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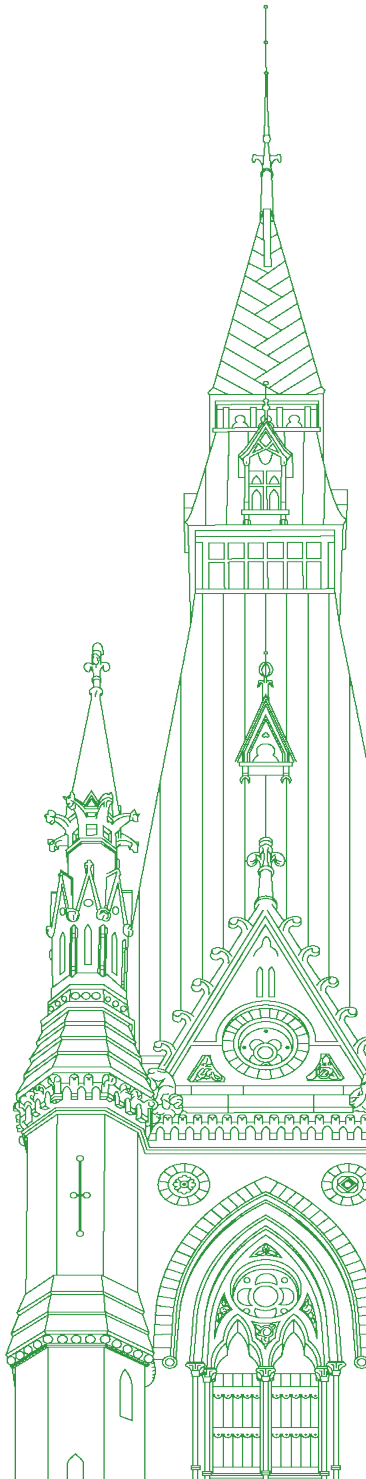

Chair: Mrs. Karen Vecchio

Standing Committee on the Status of Women

Monday, October 3, 2022

● (1100)

[*English*]

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

Welcome to meeting number 31 of the House of Commons Standing Committee on the Status of Women. Pursuant to Standing Order 108(2) and the motion adopted on Tuesday, February 1, the committee will resume its study of the mental health of young women and girls.

Today's meeting is taking place in a hybrid format, pursuant to the House order of June 23, 2022. Members are attending in person in the room and remotely using the Zoom application.

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

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

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

Of course, this is a very difficult study and I know that we have some incredible witnesses here, so I'm going to remind you that this is difficult and we'll be discussing experiences related to mental health. This may be triggering for viewers, members or staff with similar experiences. If you feel distressed or if you need help, please advise the clerk or come to me through the committee if you wish.

I would now like to welcome our witnesses. It's wonderful to have such an incredible group here today.

On the screen, we have Carol Todd, the founder of the Amanda Todd Legacy Society and the mother of Amanda Todd.

As an individual, we have Dr. Charmaine C. Williams, professor and interim dean at the Factor-Inwentash faculty of social work at the University of Toronto.

We have Emmanuel Akindele in the room, Blue Guardian's co-founder and chief executive officer.

From Future Black Female, we have in the room Timilehin Olagunju and Dr. Tapo Chimbganda, the founding executive director.

From Ka Ni Kanichihk Inc., we have Sydney Levasseur-Puhach, co-chair of the board of directors.

From the Réseau québécois d'action pour la santé des femmes, we have director Lydya Assayag by video conference.

Thank you so much for being here.

We'll be providing five minutes for opening comments from each group. When you see me starting to twirl my fingers—for those of you on the screen, you'll start seeing these hands up here—try to wind it down. That will give you about 15 to 20 seconds to wind it down, if you don't mind.

I'm now going to turn the floor over to Carol Todd, the founder of the Amanda Todd Legacy Society and mother of Amanda Todd.

You have five minutes for your opening statement.

Ms. Carol Todd (Founder, Amanda Todd Legacy Society): Can everyone hear me?

The Chair: In the room, I can hear you. We may have to raise the volume, if everybody wants to put their earpieces in as well.

If you want to start again, go for it.

Ms. Carol Todd: Okay. I will start.

Dear committee members, thank you for this invitation to—

The Chair: Ms. Todd, hold on for one minute. You're absolutely right. I'm listening to your voice and it's not very loud.

We've asked for the volume in the room to be raised, so as soon as we have that, I'm going to pass it back to you. We don't want to miss anything.

● (1105)

Ms. Todd, you can start your five minutes. We have the volume all figured out, so you can begin your five minutes.

Ms. Carol Todd: Dear standing committee members, thank you for this invitation to speak in front of your committee and provide thoughts contributing to the focus of mental health issues experienced by young women and girls, with attention to online harms and how these can greatly impact the self-esteem of this population.

My name is Carol Todd. I am the founder of the Amanda Todd Legacy Society. I am also an educator in British Columbia, but I am known more widely as the mother of Amanda Todd.

Amanda was a victim of negative online behaviours focused on her that affected her overall mental health and well-being. Her story has become prominent worldwide in the battle against cyber-bullying, sextortion and online exploitation.

The world of technology has continued to evolve at lightning speed over the past 30 years. Back then, one of the main uses of technology was for email communication. Technology devices and the Internet have created vast and varied behaviours online. There is, of course, the good, and then there is the darker side, where things are seen and heard that affect how we may feel about ourselves and/or others. In this 21st century, the Internet has allowed us to share stories, images, videos plus more in an often unglamourous and targeted way. My daughter was a victim of this technology uprising.

Amanda was born on November 27, 1996. She was just 15 years old when she took her life by suicide on October 10, 2012. In a week, it will have been 10 years since her death. As her mother, I will always carry the heartache of losing my daughter in this world where online harm and behaviours are preventable.

Amanda experienced cyber-abusive behaviours from her peers, online shaming, victimization and cyber-attacking. Amanda experienced being part of the perfect world syndrome on the Internet. Amanda was exploited online by an international predator who was extradited to Canada and was convicted in the B.C. Supreme Court on August 6, 2022 on charges of criminal harassment, luring, extortion and two counts of child pornography. Sentencing of this predator, Mr. Aydin Coban, is to occur the week of October 11, 2022, which is the day after the 10th anniversary of Amanda's death.

Amanda's life from ages 12 to 15 encompassed cyber-bullying, online exploitation, now known as sextortion, and mental illness. Young persons feel their lifeline is attached to today's world of technology. Much like oxygen, without it, they don't believe they can exist.

When Amanda was a young teen, our knowledge of what existed on the Internet was not as widespread as it is now. Amanda and her friends ended up sharing personal information with strangers and learned first-hand about the dark side of the Internet, which is a predator's playground where strangers can prey on kids in chat rooms and social media sites. This left Amanda shocked and feeling bad about her situation, instilling fear in her and our family. Her peers taunted and ridiculed her face to face and online, to the point where Amanda was afraid to leave the house. Amanda then turned to the Internet to find strength but was met with more abusive harm.

When Amanda was offline, the abusive words towards my daughter continued to swirl around social media. Not knowing what was being said and by whom added to the problems of not being able to provide support to help deal with situations. These were also young people whom Amanda at times considered friends. My once spirited and adventurous child became more reclusive and sad and felt alone, saying to me that she didn't know whom to trust anymore.

In today's world, young girls and women—also young boys and men—are dealing with a lot more than we did 30 years ago in terms of sexualized behaviours and easy access to sharing personal and intimate information over the Internet. This oversharing has created the situations we are discussing today. We have come to realize that what happened to Amanda can happen to anyone.

● (1110)

As Amanda said, in her words, “Everyone has a story.” When those stories come out and they belong to your child, your relatives and your grandchildren, it sometimes means more. No one is immune to becoming a statistic.

In conclusion, I want to thank you for the time and effort you have put into creating a space to address the harms that young women and girls face in their lives. Speaking for many Canadians who care about our country, we applaud and thank the Canadian government for putting the emotional wellness of young girls and women at the forefront of conversation. It is hoped that more resources and strategies can be put in place to address the situations we are being faced with.

Communities worldwide need to continue to work together in supporting the work that has been done to promote increased awareness and education surrounding mental wellness and online safety.

I am grateful to be able to use my voice to share Amanda’s story and this life experience to assist with any changes that may be brought forth. The voices of so many continue to remain silent, either out of fear or because they can no longer speak to be heard. It is through me and the legacy that Amanda has left behind that we can continue to make these silent voices heard.

We must work together to create a safer space for Canadians to live in.

Thank you for the time and for listening to me.

The Chair: Thank you so much, Ms. Todd, and thank you so much for being with us here today. I know that this will be very impactful to the rest of the work that we need to do.

I'm now going to pass it over to Dr. Charmaine Williams, who is here as an individual.

Charmaine, you have the floor for five minutes.

Ms. Charmaine Williams (Professor and Interim Dean, Factor-Inwentash Faculty of Social Work, University of Toronto, As an Individual): Thank you for the invitation to present to this committee.

I'm speaking from my experience as a social worker in the mental health care system and as a researcher in mental health with an emphasis on issues that affect women of colour and LGBT+ communities.

