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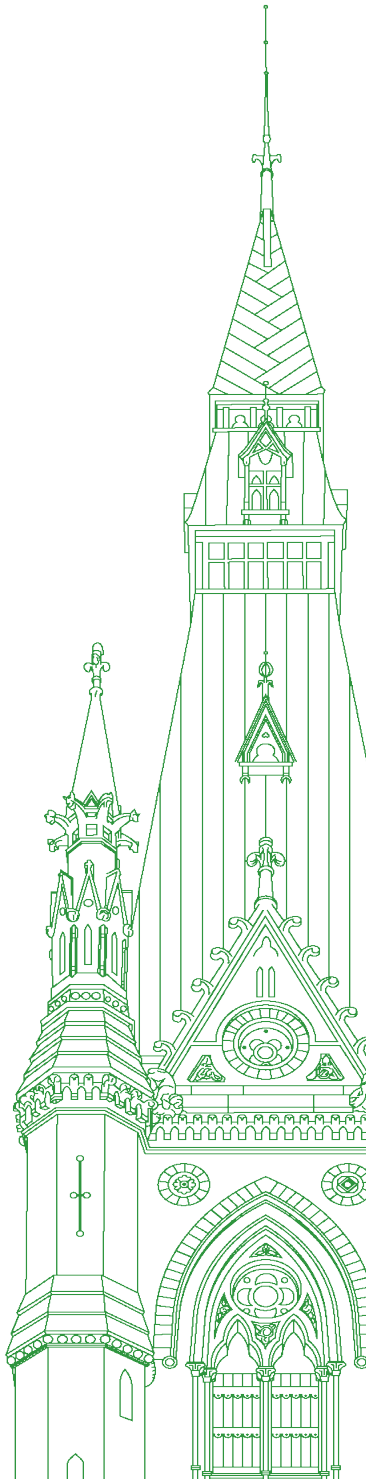

Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, September 27, 2022

● (1105)

[*English*]

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

Welcome to meeting number 31 of the House of Commons Standing Committee on Health. Today we are meeting for two hours on our study of children's health.

Today's meeting is taking place in a hybrid format, pursuant to the House order of June 23.

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

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mike, and please mute it when you're not speaking.

For those of you on Zoom, you have the choice at the bottom of your screen of “floor”, “English” or “French”.

Screenshots or taking photos of your screen is not permitted. The proceedings will be made available on the House of Commons website.

In accordance with our routine motion, I'm informing the committee that all witnesses have completed the required connection tests in advance of the meeting.

I am participating remotely today because of the situation here in Prince Edward Island. I am in one of the few buildings in Charlottetown that has electricity. Hopefully, it will be stable enough to get us through the meeting.

I would now like to welcome our witnesses who are with us this afternoon. From Children's Healthcare Canada, we have Emily Gruenwoldt, president and chief executive officer.

[*Translation*]

We also have Dr. Marie-Claude Roy, pediatrician and president of the Association des pédiatres du Québec.

[*English*]

From the Canadian Paediatric Society, we have Dr. Mark Feldman, president.

Thank you to all of our witnesses for taking the time to be with us today. Each of you has up to five minutes for an opening statement, followed by a period of questions and answers.

I would like to invite Ms. Gruenwoldt to begin. Welcome to the committee. You now have the floor.

Ms. Emily Gruenwoldt (President and Chief Executive Officer, Children's Healthcare Canada): Good morning. Thank you for inviting me today.

Children's Healthcare Canada is a national association that represents Canada's 16 children's hospitals as well as community hospitals, rehabilitation centres, and home care, palliative and respite care providers that serve children and youth. Our members span the full continuum of care, giving us a unique perspective into the health systems that serve eight million children and youth, which is a population that continues to grow.

Where Canada once ranked among the top OECD countries with respect to children's health outcomes, the 2020 UNICEF report card reveals that Canada now stands worlds apart from other rich countries when it comes to providing healthy, happy childhoods. Canada's standing has slipped to 30th of 38 countries with respect to physical health and 31st out of 38 countries with respect to mental health.

Relative to our wealth, Canada punches far below its weight when it comes to children's health. In Canada today, over 30% of children and youth suffer from chronic disease. One in five experiences chronic pain. Pre-pandemic, our children were among the least vaccinated among OECD countries. We also have one of the highest rates of adolescent suicide in the developed world. At the same time, in Ontario, over 28,000 children and youth are waiting to access mental health services—some for as long as two and a half years.

In the wake of the COVID-19 pandemic, children's health care systems are facing unprecedented demands. From coast to coast, children's hospital emergency departments are experiencing historic patient volumes that are approximately 30% to 50% higher than usual. Children and youth are often waiting 10 to 12 hours to be seen. Many of those who are admitted for serious health conditions are admitted without beds, which means there is no immediate capacity to care for these children.

In this situation, to create space and free up beds, children's hospitals are cancelling and rescheduling essential surgical procedures, putting children at risk of missing critical developmental milestones.

Mental health visits and admissions are a particular and ongoing concern. Many children's hospitals are experiencing a threefold increase in the number of patients presenting with acute eating disorders and nearly double the number of patients presenting with anxiety and depression. Between lengthy waits for mental health, surgical interventions, diagnostic assessments and child development services, children are now waiting longer than many adults for essential services.

At the same time as children's health systems are facing extraordinary demands for services, these organizations are struggling to recruit and retain a skilled workforce. Children are not tiny adults. The health care providers who care for Canada's smallest patients are among the most highly specialized.

This remains one of the most pressing and complex challenges in our health systems today. I recognize that it has already been a focus of study of this committee.

In 2020, in response to the crisis our children are facing, Children's Healthcare Canada partnered with Pediatric Chairs of Canada, UNICEF and CIHR to launch a pan-Canadian initiative called Inspiring Healthy Futures to measurably improve the health and well-being of children, youth and families. A broad, cross-sector consultation engaging 1,500 individuals and organizations identified five interlinked priorities to create conditions for children to thrive. The report underscores the need for children's health and well-being to be a priority for the public, for funders and for decision-makers.

Canadians imagine a healthier future for their children. The time is right for the federal government to develop a pan-Canadian child and youth health strategy. This strategy must enable better beginnings by prioritizing maternal and newborn health to give families the best start possible, enable advanced precision medicine and wellness through world-class care for sick children requiring hospitalization, and enable children living with neurodiversity, disability and chronic disease to transition from vulnerable to thriving.

A comprehensive strategy would not only address existing gaps, but would also anticipate needs of the future. First and foremost, we have normalized rationing and waiting for mental health services—to the detriment of kids—while we know that early intervention pays lifelong dividends. A commitment to earmarking 25% of the proposed Canada mental health transfer for children would be a great place to start.

A robust maternal and child and youth research agenda is required to contribute to the generation of new knowledge and to leverage this evidence to inform policy, programs and services.

We need a health human resources strategy that includes a focus on unique skills and experience required to delivered care to kids. This strategy must address current labour gaps, but must also look forward to fostering resilience and sustainability.

An integrated cross-sector, cross-jurisdiction health data strategy is overdue in Canada. What gets measured matters. We urgently require a strategy to address delays and access to essential child development, surgical and diagnostic services. We must improve services to rural, remote and indigenous populations.

Finally, access to safe and effective medications for children is paramount. An estimated 80% of medications currently prescribed to children are administered off-label, deviating from dose administration, patient age and, often, indications listed on the Health Canada-approved product monograph.

● (1110)

Colleagues, we stand at a critical juncture. We need to both address the crisis today facing children and youth, and the health systems that serve them, but also plan for our future. We have the expertise, knowledge and tools to restore our global standing in children's health. All we need now is bold leadership, and a commitment from governments to make this possible.

Thank you.

The Chair: Thank you, Ms. Gruenwoldt.

[*Translation*]

Dr. Roy, the floor is yours.

Dr. Marie-Claude Roy (Pediatrician, Association des pédiatres du Québec): Good morning.

Thank you, everyone, for this opportunity to appear before you today and to outline our concerns.

As president of the Association des pédiatres du Québec, I represent more than 760 pediatricians in Quebec who are expert practitioners in various fields ranging from neonatology and intensive care to community pediatrics. While challenges vary widely from one pediatric population to another, my members have a common concern for the health of our children, specifically in this post-pandemic context.

Our first concern when discussing children's health is the set of problems associated with their physical health, but there are also problems related to their developmental health. Children are the only population whose development is constantly dynamic. Developmental challenges are extremely important and an integral part of children's health.

We cannot overlook the psychological health of our children, whose lives have been greatly disrupted in the past few years. Then there's what I call “educational” health. Frequent pandemic-related interruptions in classroom instruction have raised significant impediments to continuous learning. The present and future health parameters of these children have been greatly disturbed in recent years.

Despite these concerns, many of these children's health parameters are improving. Survival rates from birth are up; vaccinations, although sub-optimal, are constantly improving; prevention programs across the country are having very positive effects; and our prevention measures have resulted in less severe trauma and other impacts, and we must continue to invest in these areas.

However, many problems are still of major concern. In Quebec, 12% of children 5 years of age and under live in financial insecurity. These are extremely important factors when it comes to monitoring the health of these children. One in 5 children, 20%, enter kindergarten with significant developmental problems, motor, language and social issues.

