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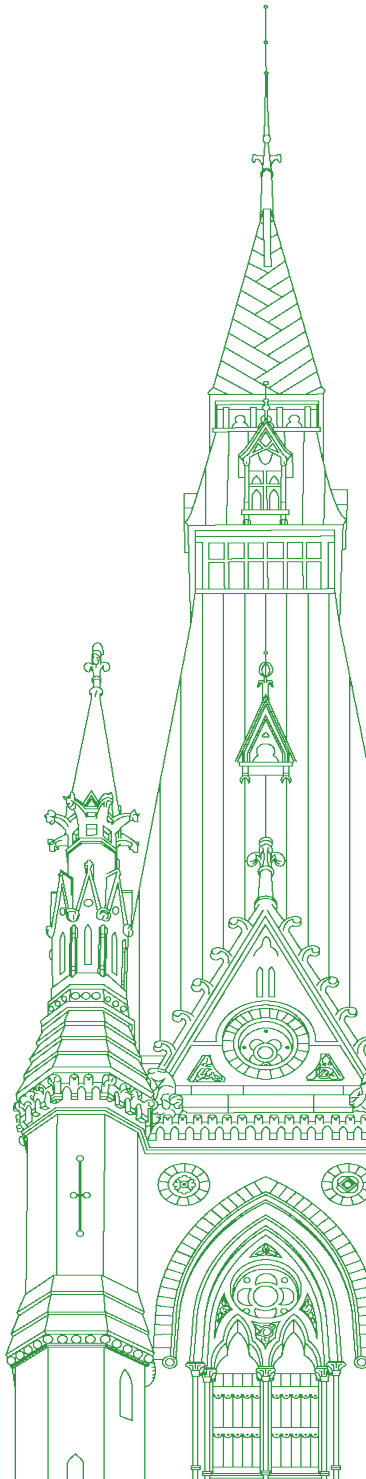

Chair: Mrs. Karen Vecchio

Standing Committee on the Status of Women

Thursday, October 27, 2022

● (1605)

[*English*]

The Chair (Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC)): Welcome to meeting number 35 of the House of Commons Standing Committee on the Status of Women. Pursuant to Standing Order 108(2) and the motion adopted on Tuesday, February 1, the committee will resume its study of the mental health of young women and girls.

Today's meeting is taking place in a hybrid format, pursuant to the House order of June 23. Members are attending in person in the room and remotely using the Zoom application. I would like to make a few comments for the benefit of the witnesses and members.

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

I remind you that all comments should be addressed through the chair. If members in the room wish to speak, please raise a hand. For members on Zoom, please use the "raise hand" function. The clerk and I will manage the speaking order as best we can, and we appreciate your patience and understanding in this regard.

In accordance with our routine motion, I am informing the committee that all witnesses have completed the required connection tests in advance of the meeting. As we noted, anybody taking part in the meeting must have one of the headsets. Thank you so much.

We are doing a very difficult study, so I'm going to remind everybody.... Before we welcome our witnesses, I would like to provide this trigger warning: This will be a difficult study. We will be discussing experiences related to mental health. This may be triggering to viewers, members or staff who have similar experiences. If you feel distressed or need help, please advise the clerk.

I would now like to welcome our witnesses for today. Everybody is on Zoom today.

From Achēv, we have Karen McNeil, senior vice-president, programs and services, and Tania Amaral, director, women, employment and newcomer services. Appearing as an individual today we have Dr. Rakesh Jetly, who is a psychiatrist. From the Northern Ontario School of Medicine University, we have Dr. Diane Whitney, assistant dean, resident affairs and Dr. Peter Ajueze, who is an assistant professor and a general child and adolescent psychiatrist, Health Sciences North, Sudbury. From Regroupement des ressources alternatives en santé mentale du Québec, we have Anne-Marie Boucher, head of communications and co-coordinator of socio-political action.

We'll provide each group with five minutes for opening comments. I'll be interrupting, usually within the first few seconds, if it goes over.

Today, as you know, we started late. We will be extending a bit, but we'll be playing it by ear, as a committee, as we go through. I hope some of you will be able to stay with us a bit after 5:30. Thank you so much.

I'm now going to turn it over to Karen and Tania for five minutes, for their organization's opening remarks.

The floor is yours.

● (1610)

Ms. Karen McNeil (Senior Vice-President, Programs and Services, Achēv): Good afternoon. Thank you for the opportunity to speak today.

My name is Karen McNeil. I'm the senior vice-president of programs and services at Achēv. I'm joined by my colleague Tania Amaral, director of women, employment and newcomer services. She has some intimate program knowledge.

For more than 30 years, Achēv has provided free services to Canadians and newcomers to Canada. Today we're one of the largest non-profit providers of employment, newcomer, language, youth and women's services across the GTA, with programming across Canada. Each year, more than 50,000 women and girls access Achēv's services in person, virtually or through a hybrid format. Our approach recognizes the unique barriers women face in securing employment, settling in a new community and building the networks they need to thrive.

Today we'd like to speak about immigrant women and girls, who represent almost half of our women clients. It's estimated that by 2031, one-third of the Canadian female population will be immigrants. We know that immigrant and racialized women in Canada face numerous barriers to meaningful employment. These barriers have been exacerbated by the pandemic, and include a lack of work-related networks, family caregiving responsibilities, sometimes language barriers and gendered or racial discrimination. Even when women immigrants are employed, they're more likely to be underemployed, work part time or in precarious employment situations, and be poorly paid compared with their Canadian-born counterparts. This has a significant impact on these women's everyday lives and their mental health.

Our clients experience many challenges when they move to Canada. Newcomer women in particular often face multiple stressors on their mental health and well-being. They often have the primary responsibility for establishing a new home, getting their kids into school, caring for elderly parents and finding a job. It's really not easy. Many are socially and linguistically isolated, and lack self-esteem and financial security. We've also seen the unique struggles that international students are facing. These include young women living far from home, some with enormous pressure to succeed, facing loneliness and limited financial resources and supports.

Every woman brings her own story of her personal struggle, and I'd like to share one with you today. Priya is a single mother. She obtained a master's degree in economics from her home country, but was working as a cashier at Walmart. Priya was stressed, tired and worried about how she would be able to handle her life and parenting. She couldn't leave her survival job, because that was the only source of income for her family. She was heavily depressed due to this dilemma. Her employment coach at Achēv was able to share a lot of resources and connect her with a woman's wellness program offered by a community partner. This enabled Priya to receive the support needed to improve her well-being and successfully secure a new and better-paying job where she felt respected.

One of the biggest issues we've seen in addressing the mental health needs of newcomer women and girls is the stigma around mental illness in their communities. In some cultures, mental health-related issues are highly stigmatized. As a result, sometimes it's difficult for them to acknowledge that they're dealing with mental disorders and should seek help. This leads to longer-term suffering. We've heard from some young women that, even when they've gathered the courage to tell their parents that they're struggling mentally and need help, they often don't know where to turn.

This is why we believe that integrating more mental health supports into newcomer, settlement, language and employment programs are critical to address the stigma and provide culturally appropriate intervention. More awareness of mental health with our newcomer communities will help women and girls access the supports they need, bridge the generational gap and encourage family conversations.

We're proud of the mental health wraparound support that we're able to provide women in some of our programs, including inviting mental health service providers into our workshop sessions, incorporating self-care practices into programs and sharing open resources, but these programs are not enough. We recommend more multi-year government-funded opportunities for community-based organizations like Achēv to include these wraparound supports for every woman or girl who needs them. We've seen first-hand the power that sharing real lived experiences and creating safe spaces to discuss mental health has had on the betterment of our newcomer women clients.

Thank you for the opportunity to share our insights today. We look forward to answering any questions you might have.

The Chair: Thank you very much.

I'll now turn the floor over to Dr. Jetly for five minutes.

Dr. Jetly, you have the floor.

● (1615)

Dr. Rakesh Jetly (Psychiatrist, As an Individual): Thank you, Madam Chair.

In my opening comments, I would like to share my thoughts on several topics, including mood and anxiety difficulties in girls and young women, the challenges of being a young woman today and a little about substance use, as well as my concerns regarding psychiatric research and knowledge translation.

Many have discussed the epidemic of mood and anxiety, particularly in young people, attributed to the COVID-19 pandemic. However, as a psychiatrist, and as evidenced by some of the testimony you've already heard, I feel that youth mental health has been a significant issue for many years.

Several times a month a colleague reaches out for help because of mental health needs within the family. I noticed very quickly that, about 90% of the time, it was a case of a daughter or a niece with anxiety difficulties. This is not a study but rather my own experience. It is particularly concerning when a 16-year-old often faces an 18-month wait to see a psychiatrist. Recently, I've been asked to help care for a young woman sexually assaulted after being slipped a hypnotic during a university social event.

There's an interesting double-edged aspect regarding psychological difficulties in young people. Never have we had a generation with such a positive attitude towards mental health and help seeking. Our generation struggled with stigma. Programs such as the military's road to mental readiness and Bell Let's Talk helped destigmatize and to some extent normalize mental health and help seeking.

This generation of young people does not need encouragement to talk. They have spoken and feel much less shame in raising their hands. While this is an encouraging societal trend, it results in even greater need overall in the system and a worsening need-care gap. Vast numbers of young women and girls acknowledge not feeling right but are unable to have timely access to evidence-based care.

My second general observation is the amplification of peer pressure, bullying and so on that social media allows. There are undeniable pluses to social media platforms. They have allowed us to stay connected, celebrate birthdays and even attend funerals during the lockdowns and the pandemic. However, there are also studies suggesting that, for some young women and girls, social media can make individuals feel more isolated and exacerbate mental health conditions such as depression and anxiety. There's a suggestion that some aspects of social media may increase the sense of inadequacy about one's life or appearance.