I anticipate that other witnesses will speak in detail about the health gaps between men and women. My addition is to suggest that, when we consider these health gaps, we also consider the more extreme gaps that are experienced by people who are not occupying either of these categories. Trans and gender-diverse people face severe mental health disparities and significant barriers to accessing effective mental health care. Their issues are easily overlooked or marginalized in work that focuses on women and girls or on people identifying across the LGBT spectrum.

The issue of who gets overlooked, marginalized or silenced when systems attempt to meet the needs of populations is key to this discussion. Strategies for mental health promotion and the prevention of mental illness that are directed at young women and girls as homogeneous groups are inadequate for understanding and addressing health disparities. Although there is value in attempting to address the shared concerns, it inevitably mutes or erases important differences that have implications for mental health and well-being.

In Canada, we have been leaders in identifying social determinants as critical factors that influence the health of populations. We know that women and girls are disadvantaged or, better stated, disempowered in categories like income, employment, education and access to health care services. However, we also know that Black women, indigenous women and lesbian, bisexual and trans women are further disadvantaged and disempowered. Consequently, action on social determinants is critical, but action must be equitable.

The strategies that this government undertakes to address the mental health of women and girls must include strategies that are directed to addressing the specific disparities and health risks for Black women and girls, indigenous women and girls, lesbian and bisexual women and girls, and gender-diverse young people. Further, action on access to timely, effective, woman-centred, culturally appropriate health care is crucial to effective treatment and recovery from mental illness for BIPOC women and girls.

In addition, these strategies must emphasize that the health disparities faced by these groups are tied to exposures to interpersonal and institutional sexism, homophobia, transphobia and racism—exposures that are often augmented by intersecting identities that expose people to their combined effects. My own research has shown that women and trans people who are also racial minorities, lesbian, bisexual or lower-income face augmented risk for depression and unmet needs for mental health care. Exposure to discrimination is one of the major factors that link them to these poor outcomes.

I have further observed, over several research studies, that exposure to violence is a determinant of mental health for women. Women and girls who are Black, indigenous or LGBT+, or combinations of these identities, report lifetime exposure to violence that begins with childhood physical, racial and sexual traumas that continue into adulthood, in which violence occurs in unsafe housing conditions, unsafe working conditions, unsafe migration conditions and within relationships that cannot be escaped for safety.

All women and girls experience risk to their mental health in social and institutional conditions that do not protect them from violence. We label some of these women and girls as “at risk” when we should more accurately identify their environments as risky and unsafe. A comprehensive strategy to promote the mental health and safety of young women and girls requires multi-sector collaboration. This is especially necessary to address issues in BIPOC and LGBT+ communities.

I will close by emphasizing the importance of developing initiatives in collaboration with community-based women's, Black, indigenous and LGBT+ organizations to engage their deep knowledge of the relevant issues and their existing ties to communities, which will enhance the effectiveness of any interventions that are developed.

I make this recommendation with two cautions.

First, if our efforts on behalf of BIPOC women and girls are to be culturally acceptable, then they will need to recognize women and girls as daughters, mothers, sisters, aunties and community members whose ties to others are part of their mental health and well-being. Strategies that excise them from these relationships, which are also connections to healing and health-promoting social and cultural supports, will not be acceptable or effective.

● (1115)

Second, we should know that community-based organizations often implement innovative programming by pursuing grant opportunities, but sustainable gains are undermined by time-limited funding that prevents the transition from pilot programs to equitable, accessible mental health care. The path to sustainable gains for the mental health of women and girls is sustained investment that integrates community-based organizations as enduring components of our mental health care systems and strategies.

Thank you for this opportunity to share my insights and offer some potential strategies to this committee.

The Chair: Thank you so much for joining us.

I'm now going to turn it over to Blue Guardian.

Emmanuel, you have the floor for five minutes.

Mr. Emmanuel Akindele (Founder and Chief Executive Officer, Blue Guardian): Thank you, Madam Chair.

My name is Emmanuel Akindele. I am the founder and CEO of Blue Guardian, a mental health early warning system that uses AI to detect mental health issues in young people and connect families with important mental health resources.

My journey with Blue Guardian started in high school, where I faced mental health issues, specifically anxiety. I remained silent about this issue I was facing and bottled it in without reaching out to anybody else. Unfortunately, I wasn't the only one to do this. I am part of the first generation to grow up with ubiquitous Internet connection. It amplified issues that my classmates felt, like depression, body image issues, self-harm and ultimately suicide.

I had left high school, and I had told myself that this was not normal and that something needed to be done so that the next generation gets better. After researching potential solutions, I started Blue Guardian, a mental health software that uses AI to detect issues in young people. The way it works is kind of like auto-correct but for mental health.

A parent and a child get together and download it on the kid's phone. As that kid types, that text is sent to an AI model, but instead of being trained to detect grammar, it's trained to detect mental health cues. We do this without storing any text data, maintaining the child's complete and total privacy. Our mission is to work with schools all over Canada to detect mental health issues and connect families with mental health resources.

I sit here with great optimism that this committee is studying the mental health crisis facing young people, especially young girls. This is why I am confident that with our individual convictions, the task of advancing our shared goals moves forward. Our commitment is to ensure that young people have greater accessibility to mental health resources, regardless of socio-economic circumstance. Our commitment is to break the stigma surrounding mental health and promote a culture that allows young people to says it's okay to not be okay—it's okay to seek help.

Thank you for the opportunity to share my story with you. I'm happy to be able to speak with you on such an important topic.

● (1120)

The Chair: Thank you so much, Emmanuel.

I'm now going to turn it over to Future Black Female. I would like to welcome Dr. Tapo Chimbganda.

Tapo, you have the floor for five minutes.

Dr. Tapo Chimbganda (Founder and Executive Director, Future Black Female): Thank you, and thank you for this invite.

Diversity in Canada's youth has increased from 13% in 1996 to 27% in 2016, with about 49,476 Black girls and young women aged 15 to 19. Available statistics do not highlight the unique challenges experienced by Black girls and women, but it is reasonable to conclude that this demographic will have a disproportionately larger number experiencing socio-economic and health challenges, especially due to COVID-19. Among Black immigrant and refugee youth, girls and young women experience more health problems than their male counterparts. National figures indicate that females aged 12 to 19 experience a higher level of depression and anxiety than their male counterparts—5% versus 12%.

At Future Black Female, our strategies promote well-being by advocating for protective factors while reducing the risk factors. We mitigate the impact of the pandemic specifically, especially the threat of longer-term mental illnesses related to COVID trauma. Our clients engage with us because we offer prompt, safe, responsive and effective programming and support.

We realize that a feminist approach is needed. Black girls and women are facing disproportionate mental health and well-being impacts as a result of pre-existing barriers and systemic inequities that have been highlighted or exacerbated by the pandemic. Our therapists have identified that these inequities often stem from various forms of discrimination and marginalization. Future Black Female uses an intersectional lens in our program design and evaluation. We consider the multiple layers to their identities—for example, gendered social norms, values and expectations; immigrant and foreign status; and poverty, which unfortunately lingers much longer for Black women than for their counterparts.

As a demographic, the girls and women we serve are less likely to afford mental health care. When hospitalized, due to anti-Black racism in the wider health care system they are often disbelieved, dismissed and sometimes even punished for not fulfilling the stereotypical expectations of providers. An intersectional perspective emphasizes the importance of looking at these forms of discrimination together while acknowledging the cumulative effects on the individuals. That's how we know that for many, there is no safe space to gather one's thoughts, let alone share them.

A culturally relevant and responsive approach is also needed. Our clients have shared that the lack of cultural responsiveness from non-Black therapists, cultural mistrust and potential negative views have impacted their experience of therapeutic care. In a recent survey conducted by the Black Health Alliance, 35.4% of Black Canadians revealed that they experienced significant psychological distress during the pandemic, and yet 34.2% never looked for health services. In 2018, 60% of Black Canadians were more willing to use mental health services if the mental health professional was Black.

Being culturally responsive is a mental health care provider's ability to recognize and understand the role of culture, both the client's and the clinician's, and the ability to adapt the treatment to meet the client's needs within their cultural framework. This is why getting access to mental health services that are culturally relevant is important for Black girls and women.

Increased awareness is needed. We often speak about a lack of awareness, but the lack is not in those who are unaware; it's in a system that applies a one-size-fits-all approach to mental health. Mental health strategies must account for the diversity within our communities and approach mental health in diverse ways so that it makes sense and indeed raises awareness. Investing in cross-cultural design for mental health promotion will contribute to destigmatizing mental health.

● (1125)

Future Black Female is eradicating the stigma of mental health by offering services from diverse Black women who can relate to the client on an instinctive level. Stigma is perpetuated by a lack of inclusiveness. Stigma is maintained by a health care system that does not pay for psychotherapy. Mental health in Canada has become a luxury that is ultimately costing us more than we can afford in human suffering.

Thank you.

The Chair: Thank you so much. That was excellent.

I'm now going to move it to Ka Ni Kanichihk Inc.

Sydney, you have the floor for five minutes.

Ms. Sydney Levasseur-Puhach (Co-Chair of the Board of Directors, Ka Ni Kanichihk Inc.): Good morning, everyone.