Quebec's Agir tôt program has been rolled out in recent years. Its purpose is to detect problems in early childhood before they become established, and to ensure that parents and the home environment stimulate children in the initial years of their lives, thus completely altering the path they are on when they arrive at school.

For school-aged children, obesity and overexposure to screens and technologies are problems that result in dependence, which will have a major impact on their health when they reach adulthood.

The health of children and adolescents greatly depends on the physical, financial and even psychological health of their parents. The pandemic obviously left children more vulnerable, and parents experienced more financial insecurity, domestic violence and mental health issues. Unfortunately, few resources are allocated to psychosocial support for those children and their families, and this problem will have to be addressed sooner or later.

In adolescents, we see that problems that began in childhood have become established. Obesity and sedentariness rates have never been this high, and they surged during the pandemic. The pandemic also had a major impact on their developmental trajectory. This population was more affected by the pandemic measures than other groups. We have observed a surge in anxio-depressive and food disorders and an increase in substance abuse. This is a population that will inevitably require attention.

The concern for us at the Association des pédiatres du Québec is to make children a priority again. Under the living conditions that technological developments have afforded us, life has never been easier, and yet the younger generation are facing health problems specific to the 21st century. The pace of life has accelerated, and everything takes place on screens and social media, which is very hard for these patients. On the other hand, technology has also helped optimize the life expectancy of very sick children who previously didn't live past the age of 5, 6 or 7 years. Even if patients are saved in the first years of their lives, there are no resources for them once they leave hospital.

● (1115)

I'm thinking of extremely premature babies and patients who have undergone a gastrostomy or tracheostomy. These children now have greater survival potential, but their parents, the caregivers of those children, have little support to help them carry on.

In future, we hope to provide parents, the children's mothers and fathers, with better tools from the conception of their children in order to optimize the family environment in which those children grow up.

We want to rely more on prevention to limit the impacts on children's health. We also have to ensure that children's environments—child care, early childhood centres and school environments—are stimulating.

We must understand the impact our lifestyles have on the young generation's health. We also need to continue efforts to provide greater access to care.

Lastly, we must bear in mind the situation of chronically ill patients as they mature into adults. As I noted earlier, sick children now have better survival potential, but we have little expertise in supporting adolescents 15, 16, 17 or 18 years old who are diagnosed with serious conditions or who require extensive care.

In speaking with my counterparts from other provinces, I have observed that pediatric populations are similar across the country. The structures in place and the problems experienced vary greatly from province to province, and that fact must be taken into consideration.

Thank you very much.

● (1120)

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

[*English*]

Next, representing the Canadian Pediatric Society, we have Dr. Mark Feldman.

Welcome to the committee, Dr. Feldman. You have the floor.

Dr. Mark Feldman (President, Canadian Paediatric Society): *Bonjour*. Thank you for the opportunity to speak to you today.

My name is Dr. Mark Feldman. I am a pediatrician. I have worked at the Hospital for Sick Children in Toronto for the past 30 years. I am speaking to you today, however, on behalf of the Canadian Paediatric Society as its 101st president. The CPS is a voluntary professional association that represents approximately 4,000 pediatricians across our country.

You've just heard that there's a critical gap in timely, affordable and equitable access to mental health care across Canada for children and youth. What I wish to do today is to provide some additional context and the perspective of pediatricians from your provinces, and to offer some potential solutions.

The other day, Dr. Ungar spoke to this committee about the concept of resilience. Resilience is in part mediated by brain plasticity. Brain plasticity is the ability of the growing brain to adapt, heal and develop normally if positive changes are made early. Dr. Ungar emphasized that missed opportunities to treat mental health disease during childhood has devastating consequences later in life.

Children with attention deficit disorder, for example, will have more typical, more normal development of their brains, as demonstrated on pictures of brains—serial imaging studies with magnetic resonance imaging—if they receive treatment early for their ADHD.

I'll give you an example of what early intervention might look like. I have a patient who I think illustrates it well.

Kareem was referred to me at the age of 10 with behaviour problems. His father was not involved. His mother struggled with alcoholism. His brother was in jail. Kareem was a good kid, however. He was smart, kind and charming. But he struggled with impulsivity and inattention, so he struggled socially and academically. He was diagnosed with ADHD, received treatment at a critical time in his brain development and improved dramatically and rapidly. Fast-forward 15 years: I had the honour of attending his university convocation along with his mother and his fiancé. He is now a loved, respected, taxpaying member of society.

Was this a one-off? High-quality research has demonstrated that intervention for children and youth with ADHD, for example, can lower the risk of school failure, suicide, drug addiction, teen pregnancy, car accidents and incarceration. It improves the quality of life. It improves the likelihood of higher education and even lifespan.

The implication of early intervention in cost-averted care for children and youth with mental health disease is significant. Mental health problems serious enough to disrupt functioning and development affect approximately 1.2 million children and youth in Canada—that we know of—yet fewer than 20% of those receive appropriate treatment. This gap existed long before the pandemic. Children and youth who are immigrants or refugees or BIPOC or who live in remote communities are even less likely than their peers to receive appropriate mental health care, and are more likely to use services like emergency rooms when in crisis.

I recently had the privilege of meeting with the presidents of provincial pediatric societies across Canada to identify priorities nationally and to share strategies locally. Without exception, each provincial lead identified the mental health care access gap for children and youth to be a number one issue.

As you know, in 1985 the Canada Health Act was created to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers". In Toronto, there's a clinic in North York that offers care for children with learning, mood and anxiety issues. The initial assessment by a physician costs $2,000. That's followed by a psycho-educational assessment at a cost of $5,000. Therapy sessions, if necessary, quickly add up to another $3,000. That's a $10,000 bill.

The wait time for publicly funded mental health care in different provinces, to see somebody like me, is anywhere between six months and two and a half years. If I then refer them for therapy, such as talk therapy, psychology services are generally not publicly funded in Canada.

On behalf of the Canadian Paediatric Society, we ask the federal government to uphold the commitment to establish a fully funded permanent Canada mental health transfer, and that 30% of federal mental health transfer payments are directed towards those under the age of 25 to ensure timely and equitable access to mental health care.

● (1125)

Some of the ways that money can be spent are funding the development of clinical practice guidelines, educational tools, navigational resources and systems as well as funding continuing professional development training programs for practising health care providers to upscale our skills and to support evidence-based mental health care for children and youth.

We would like to see that money is spent to ensure that assessments performed by psychologists and therapies delivered by psychologists or by other non-physician mental health care practitioners are similarly publicly funded, regulated and evidence-based.

I have all kinds of potential solutions, and I look forward to your questions.

Thank you.

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

We're going right to questions now beginning with the Conservatives.

Dr. Ellis, you have six minutes, please.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Mr. Chair.

I want to thank all the witnesses for being here. It's a very important topic for all of us as Canadians. Certainly, we look forward to digging a little bit deeper.

Primarily, the unfortunate thing is that this study has morphed a bit into something that we didn't really anticipate in the beginning. One of the things I would like to get out there right away is, if it really becomes the will of this committee to create a child and youth strategy for Canada, certainly we're going to need more meetings and more time to develop such a strategy or put us on the right path to do that. I'll leave that seed as it is.

First and foremost, perhaps I'll start with Emily.

You talked a bit about outcomes in your opening statement. I realize it's a big topic, but I'm wondering if you might comment a bit on how our outcomes for children in Canada fell from perhaps 10th out of 38 wealthy countries to 30th and 31st of 38 countries.

If you could start with that, please, I would appreciate it.

Ms. Emily Gruenwoldt: Thank you.

This is in reference to the UNICEF Report Card 16 that was published in 2020. Just to summarize, Canada now ranks 30th out of 38 countries with respect to children's physical health and 31st out of 38 countries with respect to children's mental health.

As recently as 2007, we were ranked 12th in a comparable ranking conducted by UNICEF, so our rankings have fallen. The scorecards are not directly comparable, but the pattern is clear, and the outcomes continue to worsen for many Canadian children and youth.

Just to give you an idea, with respect to mental health and happiness, almost one in four children report low life satisfaction, which ranks us 28th. Canada again has one of the highest suicide rates for adolescents, 35th out of 38 countries. With respect to physical health, Canada has an infant mortality rate of 0.98 deaths per 1,000 births, which puts us in 28th place. To comments by Dr. Feldman, I believe it was earlier, one in three children are overweight or obese in this country.

In almost every ranking with respect to physical and mental health, we are in the bottom third if not the bottom quarter of rankings of comparable international countries.

To a comment I made earlier, compared to our relative wealth as a nation, we would expect our outcomes to be significantly higher, especially when we look at the investments we are making and the outcomes that are tracking towards those investments.

It is an opportunity, I think, where not only would extra investments make a difference, but a broader strategy that incorporates both health and well-being metrics is overdue for this country if we're going to measurably improve the health and well-being of children and youth.

Mr. Stephen Ellis: Thank you very much for that. I appreciate it.

Dr. Feldman, if I may, you made a few comments with respect to access to mental health care being the number one issue. I have a couple of questions around that.

I have two parts to the question. Do we have enough pediatricians? If yes, great. If not, how do we entice them to become pediatricians through training? Are they paid enough, etc.?