Online bullying also, to some extent, is traditional bullying on steroids. Depending on the study one reads, about 40% of young people under 19 years of age report being the victim of bullying online. Interestingly, girls are most likely, in most studies, to be both victims and perpetrators of cyber-bullying. Victims of cyber-bullying are at increased risk of both self-harm and suicidal behaviours. Most who witness cyber-bullying do not intervene, and perhaps only one in 10 report the bullying to a trusted adult.

I also wish to switch and just briefly address recreational and social use of substances. Clearly, the opiate crisis warrants attention, and young people are not spared. However, we also need to address the most common substances abused by young women and girls, namely alcohol, cannabis and tobacco.

We can educate regarding alcohol's potential harms, but it may also help women to understand how we can separate having a drink with friends celebrating a birthday from drinking alone when feeling sad, lonely or anxious. The effects of alcohol on cognition, consent and capacity must also be ingrained.

As a society, Canada has done a great job educating our youth about the risks and harms of tobacco, and a consistent downwards trend of smoking tobacco continues among our youth, including girls. However, cannabis use among young Canadians finds our youth—depending on the study again—typically as the number one, two or three consumers in the world. While decriminalization, legalization and medical use of cannabis increases worldwide, we require a study with respect to the health of girls and young women.

There are many active ingredients within cannabis, some which can aggravate mood and anxiety and even cause psychosis. We have learned some important lessons from smoking tobacco and its impact on one's health, respiratory and otherwise. However, according to some sources, about half of the cannabis used in Canada is smoked.

There is confusion and blurring between medical use and recreational use. I will not discuss the limited evidence supporting the medical use of cannabis, although I encourage the ongoing high-quality studies that need to be done. I do, however, feel that recreational and medical use of the same substance creates an attitude that sometimes this naturally occurring plant is either good for you or at least not harmful.

● (1620)

My final point is—

The Chair: Dr. Jetly, I'm going to give you about 20 seconds to finish. I know that you have a few more paragraphs. Go for it.

Dr. Rakesh Jetly: My last point, really, is on research specifically looking at women and young girls. Quite often, I've sat at the table myself. Sometimes it's complicated because of biological differences between men and women. We have often stuck to right-handed males who are relatively healthy and then we're forced to knowledge-translate that to women, so there are some concerns about the studies. Even if we ask for the gender, do we actually analyze the studies based on gender? We just use excuses like “the sample size is too small”.

I'll stop there. Thank you.

The Chair: Thank you so much. I really appreciate that.

I now will move it over to the Northern Ontario School of Medicine and Dr. Diane Whitney and Dr. Ajueze.

You have five minutes.

Dr. Diane Whitney (Assistant Dean, Resident Affairs, Northern Ontario School of Medicine University): I'll start by saying that I'm a community-based psychiatrist in Thunder Bay, and I treat depression, anxiety and trauma. My practice is 80% women. My colleague is a child psychiatrist in Sudbury, so we bring some different perspectives.

First of all, I'll talk about the north. Individuals in northern Ontario typically have poor mental health and, in urban areas, higher rates of depression and twice the rate of hospitalization, usually for suicidal concerns, in a very fragmented mental health system—if there is one.

I'm always amazed by how far my patients will travel to get care. It has changed somewhat with COVID, but it hasn't cured everything. I have a lady who comes from a small reserve. Depending on which season it is, she takes either a boat or a ski-doo to the train, which is often six to 10 hours late, and then a van to get into Thunder Bay. Things have improved for her with the different accesses with COVID, but not all of the remote communities have Internet access.

If we move specifically to women, certainly intimate partner violence is a significant issue and is at a higher rate in northern communities and smaller communities, as are issues around transportation and emergency housing. The lady I just mentioned was assaulted by her partner, who was intoxicated, and she held him down until he passed out. It took five days for the police to get to the reserve to take the report—five days. It's a small isolated community of 30 people, just so you know.

On their experience of violence and abuse, there's such a high rate of trauma in the population in general, but in the north it's estimated that 78% have a history of child and/or adulthood trauma, and 16% develop PTSD leading to suicide and self-harming behaviour. We could talk for hours about that. Also, in our indigenous population, we see high rates of depression, with much higher rates of psychological distress, suicidal ideation and suicide attempts compared with men.

Finally, there's the impact of COVID. There have been some benefits, but certainly there have been disadvantages, and there has been disconnection as well. I was seeing one of my patients remotely through what's called the Ontario tele-video network, and what happened in the community was that the office she was using to see me virtually was taken over as a COVID testing centre, so then I had to revert to the phone.

The challenges have been many. I'm going to turn it over to my colleague. He has a few comments about eating disorders, which are a challenge to treat in the north.

Dr. Peter Ajueze (General, Child and Adolescent Psychiatrist, Health Sciences North, Sudbury, and Assistant Professor, Northern Ontario School of Medicine University): Thank you, Dr. Whitney and Madam Chair.

I have been the consulting psychiatrist of the eating disorder program in the north for the past 10 years, since I immigrated to Canada from the Republic of Ireland.

There are four key points that I want to bring up to the committee. First is the increasing number of hospitalizations that we've seen in the north around eating disorders. Second is that we have absolutely no in-patient eating disorder treatment facility in northern Ontario. Third is the increasing comorbidities and mortalities with regard to eating disorders, and fourth is the lack of adequate training of health care professionals in eating disorders.

I will briefly give a specific case of a patient I had who had a BMI of less than 10. To provide context, BMI stands for body mass index, for those who may not be familiar with it. The normal BMI is between 18.5 and 25. For extreme anorexia, we're talking about a BMI of less than 15. This young lady had a BMI of less than 10, which is almost not compatible with life. For such a person, you would think that it's going to be an emergency and a referral down south, but because of the lack of available beds.... There was no bed anywhere, irrespective of the fact that her BMI was less than 10. She ended up in the ICU twice with refeeding syndrome and almost died. Luckily, we were able to keep her in the hospital. She stayed in the hospital for a long time, six to eight months, and luckily she recovered.

Since COVID, we're definitely increasing in number. Again, to provide context, between 2017 and 2018, the number of hospitalizations of females was about 1%. During the peak of COVID in 2021, it rose to 3.2%. As we speak now, as of July, the percentage has gone up to 4.3%. We have people waiting to be transferred to the United States.

I'm going to stop at this point. I know there are probably going to be a lot of questions with regard to eating disorders.

I have also seen, during the course of my research, that there has been a big focus on eating disorders on the part of this committee

Thank you for this opportunity.

● (1625)

The Chair: Thank you very much.

For our last witness, I'm going to turn the floor over to Anne-Marie Boucher.

Anne-Marie, you have the floor for five minutes.

[*Translation*]

Ms. Anne-Marie Boucher (Co-coordinator and Head, Communications and Socio-Political Action, Regroupement des ressources alternatives en santé mentale du Québec): Good afternoon. I would like to thank the committee for inviting me to take part in its study.

The Regroupement des ressources alternatives en santé mentale du Québec represents some 100 Quebec community groups. The fact that those groups operate independently in carrying out their missions has enabled them to adjust quickly and effectively to circumstances during the pandemic and to provide high-quality support despite the health restrictions that were put in place.

The historical underfunding of these groups in Quebec is a proven fact that increasingly restricts our ability to recruit and retain personnel, thus restricting our ability to carry out our missions. Many of our groups plan projects that are designed for young adults.

Today I would like to outline some of our concerns regarding the mental health of young women and girls, who are still more likely to suffer family violence and assaults and to be economically dependent.

We can't discuss the mental health of women and girls without considering their living conditions as they relate to their ability to exercise the right to the best possible mental and physical health. This involves the fight against poverty, violence prevention and access to a diverse range of mental health resources and services.

In the context of the pandemic and associated social isolation and disruptions in the education and employment sectors, family conflicts and insecurity have exacerbated the psychological distress of many individuals, including young people. A study conducted by the Université de Sherbrooke in the summer of 2020 revealed that both male and female adolescents were experiencing twice as much severe psychological distress as before the pandemic.

According to another survey conducted in March of this year on the psychological health of persons 12 to 25 years of age, 25% of youths attending a secondary or vocational school perceive their mental health as average or poor. That percentage is even higher at the post-secondary level. Furthermore, girls and persons who identify as neither male nor female were much more likely to report poorer mental health.

This general increase in the incidence of negative feelings in young people coincides with more restricted access to public mental health services, particularly in Quebec. According to many reports that we receive, young people find it hard to access support quickly even in a crisis.

In this context, doctors have no choice but to rely on medication to address their symptoms, since they can't attack the causes of individuals' living circumstances. Consequently, there has been an increase in the use of psychotropic drugs since the pandemic began

This increase has been particularly pronounced among young girls. In March 2021, *Le Devoir* published an article stating that, according to data from Quebec's health insurance plan, antidepressant use had grown sharply among girls under 18 years of age, with numbers rising 15% since the start of the previous school year. Furthermore, by September 2020, the number of girls in that age group using antidepressants had increased 11% since the same month in 2019.

There has also been a similar rise in the incidence of attention deficit disorder, or ADD, and attention deficit hyperactivity disorder, ADHD, as well as in the number of prescriptions written to treat those conditions. The largest quantities of psychostimulants have been prescribed in Quebec

Mental health experts are concerned about the growing use of psychotropic drugs without psychosocial services that are respective of patients' rights being readily accessible in all communities. The Mouvement Jeunes et santé mentale, to name just one citizen movement, has been demanding since 2016 that a parliamentary committee be struck on the medicalization of the issues young people are experiencing and that psychosocial services be made available. The latter demand has also come from the Quebec organization Force jeunesse, which released a study calling for such services this past summer.