My name is Sydney Levasseur-Puhach. I am speaking on behalf of Ka Ni Kanichihk this morning.

I am very grateful to have this opportunity to share with you a bit of what the organization does and some recommendations that we have for the government today.

I'll tell you little bit about myself first. I am an Anishinabe woman and a member of Sandy Bay First Nation here on Treaty 1 territory. I'm also a sun dancer. I recently competed my second year in the lodge. I am co-chair on the board of directors at Ka Ni Kanichihk. I'm also a student doing my master's of clinical psychology at the University of Manitoba. Mental health is something that I am fully immersed in at all times and highly passionate about.

I will speak a bit about the organization. Ka Ni Kanichihk is an indigenous-led non-profit that offers programs and services that are culturally relevant for indigenous women, youth and families in our community. We offer services focused on training and employment, culture and ceremony connection, and health and healing.

I'll give you a bit of an overview. A few of our programs are really focused on restoring well-being in our community. We have our Medicine Bear counselling program. There we work with families of missing and murdered indigenous women. We provide elder services and therapy sessions, as well as connection to ceremony.

Our heart medicine program is designated for women who are survivors of sexualized and domestic violence. They also receive elder services, counselling and connection with ceremony.

Velma's House is a 24-7 safe space for women in the city centre who need a reprieve from domestic violence situations and an opportunity to get off the streets of Winnipeg.

We also have Mino Pimatisiwin, which is a sexual health program. We offer STBBI testing and other sexual health-related services, as we know that indigenous women are safer and more comfortable being treated by other indigenous women in the community. Often, health care services have not adequately met the needs of our community.

We also have the Butterfly Club. This is a program for indigenous youth and two-spirit youth who have the opportunity to engage in ceremony. It's really aimed at a lot of prevention work. We like to engage youth early to mitigate the risk of harms, which are quite prevalent on the streets in the city.

As I mentioned, we do both prevention and intervention work. Everything we do.... The way we see it, mental health is connected to every part of ourselves. In order to understand mental health, we also have to understand physical and spiritual health and physical safety. A big piece of that is that our environments need to directly meet our needs in order for us to be well in any way. In many ways, they do not currently. We require adequate access to resources and social supports in order to achieve well-being.

Another critical component of that is that we need to be in charge of our own well-being as indigenous people. As indigenous women, we know what we need to live a good life. As far as self-determination goes, it is such a crucial component of living well. I think we've seen a lot of issues that have arisen systemically when we are not in control of our own well-being and of our own lives.

Ultimately, I would like to iterate that we are not broken as indigenous people, as indigenous women; the system is broken. This is an inequitable systems issue that requires adequate and sustainable funding for programming that is indigenous-led. We really just need to have support in order to carry out what we need to do for our communities, for our programming, for access in remote communities to receive services that are needed to move forward and operate collectively as empowered nations.

I say *meegwetch* for your time today, and I look forward to speaking further and answering any questions you may have.

● (1130)

The Chair: Thank you so much.

I'm now going to turn it over for the next five minutes to Lydya from the Réseau québécois d'action pour la santé des femmes.

You have the floor for five minutes, Lydya.

[*Translation*]

Ms. Lydya Assayag (Director, Réseau québécois d'action pour la santé des femmes): Thank you for the invitation.

The Réseau québécois d'action pour la santé des femmes has been in existence for over 30 years. Our network boasts about 100 members across the province. What I am going to share with you today is based both on the reality on the ground and on independent research that we are conducting on women's health.

I'm echoing what all the previous witnesses have said about intersectionality, marginalized women, and needs, obviously. I'm going to focus on the reality in Quebec and what you can do for women.

Before I begin, I would like to establish some premises that underlie our interventions. The first is that—

[*English*]

The Chair: Excuse me, Lydya.

We're having some issues with the interpretation. Would you mind moving your microphone up a bit closer to your mouth?

Ms. Lydya Assayag: I'm sorry about that.

I was going to say that one of the premises when we provide services or we study women's health is the fact that health has a social basis.

[*Translation*]

When it comes to health, the social basis must really be taken into account. For example, we know that the life expectancy of people in a rich neighbourhood of Montreal can be 11 years longer than that of people in a poor neighbourhood in the same city. Regardless of individual differences, in order to have an effect on health, we really need to act on the social determinants.

The second element we want to mention before going any further is that mental health is inseparable from physical or spiritual health. They must be taken as a whole. I challenge you to give me an example of physical health that does not have a mental or spiritual effect, or vice versa. Research in neurology over the last 40 years and in quantum physics have provided ample evidence of this. To have an effect on mental health, you also have to address things that have a physical or spiritual impact.

I'm going to talk mainly about distress and anxiety and their impact on women's health.

As you know, the two major determinants of women's health are violence and economic insecurity. You know the statistics as well as I do, and we are aware of the committee's work on violence, so I won't go into detail on that. I will say, however, that it is impossible to work on mental health without tackling these two models head on.

In Quebec, the health and social services system is unfortunately in disarray. After deteriorating for more than 40 years, it has shrunk dramatically, making access to services extremely difficult. There are waiting lists of several years for mental health care. The lack of services is to blame for dramatic cases like that of Amélie Champagne, a young girl who recently committed suicide despite numerous calls for help and several attempts. There are hundreds of cases. As you know, the pandemic has exacerbated social inequalities in health between men and women.

Alcohol and drug addiction, junk food, drug abuse, cyber-violence, difficulties in reconciling work and family, eco-anxiety, a feeling that one's future is bleak: this is unfortunately the daily lot of many girls and young women, who are sometimes marginalized as well.

We would also like to highlight a physical factor that seems to be far removed from mental health, but which has a huge effect on it: endocrine disruptors, which are chemicals that mimic the action of estrogen and hormones. These disruptors have a huge impact on the health of girls and women, from puberty and fertility to ovarian cancers and menopausal stages. I could go on for hours on this topic.

A bill to amend the Canadian Environmental Protection Act, which should have been in place for 50 years, is currently at first reading. We ask that you ensure that this legislation includes a gender-based analysis, as the environmental effects are terrible for women. Endocrine disruptors have a direct effect on their mental health.

In terms of our recommendations, we're asking you to act on three fronts.

First of all, you must act in the area of prevention. In other words, violence must be eliminated as much as possible at the source, as you are well aware. You really must ensure that no one in Canada and Quebec lives with insecurity. I'm thinking in particular of providing housing, or flexibility regarding the guaranteed minimum income. I'm also thinking of telecommunications regulation, in the case of cyber-violence. We must also offer programs in schools to try to detect these various problems as early as possible and break the isolation of women.

The second area of intervention—

● (1135)

[*English*]

The Chair: Excuse me, Lydya. I just want to check in because you're over your five minutes.

Ms. Lydya Assayag: I'm sorry.

The Chair: It's all good. It's just that you had three recommendations and I know we want to hear them all. Hopefully we'll be able to get to them in our round of questions, if you don't mind. We still want to hear your next two recommendations, but we are going to get into it in our rounds of questioning, if that's okay.

Ms. Lydya Assayag: Yes, okay, no problem.

The Chair: Now we're going to start our rounds of questioning, and for the first round each will get six minutes.

I'll pass the floor over to Michelle Ferreri for her six minutes of questioning.

Ms. Michelle Ferreri (Peterborough—Kawartha, CPC): Thank you, Madam Chair, and thank you to all of our witnesses who have taken time out this Monday.

I would be remiss if I didn't acknowledge that it is Mental Illness Awareness Week as we delve into this. Mental illness continues to escalate at an exponential rate, impacting all of us. It doesn't seem to matter where we come from socio-economically; this is an issue that impacts all of us.

Ms. Todd, I will start with you, if I may. I just want to thank you, obviously, from mom to mom. I can't imagine what you've dealt with, and to have the strength to channel Amanda's legacy into awareness.

I'd like to get into the nuts and bolts, if I can, of what we need to do moving forward from a federal government perspective to ensure that this never happens again. A lot of what you talked about was fear. I couldn't help but notice that we also have Emmanuel here from Blue Guardian, who may be sitting on an answer for us moving forward with technology that could have maybe helped Amanda.

The first thing I want to ask you, Ms. Todd, is this: What do you think was missing in the education piece that would have helped you, as a parent, recognize that this was going in such a dark, dangerous direction?

● (1140)

Ms. Carol Todd: Thank you for the question.

Twelve years ago, back in 2009, when Amanda's victimization started by her online predator, we weren't very much aware of what was happening on the Internet, as parents, educators or law enforcement. We have learned so much in the last 12 years. I have to say that maybe because of what happened to Amanda, how high-profile her death was, and with the YouTube video that she posted, we keep learning and asking questions. It's those questions that will bring the results.

This isn't the first standing committee I've sat on. I've sat on a few for Bill C-13, which was for cyber-bullying crimes, keeping Canadians more protected online, and one on gender-based violence, one on cyber violence, and now this one, on mental health. I'm going to focus more on the online abuses that affect our young people.