Second, you talked, sir, a bit about psychologists and understanding.... Certainly in my practice lifetime, it appears that we don't have enough psychologists either, certainly not in the adult world or the pediatric world. You did mention a bit about funding.

Could you comment on the availability of those specialists and how you think that might be solved?

● (1130)

Dr. Mark Feldman: Thanks. That's a great question.

I should say that the number one issue identified was mental health issues during that recent meeting. The number two issue was human resources, the shortage of family doctors and pediatricians, and that's part of the access issue. There are a number of potential solutions.

One of them is that the youth hub model of delivery of mental health care might be further expanded. I work in a rural area once a month, where there's a nurse practitioner and several workers who are trained in the delivery of psychological therapy, cognitive behavioural therapy. So perhaps a more effective use of physicians' time in partnership with colleagues in a youth hub model could be explored and grown.

The second thing is that the physicians who are out there should be perhaps better trained to manage mental health issues. I think funding for continuing professional development opportunities might be a way to address the shortages in mental health care. In Manitoba, for example, the CanREACH program is funded, is subsidized. If there are programs like that that can be subsidized then we can get better and more efficient and refer less, and fewer people end up in the emergency department.

In terms of addressing human resource issues, we need to train more physicians. The demographic is there are a lot of us retiring. I hope to go for another five years or so but I would like to see the young folks get out there, perhaps with a little bit of additional curricula with regard to mental health training. For example, the family medicine program is expected to change from a two-year program to a three-year program over the next five to 10 years, recognizing increasing complexity. If mental health care competencies can be a greater part of their curricula, that's another way to deal with that.

In terms of additional training for pediatrics, in the last 10 years at SickKids, we've had a program called community pediatrics, which is an additional year of training to teach the skills needed out in the community in pediatrics. The curriculum is heavy on mental health care delivery.

There are a number of different ways of doing it but we need to train some more generalists, we need to train them better, we need to use them more effectively, perhaps in a youth hub model. I think until we address the human resource issue and the efficiency of the system, we're going to be struggling.

Mr. Stephen Ellis: Thank you.

The Chair: Next we're going to go to Dr. Powlowski, please, for six minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you.

Certainly I understand and can appreciate that under COVID there have been worsening rates of mental health problems and suicide, but I did want to comment on Dr. Gruenwoldt's comment on Canada's high infant mortality rate. My understanding is we're 31st of 37 OECD countries in terms of infant mortality. However, part of that difference is attributed to the fact that most European countries don't include newborns weighing less than 500 grams. Those newborns would certainly have a higher mortality rate and most European countries don't count them as live births. So that's part of the explanation as to why we have a higher than normal infant mortality rate.

Is that true?

Ms. Emily Gruenwoldt: I don't have that data at my fingertips, and just as a correction, I'm not a physician, sir.

Mr. Marcus Powlowski: Okay. The second thing I wanted to talk about is that we have a lot of doom and gloom on children's health but as somebody who has worked 35 years as an acute care doctor, and certainly a big part of that has been looking after children, it would seem to me that if you look at infectious disease, which is a big cause of physical morbidity and mortality in children, that has really, in my experience, in 35 years from when I started practising, appreciably decreased.

Now we have vaccinations for haemophilus influenzae, meningococcus, pneumococcus and certainly now.... When I started my practice, meningitis wasn't uncommon, bacterial meningitis.... Now you practically never see bacterial meningitis. Epiglottitis, usually caused by influenza, you hardly ever see it anymore. I think there's a lot less pneumonia. Even a colleague of mine who I went to medical school with, who does family practice, was saying he sees a lot less otitis media, again probably as a result of those vaccinations.

Now having said that, we're seeing some troubling numbers in terms of vaccination in Canada. Apparently only 76% of children are vaccinated with DPT, polio, and under...COVID apparently in parts of the country, Manitoba, Alberta, we're seeing a 20% decrease in vaccination.

I wonder if you could comment. I see Dr. Roy shaking her head there. Could you comment on how important vaccines have been in terms of improving children's health and what is happening in terms of decreased vaccination rates in Canada?

● (1135)

[*Translation*]

Dr. Marie-Claude Roy: Yes, it's very important. I've spoken at length about the impact of social media and disinformation on adolescent anxiety. I nevertheless think there are a lot of echo chambers in all the sources of information parents use. This generation of parents wants to understand, know and control the situation and that directly feeds into a collective anxiety. As they look for various sources of information, each of which is less reliable than the next, they become lost at sea. Parents seeking greater control over their children's health unfortunately encounter disinformation. That's what constantly brings us back to prevention. People swing into action once the problems are established, but all prevention programs are unfortunately viewed as an inferior solution, even though studies clearly show they have major positive impacts on children's health.

One of my colleagues here in Sherbrooke is working hard to raise vaccination awareness. His research project has proven its worth and has gone international. It's simple: within a few hours of a child's birth, he meets with the parents to dedramatize the situation, answer questions and deconstruct the myths surrounding vaccination, all in a non-threatening way. When a doctor tells parents they have to vaccinate their child, they immediately go on the defensive. However, when you inform them and listen to their concerns in the few hours after the child is born, that has a major positive impact on the vaccination rate in the following months. So the paternalistic approach should be avoided. Parents need to control the situation and to understand why things are as they are. By listening to their questions, you can better deconstruct the myths.

You're correct in noting that, despite the enormous progress made in the past 20 years to improve living conditions and treat infectious diseases, the threat at this stage is still disinformation. You have to be open to parental concerns.

[*English*]

Mr. Marcus Powlowski: Mr. Chair, is there any time left on the same issue?

The Chair: You still have a little over a minute, Dr. Powlowski.

Mr. Marcus Powlowski: I wonder if Dr. Feldman wanted to reply to that. I'm sensing he may be a pediatrician or psychiatrist.

Dr. Mark Feldman: I'm a general pediatrician.

I saw haemophilus influenzae type b wiped out of ICUs. I completely agree that vaccination has been a huge success in my lifetime, but we're seeing polio come back now.

The disinformation that Dr. Roy spoke about is huge. Managing disinformation is a huge priority for us. I've seen acute care issues and infectious disease issues improve, but I see mental health deteriorate.

The Chair: Thank you, Dr. Feldman and Dr. Powlowski.

[*Translation*]

Welcome to the committee, Mr. Villemure. You have the floor for six minutes.

Mr. René Villemure (Trois-Rivières, BQ): Thank you, Mr. Chair.

Thanks to the witnesses for being with us this morning.

My questions will be for Dr. Roy. We're going to discuss health care funding and organization.

Dr. Roy, what's your position on the unanimous demand of the provinces and territories for an unconditional, recurring increase in federal health transfers of 25% to 35% of costs?

● (1140)

Dr. Marie-Claude Roy: That's an excellent question.

Under the Canada Health Act, the transfer was initially supposed to be about 50%. Now it's 22%. I'm concerned about children's health, and I know my colleagues in adult medicine have the same concerns for their adult clientele. Approximately 40% of Quebec's budget is allocated to health, which can be explained in part by the province's aging population. That leaves little room to invest in the other parameters that have a major impact on children's health.

You have to remember that health is a provincial jurisdiction. That's never been questioned, but, if health transfers were increased, the provinces would have the necessary leeway to invest in the other parameters related to children's health. I'm thinking of education, for example, which I briefly discussed earlier. The state of our school system across the country is appalling. Our lagging performance in education, literacy, numeracy and the fight against students dropping out of school will have a major impact on the health of those children, who are tomorrow's adults.

Health transfers must be increased to give a free hand to the provinces, which are more familiar with the structure of health systems than anyone else. The problems in the pediatric population are the same in all provinces. The mental health problems mentioned earlier are everywhere, but it's obvious that the structures in place from province to province aren't the same. The deficiencies aren't in the same areas. In my view, these transfers must definitely be increased to give the provinces a free hand to act in accordance with the health parameters specific to each province, as in education and the environment. That will have a major impact on children's health.

Mr. René Villemure: Thank you very much.

You don't feel the federal government is more qualified than the provinces to invest the amounts in question.

Am I correctly interpreting your remarks?

Dr. Marie-Claude Roy: The population of each province has its own characteristics. It's false to say that Ontario, New Brunswick and Quebec have the same parameters and the same problems, even though they're similar.

The provinces are often in a better position to set their priorities because health is historically a provincial jurisdiction. Restructuring must be done and investments made in the right areas and the right ways. Earlier I mentioned the Agir tôt program, which was set up in Quebec for the early detection and stimulation of children with developmental issues. The program addressed a problem in Quebec that may not have emerged in another province. Since that problem has been addressed in Quebec, we may be able to focus more on mental health prevention and care for adolescents. Mental health services for the adolescent clientele are abysmal. We're very concerned about suicide, depression and school drop-out rates.

These variables suggest that the provinces are in the best position to take action. This isn't a matter of mismanagement. A trivial example here would be the issuing of passports. We haven't experienced all these problems just because this is a federal jurisdiction. Other factors have made it difficult to find a solution.