In short, we need to avoid medicalizing the impact of the health crisis and to provide upstream assistance with people's living conditions.

Which brings me to a few courses of action that we propose.

We believe authorities must exercise caution with regard to the medicalization of the stress responses to health crises and the impact of experienced violence. In one documented example, a large number of young women suffering from borderline personality disorder, or BPD, were assaulted and subjected to sexual violence. According to an English study, women are seven times more likely to be diagnosed with this condition than men presenting with the same symptoms. We also know that 81% of individuals diagnosed with BPD reported that they had experienced trauma in their lives.

Individuals who have experienced violence or trauma currently receive diagnoses that can help them but that may also stigmatize them, which may divert attention from the actual problems or trauma experienced and focus it on the individuals' symptoms.

In short, people must have access to mental health services even if they have not been diagnosed, and authorities must introduce approaches that are sensitive to trauma, something that few public services provide. Solutions other than medication must also be made available, along with support in reducing, and withdrawing from, the use of drugs.

We believe there is an urgent need to to consider providing support for deprescription in mental health cases, particularly support in withdrawing from antidepressants. Numerous initiatives are under way in England to ensure better documentation of dependence and the effects of withdrawal from psychotropic drugs. I am thinking in particular of the work that Public Health England and the All Party Parliamentary Group for Prescribed Drug Dependence are doing on the effects of medication use and the importance of withdrawal management and support. We believe that Canada would do well to draw on those efforts.

● (1630)

Lastly, we realize how important it is to increase federal health transfers in accordance with provincial jurisdictions. We urgently need those transfers to be increased and granted to the provinces unconditionally so they can take prompt action on mental health issues. We are currently experiencing a crisis in access to care. Improving access to services and investing in the social determinants of health, poverty and housing will change everything.

Thank you.

[*English*]

The Chair: Perfect. Thank you so much.

I'll just let all the members of the committee know that, looking at the fact that we have had a time change, we are taking our committee business, which we were supposed to do today, and postponing it until Monday so that we can have time with our witnesses instead.

We will now begin our first round of six minutes.

I'll pass the floor over to Michelle Ferreri.

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

Thank you to all of our witnesses. That was powerful testimony as we delve into this study looking at mental health in young women and how we close these gaps.

It's very nice to see my friend Dr. Rakesh Jetly as a witness here.

Rakesh, it's great to see you here. I know that you have a wealth of knowledge that can really help this committee and help the federal government make better policy decisions to help our youth with mental health.

Dr. Jetly, you've talked about this, and you addressed it in your testimony. We have this great movement where our youth are more comfortable asking for help. We've done a lot of work on the stigma, and it's paid off. But when they go to get help, there is nothing there. The resources aren't there. What's your suggestion on how we close the health equity gap?

Dr. Rakesh Jetly: Thank you very much for the question. It's a huge question.

My colleague just mentioned what is not the answer—that is, to continue to prescribe medication without psychotherapy and without counselling, and to just give these kids some stimulants and antidepressants. That's probably not the answer.

Realistically, I think we have to reconsider how we provide care. That's something we've struggled with over the years. The idea that every single person who has psychological difficulties or difficulty fitting in will have access to one-on-one psychotherapy, once a week, for one hour, for six months or eight months, probably isn't realistic, even if it was ordered. I think leveraging technology is one of the ways to do it, as is developing group-based therapies. Different kinds of platforms have been developed, such as cognitive behaviour therapy for insomnia, where one clinician can be magnified and see 12 people an hour instead of one. I believe it's multimodal. I think it's education and resources and more programs.

Clearly, the very ill, such as those with eating disorders, will need hospital beds and things, but I think, with that general wave of mood and anxiety that we're seeing, people are going to walk-in clinics or seeing their family doctors, getting prescribed meds and not really getting help.

That's not a great answer, but I think we need to rethink how we structure access and really get away from the traditional model of this one-on-one psychotherapy for everybody.

Ms. Michelle Ferreri: Thank you for that, Dr. Jetly.

We know that we have a labour crisis across this country. Frontline workers like you—psychiatrists, psychotherapists, counsellors, doctors—are not immune to this labour crisis. They're not immune to the burnout. The demand is so high for people needing help. We see these increased rises of depression and anxiety. We need more access to counselling.

How do we protect you, the frontline workers, from burnout? How do we close that gap and meet the demands of those asking for help but also protect frontline workers?

● (1635)

Dr. Rakesh Jetly: I think those are incredibly difficult questions as well. We have colleagues who are working 60- to 70-hour weeks, working until 10 o'clock with a patient in crisis. Most of us who are in practice don't turn our phones off, which we probably should. We're trying to balance the work and what we know about burnout and depression in our own professional lives and provide the care.

In terms of boosting the care available, I really believe in leveraging technology and having team-based approaches to care. Too often the burden is on one clinician, which probably isn't a great thing. I am a firm believer in team-based approaches and the efficiency of finding the right professional for the right person when there is time.

Clearly, we need to educate and protect our frontline workers, be they mental health or otherwise health workers, but that won't necessarily address the gap. The gap has to be addressed with probably an increase in funding, but then finding an efficient way to use that funding, not just continuing to throw resources at a problem that is struggling.

Ms. Michelle Ferreri: Thank you, Dr. Jetly.

I see one of our witnesses has their hand up.

The Chair: Peter, did you want to add on to that question? Is that what it was?

Dr. Peter Ajueze: Yes, Madam Chair, I don't know if I just have a minute. There was this point about the burnout. I found this question very interesting, because I think lots of health care professionals, including me, may have experienced some level of burnout in the past few years.

I've thought about this quite a lot. I was listening to Dr. Jetly when he talked about our not turning our phones off, which is what most people do. I just came back from vacation and every time I'm on vacation, I find my phone is constantly on...especially from colleagues whose kids I'm looking after. I find it causes a lot of stress. It's easy to turn off your notifications for emails when you're going to be away, but when it comes to phones you can't do that.

I think we should really start talking to medical students, because there are lots of mistakes that we made that are hard to undo now when it comes to boundaries. For me, the big message is boundaries and learning from the onset about protecting one's boundaries and being mindful about those. For a lot of us, especially when I started, we were saying, “Okay, health care providers, you do anything to support your other colleagues,” but when there are no boundaries, then we find it has that a domino effect, and we end up burning out. It's hard to now tell the same people, “Please, don't do this at this time.”

I think at this point that could be one of the things that we could look at with our medical students. When they start, they shouldn't make some of the mistakes we made.

Ms. Michelle Ferreri: Perfect—

The Chair: Michelle, we'll get back to you for another round. Thank you so much.

Anita, you have the floor for six minutes.

Ms. Anita Vandenbeld (Ottawa West—Nepean, Lib.): Thank you very much, and thank you to all of our witnesses.

My first couple of questions are for Ms. McNeil, specifically around newcomers and immigrants. One of the things that you mentioned is that there are various different stressors on immigrant women, some of them relating to things that they went through before they came to Canada. We know that in many parts of the world where there's conflict or war, immigrant women, when they were in their home countries, were subject to rape as a weapon of war.

This sometimes doesn't come out until decades later when they then start to talk about it for the first time, but at that point, they're here in Canada.

Is this something you've seen in your practice? If so, what kinds of supports might be available for those women, given that's an experience that not many practitioners in Canada would have experience with or necessarily know how to handle those kinds of disclosures?

Ms. Karen McNeil: I'd like to pass that over to Tania, if that's okay.

Ms. Tania Amaral (Director, Women, Employment and Newcomer Services, Achēv): Thank you, Karen.

That's such a great question. As an organization that provides services to women with respect to employment, settlement and language services, it's something that typically does not get disclosed, because there is, as mentioned in Karen's opening remarks, this strong stigma around.... They don't even know how to label what they are feeling. It doesn't get disclosed, because they don't even know how to talk about it. It's something that is to be kept hidden. There is intense shame that comes with that. It's not even considered a priority. When they come to us with employment needs or language needs, all of that is just suppressed and is typically not disclosed unless there is a strong rapport built between the client and their respective counsellor, coach or employment coach.

That's why at Achēv we try very hard to instill the idea of wellness as beyond physical. That is an important aspect of your life and touches every aspect of your life. If you want to be successful integrating into the workforce, you have to look at that piece. Oftentimes it is not disclosed, and because we are not mental health service providers ourselves and not experts in that arena, unfortunately, we rely on informed referrals for these women who might be in those situations.

● (1640)

Ms. Anita Vandenbeld: Thank you. That might be an area of further study for our committee.

The other question I have for you is around international students. You mentioned isolation, and I imagine during COVID-19 this was probably even worse because of the limitations on travel.

I know that sometimes international students don't have access to the same kinds of counselling services that other students do. Do you see that as a gap? What would you suggest we do about that?

Ms. Karen McNeil: At Achēv, we've seen first-hand the growing needs of international students looking for access to free supports. Based on leads generated from our social media channels, specifically in two of our Brampton locations, we know that about 42% of inquiries were from international students looking for help. Unfortunately, many of them are ineligible for a lot of the federally funded programs, as you are probably aware.

We are encouraged by recent attention being given to these issues by vice-chair and Brampton South MP Sonia Sidhu. We applaud Minister Sean Fraser for temporarily lifting the rule regarding 20 hours of work per week for international students, and we recommend that this change be made permanent.

We would also like to see the federal government expand federal programs so that international students would be eligible for supports, including supports for mental health for women and girls.