I know the focus is women and young girls, but this is about Canadians as a whole. Exploitation is happening to young girls, women, young men and boys, unfortunately, causing death by suicide across our nation and globally. As an educator, my role in my school district is to coordinate online safety education for my teachers, my students and the parents in our community. I think we need to look at preventative measures, the things we can do to prevent the possible mental health traumas that can occur because of online abusive behaviours. We have to look at what those are and what those can be. We have to teach our children how to be safer online. As with anything else, our kids are just rolling their eyes at us. Subsequently, we can't give up on talking to our students and our children. We have to focus on the adults in our country to get them better informed and better aware of cyber violence and online victimization, what happens on the Internet, and what our children are seeing.

We also have to make sure that our law enforcement services are educated. I feel that, initially, back in 2009 to 2011.... Because I sat at Amanda's trial for nine weeks, I was determined, as her mom, to be there to listen to what the jury was listening to. One of the gaps that I found was in some of the preventative things that law enforcement could provide in terms of taking a crime seriously—making sure that it's investigated and that there is no victim shaming, not making my daughter feel that she was responsible, and not making her parents feel like they were at fault. There's a huge piece in that education and training part that needs to go into our police services and RCMP services in order to better handle the reports and case files that come in.

There also needs to be government funding for resources that is unilateral in our country, so school districts and provinces aren't made to try to find the pieces. If there was a set curriculum somewhere that our teachers could pick up easily—because our educators have our children six hours a day for 285 schooldays in a school year—they could be the frontline teachers of our kids to make sure they understand and know what to look for and what they're seeing. Also, we have to educate the teachers so they're comfortable in being able to talk about it in their class. I've known many educators—

● (1145)

The Chair: Ms. Todd, I'm sorry. We've gone quite a bit over. You have so much to offer our committee. I'm feeling very rude, but we will be sure to get back to you.

Marc Serré, you have the floor for six minutes.

[*Translation*]

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

I want to sincerely thank all the witnesses for being here today and for the committed work they do in communities for all Canadians, but especially for young women and marginalized women. As they mentioned, it is very important.

Ms. Todd, I've had the opportunity twice before to hear you give evidence here. I have three daughters myself, and I want to thank you for the courage you've shown over the last 10 or 12 years. I thank you very much for providing solutions as well.

I had similar questions to my colleague, and you have already answered many of them. That said, I want to thank your organization, the Amanda Todd Legacy Society, for the work it does in raising awareness and fighting exploitation.

My question is for both Ms. Williams and Ms. Chimbganda.

Federal and provincial bilateral agreements are currently being negotiated. In 2017, a $5 billion, 10-year agreement was reached, and $600 million is being provided. However, we have heard clearly that in the past, some very specific needs have not been addressed with a view to the future.

[*English*]

My question is around the recommendations that you would have for the committee on negotiating bilateral agreements with the provinces. When we look at virtual care and eating disorders, previous witnesses have talked about shortages in psychiatry and at the first level. I want to get a sense from both of you of what specific recommendations you have for us in ensuring that we have those best practices in place when negotiating with the provinces to look at delivering the next step of services.

Dr. Williams, perhaps you can start.

Ms. Charmaine Williams: Thank you for that question.

My first thoughts are that, as I said in my remarks, we want to take advantage of the wisdom that's available within communities, which means a local focus. I would wonder about methods to really fund people who are closer to the site in terms of their knowledge of the issues and the capacities in various communities.

I would emphasize again that I think it's actually really important to be funding existing community-based organizations, because they have the credibility in the community, and often they have the innovations. Part of what we've heard about in today's remarks is innovations that have happened because somebody within the community, somebody with lived experience, took action. I think many community agencies have stepped into the gap, the gap that exists because we don't have accessible mental health care and mental health promotion services. We want to invest in those community-based organizations to really get the best results.

I can pass it to the other doctor now.

● (1150)

Dr. Tapo Chimbganda: Thank you.

I agree with Dr. Williams that, as I suppose we would be called a grassroots organization, funding is very difficult to obtain. A lot of funding requires us to have our charitable status, for example, which can take a while.

I've worked in community mental health specifically for quite a long time, and I know that in marginalized and racialized communities, for people to see a psychiatrist it has to be an advanced crisis, I will say. Normally what happens is that they look for information within their neighbourhoods and within their communities. They're looking for supports that are not quite as stigmatizing. When they do finally see a psychiatrist, it's at a point where things have gone on for way too long. Investing in grassroots organizations and supports will help mitigate some of those crises.

The other thing is that with psychiatrists, we do have a shortage, and it is good to increase funding in that area specifically, but most psychiatrists can't spend more than 15 minutes with a patient. As a therapist myself, the complaint I often get is, “You sat with me for a few minutes. The next thing I knew, you were giving me medication. I don't want to be on medication.” There's a disconnect in what is funded and how the people take up those services.

A lot of people also don't understand the difference between a psychiatrist, a psychotherapist and a physician. The system itself is quite confusing. They don't know that to see a psychiatrist, they need a referral, which means they need to see their family doctor first. A lot of people don't have family doctors right now. It's difficult to even get a family doctor.

So there are a lot of challenges along the way within the system itself.

The Chair: Thank you so much.

I'm now going to move it over to Andréanne.

Andréanne, you have six minutes.

[*Translation*]

Ms. Andréanne Larouche (Shefford, BQ): Thank you very much, Madam Chair.

I thank the witnesses for being here. Their evidence is chilling and reminds us of the importance of working on this issue.

Ms. Todd, I have been a new mother for almost eight months. I can no longer imagine life without my daughter. So I offer you my deepest condolences.

We are also at the beginning of Mental Illness Awareness Week. It's a week that prompts us to think about what it brings and creates around us, as well as the importance of destigmatizing it and talking about it more. The witnesses have addressed this issue.

In this committee, we are also focused on solutions. My first question is for Ms. Assayag.

This morning on the radio, it was interesting to hear that we cannot work to provide more mental health services if we do not talk about funding. You made that clear. I also heard that there were projects in Quebec, but that they were on hold because of a lack of funding. In countries that operate according to different models, such as Australia, it has been proven that the more we invest in the prevention or treatment of mental illness, the more we succeed in reducing the number of people who suffer from it. It's simple math.

But how can we talk about all this without noting that mental health remains a provincial jurisdiction, in this case that of Quebec? As I said, Quebec has projects, but they are on hold because of a lack of funding. This shows the importance of investing in our health care system. What's more, as you said, the pandemic has exacerbated the problems. So we need to invest more in this area. The whole issue of health transfers is crucial.

● (1155)

Ms. Lydya Assayag: Thank you for the question.

Indeed, one of our recommendations is to double health transfers. However, money is not the only issue; we also need to rethink the health care system.

In its current state, the Quebec health care system is solely curative. Less than 2% of the health budget, which is substantial, is devoted to prevention, which is completely abnormal. We should follow the example of the European Commission, which devotes 34% of its health budget to prevention.

In short, we need a paradigm shift. It is not only a question of money, but also of operation. We must not wait for a crisis. To do this, we need to work in the schools, as Ms. Todd pointed out. We also need to work in the community, because people with mental health problems are often isolated. The people around them can also offer help.

I also come back to the recommendation regarding community networks. Our network includes a hundred or so community networks, and we see on a daily basis all the resourcefulness and innovation deployed to receive desperate people, for whom these networks are a last resort. Unfortunately, these networks are underfunded and too few in number. There is also a whole network of alternative community mental health resources that can act as a buffer before a crisis occurs.

Ms. Andréanne Larouche: I would like us to come back to the issue of community resources, because they are part of prevention. In Quebec, they are also funded by the department of health and also require more funding.

At this point in the debate, I think it is important to point out that there are projects in Quebec that require funding. Representatives within the department would even like to invest more in health. The first step would be to provide resources. I'm obviously talking about financial resources. Then people could set up the organizations they want. But the question of financial resources is crucial.

Ms. Lydya Assayag: Yes, absolutely.

Ms. Andréanne Larouche: We can come back to the issue of prevention during the second round of questions.

As part of all the work done by the Réseau québécois d'action pour la santé des femmes, your organization considered the fact that women feel mentally overloaded. In fact, their mental load is increasingly heavy. Women feel the weight of multiple responsibilities on a daily basis. When the mental load is too great, psychological problems can arise.

Could you talk more about the impact of mental overload, a problem that the pandemic also seems to have exacerbated?

Ms. Lydya Assayag: The pandemic has greatly exacerbated this problem, because the childcare and education systems have failed from time to time. When crises occur, it is always the women who are left with the work. We must also think about all the invisible work and task sharing.

I was talking earlier about collective factors linked to mental health. Obviously, women are the ones who help others: they are caregivers, they take care of children and friends. They form a natural network and they look after the health of others, while very often neglecting their own health. There is this overload due to the lack of equal sharing of housework and child-rearing. They take over from the flawed health care and school systems. They also take care of their parents. All this means that they have just too much to deal with.

[*English*]

The Chair: Thank you.

[*Translation*]

Ms. Lydya Assayag: Of course, it causes a lot of anxiety.

[*English*]

The Chair: Thank you so much.

We're now going to turn it over for the next six minutes to Leah Gazan.

Leah, you have the floor.

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

I want to start by offering my condolences to Carol Todd. Thank you so much for your courage in sharing your daughter's story. It's truly touching, and I think a real gift to the world so that we can learn and so that other young people don't have to go through the same hurt, and parents through the same trauma.

My first question is for Sydney Levasseur-Puhach.