Similarly, the current restructuring of health care is a difficult issue for many reasons. They may include, for example, the aging population, labour shortages and obsolete structures. It's not a management issue; it's a matter of sociodemographic parameters as a result of which our health system must be reorganized. In my view, setting conditions on this funding merely raises another barrier between children and the resources they deserve.

Mr. René Villemure: So you disagree with the federal government's setting conditions on the transfer of amounts owed to the provinces.

Is that correct?

Dr. Marie-Claude Roy: I think the federal government's concerns will definitely be the same as those of the provinces. Introducing restrictions limits the freedom and fluidity with which services are organized, and that, once again, puts another barrier between the resources and the child.

My concern is to ensure that children get the right resource at the right time, whether they're in British Columbia, Ontario or New Brunswick, for example.

Mr. René Villemure: Earlier you mentioned literacy. Please tell us more about that.

Dr. Marie-Claude Roy: A study was done in the United States, and I think we can draw on it since it may apply to the problems we have in the same area here.

The pandemic set our young children's reading and writing skills back 20 years. Good reading skills from the start of primary school are the most significant factor enabling children to do well in school and earn their diplomas.

That's an aspect that must be addressed. That's why I discussed “educational” health in addition to physical and psychological health. We now have children in grade two or three who didn't go to school during the pandemic. They've experienced interruptions since their education started.

That's an example of the unique nature of a province. I'm extremely concerned that, as a result of the COVID-19 pandemic measures, children in Ontario can still choose not to go to school. We feel that attendance at school, without negotiation or compromise, is extremely important because it's their reading, writing and numeracy skills that will enable them to improve their educational trajectory. This is what was done in Quebec when students went back to school for the first time in the spring of 2020. It wasn't a choice. The children had to go to school unless there was some major health problem.

We know that school attendance is an extremely important health parameter for educational skills and the social safety net that the school system represents. It's an environment for growth that can't always be offered at home for certain children.

● (1145)

Mr. René Villemure: Thank you.

The Chair: Thank you, Dr. Roy.

Thank you, Mr. Villemure.

[*English*]

Next, we have Mr. Davies for six minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you to all the witnesses for being here.

We're only on our third meeting regarding this important study and I already detect a theme coming through, which is the importance of early identification, intervention and treatment for children. We had speech pathologists and audiologists here last week, who talked about that crucial period between zero and four, when language and communication skills are being developed. Dr. Feldman mentioned the concept of brain plasticity.

Ms. Gruenwoldt, I want to put my first question to you.

You brought up, as one of your three suggestions, better beginnings for maternal and newborn health. Can you expand a bit on what you would like to see as elements of a maternal and newborn health strategy?

Ms. Emily Gruenwoldt: To your point about those early days, weeks and months of a child's life, we know how critical maternal health is pre-pregnancy, as well as health and well-being throughout pregnancy and in those early days, weeks and months after birth. We know it's a critical time period, where early intervention matters in terms of the mental health of the family—mother, father and others who might be part of that family—as well as the critical care delivered within the hospital institutions.

Across this country, right now, we're seeing increased pressures and demands on neonatal intensive care units unlike anything we've ever seen before. Hospitals are now preparing different strategies to cope with that demand and to get a sense, from a health human resource perspective, of how we are training those pediatricians, specialists, nurses, etc. caring for children.

What I'm trying to say is that we need to think about the full continuum of the child's life, which begins before conception. We need to think about the research strategies and the gaps in our knowledge. We need to think about the data strategies, in terms of what we understand about the health and well-being of those children at that age, set clear targets and parameters for what that ought to look like, and look at international comparisons, as well.

Mr. Don Davies: Thank you.

I will turn to you, Dr. Feldman.

Are kids in Canada, from birth to the age of five, getting the kind of access to therapy and treatment they need, resulting in the kind of great story you relayed to us about that young man who graduated?

Dr. Mark Feldman: Unfortunately, the simple answer is no. They're not getting the access. We think about 20% of people are getting access to the care they need. This is a grave problem right now. There's a huge gap in the delivery.

Mr. Don Davies: Could you perhaps give us some of the key areas where they're not getting it? I guess this would be a relatively comprehensive problem, but where do you see the most acute needs in those gaps?

Dr. Mark Feldman: There are a number of things.

Assessments for kids with learning problems, psycho-educational assessments, cost about four to five thousand dollars. They're done privately, so most people can't afford them.

Now, there was a “right to read” inquiry in Ontario, and those psychological assessments have now been identified as a barrier to learning to read, because often an individual education plan in school is not enacted until they have that assessment, which for a publicly funded assessment in a school may mean being on a two-year wait list. Assessments are one thing.

Another thing is the learning and educational issues that Dr. Roy spoke so articulately about.

Another thing is therapy. For kids with anxiety or depression, the first line of therapy is a type of talk therapy called cognitive behavioural therapy. Cognitive behavioural therapy is an evidence-based, proven, effective strategy. Psychological services that deliver CBT, again, cost big money and they are private. They're not publicly funded or available, and so often kids are put on medication—which is a second line of therapy—first for their anxiety or depression.

I'm sorry. Go ahead.

● (1150)

Mr. Don Davies: I hate interrupting you, but I have only six minutes.

You brought up medication, which made me think of another question I wanted to direct to you. The Canadian Paediatric Society has been leading the call for child-friendly pharmacare in Canada. A few years ago, the CPS issued a statement with respect to the NDP's Canada pharmacare act that said the following:

> The establishment of paediatric-sensitive national pharmacare is an opportunity to correct the long-standing regulatory neglect that has led to a poor availability of paediatric drugs and child-friendly formulations. We...strongly support a pharmacare system that prioritizes the needs of children and youth and upholds the core principles reaffirmed in Bill C-213 of public administration, comprehensiveness, universality, portability and accessibility.

Those are the Canada Health Act principles.

Could you outline the barriers that Canadian children are currently facing in accessing affordable and effective medication?

Dr. Mark Feldman: I'm going to defer to Ms. Gruenwoldt, who has been much more involved on that.

Very quickly, there aren't a lot of pediatric-friendly formulations. A lot of what we learn and apply to children's care comes from research in adults. There are a lot of medications that are simply not on public formularies. There are a number of strategies for which a pharmacare strategy will be important.

Mr. Don Davies: Thank you.

Ms. Gruenwoldt, before you answer that—I want you to—I'm also going to throw in another question.

You mentioned that Canada is 35th of 38 in adolescent suicides. Is there any data or theories as to why that's the case, as well as the other question?

The Chair: I don't know that you're going to be able to get both questions in given that we're out of time, but we'll allow you time for a brief response if possible and you can supplement it in writing afterwards if you wish.

You can give a brief response, please, Ms. Gruenwoldt.

Ms. Emily Gruenwoldt: Sure.

With respect to the pharmacare program, I think any opportunity we have to increase access to safe and effective medications for children is a step in the right direction. We know that one in six families has struggled to fill prescriptions that have been directed for their children because of cost.

In terms of the safety and efficacy of the formulations themselves, 80% are prescribed off label, which means that it is not an approved, regulated dosage for a child or a youth. Safety and efficacy matter. Children have very specific sizes and develop at very specific stages and so it's not appropriate to look at an adult dosage and scale back. There are lots of challenges in terms of regulatory barriers for pharmaceutical companies to invest in the clinical trials for children, so that's an opportunity that the CPS has been leading in terms of regulatory reform for pharma.

The Chair: Well done. Thank you.

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

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): Thank you, Mr. Chair.

Dr. Powlowski brought up disinformation, and I share his concerns. In fact, in 2018 as a parent of a child with autism, I wrote an op-ed to talk about Andrew Wakefield's disinformation and the impact that it had on parents' decisions to vaccinate their kids.

I'm also concerned about another form of disinformation that comes in the form of a political party—when it comes time to run in an election—putting out promises and then clearly not delivering on those promises—like the promise by the Liberal Party to spend $4.5 billion on a Canada mental health transfer and page 75 of their platform document, which clearly indicates that $875 million would have been allocated by now.

Ms. Gruenwoldt, I think your suggestion was for 25% of that Canadian mental health transfer. Unfortunately, 25% of nothing is still nothing, so it wouldn't result in a change, but if the government had delivered on that promise by now and put $875 million towards a Canada mental health transfer, your proposal would have meant over $200 million delivered to benefit children.

What kind of impact would that have had? What would that money have been spent on had that promise been delivered?

● (1155)

Ms. Emily Gruenwoldt: Absolutely.

In Ontario, we know that prepandemic there were 28,000 children on a wait list for mental health services delivered in the community or acute care centres. We anticipate that number has grown over the course of the pandemic. Across Canada, that number is closer to 100,000 children on a wait list.

We know the impact that early intervention can make on children's mental health. It pays lifelong dividends in terms of their overall health and well-being. Proportionately, 25% reflects roughly the number of children and youth under the age of 18 in Canada. What we don't want to see is children left behind in any sort of funding envelope to address mental health, children being an afterthought. We really want to make sure they are prioritized in the rollout of any programs and services to improve their access to care.

Whether that is increasing the number of providers who are trained in the pipeline to provide services in the community, or whether that includes space in our acute care facilities to care for the most complex acute mental illnesses amongst our children and youth, those are all opportunities that immediately require investment that those dollars would support.

Hon. Mike Lake: Thank you.