Ms. Anita Vandenbeld: Thank you. I'm pleased to say that Sonia Sidhu is on our committee and is here today, so I appreciate my colleague's action on that. I think we could potentially take that as a recommendation from this study.

My next question is for Ms. Boucher. I just want to pick up on something you said the U.K. Parliament is looking at, which is the “de-prescribing”, the withdrawal, because we heard in previous testimony that often when young girls present at emergency, they're given medication and they're sent home, and then there's no follow-up. Some of this can be very difficult to withdraw from.

You said there were lessons to be learned there for Canada. Could you maybe, in a very short time, elaborate on what those lessons might be?

[*Translation*]

Ms. Anne-Marie Boucher: Yes, of course.

The mandate of the committee that was struck in the United Kingdom was to study, first, dependence on prescription drugs, including psychotropics, and, second, how to support persons in withdrawal.

What we're seeing on the ground, particularly in the community sector, as you said, is that many young women and older people are prescribed antidepressants and anxiolytics without there being any monitoring of that medication or instructions as to when to stop taking it. Consequently, those drugs may be prescribed for years without the patient being advised on dosage reduction or withdrawal methods.

People are also very rarely informed, before they take certain drugs, about how difficult it is to withdraw from them. We've observed that inadequate information is provided when drugs are prescribed. Even health professionals aren't always well equipped to ensure that withdrawal is done properly. That has been studied in the United Kingdom, and we think we should examine that particular issue in Canada too.

[*English*]

The Chair: That's perfect. Thank you so much, Anne-Marie.

We're now going to turn it over for the next six minutes to Andréanne Larouche.

Andréanne, you have the floor.

● (1645)

[*Translation*]

Ms. Andréanne Larouche (Shefford, BQ): My sincere thanks to the witnesses for being here and for testifying today. I've noticed a recurring theme here on the importance of working upstream on the social determinants of life, particularly on what causes a woman to experience mental health problems. This is very interesting.

Ms. Boucher, you just mentioned psychotropics, but you also raised the issue of social determinants. You also described the Quebec model of autonomous community organizations.

The situation is urgent. We know that the health system and community organizations don't lack for projects or initiatives regarding access to mental health services. Yours is a good example of that.

However, one of the major problems is the glaring lack of funding. Organizations want stable and recurring funding from the government. To meet that demand, the Quebec government must necessarily increase the budget it has set aside for the health system. Your organization's funding depends on that as well.

So don't you think the federal government should make its contribution and adequately fund the provinces and territories by transferring the missing amounts to them unconditionally?

Ms. Anne-Marie Boucher: Health transfers are obviously critical in supporting the health systems of the various provinces. We can see that there's an urgent need to increase funding, particularly for mental health, which is the poor cousin in the budget of Quebec's Ministry of Health. In addition, we definitely would like an increase in federal transfer payments, but those payments must also be made promptly and unconditionally.

I previously worked in the homelessness sector, and I very clearly remember long negotiations over Canada-Quebec agreements such as the Homelessness Partnering Strategy. The funding was slow in coming on the ground, but we needed it urgently.

We hope that the health transfer payments will be made in a manner consistent with provincial jurisdictions and that we can quickly have access to funding that enables us to increase the community sector's efforts on the ground.

Ms. Andréanne Larouche: You cited the example of delayed assistance for combating homelessness, but I can tell you that assistance, which was earmarked for women victims of violence, was also very slow in coming during the pandemic.

So we can see that the federal government sometimes creates programs that fund organizations and projects such as yours but that overlap with those of the provinces. I'd also like to go back to that issue because I know you're requesting stable, recurring and unconditional funding. You said that.

I know that federal-provincial program overlap requires community organizations such as yours to spend a great deal of time and energy completing application forms. Project funding and the obligation to be accountable result in a lot of red tape and criticism.

Would you please tell us a little more about that issue and the fact that project funding doesn't help you support young people over the long term?

Ms. Anne-Marie Boucher: Project funding can definitely be useful at times in developing new ways of doing things. However, what community organizations in Quebec and elsewhere want is mission funding. Then they could promote and support mobilization using that resource.

Consequently, we need to support the mobilization of young people so they can develop their own projects, test initiatives and roll them out. Project funding is often very limited and involves milestones that are imposed on us from above, which very often runs counter to the practices of the community sectors. Accountability, which is a major responsibility, takes up time that we should instead be devoting to developing our mission and animating association and democratic life

Of course, what we hope for is public, recurring mission funding that truly enables groups to maintain their independence and agility in developing projects based on demand on the ground.

There's considerable demand for youth projects right now. We think mission funding could help to develop them. Certain initiatives are also headed in that direction, even where there's no specific project.

Ms. Andréanne Larouche: You're already receiving mission funding from the Quebec government. As for funding from the federal government, which imposes its standards on you, you'll obviously have a contact that you can speak with.

Ms. Anne-Marie Boucher: Yes, something like that.

Ms. Andréanne Larouche: What you need is operating funding. That's what we're hearing.

For all the reasons you cite, your community groups are also familiar with the situations on the ground and are really more directly plugged in to people's needs in each of the regions.

● (1650)

Ms. Anne-Marie Boucher: Yes, that is really what we are negotiating, including when there is federal funding that occasionally comes to us.

We want the communities to be able to decide for themselves where the money will go. When we receive project funding, like under the Homelessness Partnering Strategy, we want the communities to be able to define the priorities and guidelines. It is obviously even better when we are able to receive mission funding that doesn't come with conditions or require specific practices, so it allows us to develop what the communities need in the here and now.

[*English*]

The Chair: You have 10 seconds.

[*Translation*]

Ms. Andréanne Larouche: I will probably have an opportunity to come back to the subject and get your comments on violence against women, but we will have to wait for the second round, because my six minutes of speaking time are up.

[*English*]

The Chair: Thank you.

I'm going to pass the floor over to Leah Gazan.

Leah, you have six minutes.

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

My first questions are for the Northern Ontario School of Medicine University, Diane Whitney or Peter Ajueze.

In your presentation, you spoke about the lack of access to care, but also the impacts of colonization on mental health, particularly for indigenous women, girls, and two-spirit people. We had a historic day today in the House of Commons, which unanimously passed a motion recognizing what happened in residential schools as a genocide.

From your testimony, you see those realities on the ground with the lack of resources. What changes do you think urgently need to be made to address the current crisis?

Dr. Diane Whitney: The question is, what part of the current crisis? There are so many.

In listening to people.... Why do medications get prescribed, particularly to young people, who probably don't need the medication? It's because there isn't any counselling. That doesn't require me as a psychiatrist to do that.

I've been struck, since I've been in the north.... I've been in the north for 12 years. When I first arrived, I was getting referrals for grief. I was thinking, “That's not a psychiatric issue. It's a family and social issue.” The tremendous lack of counselling is very significant.

As Dr. Jetly says, we can't keep doing the same thing we've been doing, which is doing one-on-one counselling weekly. The lineup just grows. How do we offer things differently?

I do mindfulness in my clinical practice. I've been running a group for 10 years. When COVID hit, I reluctantly switched to Zoom. I had more people in the group. They stayed longer in the group, and I was able to deliver it virtually. It was an amazing experience.

Ms. Leah Gazan: In one of the programs they had many years ago at the Opaskwayak Cree Nation in northern Manitoba, they would take families who were impacted by intergenerational trauma and having involvement in the child welfare system, and put them on an island as a family, with a psychologist and an elder. They would teach families how to be together as families and to understand the historical trauma that resulted in the current struggles the family was having. It was rooted in culture, outside of western practices, in terms of mental health care.

Are you familiar with any programs like that? Do you think that those kinds of programs are critical, particularly when working with isolated and indigenous communities?

Dr. Diane Whitney: I'm not aware of any program like that in northwest Ontario, but I think it would be quite healing for the family as a whole in relation to the trauma experience.

Peter, in your northern part of the province, in Sudbury or elsewhere, does any program like that exist for families?

Dr. Peter Ajueze: There are no programs specifically about general psychology or intergenerational trauma, but there are for substance use.

I appreciate that question. I am currently in Sault Ste. Marie attending a clinic for an indigenous group. When you ask whether we think using a culturally based approach would be helpful, the answers is, absolutely.

Since I studied in this clinic with this group, I have learned a lot about some of the indigenous approaches, particularly toward trauma. We have been incorporating it specifically in the clinic where I work. I am also aware of these...they call it land-based treatment, where people struggling with addiction and substance use would go. It's specifically for the indigenous population.

I had a patient who attended and found it very helpful. I think they usually stay for a month to three months. I've heard good things. It's something that I think physicians, including me, need to learn even more about, to see how we can incorporate that into our own practices.

● (1655)

Ms. Leah Gazan: Thank you very much.

Going back to addiction, we know that people who are using substances are often using them to self-medicate more complex mental health and trauma issues. Do you think that the lack of available support exacerbates substance use in remote communities?

Dr. Diane Whitney: Yes, it does, significantly. Trying to find, particularly in the north, addiction treatment and treatment facilities that are able to manage patients with "complexities"—to use that term—is next to impossible.

Ms. Leah Gazan: We—

The Chair: Actually, your time is up.

Ms. Leah Gazan: Sorry, I was trying to get an extra two minutes.

The Chair: I know. You always push it. It's all good.

We're now going to go to our second round, switching to five minutes, and then two and a half minutes for Leah. I'll remind Leah that it's two and a half minutes for her.

We'll start with Anna Roberts for five minutes.

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

Thank you to all the witnesses. This is a very difficult topic.

I have some questions for Dr. Jetly.