I think it's no secret that I've been a big advocate for Velma's House in Winnipeg Centre. You made a point during your presentation about how important it is for indigenous women and girls and gender-diverse folks to be in charge of their own care. One of the reasons why I was advocating strongly for Velma's House is the fact that it's a low-barrier safe space. For example, we know there is a direct correlation between people who use substances often and mental health.

Can you speak to the importance of offering low-barrier care, particularly for young people, that is readily available in communities 24-7, and why that's a life-saving measure?

● (1200)

Ms. Sydney Levasseur-Puhach: Absolutely. I think we need to prioritize whatever we can do to reduce red tape when it comes to accessing mental health-related and overall well-being services, and safety services specifically, because the last thing people need to worry about is how they are going to get this.

When people need support, when support is urgent, it needs to be there for them. That's something that Velma's House offers and that we want to make sure we have a lot of in our programming at Ka Ni Kanichihk as well. I think one of the ways to aid in that is to have funding that is available for multiple years with as few reporting provisions and requirements as possible, because things come up in life, and I think reducing red tape is critical so that we can offer support to as many people as possible who are in crisis and in immediate need.

Ms. Leah Gazan: Thank you so much.

My next question is for Future Black Female.

You spoke in your testimony about how there are significant struggles for Black women and girls to access mental health supports. One of the things you spoke about was systemic racism in care. You spoke about the importance of representation and that representation matters so that people can see themselves in that care, and the importance of culture.

You also spoke about racism, and I know that in Manitoba, particularly with indigenous people, we've had significant issues with racism in the health care system, which has, in fact, sometimes resulted in death, with people literally dying in waiting rooms trying to get access, and a minimization of health care struggles.

Can you expand a bit more on what you think needs to be done to improve access and remove violence, systemic racism and stigma from systems that are servicing Black and indigenous people and people of colour?

Dr. Tapo Chimbganda: I think one of the main things, as I said before, is the system navigation. I think we need more representation across the health care system. I know that a lot of universities are now implementing recruitment strategies that attract and retain more physician trainees from marginalized communities, but we need to see this across the board, not just with physicians but with other health care providers.

The other thing is that, in 2016, there were about 6,000 registered psychotherapists in the province of Ontario, and that excluded indigenous practitioners. At the time, I was on the council for the College of Registered Psychotherapists of Ontario, and they made the decision to exclude indigenous practitioners because their system did not account for indigenous practices in mental health care. Indigenous practitioners were told, "Figure out your system, and let us know how you want to register your practitioners." A lot of systems, when they're put in place, do not account for diversity from the get-go, so—

Ms. Leah Gazan: I'm sorry; I have limited time.

Do you think it's because, when we're looking at health care like mental health care, it's still implemented through a colonial lens?

Dr. Tapo Chimbganda: Yes, absolutely.

Ms. Leah Gazan: Does that impact funding?

Dr. Tapo Chimbganda: Absolutely, yes.

Ms. Leah Gazan: Thank you very much.

My last question is for Emmanuel Akindele.

I was listening to you, and I was blown away. I don't know a lot about technology in terms of being able to create a system, especially for somebody who is kind of technologically not very efficient. You were talking about AI as a way to measure mental health. Who gets to see this AI data? How is that data protected? For example, in Manitoba, people used to be able to readily access child welfare files even when people were out of care, so how is this data protected?

● (1205)

The Chair: Emmanuel, you have about 30 seconds to respond.

Mr. Emmanuel Akindele: I'll be brief.

The first part of it.... It starts with being able to train the model. We need to bring in engineers. We also have young people annotating data, meaning strings of sentences—for example, "I'm having a bad day." The young person can come in and annotate that data. You can also bring in psychologists to look at the overall data.

The main thing in terms of the data storage is that, when you train the AI model very effectively to detect signs of mental health—whether the language is neutral, sad or happy—you don't need to store the data. It's kind of like auto-correct or Grammarly. They're not storing all your emails; they're not storing your messages. Essentially, it's kind of filtering through the system, and it's able to get a score. On our end, what we have is a score on—

The Chair: Excellent. Thanks so much, Emmanuel. I'm sure we'll be getting back to more of that, so no stress there.

Dominique, I'm now going to pass it to you for five minutes.

[*Translation*]

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

I thank each and every one of you for being here today.

As I said to my partner a fortnight ago, you really have to be strong to listen to the news these days. Indeed, it can be quite discouraging. We hear about horror stories. You mentioned earlier today the horrific story of Ms. Champagne, who took her own life by jumping from the 16th floor because she could not get the services she needed, including psychiatric services. There are also all these femicides, in Quebec among others, that we hear about, not to mention the news from abroad. Finally, we really need to have a strong heart. This can shake us up in our daily lives.

Ms. Todd, I thank you for your testimony. Several of us have children. We are therefore very affected by what you have told us today.

As Ms. Larouche said, we are looking for solutions here today. We are really trying to find solutions to help more and more people who are living with mental health problems.

It is also encouraging to see, in the world of sport and culture, for example, people talking openly and publicly about their anxiety and the problems they are experiencing, and using the right terminology. I think that there are some fairly positive things happening at the moment.

Mr. Akindele, I'm going to give you the opportunity to clarify a few things. I would like to know how a service such as the one you offer could have prevented what happened to Ms. Todd's daughter.

I should point out here that many of us do not follow the fast-moving technological developments very closely. I don't know if this is the case for you, but I personally find it difficult to keep up. Please explain how your software could have helped Ms. Todd in such a horrendous situation.

[*English*]

Mr. Emmanuel Akindele: The first thing our software does is.... We want to get a parent and a child to actually have a conversation that mental health matters, at least having a first step in which the parent is able to download a piece of software on the child's phone and they have a conversation around this. That's kind of the first step.

The second step we want to do.... With our AI model, we're doing something called sentiment analysis. This is under the branch of natural language processing. Above that, there's AI. With that, we have the capacity to take strings of code and strings of text, and we are able to classify it—whether it's happy or sad, or what the context is behind that sentence.

We do that—

● (1210)

[*Translation*]

Mrs. Dominique Vien: I find it difficult to understand how this works in practice. Is it done as part of a conversation?

[*English*]

Mr. Emmanuel Akindele: Yes. The way it works is.... Let's say you're texting. We're able to take that sentence after you text it. It will go through our AI model. On the back end, it will take that sentence and classify whether or not we see it as a positive sentence. For example, “Today I'm having a really good day” would probably have a high score of positivity, but “Today I'm having a very bad day” would be classified as negative.

[*Translation*]

Mrs. Dominique Vien: This system then provides the parents with information about the child's condition, if I understand correctly.

Dr. Chimbganda, as a therapist, how do you see technology like this? How would you describe it? Is it promising? Can it work?

First of all, did you know about this technology?

[*English*]

Dr. Tapo Chimbganda: I wasn't aware of it, but I've written his name down. I'm thinking I'll find him on LinkedIn. It's the most brilliant thing I've heard. I've worked a lot with children and youth in mental health, and parents are often distressed because they don't know what's going on until it's too late. Sometimes children hide these things because they don't want to disappoint their parents. They're afraid their parents will overreact. Sometimes their parents don't believe them. So having this technology where the parent can care for their child's mental health without being in their child's face I think is really groundbreaking.

Well done, Emmanuel.

The Chair: Dominique, we will come back to you, but your five minutes are up. I'm sorry.

I'm now going to move to Sonia Sidhu for the next five minutes.

Sonia, you have the floor for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Madam Chair, and thank you to all the witnesses for being with us.

Ms. Todd, thank you for your strength. It's nice to see you again. Thank you for the work you are doing for the coming generation.

What should we do so that young kids don't have to face what Amanda faced? We heard about the algorithm, and you talked about how communities need to work together. What kinds of strategies should be in place so that we can all work together so youth do not have to face what Amanda faced?

Ms. Carol Todd: That's a big question. That's a question that has been floating around for a long time.

I also have to say that October 10 is World Mental Health Day, and that's the day when Amanda took her life, not realizing it was World Mental Health Day, so awareness is really important.

The strategies and tips.... In my opinion, it's all about prevention, because when you talk about online harm and online abuses, those are triggers that lead to mental health distress. Some of the mental health distress, of course, can be organic within a person, or it can be developed with ongoing trauma, with post-traumatic stress, with ongoing victimization. Without the supports needed, it doesn't go away. It just grows and grows until it bursts, unfortunately. We don't want things to burst.

Preventative measures, education resources, funding for adequate health care.... We talk about psychiatrists. We talk about psychologists. We talk about counsellors. No child, no person should have to.... If they are going to a provincially funded health care provider—for example, in B.C. we have children's mental health teams working with youth up to the age of 24—no one should have to wait on a six-month waiting list. If there is a six-month to one-year waiting list, then the next step is private.

My problem with psychiatrists is that they want to give medication, and medication is not always needed. There are other ways to provide supported care—spiritual care, physical care—to a young person. Then you go with the counsellor or the psychologist route, which of course needs money. Even if the parents have the best benefits in the world, they don't provide for ongoing care, and I've heard that from many parents who have contacted me. Something I am dedicated to is supporting that with Amanda's Legacy. Then you see the improvement.