Dr. Feldman, I'm wondering if you could weigh in.

Say over $200 million that was promised had been delivered, and $800 million for Canadians across the board. Let's say that about $200 million was spent already by now, invested into the system.

Where would you suggest allocating that money?

Dr. Mark Feldman: I would perhaps look at advanced training programs, more doctors, more training for doctors out in practice, and continued professional development. I would also look for more publicly funded therapy and regulated evidence-based therapies.

I can spend it pretty quickly.

Hon. Mike Lake: Just doing a quick calculation, if you calculate the $875 million that was promised to have been spent by now, about $200 million would have gone to Quebec.

How do you think that money would have been best spent in Quebec, the $200 million toward mental health?

[*Translation*]

Dr. Marie-Claude Roy: Is that question for me or for Dr. Feldman?

Hon. Mike Lake: It's for you, Dr. Roy.

Dr. Marie-Claude Roy: I entirely agree with Dr. Feldman's remarks.

Personally, I'm obviously in favour of prevention and having more professionals. Both my colleagues also mentioned that.

I think that the share allocated to childhood should be far more than 25%. As regards mental health, what ensures a positive future for an adolescent or adult is first and foremost having the tools to help us address mental health issues.

If we invest more in mental health prevention for children and adolescents right now, the entire population will benefit. So I wouldn't simply go on a per capita basis. Most of that money should be invested in mental health prevention for children and adolescents.

As Dr. Feldman said, we're currently trying to solve the problem with medication because we lack resources. We medicalize problems when patients should be supported from a very early age.

We'll very likely reap the benefit of investments made in support, therapy and, especially, tools of all kinds in 10, 15 or 20 years. Individual therapy won't necessarily be for the long term.

Prevention programs must be put in place. We have to take a generational approach to preventing mental health problems.

[*English*]

The Chair: Thank you, Dr. Roy.

Next, we have Mr. Jowhari, for five minutes.

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair, and thank you to all the witnesses for coming today.

I'm going to begin with Ms. Gruenwoldt.

In your opening remarks you talked about an initiative that was launched called “inspiring healthy futures”. You talked about five interlinking priorities. I noticed you ran out of time to be able to cover all those priorities. There were a number of them that stood out in my mind. We've been actually talking a lot about mental health.

Can you briefly talk about the research data collection and the sharing of data? As one of the interlinking recommendations, could you give us some background?

● (1200)

Ms. Emily Gruenwoldt: Sure. I think right now, if we look across the country, different data elements related to children's health are being collected by different jurisdictions. They have different levels of access for folks like researchers, or for program and service providers and policy-makers. We're looking for more of a robust, continuous, integrated data strategy that would be accessible to all those different communities to help us make better, evidence-informed, more timely decisions for children and youth.

Throughout the “inspiring healthy futures” consultations, we heard a number of calls to action. We agree that Canada needs to develop and implement a consistent, comprehensive dataset, regardless of where services are provided, which is comparable across different jurisdictions, whether it's health, health care or health outcomes, and linked to our education data as well. We also need to ensure that the folks who are impacted by this data are included in the design of the data and that we respect indigenous data sovereignty.

The third element is that we need to make sure, as I said, that all of this data is accessible to the different stakeholders who can make use of it, so that it is supporting evidence-based decisions.

Mr. Majid Jowhari: Thank you.

In the closing part of your remarks, you talked about bold leadership and commitment from the government. Can you elaborate on what you meant by “bold leadership”, and what kind of commitment you are looking for from all levels of government, specifically the federal government?

Ms. Emily Gruenwoldt: To begin with, this is a great opportunity that we have today to discuss children's health and well-being. This opportunity hasn't existed in several decades, as far as I'm aware, so the opportunity to think about a pan-Canadian child and youth health strategy is timely and urgent, I would argue.

In terms of a bold strategy, we need to think about how we are investing in policies and programs that support children, youth and their entire families, and how we make further investments, for example, in maternal and parental leave, children's benefits and the access to programs and services that exist.

We also need to be attentive to and respect the vision that children and youth have for their future. What we learned through the “Inspiring Healthy Futures” report is that they have a very clear vision and some very clear ideas and ambitious goals about what they would like to see in terms of opportunities to support their health and well-being. I think that is important. Inviting youth to this committee would be a great start, to hear from them directly on what some of those options might be.

Lastly, to be accountable, we need targets, measures and instruments that will hold the federal government, the provincial governments and organizations like mine to account, so we know that we're making meaningful and measurable progress for children and youth. Whether that's the idea of an independent accountability office or a commissioner or otherwise, that sort of leadership would be welcome at this time.

Mr. Majid Jowhari: Thank you.

I'm going to move on to Dr. Feldman.

Dr. Feldman, you were talking about CBT and early intervention, and that being a method of making an early impact in a much shorter time frame than other prescribed methods.

Can you expand on that? You ran out of time while trying to cover that point. I have about a minute, and I'm going to give that to you to finish that thought.

Dr. Mark Feldman: Thank you.

Services offered by psychologists for the younger children that are currently not publicly funded are really about assessment for learning, behavioural and development issues. There are small amounts that are publicly funded through schools, but the wait-lists are untenable.

Services for kids who are a little bit older that psychologists or other health disciplines trained in the delivery of CBT provide are similarly very difficult to access, and generally speaking are not publicly funded.

CBT is an evidence-based therapy that makes a considerable difference in terms of function and quality of life for kids with anxiety and depression. CBT is first-line therapy, and medications like Prozac are second-line therapy, but often they're started first because we can't get a psychologist.

● (1205)

The Chair: Thank you, Dr. Feldman and Mr. Jowhari.

[*Translation*]

Mr. Villemure, you have the floor for two and a half minutes.

Mr. René Villemure: Good afternoon, Mr. Chair. Thank you.

My question is also for Dr. Roy.

Dr. Roy, did the provinces and territories take the same pediatric health approach during the pandemic?

Dr. Marie-Claude Roy: The pandemic actually landed on everyone's head like a ton of bricks. I think you could put it that way. We had to make an enormous number of adjustments and adapt to the situation. We've talked about leadership, exchanging approaches and sharing topics of concern. That's Canada's strength, and we have to remember that.

Earlier I talked about Ontario, but, in Quebec, we immediately recommended that children go back to school, knowing that COVID-19 wasn't a serious threat to them. It was a calculated risk. We knew that, since the pandemic seemed to be dragging on, and is still with us today, the impacts on children's health would be drastically greater if we decided to limit school attendance, the social safety net, financial and food support and measures designed to limit family violence.

We had numerous discussions with our Ontario colleagues, who were concerned that children weren't going back to school. We had discussions with the Canadian Paediatric Society. The approaches were different, first of all because fears varied considerably from coast to coast and province to province. Populations and health systems reacted differently. However, we communicated with everyone and gathered assets and ideas from everywhere. It was a great way to work.

So approaches were different, but we've managed to improve how we work together. I'm thinking, in particular, of the long-term residential care centres, the CHSLDs. We drew on certain models in Quebec because we felt that things weren't going well in that area. The situation was much better in British Columbia, for example. Even though approaches were different, it was this variety of methods and pooling of approaches that enabled us to move all the provinces forward.

Mr. René Villemure: I believe that this wide range of interesting approaches you've mentioned shows that we should be learning from other provinces, while still allowing them to choose the therapies or other measures they would like to adopt.

Don't you agree?

Dr. Marie-Claude Roy: Each of the provinces would benefit, and then collectively, so would the federal government. A single recipe would not work. That was clearly demonstrated during the pandemic response, which reflected the diversity of the population's needs from one region to another in Quebec, and also from province to province across Canada.

Mr. René Villemure: Thank you very much.

The Chair: Thank you very much.

[*English*]

Mr. Davies, you have two and a half minutes.

Mr. Don Davies: Thank you, Mr. Chair.

Ms. Gruenwoldt, I asked you at the end of my last round to answer why Canada is 35th out of 38 in adolescent suicides. What are the causes of that?

Ms. Emily Gruenwoldt: I'm not a mental health practitioner, but we do know that children and youth have struggled in academic environments. Being in and out of school over the course of the pandemic has likely served to stress a particular population of children who weren't thriving in the at-home environment. There are lots of risk factors at home for some of those children as well.

Otherwise, the support and community based services—which are either preventative or early intervention services—largely aren't available or accessible. The two-and-a-half year wait is a very long time to wait for a child or youth and their family when they're suffering from mental health concerns.

I would also say, to Dr. Feldman's point earlier, that the opportunity to train our general practitioners, pediatricians and some of those frontline health care providers to earlier identify concerns and diagnose and refer is a great place to start. We also need to think about how we deliver access to children who are rural, remote, indigenous, new Canadians or not English first, etc.

Mr. Don Davies: Thank you.

Dr. Feldman, in your practice or among other pediatricians, I'm curious about the extent to which you see a lack of access to universal dental care manifesting in children. Is that a significant oral health issue in Canada?

Dr. Mark Feldman: Yes, I do think it's an issue. It's not my area of expertise, but certainly when I looked at the first meeting of this committee, I found the concerns raised by the dental association leads quite compelling.

Although I'm a general pediatrician, my practice is now more specialized in kids with mental health and learning issues.