Recently I spoke to a family, a single mother now, who had a child with disabilities, both autism and ADHD. The child was given medication. I don't know the exact numbers, but I know there are a large number of divorce situations when a child with disabilities is born. Usually, the mother ends up being the caregiver. In this particular situation, it's a culture thing, so the family—both families—felt that it was.... I guess they wanted to blame someone, and they always blame the woman. However, nobody thinks about the single mom who is trying to take care of the child.

All she was advised to do was to suck it up, buttercup, and move on. They provided her with medication. That wasn't the answer. She struggles each and every day. She had to finally break down and put her child in a home, because she felt that she was a threat to her child.

Have you seen any situations of that magnitude? If so, what can we do to recognize that, and how can we help them?

Dr. Rakesh Jetly: Our colleagues have alluded to this. As a physician, I was a generalist. I was a family physician with the military. Then I became a super specialized guy; I became the trauma guy. Later in my career, I became much more of a generalist.

I agree with what my colleagues were saying here, in the sense that there are determinants of health. Determinants of health are much more than health care. It's a societal thing. It's loving relationships, supports and things.

I do think the answer to this one.... It's a tragic outcome for the woman not being able to take care. Overall, the societal support or the cultural support has to be there. I do, sadly, see cases like this. I've had cases in my own practice like this, as well. Not to be the big bad psychiatrist, but I think medication may have been part of the answer for this child if there's a severe neurological disorder such as ADHD, but that's the beginning, not the end.

Unfortunately, the emergency room analogy that one of our colleagues gave about prescribing that young woman benzodiazepines or something like that isn't the end of her story; it's the beginning. I think that a more holistic approach that looks at well-being, employment, stable housing, occupation.... The mother probably needs respite—she can't look after a sick child herself all the time.

If we step back and look at what's really needed.... The Canada Health Act—I could go onto a whole other topic—isn't really a health act. It's to pay for medication if somebody steps on a nail. It never really accounted for mental health, psychology, social work and all the other paraprofessionals we have. We have psychologists, chiropractors and physiotherapists who aren't covered by the Canada Health Act. They're all part of health.

I think the issue we're facing here is that the answer isn't a magic bullet. The other answer is a much more complicated one, but we tend to kind of ignore it.

● (1700)

Mrs. Anna Roberts: I guess what really boggled my mind, and I didn't understand this, was how the husband got away without paying for support, etc. and ended up leaving the country. The poor woman tried to get a job to support the child. It caused trauma to her. She didn't have the benefits to help the child or herself with therapy.

How can we ensure that this doesn't happen again? Let's be honest, most women are the caregivers.

Dr. Rakesh Jetly: Again, I mentioned earlier the advantages of team-based care. Back in the day—I know Diane has practised for a long time as well and I know her as a colleague—when somebody was hospitalized years ago, they actually got treatment in the hospital. Social workers and occupational therapists were there making sure they were safe and learning skills. Now you're hospitalized just to make sure you're not suicidal anymore, and then you're discharged.

I think, really, the paraprofessionals will teach us psychiatrists a lot. They will teach the patients a lot. It's really that team-based approach. There were centres throughout the place. There is George Hull Centre in Toronto, for example, that's been around, where you have the different professionals—social workers, occupational therapists, all those—who can work with the parents and the children.

Programs for a woman like this need to be very family-oriented to help the mother and child communicate with each other. They're quite extensive, but they used to work.

The Chair: Thank you so much, Dr. Jetly.

I'm now going to pass the floor over to Sonia Sidhu for five minutes.

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

Thank you to all the witnesses joining us on this important study.

My first question is for Achēv. Thank you, Tania, for the work you are doing on the ground in Brampton and across the GTA.

StatsCan has a report that says, "Immigrant women have fewer...social connections" than Canadian-born women. In your experience, how do newcomer women benefit from early integration? The last time I visited there, you were talking about the career pathways program. Can you explain what that was and how a newcomer can benefit from that early intervention?

Ms. Tania Amaral: Sure, I'll address this one. Thank you so much for the question.

The overarching issue with newcomer women, social isolation and social integration is that we need to talk about the systemic racism that is entrenched in that aspect. Not only are they facing multiple barriers, not only are they incredibly stressed and mental health is something they cannot even talk about, but they encounter racism at every turn. The benefit of the early intervention with social connections is key, particularly when they are the backbone of their family. They are the ones who are responsible for taking care of the household and for the child rearing in those cases. In a lot of cases, particularly with some of our communities out in Peel, newcomer families are in multi-generational homes, so there is the added burden of senior care that comes with being a woman who also has to take care of children.

What importance, in that long queue of priorities, does social connection and reducing social isolation take? At first glance, of course, they don't see it as such. Women put others' needs ahead of theirs. Newcomer women, particularly racialized or marginalized newcomer women, will place the needs of others ahead of theirs.

Again, getting back to my earlier point about how wellness goes beyond the physical, making sure they're aware of that and making sure there are resources available to them when they come to access our services makes it okay. It's okay for you to think about yourself. It's okay for you to take some time to connect with other women or connect with other female professionals or female entrepreneurs. It's okay to take care of yourself. In fact, you need to take care of yourself in order to be the caregiver, which is expected of you when you return home.

I'm not sure if that really answers your question, but that's certainly something that comes out a lot, and we're incorporating that into our services. For example, concerning the career pathways program that you mentioned earlier, we make it a point to have a meet-up group every month where women can connect with other women like them who perhaps look like them or have similar stories to theirs. They talk about wellness and well-being and can share stories and empower each other. The career pathways program is about finding a job, but we make a point to have those conversations at the table and have the women have these conversations with each other.

● (1705)

Ms. Sonia Sidhu: Thank you.

We heard before that when newcomer women encounter discrimination, it creates significant psychological stress. Can you speak about the impact this can have and how we can make sure supports are reaching those who need them?

You talked about stigma; you talked about language barriers. How is Achēv making sure that early support can reach out to them?

Ms. Tania Amaral: I think an important factor, when you're looking at what programming is going to serve that community best, is looking at the cultural appropriateness of such intervention. If you're able to tap into that to get the buy-in from the user—and the user in this case is the newcomer woman—if they feel comfortable and safe to talk about things that perhaps they're not able to talk about at home, and you do that from the get-go by making sure, again, that it speaks to the specific needs of a newcomer, a marginalized, racialized woman, I think that—

The Chair: I'm sorry, Tania. Thank you so much.

We're now going to head over to Andréanne Larouche for two and a half minutes.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

Ms. Boucher, you said earlier that your group received its funding directly from Quebec's ministère de la Santé et des Services sociaux. You also gave a good explanation of how much federal health transfers, with no conditions and for up to 35 per cent of the costs of the system, would help you.

However, I would like to come back to the subject of violence against women and other factors, given the importance of prevention.

As you clearly explained, mental health cases have really exploded in the context of the crisis created by the pandemic, and we now find ourselves dealing with inflation, and so with a cost of living crisis. If we provide support for social housing, could we not invest more and also support women's health and safety?

Ms. Anne-Marie Boucher: Exactly.

In fact, these concerns are to some extent related, for example in the case of violence against women in a spousal or family relationship. The housing crisis exacerbates that violence, because it is extremely difficult for some women, at present, to leave the family home with children and find new accommodation.

I am not familiar with the situation everywhere in Canada, but in the case of Quebec, we are currently experiencing an unprecedented housing crisis. There are real problems with building enough social housing. The cost of housing has exploded and the housing available is no longer affordable. That is one of the determinants of mental health that is doing the most harm right now, with the rise in the cost of living.

Obviously, preventing violence against women and girls should be a priority when we are talking about women's mental health. Recently, I happened on a study of women hospitalized for psychiatric care. It stated that 90 per cent of the women had experienced violence and assaults during childhood or adolescence.

We are talking about the importance of preventing violence, but also of responding and of supporting people who have experienced trauma. We have to make sure that there are services that offer compassion and listening. We have to take individuals' history into account and not simply act on the symptoms, their expressions of anger, distress or suffering. We therefore believe that it is urgent that there be places that offer approaches that are sensitive to trauma and are readily accessible to women and girls.

● (1710)

Ms. Andréanne Larouche: I am going to have to come back to this question on my next turn. There was actually a demonstration this weekend to denounce the violence committed against women. I will come back to that.

[*English*]

The Chair: Thank you so much.

We're going to move over to Leah Gazan.

Leah, you have two and a half minutes.

Ms. Leah Gazan: Thank you so much.

I want to continue on with the Northern Ontario School of Medicine.

Call for justice 3.4 of the National Inquiry into Missing and Murdered Indigenous Women and Girls says:

> We call upon all governments to ensure that all Indigenous communities receive immediate and necessary resources, including funding and support, for the establishment of sustainable, permanent, no-barrier, preventative, accessible, holistic, wraparound services, including mobile trauma and addictions recovery teams. We further direct that trauma and addictions treatment programs be paired with other essential services such as mental health services and sexual exploitation and trafficking services as they relate to each individual case of First Nations, Inuit, and Métis women, girls, and 2SLGBTQQIA people.

From what you've shared, it's clear that that's not happening. Part of the issue is the funding structures. We saw that with the Canadian Human Rights Tribunal ruling where they said there was “willful and reckless discrimination” against first nations children on reserve by not providing the same funding as for kids residing off reserve—no reason. However, we also see this in the health care system, different allocations of funding.

Would either one of you say that that's an example of systemic racism?

Dr. Diane Whitney: I'll agree there. When something like that gets written but then is not implemented, why is that? There are examples in northern Ontario of racism within the medical system, to be honest about that. What is also done.... I was the program director of the psychiatry residency program for the Northern Ontario School of Medicine, and I actually had some of my psychiatry residents expressing concern and frustration. One of them finally made a complaint about the behaviour of an emergency physician at a facility in northern Ontario.

