is to destroy the woman's sense of self. I think that's why it's so horrific for women who have been gang-raped to come forward. It's because they are so shattered. If you can imagine rows of men coming at you when you're incapacitated, it's a violation that needs to really be understood in the misogyny that happens in our country.

[*Translation*]

Ms. Andréanne Larouche: Coercive control is precisely the subject of the next study I will be bringing to the Standing Committee on the Status of Women. It will help us broaden the definition of what constitutes violence, which to me is very important.

I have 30 seconds left.

Ms. Enright and Ms. Sarson, in our report on the mental health of young women and girls in Canada, it was recommended that the government introduce legislation to combat online hate.

How important would such a law be to counter the hatred of women? Could we have a very quick answer, please?

[*English*]

Ms. Jeanne Sarson: It is hate against women. I think we have to keep naming it, and we have to keep saying that it's the system. The system does it over and over again. If we want justice, justice starts on the Hill. It starts with naming the crime so that people can tell the truth and be heard and believed. Misogyny prevents that.

[*Translation*]

Ms. Andréanne Larouche: Ms. Enright, could you quickly share your opinion on a law to combat online hate?

[*English*]

Ms. Jocelyn Enright: I think it's incredibly important. I think we see a lot more of that. I do a lot of work going into schools and talking to young kids about this, young men especially. It's starting younger.

When I go into high schools, people think maybe that's still too early. When I go into elementary schools, everybody is connected to the Internet. We need to have more information about that.

In particular, don't just talk to young women about this because they experience this more. Talk to young men about this as well, because oftentimes they are the perpetrators. We need to look at why that is and how we stop that from a young age.

The Chair: Thank you.

Ms. Gazan, you have two and a half minutes, please.

Ms. Leah Gazan: Thank you very much.

I want to go back to training. I know that you're both researchers, but you're also scholars at universities. Would you say that training needs to be changed, medical training specifically, because we're talking about postpartum, to include a focus on training around postpartum for women? Part of the reason I'm asking is because you've been very clear that we become a vessel for babies, and then we become a separate physical entity once we give birth. I wanted to hear your thoughts about that.

Dr. Liisa Galea: Sure, I'll start.

Yes, we need more training, but again, to be able to train people, we need to know what to train them and what the evidence-based information is that we can tell our health care practitioners.

I also want to underscore that postpartum is really important, but I don't want the women's health committee to only focus on the postpartum, because it's the whole lifespan. I know you're not.

We've talked about perimenopause, menopause and puberty. All of these time periods are really important and are so understudied in girls, women and gender-diverse individuals.

● (1300)

Ms. Leah Gazan: Do you think it would be helpful to have programs specifically geared to women and gender-diverse folks to enter the field? I know that this field is still predominantly populated by males. Do you think that it would be helpful in changing some of these systemic barriers?

Dr. Nichole Fairbrother: Yes, I do think that it would be helpful to have increased representation within health care for women's health, absolutely.

Dr. Liisa Galea: Also, empower women. If we tell people that women's health is valued information to have, then more people will do it. Right now it's so undervalued, and I think that's part of the problem.

Ms. Leah Gazan: I share that. With all due respect, I'm glad there are women around the table, but the health committee currently, in terms of regular members, outside of one woman, is all men. I think that's demonstrative of the lack of focus on women's health issues in the system.

There are two now. There you go.

A voice: That's a 100% increase.

A voice: The problem is that we're only 30% in the House of Commons.

The Chair: Thank you.

Mrs. Roberts, you have five minutes, please.

Mrs. Anna Roberts: Thank you very much, Mr. Chair.

I'm going to ask my questions to both Jeanne and Linda. I need to know, from your explanations, the difference between state and non-state torture, because Canada does not recognize non-state torture. I'm sure everybody has heard about the young girl, who was raped and tortured at 11 years of age, Kerri Kehoe; and nobody believed that she was tortured. Nobody believed that she was raped. The rapist finally got arrested and was let out on parole. Kerri Kehoe is reliving her experiences all over again. How do we change the justice system in this country to realize that that is torture? It's not abuse; it's torture. If we can make it torture, we can increase the sentences so that these guys don't have an opportunity to get out of jail and revictimize the victims.

Ms. Jeanne Sarson: That is an excellent question, because it's one Linda and I were shocked about in 1993 when Sara came to us and said she was tortured. We looked around and were shocked to find out that Canada does not recognize torture by non-state actors. Then we went global to try to understand the discrimination that occurs in the law. We found out that, in Canada, section 269.1 of the Criminal Code says very clearly that a torturer can only be a public officer, a police officer or a military officer, because it was not thought that women and girls, or children, were ever tortured in the private domain. Back in the eighties when the convention against torture was created, violence against women and children in the family was a family matter. Everybody knew about it, but nobody paid any attention to it.

What has happened, in our opinion, is that when the convention was rolled out—and it had discrimination in it, that it only happened really to men in war, or men in terrorism—countries all over this planet decided to make a law that mimicked the convention, which said that it could only be a public official. Nobody every thought of women.

Linda and I work with a group in Vienna. We asked one the experts about when they were creating the convention, if they ever thought of women and children; and he just said no, that it wasn't even a thought in their minds.