● (1210)

Mr. Don Davies: Do you have any explanation for why we seem to have a burgeoning crisis in adolescent suicide in Canada? What are the causes of that?

Dr. Mark Feldman: A lot of this is conjecture. The numbers are there, but much more research needs to be done. There's been a huge rise in eating disorders during the pandemic. I think the access issues that were just spoken about are going to turn out to be a really big part of that.

For example, kids with ADHD are more likely to commit suicide if they're not treated. In fact, specific treatment for their ADHD, not simply depression or anxiety, reduces the impulsivity and the likelihood of suicide.

I think the isolation that we all experienced through the pandemic must have played a role.

There are so many different theories, but further research into this area needs to be done. Certainly we need to address the access issue now, but more research and more targeted approaches are needed.

The Chair: Thank you, Dr. Feldman and Mr. Davies.

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

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

Thank you to all the witnesses for your testimony today.

Something that I'd like to touch on is something that's been pretty active in the news as of late. It's something that I know touches a lot of parents and is causing a lot of stress. That's the shortage we're seeing in children's Tylenol, Advil and Motrin, specifically in the infant formulations.

I was wondering if you have anything to add, or is there anything that the Government of Canada could do to try to alleviate some of the shortages and diminish the stress that so many families are seeing?

I see Ms. Roy shaking her head.

[*Translation*]

Would you like to go ahead, Ms. Roy?

Dr. Marie-Claude Roy: Yes, thank you.

I'm shaking my head because that situation and the milk shortage became a major problem.

We worked hard on the issue during the shortage of hydrolyzed formulas for infants with an intolerance to cow's milk proteins. The same was the case for Tylenol and Advil. Worker shortages were frequent, I believe, and we also ran short of all kinds of things other than medications.

It's clear that the federal government can help us by reaching out to other countries, like Europe and other markets. Of course we need to restrict ourselves to what's approved here in Canada.

Nevertheless, versatility, flexibility and the ability to adapt quickly were clearly in evidence during the pandemic. This kind of flexibility is essential for us. When you start running short of very specific medications for children, then I think other options have to be available. It's important to be able to resort to international solutions to at least attenuate the impact of the whole situation, which was very difficult for many parents.

[*English*]

Mrs. Laila Goodridge: As a mom of a little boy who is getting his first molar, the shortages have really amplified the stress, and it's made me really curious as to why something that is so required and can prevent children from filling up your ERs is so hard to come by.

I was wondering if Ms. Gruenwoldt has anything to add on this subject.

● (1215)

Ms. Emily Gruenwoldt: What we have been encouraging parents to do is lean into trusted resources, their pediatrician or their children's hospitals, for other sources of information or advice to manage pain. There is also a federally funded NCE program called Solutions for Kids in Pain that offers a number of different pain management strategies that parents might find of use.

To the general problem and the role of the federal government, I have nothing to add to Dr. Roy's testimony.

Mrs. Laila Goodridge: Thank you for that.

I'll go back to one of the pieces that was touched on by Dr. Feldman about eating disorders in kids. I think that's incredibly troubling.

How young are the children we're seeing eating disorders in, and are there any causes that are being identified that perhaps we could address as a government to make sure that we are taking care of these children?

Dr. Mark Feldman: Unfortunately, in young, prepubertal kids, we're seeing eating disorders. The cause of it is unknown. There is conjecture again, in part. Speaking with some adolescent medicine colleagues and asking them the very same question, one of the theories is that during a period of time in this pandemic, with no sense of control, it was the one thing that they could control.

Other theories include online learning, dissatisfaction with their image and social media.

There are a number of theories, but we don't know 100% for sure.

Mrs. Laila Goodridge: Thank you for that information. This is clearly a space in which mental health is driving some of this, and it has long-term impacts. It can impact fertility later on in life. It can impact overall health.

Do you have anything to tell parents who might be listening about what they could do to help kids who are struggling with eating disorders?

Dr. Mark Feldman: I'll defer that one to Dr. Roy, if she sees a lot of kids with eating disorders.

It's not a part of my practice, but, in general, we know that being very positive, not telling kids that they're worried about their appearance, talking about healthy lifestyles and not appearance.... These are some very general recommendations.

Largely why some kids are affected by anorexia nervosa and others aren't is still a bit of an unknown.

The Chair: Thank you very much, Dr. Feldman and Ms. Goodridge.

Next is Dr. Hanley for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you to all three of you for the testimony today.

When we're thinking of recommendations and outcomes from this study.... I think part of the context of the child health study was the pandemic and the effect of the pandemic on children's health. There are various questions around what the pandemic has revealed or laid bare in trends that were already happening. What has it perhaps exaggerated? What are the direct effects of the pandemic?

If you had $4.5 billion, what is going to heal, as we heal as a society? What can we perhaps leave to heal as more of the transient, stress-affected results of the pandemic? Where do we need to focus on targeted interventions?

Dr. Roy and Dr. Feldman, you have both talked about that to some degree, but I'm thinking with this amount of funding, we need to be very efficient in how we use it, because it will disappear, especially if it is not well used. Perhaps each of you could comment—Dr. Roy first and Dr. Feldman in a minute.

Where you would put that money and get the best bang for your buck?

● (1220)

[*Translation*]

Dr. Marie-Claude Roy: I really liked the way you put it, meaning that the pandemic exacerbated an existing problem.

Let's go back to adolescents. There are many hypotheses about this, but what mainly allows adolescents to develop and grow towards adulthood is the ability to leave home. That's because they've assimilated their family's values, turned outwards, and made other connections. Parents become secondary and friends become a priority. After that, they fashion their own personality. That's precisely what the pandemic prevented them from doing. It forced adolescents to turn inward and to depend on screen time and social networks, immersing them in a flow of images of perfection and the feeling that they have completely lost control, which is toxic for them.

It's essential to consolidate what adolescents and young people learn, and to strengthen their feelings of accomplishment and self-esteem. Mental health support is, of course, the starting point, as was mentioned. Young people consolidate what they have learned and blossom as they succeed at school, as they get coaching, tutoring and encouragement for their educational performance at school. They can apply their talents to sports and physical activity, as well as in positive interactions with coaches or other adult models they can emulate.

A massive investment is needed in all the social safety nets for children. As was mentioned earlier, the family setting is not always solid enough to consolidate children's achievements.

But as I was saying, the provinces need latitude so that they can invest in other sectors that can have an impact on children's health, like education, sports and other forms of support. Of course, prevention programs also required to help them develop properly.

The health sector needs to be decompartmentalized and health needs to be viewed as a set of parameters that gravitate around children, precisely to help them consolidate their personality. I believe it's a potential solution that ought not to be ignored.

[*English*]

Mr. Brendan Hanley: Dr. Feldman, perhaps you can add to that.

Dr. Mark Feldman: Thank you.

I think of it as both quality and quantity of health care delivery. For quality, I break it down into efficiency and effectiveness. How are we more effective? We need to make sure that therapies are evidence-based. We shouldn't be giving any money to unproven therapies. Effectiveness is through evidence-based practice.

Through efficiency, there are a few strategies. One is to have, perhaps, the mental health care team model in which only one of them, perhaps, is a physician, pediatrician or a psychiatrist, and there are a number of more cost-effective solutions and team members that can provide care.

In Toronto, there is something called the family navigation project, which helps with more efficient navigation of referrals, getting the people to the right place at the right time to navigate waitlists. So, it's efficiency through navigation, efficiency through involving our non-physician colleagues, and effectiveness by demanding that they be evidence-based practices. In terms of quantity, we need more health care providers.

The Chair: Thank you, Dr. Feldman and Dr. Hanley.

Next we have Mr. Lake, please, for five minutes.

Hon. Mike Lake: Thank you.

Ms. Gruenwoldt, I was really struck hearing.... We've talked a lot about it, but those numbers from the 2020 UNICEF report are very problematic and troubling: We're number 30 out of 38 countries on physical health and number 31 out of 38 countries on mental health.

What is the connection between mental health and physical health? Maybe speak to that because I think those numbers.... It's not coincidence, necessarily, that we're around the same ranking in both.

When we think about mental health—and I'll go to the two doctors after this on the same question—as mental health deteriorates, what's the impact on physical health for kids?

Ms. Emily Gruenwoldt: That's probably a great question for your two pediatricians, but my observation would be that a piecemeal approach to addressing children's health and well-being—physical health and mental health—has not served us well to date and, I think, is not what is required to get us...or to measurably improve children's health. We really need to think more systemically.

What we heard through the "Inspiring Healthy Futures" report was that there are five interlinked areas that require simultaneous investment and consideration. That's around children's physical and mental health. It's around the schools and communities in which children live. It's around a robust health research agenda. It's around strong policies to support children's physical and mental health and well-being and social development. It also involves that idea about empowering youth. Looking forward, we have piecemeal investments. Where do we start? We really need to think about this more systemically. This isn't "throw money at one particular problem and we're going to solve children's health."

As for your point about mental health impacting physical health, I'll defer to the two physicians on the line.

● (1225)

Hon. Mike Lake: I just asked you first because you were the one who raised the statistics.

Ms. Emily Gruenwoldt: No problem.

Hon. Mike Lake: Dr. Feldman.