Unfortunately, it's still there, and it's still alive. It's nice to see the young doctors saying, “This isn't right”, and I support that resident's making that complaint.

Ms. Leah Gazan: So, just to—

The Chair: We will make sure we get back to you, Leah.

Dr. Diane Whitney: Okay, perfect. Thank you.

The Chair: We're going to be starting our third round. We'll pass the floor back over to Michelle Ferreri for five minutes.

Ms. Michelle Ferreri: Thank you, Madam Chair.

I'll go back to Dr. Jetly.

I know you started to finish something you were doing in your testimony, and I want to give you the floor to finish that in terms of what you think we should be focusing on with regard to research and women.

Dr. Rakesh Jetly: Thank you very much for that.

First of all, I completely agree with my colleagues that medicine isn't always the answer, but sometimes it is. If we are going to medicate, we need to be careful to make sure that we are translating studies correctly.

Years ago, we used to think that children were just little men and women. We used to give them medication based on weight, without understanding their liver and things. Years and years ago, we used to exclude women almost all of the time because of menstruation, because they might get pregnant, because they might get.... We had very good justifications for not including them because you couldn't control for time of month and things like that, but then when the medications get released, we give the same medications to women as well.

The problem ends up being that, when we include and analyze by gender, we tend not to have enough money to have enough women, especially in military veteran studies, and then you don't really report on them because they're not significant.

There have been laws passed in the U.S., such as the NIH Revitalization Act of 1993, but I think these things haven't really been followed. In 2013, the FDA cut in half the dose of Ambien, which is like our zopiclone, because they found out that women were clearing the medication less, which means they had a higher dose in the morning when they were supposed to be up. Guess what? That's when you're driving the kids to school; that's when you're getting breakfast, and so mom is kind of stoned in the morning.

We have to really look at making sure that the studies...that we don't just GBA-analyze and say, “Yes, we've considered it” but actually report on the differences, because menopause happens; pregnancy happens; postpartum depression happens; menstruation happens. That yucky biology does make studies harder, but then we end up applying the medications to those people.

I just think that's really important for us to move forward. The funders can ask for it, but if we end up having 90 men and 10 women, and our differences aren't statistically significant, it's not helpful. That's one of the points I wanted to make, just from a pure biological psychiatry perspective.

● (1715)

Ms. Michelle Ferreri: Thank you, Dr. Jetly.

Dr. Rakesh Jetly: The brain studies are the same. We did right-handed men because that was easier for brain studies.

Ms. Michelle Ferreri: Interesting, thank you. There's lots of information to dissect there.

I hope to get two more questions in here.

I'm going to direct this again to you, Dr. Jetly.

A UNICEF report came out in 2020. It is really shocking and upsetting that Canada ranked 35th out of 38 in top “rich countries”—their definition—on their report card of rates of teen suicide. Why do you think we are getting so much worse when we're supposed to be this great country?

Dr. Rakesh Jetly: I think it goes back to the whole holistic society thing—well-being, social supports, the connectedness or disconnectedness of a society. From a treatment perspective, when we have a lack of access to care, a lot of times it's social things, but there are kids who become depressed, who become psychotic.

It's abysmal. In my city, Ottawa, it's a year-and-a-half wait for a psychiatrist for a teenager. I have kids that age. A year and a half is a lifetime at that age.

I just think that, again, it's that need-care gap. They'll go to the emergency room time and time again, and eventually they'll complete suicide. I think it's the whole thing, from societal things.... We talked about bullying. We talked about these things—a safe place where there is help and care by paraprofessionals—but that acute suicidality needs urgent psychiatric care sometimes, and we really don't have that.

We can talk all about universal health care if we want, but the reality is that it's abysmal how long kids have to wait. That's why my colleagues are phoning and asking me for help all the time.

Ms. Michelle Ferreri: It's true. Those are staggering statistics, and you said it really well. The other thing you said that I thought was really powerful was that social media is “traditional bullying on steroids”.

I have barely any time left. I'm going to direct this to Dr. Peter Ajueze.

I'm curious if there's data or research to say that an eating disorder is a symptom of trauma.

Dr. Peter Ajueze: There are definitely connections between eating disorders and trauma. Specifically, I know eating disorders are a big umbrella term. You have anorexia. You have bulimia. You have binge-eating disorder. You have avoidant/restrictive food intake disorder—

Dr. Diane Whitney: I'm going to help you out here, Peter.

I'd say, yes, most patients with eating disorders have a history of trauma. It's not all, but sort of like the numbers for borderline personality disorder: You're talking about 80% to 90%.

The Chair: Thank you so much.

I know that all of you have so much more information in your heads, so let's get in as many questions as we can.

We are going to Marc Serré for five minutes.

[*Translation*]

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

I want to thank all the witnesses very much. I would have liked to have more than five minutes' speaking time to ask each of them questions.

In the case of Dr. Ajueze and Dr. Whitney, it is important to put things in context. These two witnesses are talking about northern Ontario. However, Dr. Whitney is in Thunder Bay and Dr. Ajueze is in Sudbury, two cities that are 11 hours apart by road. The extent to which Canada is rural is remarkable. These two doctors cover nearly 90 per cent of the province of Ontario, where approximately 115 First Nations live and where the delivery of services is nowhere near comparable to what happens in Toronto or in the other major urban centres.

● (1720)

[*English*]

My question is for both of you. Specifically, we're looking at $4.5 billion to negotiate with the provinces. Yes, the federal government has a role to play with the provinces, but I wanted to get your sense of this.

When we look at the lack of training and the lack of professionals, and at innovation and obviously the video conferencing that you're utilizing, what can you recommend to the federal government for us to be negotiating on with the province to ensure we have the supports needed in terms of the massive gap that you have to deal with? Dr. Whitney talked about bereavement leave. It's just very difficult.

I'll start with you, Dr. Whitney, on recommendations to the federal government, and then Dr. Ajueze could chime in.

Dr. Diane Whitney: One is supporting infrastructure, including Internet access. Outside of Thunder Bay and Sudbury, it's not that easily available. That's number one.

I actually have a paper here if somebody wants it. It's from the Ontario Medical Association students who have solutions, including covering counselling for everyone—counselling that's universally covered or OHIP-covered, whatever you want to call it—so that people have access to proper counselling.

On a positive note, having been the former program director for the psychiatry residency program at NOSM, I will say that we've now graduated eight residents, two of whom are indigenous and practising in the north. Out of those eight residents, six are practising in the north, and one of them is living in northern Toronto but does all her work remotely.

Last is to support the medical school. We're trying to do some really unique things, I think, and we often attract people who finish medical school and who are from the north, and those are the people who are staying in the north—

Mr. Marc Serré: Okay. I have just two minutes left. I'm sorry, Dr. Whitney. I know you have a lot more to say, but I'm trying to get the time in.

Go ahead, Dr. Ajueze.

Dr. Peter Ajueze: Thank you to the honourable member.

There's one thing I wanted to add, because you rightly said that the vast area in the north.... From my experience working in England and in Ireland, they have a different model for mental health. Let's say that you had four psychiatrists looking after a community; that community would be divided into those sections, and each psychiatrist would have a multidisciplinary team of social workers and nurses. It is easier to track and to follow up with patients with difficulties.

I feel that because of the uniqueness of the north, this could be considered, whereby with those models we would have teams of health care professionals looking at certain areas and making sure that we don't miss any areas. Yes, it's good to have Zoom and virtual care, but that is not adequate. It's not the same. I see that when I come to it in person versus when I do Zoom.

We have so many doctors from the United States and from down south who are able to provide these Zoom services and prescribe medication, but I think we need more. We need teams and people who know the community and can follow patients and be able to.... I think that would be better care.

Thank you.

Mr. Marc Serré: Thank you.

I think I have 30 seconds left, and I wanted to mention the Northern Ontario School of Medicine and thank you for what you do. Since 2005, you've added 838 medical professionals; 65 doctors are indigenous and 171 are francophones. I know you mentioned infrastructure, so I wanted to look at what better.... I know that the federal government has been supporting it since 2005.

Maybe on a last note, as I know the chair is looking at me right now, on a personal note, there's something that I haven't said in 20 years or I haven't said to anybody. I just wanted to personally thank you, Dr. Ajueze, for the support you provided me over two years, many moons ago, and I just wanted to thank you for what you do for people across northern Ontario and across the country. Thank you for choosing Canada.

Dr. Peter Ajueze: Thank you, sir.

The Chair: Thank you very much, and thank you, Marc.

The time to get that opportunity to say thanks is sometimes when you have to do it, and I appreciate that.

I've messed around with the schedule—sorry about this, everybody—for Andréanne and Leah. I love it when the clerk looks at me and thinks, “What are you up to, Karen?”

I'm going to go with six-minute rounds to provide you with extra time. Instead of going back into a round and having to cut you off, we'll continue with six minutes. For Anna, it will be four minutes; for Jenna, four minutes; and for Emmanuella, four minutes. As chair, could I have three or four minutes to ask some questions? Is everybody good with that? Okay, fantastic.

I'm going to pass it over to Andréanne, for six minutes.

● (1725)

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

I want to thank the witnesses again for being here today.

Ms. Boucher, you talked about the question of social determinants in your remarks and you mentioned that when I asked my questions. What I understand from your testimony is that your groups need financial support. The question of transfers is therefore important, particularly for the workforce, to offer better pay for the people who staff your organization. I also understand that more investment has to be made in social housing, a field in which the federal government can also do something and one that we can look into.

I also wanted to talk about the issue of violence against women. My reason is that the Government of Quebec has published a very interesting report on combatting sexual violence and spousal violence, "Rebuilding Trust", which contains a number of recommendations.