That created the discrimination, and it has rolled out across this planet. We think it's really important that the UN has been trying to change that attitude. For example, the committee against torture in 2008 in paragraph 18 said very clearly that non-state actors commit torture and the countries should look at that and change their law.

Women and men in this country might be surprised that it was only in 1993 that the abuse and torture of women was acknowledged. They were talking about women at the convention on human rights in 1993 in Vienna. That was the first time, really, in human rights history around the conventions that the issue of abuse and torture of women came up. We're very new at the issues that we're all talking about here. That's not a very long time.

Also, the CEDAW committee, which is to remove discrimination...and Canada has ratified both of these conventions. They too are trying to catch up with modern times. In their recommendation 35, they also brought in that non-state actors can commit torture.

● (1305)

Mrs. Anna Roberts: I want to just read from page 45 of your book. It says: “This is what torture is—it is the destruction of a human being—it is the actions of a torturer that dehumanize and attempt to destroy another human being—it is a bone chilling reality.”

I believe from reading your book that this is what Sara and some of the women you've helped have experienced. We need to, at the federal level, ensure that we bring a law forward to change it, to let people know that what these victims are going through is not abuse—it's torture. I had tears in my eyes just reading some of the descriptions in the book, because this is what they're doing to our children. We as women have to stand up for them, because our justice system has failed us.

Ms. Jeanne Sarson: I would like to add a little bit about babies for the discussion that we've had.

The one issue that hasn't come up is that this can be intergenerational. The women have told us that if that's not talked about in prenatal care and if it's not talked about in labour and delivery, these families get missed.

For the women we've supported, all they ever wanted was to be taken out of their families.

The Chair: Thank you.

Ms. Jeanne Sarson: If we don't name that torture can be happening in families, we have blank spots in our knowledge. There's sufficient knowledge out there now that we can do better than we're doing.

The Chair: Thank you.

[*Translation*]

Our final questioner will be Ms. Brière for five minutes.

[*English*]

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

I want to thank you all for making a difference in the lives of women, mothers and mothers-to-be.

[*Translation*]

Going back to the previous discussion, I would first like to point out that, in 2016, the Standing Committee on Justice and Human Rights looked at the definitions of such offences as assault, torture and aggravated assault. It concluded that the existing provisions of the Criminal Code already included these definitions.

My questions are for Ms. Galea and Ms. Fairbrother.

You have developed a series of online interventions for perinatal anxiety disorders. Could you tell us more about that?

[*English*]

Dr. Nichole Fairbrother: I have not developed online interventions.

Dr. Liisa Galea: I haven't either.

Dr. Nichole Fairbrother: What I could say is that, maybe in large measure as a consequence of COVID, I think there's been a realization that we can broaden access to mental health treatment by having Internet-based e-health interventions. This is particularly important for people who live in rural and remote communities, who historically would have to travel long distances to access specialized care.

In addition, it is possible—although I think we are still in need of additional data and research on this—that some combination of self-help by the patients themselves mixed with therapist support may be able to produce similar outcomes to face-to-face treatment at a much reduced cost. I wish I knew a little bit more about how well that works.

I know that if you remove the therapist support piece from Internet-delivered therapies, the effectiveness of the therapies drops through the floor. You have to have the therapist support. At exactly what dose in order to bring it up to the same level of expertise, I'm less confident of.

Dr. Liisa Galea: Yes, I think maybe what you are remembering is the Summit trial by Daisy Singla, Simone Vigod and others.

I'm not super familiar with it, but they were training non-professionals to be sort of like therapists in certain situations in the postpartum and it worked very well. The trial results are released already. There will be more big announcements about it, but it does seem to be a low-cost, effective tool that can be used.

● (1310)

[*Translation*]

Mrs. Élisabeth Brière: Thank you.

Earlier, you said that the focus was often on the baby to the detriment of the mother's needs, particularly in terms of mental health, and that this could pose a risk after childbirth.

Can you tell us a little more about that?

[*English*]

Dr. Nichole Fairbrother: I'm trying to think of how we can have healthy babies with unhealthy mothers. I'm not really seeing how that can be. I think we need mentally healthy mothers to have healthy babies.

This hasn't really come up today, but I think it's worth nothing that if you look at the data on unpaid domestic labour in Canada and who is doing this unpaid labour, it is still largely women. As women, we are doing much more of the child care typically, compared with men.

Therefore, there's this additional burden, which can also impact mental health. Having that weight of responsibility is also significant for women's mental health, so I think we have to be paying attention to that.

Dr. Liisa Galea: Just speaking outside of the postpartum, women are also more likely to be significant caregivers to their elderly parents as well. That also creates a big burden.

I just want to say something about the women's health committee and the percentage of men on the committee. We also need male allies. It can't just be about women helping women. It also has to be about men and gender-diverse.... We're stronger together. I applaud the men who are on the committee.

Thank you.

The Chair: What an excellent note to finish on.

Thank you, all, for your very powerful presentations.

Ms. Roberts.

Mrs. Anna Roberts: I just want to say that I am so honoured to be here today. I'm not normally on this committee.

I want to say thank you to our panellists. It has been both educational and rewarding to know there's someone out there fighting for us women. I give a big round of applause to you.

The Chair: Is it the will of the committee to adjourn the meeting? I see consensus.

The meeting is adjourned.