Funding is really important. Provinces need to add psychotherapy, psychologists and counselling to their medical plans so that this is accessible.

● (1215)

Ms. Sonia Sidhu: Thank you.

How can parents best support their children, Dr. Williams?

Ms. Charmaine Williams: Thank you for that question.

I appreciate the opportunity to say that.... I think the technology that Blue Guardian has is very exciting. It's essentially an alert system, which we didn't have, and a window into young people's experience that we didn't have before and that would be very exciting to have, but we still need parents, teachers and other community members who are prepared and ready to respond. There is a part of this that is about public education, mental health literacy and mental health promotion within communities that is tailored to specific communities, and it also has to be backed up by services that are accessible and acceptable to these different groups.

I think the federal government has the opportunity to be innovative in a way that provincial governments can't be, or haven't been, because it can think outside the existing silos of community services, family services and health services to create something that could be different. I think there could be something exciting. We could think about this in terms of what we have available to individuals: What do we have available to peers of these young women and girls? What do we have available to family members and trusted adults who are around these women and girls? What are the services that are available?

A few people have talked about psychiatrists and the limitations of the tools they use. We need to think more expansively about the type of service providers who are available in the system. I return to my point: not just funding a project here and a project there, but thinking about a health care system that includes healers, psychotherapists and other types of practitioners who might really help with mental health promotion.

The Chair: Perfect. Thank you so much, Ms. Williams.

I'll now turn the floor over to Andréanne for two and a half minutes.

[*Translation*]

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

I'll continue to talk to you, Ms. Assayag.

As Ms. Vien mentioned, we have seen cases like Amélie Champagne's in Quebec recently. Like my colleague, I offer my condolences to Amélie Champagne's family. You also mentioned this case, Ms. Assayag. Of course, her story has revived the debate on mental health care.

However, as Ms. Vien said, we are very happy to see public figures talking more about their mental health problems, such as Carey Price, Simone Biles, Naomi Osaka and Geneviève Jeanson, who recently came forward. We also see public figures talking about the impact of being a caregiver to someone with mental health issues.

On your website, there is a reference to invisible work, which includes the issue of caregivers. It says that women still do at least two thirds of the housework and that they take on twice as much childcare responsibility as their spouse. I would add that the role of caregiver falls largely to women.

Can you suggest a solution to better recognize this invisible work? For example, could we introduce a day of recognition or other similar measures?

These people provide direct assistance to their loved ones and often suffer a great deal from this mental load themselves.

Ms. Lydya Assayag: Thank you for the question.

Indeed, the role of caregiver is central in the lives of women. Naturally, as mothers, we take care of our children, but this tendency to take care of people in need is widespread. Studies show that some caregivers die before the person they help, because they are so worn out from the work. This is to tell you what this can lead to.

Unfortunately, the health system does not consider the family caregiver to be part of the care plan or file. Many suggest that when a person is taken into care, their caregiver should also receive support.

Another popular suggestion is to officially recognize this work in law. In Quebec, there is a law on caregivers, but it has not yet been applied in the system.

In addition, it is important to offer respite services. Often, it's not a financial issue, even if it has financial consequences; it's that these people never get respite. They are there 24 hours a day, 7 days a week, and they wear out, just like any other human being. Because they often do it for love, they don't realize the impact on them. There is a real need to offer respite services to caregivers and to conduct a gender analysis.

● (1220)

[*English*]

The Chair: Thank you so much.

We'll be able to get back around to you for sure.

I'll now pass it over for the next two and a half minutes to Leah Gazan.

Ms. Leah Gazan: Thank you so much.

I have more questions for you, Emmanuel, as I'm very interested in this.

There are a couple of things. Is this particular application just for the parent and child or the caregiver and child?

Mr. Emmanuel Akindele: It's for the parent and the child. If you download the same app, you would be able to see the same emotional insights.

Ms. Leah Gazan: Okay.

One thing I know from texts, being a mother of a 23-year-old son, is that sometimes he texts me things and I can't read his tone, so I ask him if he's okay. I can't do that as a human being, so how does the application decipher tone, whether you are okay or not okay?

Mr. Emmanuel Akindele: The way it works is.... First and foremost, you need data annotators. You need people who can actually physically and manually give context to sentences, and then train the AI model to detect tone. You would take sample text. I gave the example "Today I'm having a bad day." If you had a sentence like that, a person would need to give context. Ideally, you would want a young person who has more context, because kids have different language patterns and lingo. From there, that's how you would be able to train a model to detect tone.

Ms. Leah Gazan: Is there a pilot currently happening with this application?

Mr. Emmanuel Akindele: I'm from London, Ontario, so we started a pilot with some parents in London. Our next step is to start a pilot with schools as well, to see how it works at an academic level.

Ms. Leah Gazan: That's good, too.

I was a teacher at one time in my life. I ended up teaching in the faculty of education. With kids who are experiencing significant difficulties, often the parent needs to work with the school and sometimes, if necessary, with outside agencies.

Has any thought been given to trying to get all the service providers working with the child and collaborating together, particularly around mental health? Is your application part of that?

Mr. Emmanuel Akindele: That's definitely something we'd like to do down the line.

One thing I've noticed, talking with schools, is that a lot of the services they have available for students.... They feel very overwhelmed. It's beyond the capacity of the school. So that's another thing. There's an issue beyond just directing parents to services. There need to be more services. One of the issues is that some of the schools say, "We love the idea, but we're already so overwhelmed." We're going to be directing a lot more people to an already overwhelmed system.

The Chair: Thank you so much. I know we'll be coming back to you for sure.

We're back to six-minute rounds, and I'll pass it back to Michelle Ferreri.

Michelle, you have six minutes.

Ms. Michelle Ferreri: Thank you, Madam Chair.

Thank you, Emmanuel. You have a lot of people in the room, and your biggest hurdle is probably going to be figuring out how to explain this technology, ironically, to a demographic, especially parents, as they navigate this.

It's Mental Illness Awareness Week, and I've already downloaded your app sitting here. You write in your app, under Blue Guardian, "It is projected that by 2030 untreated mental health problems will be the leading cause of mortality and morbidity globally." I couldn't agree more, as a mom, and I think we are just starting to see the impacts of the pandemic. I think we're going to see this for years and years to come.

You say, "Choose proactive instead of reactive parenting". The first thing I would ask, and I think it's been touched on, is this: Do you have any data as of yet regarding the success of this app?

● (1225)

Mr. Emmanuel Akindele: We're still at pretty early stages, so the sample size would be too small for me to share anything with you right now. The main thing is that I have a lot of stories from parents who have been able to use it.

There is one story I would like to share. I went around my neighbourhood during Mental Health Day, and I walked up to a parent who had a 17-year-old daughter. She already had diagnosed mental health issues and prior mental health diagnoses, so he was in a position where.... He said, "How do I let my daughter go off to university knowing that she has a lot of issues?" He was feeling kind of distraught about it. I presented a solution and an idea.

We're still at a pretty early stage. We're nowhere near what it can do, in terms of the emotional insights, but he said it removed a lot of stress off his shoulders, because ideally, if she goes off and he can still remain there and be able to monitor and have that conversation if something goes bad, it removes a lot of stress off him.

Ms. Michelle Ferreri: Well said.

We talked about this in the study before when we looked at co-regulation. If the parent is not regulated, that goes down to the child and vice versa. There's a saying my grandma always said, that you're only as happy as your most unhappy child. That's really powerful.

I'm curious how you're funded right now, the funding model you have.

Mr. Emmanuel Akindele: The way we've been funded is.... I was a student at Western, so I got a little funding from Western. I've also done a lot of funding for myself, so I was able to self-finance.

Ideally, the model I would like, in terms of being able to fund this and recruit a lot of engineers to work on the solution, would be to see if a school would be willing to purchase it on behalf of its students, and from there make it accessible to the entire student body.

Ms. Michelle Ferreri: That's great.

When we're looking at mental health—and back to Ms. Todd, when she was talking about prevention—I think your app, Blue Guardian, can be a really critical piece of that prevention, because when we have a language and we're able to identify a feeling or an emotion, then we can move forward. Half the problem is that a parent isn't speaking the same language as the child, so there's this big barrier. As a result, you're basically not able to connect.

The other aspect would be resilience and grit. These are the key components that we need to teach our children. With social media, none of this stuff is ever going to go away, so how do we instill resilience and grit? It would be great to see a next level of Blue Guardian teach that: This is how you're feeling, so how do we now instill resilience and grit, and how do we manage those feelings?

Mental health first aid should also be on the record, when we talk about Ms. Todd and prevention. I think it should be key for all of that.

Some of the push-back may be from people who don't feel apps are trustworthy in terms of data collection, which I know Ms. Gazan touched on. Does it read your facial expressions? We know that this is one of the most powerful ways to gauge emotional response—happy, sad, etc.

Mr. Emmanuel Akindele: It doesn't read your face. We use only natural language processing. It's based on the language you're using and what you are typing, browsing or sending in an email. It tries to take context from that text and give it to a parent in a digestible format—whether happy, sad or neutral, or potentially, down the line, more specific.

● (1230)

Ms. Michelle Ferreri: Is there an interest in facial recognition at all?