At the end of last week, on Sunday, a demonstration took place to denounce spousal violence and the fact that men whose sentences are under the federal government's jurisdiction do not get the same treatment as men whose sentences are under Quebec's jurisdiction, particularly with regard to the notorious electronic bracelet question. When it comes to all these safety issues, the federal government needs to align its strategies to combat violence against women with Quebec's and prevent one of the social determinants that has consequences for women's mental health.

Ms. Anne-Marie Boucher: Excuse me, but what aspect did your question address, exactly?

Ms. Andréanne Larouche: You work with community groups and you raised the issue of violence against women and the fact that the federal government should align its strategies with Quebec's recommendations.

One possible solution would be to align the programs to combat violence against women so that both levels of government are working together on that issue. How could that collaboration help to solve this mental health issue?

Ms. Anne-Marie Boucher: We think it is obvious that there has to be support for the actions taken by community groups, particularly regarding mental health, but also the activities of women's groups, violence intervention groups, and groups that support men who commit spousal violence. Those grassroots groups need support.

Obviously, what Quebec does has to be aligned with what the federal government does, to provide these groups with financial support so they are able to carry out prevention actions and support people who are experiencing problems.

Ms. Andréanne Larouche: Briefly, regarding the last concerns you mentioned, specifically medicalization and cessation support, what do you expect from the federal government in that regard?

Ms. Anne-Marie Boucher: We believe the federal government could study the questions of prescription drug dependence and cessation support. It could do a Canada-wide study to see what is happening in terms of practices. It could make recommendations so that when a medication is prescribed, people receive the right information and health professionals are able to support them when they want to reduce or change the dose of their medication, or even stop using it.

These are the issues that we think need to be addressed. Health spending includes the cost of prescription drugs. We have to take a look at those costs to see whether everything being prescribed is always necessary, which is not always the case. However, cessation is really a hard road to take, and that means that the medication may stay in the pill box for a long time, even if the person no longer wants to take it.

Ms. Andréanne Larouche: You're talking here about research at Health Canada.

Thank you, Ms. Boucher.

Dr. Jetly, you talked a lot about bullying on social networks and the fact that those networks are leading to an increase in feelings of isolation and an increase in online harassment, including cyber bullying. During the pandemic, that entire issue was exacerbated, and this has had consequences for women's and girls' mental health and self-image.

Could a law to combat this online hate help to moderate hateful comments and reduce the burden that this phenomenon places on women's and girls' mental health?

[*English*]

Dr. Rakesh Jetly: I believe so. I don't have the answer for it, but I do believe it exacerbates the anxiety. It exacerbates, sometimes, the loneliness and isolation. For example, when some of us were growing up.... If I did something embarrassing in class, seven or eight people who saw it might laugh at me and make me a bit embarrassed, but now, by the time I get home, it could be uploaded and everybody in my class, my school, and my town could see it. That might affect me in not going to school. My parents would take me to the doctor and wonder what's wrong with me.

I think there are lots and lots of positives with social media—don't get me wrong at all—but I do think it's very double-edged. It may involve helping young girls and women to separate the fantasy that is social media. I have daughters exactly that age, and every kid at that age wants to be a Kardashian and wants to be famous. That's the world they live in, unfortunately.

I do believe it's a problem. I do believe there are many benefits from it. If you are away, you can speak to your loved ones halfway across the world, so that's fantastic. You can also tease and bother them. I do think that some education.... If only they could feel comfortable going to an adult, for example, and saying, “This is difficult.”

● (1730)

[*Translation*]

Ms. Andréanne Larouche: Dr. Jetly, apart from the field of education, how could a federal law tackle hate speech? As we can see, social networks are no longer this famous safe space that everyone talks about. The opposite is true: it is now a place of bullying, threats and violence.

A law designed to reduce, combat, and control the hateful comments a bit better is an initiative we could take, as elected federal representatives.

[*English*]

The Chair: I will allow a 15-second response, Dr. Jetly.

Dr. Rakesh Jetly: Absolutely. I'm stepping out of my expertise. I'm not a lawyer, but, absolutely. If we're encouraging.... If it's hate speech, we have legislation. Maybe some of this needs to be expanded to cover platforms, so that we keep up with the technology.

The Chair: Perfect. Thank you so much.

I'm now going to turn it over to Leah, for six minutes.

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

I want to talk about call for justice 3.4. One of the problems I asked about was systemic racism. I want to expand on that, because one of the things that were shared earlier by Dr. Ajueze was that people often have to leave their communities. I know that Dr. Whitney often experiences systemic racism in hospitals. We know this exists, certainly in the city of Winnipeg. I have a picture of an indigenous man who died in the waiting room, waiting for help, because they thought he was intoxicated. He literally died in his wheelchair. We hear stories like that all the time.

I am asking this, because people dealing with complex mental health have to go to places where they experience systemic racism. Compiled with that, they are now away from their loved ones and support systems.

Can you explain how these disparities further exacerbate mental health issues?

Dr. Diane Whitney: They do, in the way we've been talking about social determinants of health, isolation from family and support. COVID-19 exacerbated that even further. At a NOSM event, recently, some indigenous patients shared their experiences of being in hospital during COVID-19, and it was actually quite frightening.

My question is, is there a way to provide those patients with some type of support in hospital from their own cultural point of view, from an elder or an advocate, or whatever word you want to use? Would that be helpful? Would it have to be 24-7 support? It can't just be Monday to Friday.

Ms. Leah Gazan: Building on that.... That's wonderful, and we absolutely need that support and care in hospitals. I want to go back to what my good colleague, MP Serré, was talking about regarding the importance of training, so that people can stay in their communities and get the help they need in their communities. Would that be a better solution?

Dr. Diane Whitney: I can't disagree with that, but the challenge is with some of the really small communities. For example, my patient is on a reserve with 30 people.

Why can't we have a hub-and-spoke type of approach to it, where we have more than just a hub in Thunder Bay and Sudbury? That's a long way for people to come. Can we not offer some basic services closer to home?

Ms. Leah Gazan: We can have more holistic mental health care, rather than just in bigger urban centres.

Dr. Diane Whitney: That's right. It's also about, as my colleague Dr. Ajueze mentioned, actually having a team. I'd love to have access to a psychologist, a social worker or an occupational therapist. I practise alone in the community, by myself. I have residents, and my husband runs my office, but that's it. I don't have a social worker. I don't have an occupational therapist. It doesn't mean that I need to have one full time. It just means that I need access to one.

I don't think that's just a northern issue. It's an organizational issue.

● (1735)

Ms. Leah Gazan: Yes. It's also a funding issue, I would argue.

I have time for one more question, and I want to move on to Achēv.

Many immigrants and refugees who come to Canada have trauma and other complex mental health issues like PTSD, especially if they're coming from places where there's war, for example, and are leaving situations of conflict. In 2021, a report released in the International Journal of Environmental Research and Public Health, which was entitled “Refugee Women with a History of Trauma: Gender Vulnerability in Relation to Post-Traumatic Stress Disorder”, found this:

> After a review of the different studies, it seems clear that the higher predominance and severity of PTSD in refugee women is related to gender-based traumatic experiences, such as rape, sexual assault and abuse, or genital mutilation, among others.

People who come here with diverse experiences often don't have care that they can access with people who actually understand their experiences. It's clear that there's not enough culturally responsive and culturally safe trauma care.

How do you think that needs to change immediately to ensure that immigrant and refugee women and girls receive the mental health care they require?

Ms. Karen McNeil: I'll let Tania answer that too, but I will just say that there's also the language barrier. Many people have difficulty not just with culturally appropriate counselling and resources but also with interpretation and translation, ideally with somebody who even comes from their own cultural background or community and speaks their own language. That would be extremely important.

Perhaps Tania can add to that.

Ms. Tania Amaral: Thank you, Karen, for saying that.

Actually, I've been thinking about what my co-witness Ms. Boucher said about project-based funding. To your question about what we can do to have this happen immediately, I think one of the things is to put less emphasis on project-based funding, because it is quite restrictive. Just when you're about to have a breakthrough and you have some momentum, you feel like suddenly the rug gets pulled out from underneath you and you can no longer provide service.

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

We will now go into the four-minute round.

Anna, you have the floor for four minutes.

Mrs. Anna Roberts: Thank you.

Dr. Ajueze, you mentioned Ireland. My colleague Michelle shared with me the reference of the top three countries: the Netherlands, Denmark and Norway. How can we learn from other countries on how we can develop the same programs here that would benefit our community?

Dr. Peter Ajueze: Thank you, honourable member.

I was born in Nigeria. I grew up there and I did my medical school, and then I moved to Ireland, where I trained as a psychiatrist before moving to England to train as a child psychiatrist. Then I moved to Canada, so I've had the opportunities to learn from different countries and different practices.

I must say that every country is unique in its approach with regard to mental health. One thing I noticed when I first came to Canada was that there was a different approach. It was more like specialists. We have different mental health professionals who would focus on an area of special interest. For example, mine is eating disorders. We have people for addictions and different areas, which is good.

In those other countries, specifically Ireland, I found that the approach was different. It had its own advantages when it came to this team approach and being multidisciplinary, with social workers and nurses who would know almost everybody in a community. They'd have a team assigned to one community. They would know when there was a family moving out and a new family moving in. It was easier to monitor.

We find that generally in Europe. You mentioned the Netherlands. That's where sometimes you see a lot of research. It's easier to monitor and do longitudinal studies—even for 10 years and even when people move to a different province—because there is a team of health care professionals who are quite close to them. They know them and the families are comfortable with their health care providers. They know almost everybody.