Dr. Mark Feldman: Thank you.

It's a great question. Kids with depression, anxiety, learning and attention issues are more at risk for drug addiction and alcoholism, and that's going to affect their health. Kids with ADHD are two to three times more likely to be obese because of impulse eating, and that's going to affect their health. Kids with eating disorders have consequences from their food restrictions. Kids with mental health disease in general make poor nutritional choices and lifestyle choices, and then there are some—not to go into too much detail—conditions that lead to both health and mental health issues. There are kids with medical complexities who have mental health issues as a result of their medical issues. So, they are intertwined and additive to each other.

Hon. Mike Lake: Dr. Roy.

[*Translation*]

Dr. Marie-Claude Roy: I would add that mental health definitely has an impact on physical health, but that the reverse is also true: physical health has an influence on mental health. Another point worth making is that the mental health of parents also has an impact on the mental health of their children.

As for psychological health, children and adolescents who are not doing as well, or who are less active, will suffer more from problems of obesity and too much screen time. Behavioural and emotional problems in children inevitably lead to distress for parents. Exhausted parents are also less likely to be proactive about doing something to adopt healthy sleep and diet habits for themselves and their children. It's all highly interrelated.

Nor should chronically ill patients be underestimated. It's often been said that mental health has an impact on physical health. Chronically ill patients experience distress and their children don't have a normal adolescence. This can generate considerable psychological distress.

And the social and emotional aspect mustn't be forgotten. It's been shown that having a less caring family network, in which emotional ties are limited, with signs of attachment disorder, automatically has a harmful effect on children's height and weight.

All these parameters are interrelated. Earlier, we were talking about brain plasticity and development. That's why the psychological health of parents ought not to be underestimated. From very early on, in the first few weeks of life, the parents' psychological health has an impact on their child's physical and emotional development.

[*English*]

The Chair: Next is Mr. van Koeverden for five minutes.

Go ahead, please.

Mr. Adam van Koeverden (Milton, Lib.): Thank you very much, Mr. Chair.

Thanks so much to all the witnesses today for their extraordinary testimony.

I have two main questions, both a little vague.

As we've been talking and poring over data tables and things like that, I've been a bit distracted by the numbers.

I'm curious about folks and their opinions on the dichotomy between the fact that Canada tends to rank fairly high on health care expenditures and quite low on good outcomes. It strikes me that either our challenge is greater or the delivery is flawed, or there are other factors at play. I tend to want to resist the temptation to recommend that we throw more money at the problem. If it's not currently being spent as efficiently as other countries, then I want to investigate how we could be doing more and better with the money that's currently being spent before we react with more health care transfers to provinces.

I really appreciate the intervention from Madame Roy with respect to the upstream challenge of health care, primarily from a mental health perspective, but a physical perspective as well in preventative medicine and trying to provide better conditions rather than only just mental health services.

Certainly, I take your comments very well, Dr. Feldman, with a need to provide more remedial services but at the same time ensuring that we're building resilience and ensuring that kids have access to all of the things that keep them resilient, happy and healthy—from good food, good living conditions, access to sports and the arts. I think that very good living and education environments are key.

Could we have a brief comment from each witness, perhaps, on the necessity to focus in on some key areas with respect to efficiency and spending, and areas in which they believe we could be more efficient with that delivery, and on that upstream challenge with respect to how Canada differs?

I think I'm less concerned with the rank and more concerned with outcomes. It's obvious that we need to improve outcomes for Canadians.

Perhaps I could start with you, Dr. Roy, since you're nodding.

[*Translation*]

Thank you.

● (1230)

Dr. Marie-Claude Roy: There are several aspects to your question. I agree with you. The numbers and the rankings are not what I am most concerned about. We discussed deaths, for example among highly premature infants. I think we need to get away from the numbers and begin with the outcomes. We need to see what we want for our children and how we can have a real impact. We need to ask why there are still gaps and how they can be addressed.

Unfortunately, whether what's involved is mental health or child protection services, the system has perhaps always been accustomed to taking action when the problems had become clear and obvious, and when it was too late to do anything about them. We need to return children to the top of our priority list and focus on prevention. It's easy to say that we're going to work on preventing anxiety in the schools. While there's nothing the matter with that, I believe prevention has to be at the societal level.

I'm thinking of some parents who, morning, noon and night, don't have meals with their children. This might seem to be a minor point, but prevention is also to be found in sound family values that help children develop properly. We're talking here about teaching people to adopt healthy eating practices, to sit down to eat properly, and to have a healthy lifestyle. It may sound trivial, but it's what has the greatest impact in the everyday lives of parents.

Children with ADHD do better when there's a family structure, some form of regularity in everyday life. When children engage in outdoor activities, and get moving, the use of medications drops. The same is the case for ADHD and developmental problems. That's where prevention lies.

Prevention can also take the form of raising awareness in society. What I'm talking about here is social networks. Children have a cell phone when they're 10 years old. They learn to use it when they are very young. A child's right to have a smart phone of their own has become a societal norm. Why? It has to do with parental anxiety. As a result, children are exposed to cyber predators. They also are constantly exposed to images of perfection. The result is a form of dependence that becomes central to their life. Life has become virtual and faster.

Prevention therefore requires a much broader approach. Adjusting these parameters is what might eventually lead to results. Problems need to be dealt with when they appear, but it's also important to try and prevent them by exploring new avenues.

Mr. Adam van Koeverden: Thank you, Dr. Roy.

The Chair: I'm sorry, but there's no time left for the other witnesses.

I will now give the floor to Mr. Villemure for two and a half minutes.

Mr. René Villemure: Thank you, Mr. Chair.

Once again, I have a question for Dr. Roy.

Dr. Roy, I have greetings for you from Mr. Jean-Denis Garon, who couldn't be here this morning.

I'd like you to talk to me about the delivery of health care for children as seen through the prism of the Association des pédiatres du Québec.

What are the greatest challenges in Quebec in terms of the provision of care for children?

Dr. Marie-Claude Roy: I'll speak to you about the challenges of greatest concern to us in the delivery of health care. As we know, in the early stages of life, there are many more premature births, chronic problems like encephalopathy or exploited children. These children are rescued and sent home, but the parents receive no support. The caregiver concept is also very important in pediatrics.

For school-age children and adolescents, mental health, psychological, and social and emotional support are also crucial. And for our chronically ill patients who are transitioning from adolescence to adulthood—and I'm talking here about patients who would otherwise not have survived to adulthood—there are few resources. We deal with them up to 18, 19, 20 or 21 years of age and have trouble letting them go because there are no resources for them. Accepting their chronic state is often difficult in adolescence.

I think that those are the main aspects that need to be prioritized. Acute health care and accessibility are challenges, but not the issues of greatest concern. They are at the same level as all the others. The ones I just mentioned, however, are more specific pediatric problems.

● (1235)

Mr. René Villemure: Do you feel that the federal government is spending enough on promoting children's mental health?

Dr. Marie-Claude Roy: I believe it is a matter of concern, as confirmed by the work of the committee today. From province to province, the problems are the same. The fact that we are now looking at these issues leads me to hope that major funding will be forthcoming. It is needed. We don't have a choice. We can no longer ignore these problems.

Mr. René Villemure: You spoke about literacy earlier. Are there any studies that document the impact of the pandemic on children's socialization and education?

Dr. Marie-Claude Roy: Yes, there have been some from the start. We're lucky because retrospectively, we've been in a position to evaluate the situation over the past two years. We were able to observe, even clinically, very young children who had trouble relating. They would draw pictures of children, but would no longer put a mouth on the face because they couldn't manage to show us a smiling face. There were problems with language. However, there seems to be some improvement, because early childhood has become a priority.

For schooling, goals had to be lowered. I think this applied across the country. It has to be viewed as an adaptation to normal childhood development. It doesn't have to be seen as a highly specific form of educational development. But things are definitely lagging behind and it's obvious. Unfortunately, we can expect waves of dropouts.

Studies have confirmed the phenomenon.

The Chair: Thank you, Dr. Roy and Mr. Villemure.

[*English*]

Next is Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: Thank you.

Ms. Gruenwoldt, sorry if you've covered this but I want to be clear, do you know what portion of overall health care spending is currently allocated to children's mental health services in Canada?

Ms. Emily Gruenwoldt: No, we do not.

Mr. Don Davies: Okay, thanks.

Dr. Feldman, in March of this year, CPS then-president Dr. Ruth Grimes wrote a letter to the federal government that said the following:

> On behalf of the Canadian Paediatric Society (CPS), Canada's national association of paediatric health experts, I am writing to ask for immediate action on the federal government's long-standing commitments to support healthy eating initiatives, namely, finalizing front-of-package nutrition labelling regulations and restricting the marketing of food high in sugar, saturated fats and sodium to children.

Can you outline why the CPS supports these initiatives?

Dr. Mark Feldman: Very simply, we want to promote healthy eating.

Mr. Don Davies: Dr. Roy, the Canadian Paediatric Society says that they would like 30% of federal transfer payments under the Canada mental health transfer to be dedicated to timely and equitable access to mental health care for children and youth under the age of 25, and Children's Healthcare Canada—both are appearing today—is requesting that 25% of the federal health transfer be earmarked for children.