Mr. Emmanuel Akindele: I would say no, personally. The main reason is that I wouldn't personally feel comfortable with our data collection taking that kind of data. I feel a lot more comfortable with text data because it's a lot better to break down.

Ms. Michelle Ferreri: That's a great answer. I'm with you on that one.

Are we done?

The Chair: Carol, I see you have your hand up. We have only about 10 seconds.

Do you have about 10 seconds of comment? Go ahead.

Ms. Carol Todd: As educators, we talk about apps. They're great to use. Emmanuel's app is the first stage, but you also need the stage after there's been an alert, and what happens. My big concern is.... Apps can be downloaded onto a young child's phone, but what happens with a teenager who's 13 or 19 and doesn't want their parents on their phone? That kind of solution is not going to work. It's really important that we build other solutions for education, social and emotional wellness within that online digital wellness part. That's my two cents.

The Chair: Thanks so much, Carol.

I'm just sitting here looking at the people we have at our table. I think with this group right here, we could get to work, so thank you, Carol, for adding that. I think it's all about this type of conversation. Thank you so much.

I'm now going to pass it over to Francesco.

Thank you so much for joining us today, Francesco. You have six minutes.

Mr. Francesco Sorbara (Vaughan—Woodbridge, Lib.): Thank you, Chair.

Thank you to my colleague Anita Vandenbeld for the time.

To the presenters today, I would like to start off with some of the earlier comments, which I found very interesting, in terms of government funding and government programs. There was reference to the time-limited funding and how pilot programs are translated into permanent programs. These are just some comments that I took some notes on. I believe that was stated by Dr. Williams, if I'm correct. If I have the wrong person, I apologize.

Dr. Williams, can you comment on that?

Ms. Charmaine Williams: Absolutely, it was me. I take responsibility for those comments.

I want to recognize that the government has actually tried to address a lot of these issues. It has these calls for funding, calls for proposals, and community agencies take those and develop programs. Sometimes they're moving from grant opportunity to grant opportunity. Certainly in my discussions with community agencies, one of the things we talk about is that Black organizations, indigenous organizations, organizations focused on people of colour that are in this space are moving from project and proposal to project and proposal while the system is being built somewhere over there.

How do we make these innovative solutions, these interventions that are working within communities, a sustained part of our mental health care system? I wonder if it's about redistributing resources, defunding in some places and moving that into places where they're actually reaching the communities we're trying to reach and thinking through the lens of equity. This is about reaching out to the communities that need it the most. We need to think differently about our resources. Is it redistribution of stuff from health, redistribution of resources that are going to public health, since there's a population health issue and also a health promotion issue? Those are my comments. I think there's a lot of innovation and exciting work happening within community-based organizations.

The other thing is that we could be thinking about making sustainable changes in the mental health care system by building a “person force” that can actually deliver these mental health care services from within the communities themselves. That requires, I guess, scholarships to get people skilled appropriately, but also recognition of other types of health care provision that are relevant to the mental health of young women and girls.

Mr. Francesco Sorbara: Thank you, Doctor, for that.

My next question is for Ms. Olagunju. I wanted to say thank you for your participation in Future Black Female and for all you do there.

This is a direct kind of question. What would someone in the youth community, a leader within the community...? What would you like to see?

● (1235)

Ms. Timilehin Olagunju (University Student and Youth Participant, Future Black Female): Thank you very much for that question.

I'm an immigrant from Nigeria, so one thing I really want to see is prioritizing immigrants' mental health, because you go through a lot just being an immigrant, both from the process of immigrating and the trauma that you faced back home. I think that's something that should be looked at.

Another thing that I feel should be looked at.... We were mentioning something about the language barrier between parents and their kids, but I think that something parents should learn to start doing.... From the first instance when the child comes and talks about their issue, they should take it with so much interest. That's something I feel should be taught, that if I come to you, obviously I'm not lying. I have a reason, so please pay attention to what I'm saying. This also goes to our teachers or anyone in the community. If I come to you, I'd really appreciate it if you take whatever I'm saying as important.

Mr. Francesco Sorbara: The next question is for Sydney.

I've read about some of the activities you're involved in, the initiatives, and kudos to you and the entire team there. Can you provide further commentary with regard to these activities and how they're making a difference in the lives of the people participating in them?

Ms. Sydney Levasseur-Puhach: Absolutely. We serve as many people as we can. We are open to the public, to folks not only in Winnipeg but also from reserves around Manitoba who come into the city.

We focus a lot on protecting youth—that's one of the big things we are interested in—where there are dangers, especially with vulnerable indigenous youth who come into the city to predators, to gang involvement and to sexual exploitation. We try to welcome them with open arms at their first meeting, whether they're coming in for school or for other programming, and ensure that they have a safe space to live, learn and develop this network of care and safety. That is really critical. That is on our prevention side.

As for intervention, we try to adapt to where the needs are in the community, whether that is in solidifying a safe space for women, addressing the murder crisis of indigenous women in Winnipeg and providing support for families who are experiencing that, or addressing women who experience sexualized or domestic violence, and then providing a ceremony space in an urban setting for indigenous folks to come together and get back to the way that we heal traditionally as indigenous people collectively, and in this—

The Chair: Thank you so much, Sydney.

I know there's so much to add, so I'm sorry to all of the questioners today because I'm really messing around with your time.

I'm passing it over for six minutes to Andréanne.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Madam Chair.

Ms. Assayag, to add to what we were saying about caregivers, I want to highlight the work of a man from my riding, Jean-Philippe Dion, who is the spokesperson for the organization Avant de craquer—Before you break down. He talked a lot about what he did as a caregiver for his mother, who had mental health problems. I salute him.

You also led the way on recognizing invisible work, so I would like to come back to that. I would like to remind you that in 2010, one of my predecessors in the Bloc Québécois, Nicole Demers, tabled a motion to create Invisible Work Day, during which we could reflect on all this. Unfortunately, this issue has not progressed since 2010. I hope that one day elected officials will start thinking about the importance of better recognizing those who do invisible work.

I would also like to hear your comments on GBA+, that is, gender-based analysis plus, which is not done everywhere or enough. It should be done more in Ottawa. I'd like you to tell us how important that might be on the issue of mental health. You've touched on that, but if you want to add a few words about the importance of GBA+, I invite you to do so.

● (1240)

Ms. Lydya Assayag: Thank you for the question.

Indeed, GBA+ is very important, because it is the lens through which we can see the effects that programs have on men, women, young people, older people, racialized people, etc. Without this lens, it looks like they are homogeneous groups. We are acting in good faith and putting programs in place thinking that this will help everyone, but it is not at all the case. It can only perpetuate exclusions. I think the other witnesses have mentioned that. So GBA+ is an essential tool, among others, that allows us to see the inequalities and avoid perpetuating them.

As for women's invisible work, this is a long-term battle, unfortunately. Society has not adapted. We have allowed women to study and to enter the labour market, but we have not adapted to their reality. The reality for women is that we wear many more hats than men, in general. Although there are also men who are family caregivers, it is a predominantly female role. Women play the role of cook, educator, mother, daughter, caregiver, and so on. At some point, they wear too many hats. So women turn to coping strategies, such as alcohol, drugs or medication. Sometimes this can go as far as suicide. All hats worn by women are considered natural, but they are not so natural. In reality, it is a social division of things. Until we make all these hats visible, we won't realize the weight that these young women have on their shoulders.

There is also the whole pressure of body image and hypersexualization, among others. We don't see it, but young women and girls are under a lot of pressure and suffer a lot. Until we have a gender-based analysis, we won't see it. We need this lens.

Ms. Andréanne Larouche: You are absolutely right. Thank you very much for your comments. Moreover, you have used the right terminology: we are talking about family caregivers. That is indeed the term that should be used now, instead of “natural caregivers”, because, no, it is not natural to be a caregiver. We must remember that.

I also congratulate AFEAS, the Association féministe d'éducation et d'action sociale, which has taken up the fight for invisible work to be recognized. This organization is very active in this area.

Thank you very much for your testimony today, Ms. Assayag. I may have the opportunity to come back to you in the next round, but I would like to end this one by addressing Ms. Todd.

Ms. Todd, you talked about cyber-bullying, which is another issue that is very close to my heart. You mentioned the importance of introducing legislation on this issue, because online hate affects the mental health of young girls. As you explained, social networks have exacerbated these problems.

What does such a bill mean to you?

[*English*]

Ms. Carol Todd: I'm really glad you mentioned that because I was just thinking about it.

Back in 2014-15, the Conservatives brought up Bill C-13. You can google it. It was about protecting Canadians online. They called it a cyber-bullying bill, but to me it's not about cyber-bullying. It's about online victimization because it is about sharing sexual images of someone without consent. It takes away the child pornography part because the age of the person in the image can be all the way to adulthood. It's in the Criminal Code. You can get a jail sentence of up to five years. It's been more than five years since that bill was passed in 2015, and I believe it needs to be revisited. It's on my to-do list with the MP in my community.

Because it's labelled a cyber-bullying bill, I believe you have to really define what cyber-bullying is and define what online victimization is. Sharing intimate images is exploitation. Cyber-bullying is hateful speech, which is under harassment.