I don't know how practicable it is to incorporate some of this model, but I think it is definitely worth trying. There are a lot of advantages to using that approach.

● (1740)

Mrs. Anna Roberts: One thing we heard in the budget was that the government promised $4.5 billion for mental health. I'm not sure where that money's gone yet.

What is the cost, per capita? Would you know that information—probably not—about what other countries are spending compared to Canada?

Dr. Peter Ajueze: No, unfortunately, I don't.

Mrs. Anna Roberts: I don't expect you to.

I'm curious about how we can rank so poorly, being one of the richest countries—or so they tell us. Why can't we learn from other countries how to better assist our own communities here in Canada? There's a lot of learning there to have, just as you explained to us about what's happening in Ireland. It has a lot of rural areas, and so do we.

We're hearing today from different witnesses that the rural areas don't have Internet and they don't have access to the infrastructure. What is it that we can learn to implement those same procedures here in Canada?

Dr. Peter Ajueze: That's a good question. One of your colleagues mentioned mobile services for indigenous areas. That was the first time I heard about it. I have been working in this community that I came to for the past three years now. I've never heard of anything like that.

I know somebody had asked if it was a form of institutional racism. I couldn't say that, but I wonder. I think, maybe starting with accountability about where that money is—

The Chair: Perfect. Thank you so much, Doctor.

I'm now going to move over to Jenna for four minutes.

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

Thank you very much to all the witnesses for their testimony, but more importantly for the work they do every day.

I'd like to direct my first question to Dr. Jetly.

You made the comment a few times that right now it's a year and a half or an 18-month wait for someone to see a psychiatrist here in Ottawa. Throughout this study and in some of the testimony we've heard from other witnesses, when we've been talking about mental health, in particular relating to young women and girls, we've heard about the impact of psychotherapy. We've heard about how useful talk therapy has been for young women, as well as that peer-to-peer discussion and having peer support.

I'm wondering if you can speak to that.

Dr. Rakesh Jetly: Thank you for that. Those are good points.

One thing with the 18-month wait is that we have the psychiatrist as the holy grail. You get to see a psychiatrist and are suffering till you get there, but the psychiatrist doesn't have all the answers. The idea is to have more of a team-based care, exactly as Peter spoke of.

I think that, yes, it starts with the community. It starts with peer support. It starts with trusted adults, trusted peers, mentors and mentees who create this community where discussing how they feel has been normalized. It's something we worked on in the military for 20 years. If your colleagues know you when you're well, they'll notice that subtle change and have the courage to tell you to go get help.

I think we've done a good thing that way. The lack, of course, is that we don't always have the help when people.... I've always looked at soldiers, veterans or children the same way: You have a window that's open. That window is open briefly and you need to get the help quickly for that.

Ms. Jenna Sudds: That's incredible. Thank you.

Dr. Rakesh Jetly: I do believe it starts with community. It's a community thing, for sure.

Ms. Jenna Sudds: Thank you very much.

To quickly turn to Ms. Boucher, I was really struck by some of your testimony around the use of psychotropic medication and the medicalization of young people. I'm wondering if you can expand upon that, particularly on any observations you may have over time. How has this perhaps changed or evolved one way or the other through the pandemic?

● (1745)

[*Translation*]

Ms. Anne-Marie Boucher: In 2016 in Quebec, before the pandemic, the realization of the problems young people were experiencing in connection with medicalization led to the creation of the Mouvement Jeunes et santé mentale. That movement focused particularly on marginalized youth and observed that in situations where young people who were in distress or were suffering had little access to support or help to improve their living conditions, what we had to offer them was medication. That movement held consultations and published data about these facts.

For example, a marginalized youth who has experienced disaffiliation, family breakdown or homelessness has a much higher chance of ending up with multiple medications than a youth who is living in more favourable circumstances. As well, we have observed that the pandemic led to accelerated prescribing of anti-anxiety medications, antidepressants, and even medications for attention deficit disorder with or without hyperactivity.

The question we ask ourselves is to what extent that medication is being used to make up for a deficit in public services and support. Some people today explained how difficult support services were to access. Often, the public is not very familiar with the other services that are accessible, such as peer support groups. People automatically want to look for psychological support, but because that is not always accessible, the doctor will prescribe medications.

[*English*]

The Chair: Thank you so much.

We're now going to pass it over to Emmanuella Lambropoulos.

Emmanuella, you have four minutes.

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

I'd like to begin by thanking our witnesses for being on the panel today and for the incredible work they do in their communities to help those in need.

Of course, every single session we've had with panellists has been very difficult to hear, because we know to what extent Canadians are feeling pressure right now and are experiencing mental health issues.

I'm going to ask my first question of Dr. Whitney.

You mentioned that there is twice the rate of suicidal hospitalizations in the north and that 78% of people experience childhood or adult trauma in the north. Obviously, the need is greatest there, yet there are fewer resources there than anywhere else. You also said that, during the pandemic, things got a little bit better because you were able to speak to more than one person at a time. You did sessions and you were able, within an hour, to help heal up to 12 people—I don't know if you gave a number—but this obviously created a barrier to accessibility for a lot of people who don't have an Internet connection, and this is another really big problem.

Can you speak to the importance of getting Canadians in the north Internet connectivity, as well as the infrastructure that needs to be in place in order to get people from place to place more quickly in order to get these services faster if they're not going to be in their communities?

Dr. Diane Whitney: Certainly, Internet service is essential. I'm not saying that's the answer totally for care, but it makes such a difference.

With regard to my group I was describing, at least I was able to include some people from outside of Thunder Bay, rather than having to do it in my office. I was a big proponent of using Zoom. I did not use phone much, because with Zoom you can see somebody. You can see what somebody's house looks like. Is it messy? You do an evaluation on a person and their house. I'm passionate about that.

The infrastructure is multi-faceted. With regard to the transportation to get people into a major centre for the care they need directly, the transportation and hotel costs are through the roof. I had a young woman come in with her mother, and I helped them deal with some of the hotel costs. Those practical kinds of things about getting people around in northern Ontario are not easy. We're not talking about small distances, as someone mentioned.

For the indigenous patients, I'll be honest: Sometimes the structure for them to access their benefits is very difficult. I can't remember what administrator.... My husband deals with it. However, with one of the indigenous organizations, we have to send a letter to the organization before they can book their travel. That's crazy. There are a lot of very practical—as you can tell, I'm practical—day-to-day things that are barriers for patients getting care. I worry about the patients who don't get to me.

The other thing I do is work with the maternity centre. This is a plug for this, because it's a nightmare trying to get a young indigenous woman seen and following through with appointments, for various reasons. We're talking about the unborn child, the other children, the mother. A lot of times, they don't end up in my office after the initial assessment because there's no support to get them there. It's one of the barriers to getting them there. It's significant.

That's work that I'm passionate about.

● (1750)

Ms. Emmanuella Lambropoulos: Thank you.

I guess that's what continues the cycle of intergenerational trauma. The mother doesn't get the help she needs, and then it passes on from generation to generation.

Karen, I'm going to let you go ahead.

The Chair: Thanks so much.

I'm going to build a little bit from where Emmanuella was. Thank you, everybody, for giving me the opportunity.

I'm going to take this question to Dr. Jetly.

I have your paperwork from earlier, and you were talking about mood and anxiety disorders that occur in women. It's one of those things that I think, if only I knew.... As a 51-year-old woman, I reflect on what it was like as a teenager, and raising my own teenager girls and what that was like.

We talk about mood and anxiety disorders. We talk about hitting puberty. We talk about prenatal care and all of these different things. I do not think we're doing enough in talking about the fact that women's hormones are going like this all the time. We're up and down.

What should we be doing to ensure that women and young girls are aware that this is normal and that we need to regulate ourselves?

Dr. Rakesh Jetly: That's a great question. Thank you for that.

I think part of it is to separate normal from disease. Having raised two girls, and continuing to raise—I guess you never stop—two girls through this whole period.... One is 20 and one is 18. The problem is that we have these classifications of diseases. If you are in this check box and you have these symptoms, then you have a disease. However, people are so different.

Let's take depression. With a 56-year-old post-menopausal woman who is sleeping 18 hours a day, eating carbohydrates and gaining weight, and a 19-year-old male student who is losing weight and can't sleep, we call it the same disease and often give them the same medication. We have to understand the differences and individualize things. I think what is normal, what is not normal, and when it is a disease are almost three different categories. I think that's really important.

I'm going to quickly jump in for my friend, Peter. The interesting thing in the Netherlands is that it's 0.05% the size of Ontario. The beauty of the Netherlands is that every single soldier in their military is within two hours' train ride to the Central Military Hospital.

This is the problem we face. I'm in the NATO group quite often, and the Canadian solution is going to be different. We can borrow and help.... If you think about a map, it's smaller than southern Ontario.

The Chair: Thank you very much.

Today has been an absolutely fascinating panel. I think that if people actually watched our committee, they would see that, in our own way, we're doing a little bit of counselling here because it's helping us understand how this all is going forward.

On behalf of the status of women committee, I would really like to thank our panellists for being with us today. Thank you bringing your expertise and adding to this. If there is additional information that you have not submitted to the committee, I will remind you to do so because I know that someone mentioned, “Hey, I'll just send that forward.” Please do. All of this information is very helpful.

I'm just going to remind the committee that, with respect to our human trafficking and sexual exploitation study, we need to have all of our witnesses in by tomorrow, October 28.

Also, I will remind everybody about the recommendations. Everybody would have gotten their version one today of our study. Please review that. We would like to have recommendations for our study number two—this is very important—by 3 p.m. next Friday, November 4. Please send those in to the clerk. Thanks.

We are adjourned.