Maybe we need to look at criminal harassment because so many people who are saying they're being cyber-bullied are really being harassed, which is criminally chargeable. However, you can't get a police officer to investigate unless that harassment has a death threat on it. We need to really define it, look at what it really means and make it more punishable.

We need to do something. I think the government should look at that.

● (1245)

The Chair: There need to be teeth. I think this is where you're going with this.

Thanks so much, Ms. Todd.

I'm now going to pass it over for six minutes to Leah Gazan.

Ms. Leah Gazan: Thank you so much.

My next question is for Dr. Williams.

I really liked when you said that it's not individuals at risk but systems that are at risk of not meeting the needs of individuals. I used to say that in my course. Let's stop talking about at-risk youth and let's talk about systems that are at risk of not meeting the needs of youth. I think the onus is often placed on individuals with systems that are not adequately responding to needs. I really appreciated that. I love that so much.

You spoke about problems in mental health care, particularly because we often address mental health using a homogenous lens. We know it's not true that we're all the same, particularly for individuals coming from BIPOC communities.

The murder crisis of indigenous women and girls was mentioned today. For example, in the city of Winnipeg—the city I'm from—even walking around, your mental health is impacted. You never feel safe because there's a target on your back. Those things are often not discussed when we're talking about mental health and creating proper mental health supports.

We know that the experiences are different for non-racialized individuals, or 2SLGBTQIA+ individuals. Can you expand on some of the more unique supports—you talked about the importance of culture and being socially relevant—or unique mental health care models that respond to intersecting identities better than what's currently available in the mental health care system?

Ms. Charmaine Williams: Sure. Thank you for the question.

I think of it in two directions. One direction is that if we think about where people seek help when they are dealing with emotional health or mental health problems, we want to be thinking about how that care is tailored to the needs of specific populations. I think I said at the end of my comments that we need women-centred spaces and girl-centred spaces. However, we need spaces that are also BIPOC-centred spaces, so that a Black woman has the opportunity to be in a service where she knows that people understand the issues of Black women and girls and that she's going to meet practitioners who represent that population or have deep knowledge of that population.

The other half of that is the health promotion component. In terms of health promotion, I go back to what you just said. There are populations that are dealing with collective trauma and stress because the world is not safe for certain populations—certain groups of women and girls. We need to think about health promotion that deals with that kind of collective trauma and stress. Also, there's the cumulative trauma and stress. If you look at the research, you see that women of colour, sexual minority women and gender minority women have histories of lifetimes of exposure to violence and trauma. Part of what is difficult in our system is that it's not ready for them when they are ready and able to actually deal with that work and in turn deal with those traumas.

In terms of best practices for treating traumas, we know you need regular supports, community supports, connection and this kind of thing. We don't have a system that's built to deal with that. We have a system that has a one-size-fits-all approach, which I'm frankly not even sure fits anyone anymore. However, certainly for Black or indigenous people, people of colour, or women and girls, it's not a good fit.

Ms. Leah Gazan: Thank you so much for that.

My next question is for Ms. Olagunju.

You spoke about your experience. In Winnipeg Centre, 70% of refugees in the province of Manitoba move into my riding. One of the things I've been fighting for is programs for youth, for a couple of reasons. One is that a significant number of young people moving into my community deal with Islamophobia on the regular. It's growing and it impacts people, and what we're seeing in my riding is that as a result of failure to provide support for youth, more youth are joining gangs.

There was a model by a guy named Dr. Martin Brokenleg, and he talked about the "circle of courage". He said that kids need a sense of mastery, generosity, independence and belonging, and when they don't have that, they'll find other ways to fill those needs.

Why is it critically important to have readily available supports, particularly for newcomer youth who are coming from diverse experiences, sometimes with significant trauma and especially leaving situations of war? Why is it important?

● (1250)

Ms. Timilehin Olagunju: Thank you very much.

This is just a fun fact: I used to live in Winnipeg. I was a refugee in Winnipeg. It was hard, very hard, because they have this thing that refugees aren't people. I was very isolated.

To answer your question, I think it's very important for youth to have the environment so that they don't turn to those other vices. I think refugees, immigrants and indigenous people need the space to speak to someone, to talk to someone, just so this doesn't happen. With the trauma and the problems we face, if we're unable to talk to someone about it, it just eats us inside. The only way to pass out the thing that's eating us is to either be on our own or join the gangs to find our safe space.

The Chair: Thank you so much.

We are down to our last six minutes in this committee for rounds of questions, so it will be two minutes, two minutes, one minute and one minute. I'm probably going to keep it pretty tight so that we can end on time.

Dominique, you have two minutes.

[*Translation*]

Mrs. Dominique Vien: Madam Chair, since it would be difficult for me to ask my questions in two minutes, I will change my approach.

Earlier, I told you that we were here to find solutions. Some of you have put forward ideas. It would be frustrating for me to use my two minutes to ask you questions, because I would only be able to speak to one person, so we would not be able to hear the range of your proposals. What I would invite you to do is to reflect, in each of your organizations, on the good things that you have done and the best practices you have put in place or observed. Ms. Williams mentioned this. Our committee would welcome that information. It would certainly help us in our reflection on the important issue of women's and girls' mental health. I think it would be very helpful.

I would like to end by thanking you very much for your testimonies. I have learned a lot and I am very grateful to you.

Once again, I hope that peace of mind will prevail and that we will be more attentive to the mental health problems that many people unfortunately experience today.

[*English*]

The Chair: I'm now going to pass it over to Jenna for two minutes.

Ms. Jenna Sudds (Kanata—Carleton, Lib.): Two minutes.... That's impossible, but thank you, Chair.

Thank you to all of the witnesses, first of all, who have joined us. It's been really incredible and useful to hear your insights and suggestions today.

Dr. Tapo, it's great to see you once again. You made a few comments that I wanted to dig into. One was on how confusing the system is. One was around psychotherapy and counselling not currently being covered within our country. The other piece was that the one-size-fits-all approach to mental health doesn't work and we need a cross-cultural design.

I'm really just going to open it up for your comments, in the remaining minute that we have, to expand on any of those items.

● (1255)

Dr. Tapo Chimbganda: One thing we're working on at Future Black Female is a national mental health campaign for Black girls. We are going to roll out a national survey, because there is no information on the mental health experiences of Black girls. We can only surmise from other sources of data. We're rolling that out and we're looking for funding for mental health promotion specifically for Black girls and women.

Take PMS, for example. Black girls and women are more likely to be diagnosed with polycystic ovarian syndrome, which means they're more likely to have more difficult periods and to suffer from PMS. This is not something that is talked about at all. It is stigmatized. It is even made fun of. We all make these jokes—"Oh, she's PMS-ing" and all that—but it's a significant mental health issue within that community.

These are the kinds of approaches we need. We need to understand the mental health struggles of different communities and where they're coming from, even if it is from physical health. Polycystic ovarian syndrome is something that's diagnosed by your physician, not necessarily by your psychiatrist.

The Chair: Thank you very much.

I'm sorry, Jenna. I know this conversation could continue. It's been excellent.

I'm now going to pass it over to Andréanne.

Andréanne, you have one minute.

[*Translation*]

Ms. Andréanne Larouche: Again, I thank the witnesses.

I'm going to proceed quickly.

Dr. Chimbganda, could you tell me in 20 seconds why the feminist approach is important to this mental health study?

[*English*]

Dr. Tapo Chimbganda: I think the lens of women and girls is important because, more and more, as a society, we are putting more demands and expectations.

We've been talking about social media. If you look at the representations of girls and women there, they're impossible. Their mental health is suffering, because society is changing. Even as we're working hard for equality and equity in gender perspectives, we discover more information. We need to be responsive to that information.

It's not enough to just celebrate women. Let's also protect them and provide for them.

The Chair: Thank you so much.

Leah, you have the last minute. Go for it.

Ms. Leah Gazan: I want to follow up with Ms. Olagunju.

You said that you were invisible, that you didn't matter.

One thing I've been fighting for in Winnipeg Centre is a place called the Bilal Centre. It's particularly centred on assisting Muslim youth. They put in applications and keep getting refused, even though we know things are getting dire.

Why are organizations like Bilal critical, life-saving organizations?

Ms. Timilehin Olagunju: I'm sorry, but I need you to reconstruct the question, because I got lost.

Ms. Leah Gazan: Why are organizations like Bilal, which provides services for Muslim youth...? We talked about racism and life-saving organizations. Why are they critical?

Ms. Timilehin Olagunju: I feel they're very important because, as minorities, we need to have a representative front so our voices can be heard. That's why I feel the organization is very important for young Muslims in Winnipeg.

The Chair: Thank you so much.

I would like to thank all the witnesses. Today has been an excellent sit-down and we got a lot of information.

To those people in the last round of questioning, I'm very sorry for removing your time. I just find some of that very challenging, because.... I'm sorry, but I will never cut off Ms. Todd. She has too much to offer. I think that's the thing. I hope everybody recognizes my flexibility, because we have such incredible witnesses. I do apologize.

We will be meeting once again on Thursday at 3:30 p.m.

I remind all of our witnesses that, if you have additional information or briefs you would like to send in, please send them to our clerk. Those are due by October 31.

Thank you so much.

Today's meeting is adjourned.