Would you support this, Dr. Roy, that a certain percentage of the federal mental health transfer to provinces be conditioned on it being spent on children?

[*Translation*]

Dr. Marie-Claude Roy: Clearly, the priority has to be children, one way or another.

I believe that the provinces have to be free to take action as they see fit. As I mentioned, there are definitely some provinces for which funding should be increased by more than the 30% earmarked for children. Perhaps other provinces have already made that a priority.

From 25% to 30% of funding should be focused on children's health. I don't think that this should be a federal government requirement, because even though the distress is the same from sea to sea, the measures already in place vary from one province to another. Some may decide to spend more, which would be a good thing.

Once again, perhaps a base level should be established. After that, some latitude should be left to the provinces.

The Chair: Thank you, Dr. Roy.

[*English*]

Thank you, Mr. Davies.

Next is Mr. Barrett, please, for five minutes.

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): Thanks to the witnesses for joining us today.

I'll throw this question out and see who wants to answer first. I'd like to talk about the backlog for pediatric cancer screening, treatment and care appointments and see what you'd suggest as a remedy for that backlog.

We can start with you, Dr. Feldman.

● (1240)

Dr. Mark Feldman: I would probably reflect back on the first meeting that you had with regard to some of the suggestions made regarding cancer care. The pandemic left a big backlog for surgeries and treatments. I think there were a number of recommendations made in the first meeting about that.

It's certainly not my area of clinical expertise, but I not only know of patients who have waited for cancer care, I also have colleagues who have waited six months to get their breast cancer surgery. It's a big issue and it needs to be addressed. But it's not my area of expertise.

Mr. Michael Barrett: Would you find helpful things like the scaling up of virtual care and increasing the number of practitioners in the field of medical practitioners by making sure we're licensing and speeding up our training for internationally trained doctors? Would some of these solutions, do you think, be immediately helpful to address this problem?

Dr. Mark Feldman: In terms of licensing internationally trained physicians, I've been actively involved in supporting that but with a great degree of caution.

There are a number of international medical graduates who do training at The Hospital for Sick Children, additional training. Over the two to three years of their subspecialty training, we get to know how good their training was before that and what sorts of individuals they are. Then we're in a position to advocate on their behalf to get licensing through a process called “academic licensure” here in Ontario. I've been very involved in that. I think it's an amazing potential resource to address some access gaps, but cautiously, because there are places in the world that don't have the same sort of training we do.

Mr. Michael Barrett: Dr. Roy, did you have something you wanted to add or was it just your concurrence with Dr. Feldman?

[*Translation*]

Dr. Marie-Claude Roy: I fully agree with Dr. Feldman. We ought not to deprive ourselves of these resources, but we need to be careful, because we have standards to meet. We are having trouble meeting demand, because currently, we expect nothing less than perfection. As doctors, that's what guides us, and we want what's best for our patients. And, of course, it's essential to establish standards of practice.

[*English*]

Mr. Michael Barrett: With respect to virtual care, do you see that as an emerging opportunity—one that was scaled up during COVID and perhaps one that can be expanded on—for alleviating some of the swelling that we have in our primary care offices, as well as in emergency rooms, for non-emergent situations?

Dr. Mark Feldman: Maybe I'll start with that one.

There's a real potential for added value with regard to what we've gained in terms of technology advancements, but again...cautiously. For example, if I see a patient who has been referred to me with suspected autism and it's a mild form, I can't tell on Zoom, but I can tell within a few minutes of seeing them in person.

There are limitations to what we can provide with distance care, but it is a great additional tool for certain clinical scenarios.

Mr. Michael Barrett: Do you have anything to add, Dr. Roy?

[*Translation*]

Dr. Marie-Claude Roy: Yes, I'd like to add that there are some very specific client groups for whom technology was used, particularly for follow-up treatment. We were discussing the problem of too much screen time among adolescents, but they can sometimes be more flexible because they're accustomed to interacting virtually. I've had some very good results working virtually. It also provides more access for remote families who don't have services available, and for underprivileged families, for whom it is easier to consult a doctor by telephone or virtually than by travelling.

There is no doubt that this practice should remain in place, but it should not be overused, because human contact is extremely important.

● (1245)

The Chair: Thank you, Dr. Roy and Mr. Barrett.

Ms. Sidhu, you have the floor for five minutes.

[*English*]

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Chair. Thank you to all the witnesses for joining us today.

We heard from you, Dr. Roy, that depression, anxiety, obesity and some medical conditions also lead to bad health.

I want to bring your attention to celiac disease, which can develop at any time. After wheat or other gluten food are introduced into the diet, many kids are diagnosed when they are between six months and two years old. Celiac disease is treated by not eating gluten, but this can be hard because gluten is in many foods. It is the same thing for diabetes type 1.

How can teachers and the school play a role in assisting children with those kinds of chronic conditions?

[*Translation*]

Dr. Marie-Claude Roy: You've just pointed out how important teachers and the school system are for children's health. You mentioned two problematic conditions that occur frequently, but there are many others. Teachers are under a lot of pressure at the moment. They need to be capable of dealing with behavioural and social-emotional disorders, not to mention the usual teaching problems, and now, they're supposed to be able to learn how to deal with celiac disease and diabetes.

One of the secrets of success is the partnership between the health and educational systems, not only for behavioural and learning disorders, but also health. There are several pilot projects underway in Quebec on this. There are often nurses in the schools, but fewer and fewer of late because they too are in short supply.

Having medical staff and health professionals support the school systems is the key to success for these children. The families need to be equipped, but so do the schools.

[*English*]

Ms. Sonia Sidhu: To follow up on that, we also heard a bit about how the increased use of social media and screen time is having an impact on children's health.

Do you have any thoughts on how we can best promote health and development for our children in an increasingly digital world?

[*Translation*]

Dr. Marie-Claude Roy: The threat comes from people treating all this as normal and trivial. In my office when I'm dealing with parents, I have to challenge the 12 hours of screen time a day on a regular basis. Everyone looks at me as if I were crazy.

Just as we practise prevention by advocating physical activity and discouraging smoking, we need to make parents aware of their role and make society aware of the fact that it's not normal for a child to interact with the screen 12 hours a day, or even 18 hours a day. It needs to be seen as an opportunity for this generation, but also definitely as a threat to family life and to the development of these children.

[*English*]

Ms. Sonia Sidhu: Thank you.

Dr. Gruenwoldt, I have heard very positive feedback about virtual care, that for some older folks or due to a lack of time, virtual care is a good tool. Do you see any gap there, or do you think virtual care is good for Canadians?

Ms. Emily Gruenwoldt: I think we heard earlier that we've observed some very positive early outcomes in terms of accessibility to health care services, especially for families of children with complex medical conditions who are making frequent visits. It saves time. It saves dollars. It supports them in their family environment.

I think from a health systems perspective, there's lots to learn. There's lots to watch. But there's been lots of very early indications of success. We've seen lots of innovative programs and services pop up, including the virtual emergency department and other virtual clinics to serve specific patient populations.

I think it is a promising step in the right direction.

Ms. Sonia Sidhu: Thank you.

Dr. Feldman, we did a human health resources study. You were taking about the navigation project. Can you explore that project and what it is?

● (1250)

Dr. Mark Feldman: It's a pretty impressive project that comes out of Sunnybrook hospital in Toronto. What they do is they have some people at the other end of the phone who help find shorter wait-lists. When there is a mental health service that is private, they help negotiate lower rates. They help ensure that the referral is appropriate and that it's going to the right place. I've had patients referred to me who waited months, and it was clear that they should have been referred for a different type of specialty. I've had kids referred to me who really ought to have been managed by perhaps more of a generalist. With the resources provided by these navigation project offices, sometimes this can be circumvented. It's exactly what I think was talked about earlier in terms of not throwing money at things in making things more efficient.

Having said that, there's still a big human resource gap. There's a big two-tiered system with regard to mental health delivery that needs to be addressed. I think some funding will need to be applied.

The Chair: Thank you, Dr. Feldman.

We'll now go back to the Conservatives.

I would like to welcome Mr. Maguire to the committee.

Mr. Maguire, I would invite you to take the floor for the next five minutes.

Mr. Larry Maguire (Brandon—Souris, CPC): Thank you, Mr. Chair.

Thank you to the witnesses. I wasn't here for the first part of this, but it's been very interesting to hear your comments and the questions from my colleagues from all parties here on these issues.

Dr. Feldman, I think it was you, or maybe it was all witnesses, mentioning the priorities of youth and online training, which Ms. Sidhu was just asking about as well. The amount of time or the ease of being able to do that online is one thing for remote and other areas, which I believe Dr. Roy mentioned. Are there specific age groups, when we're talking about youth, that can be more helped in that area than not, using the example you used about autism, I believe?

Perhaps you would be able to expand on that.

Dr. Mark Feldman: Yes. It's a wonderful resource to now have this technology to save time, money, visits, etc., but it has its limitations. You would think that the sort of patients that I see in mental health would be ideally suited for distance learning, because you don't have to examine their abdomen or listen to their chest. But it turns out that you need to interact with them in person, frequently, to truly get a sense of their mood, their level of anxiety, their ability to pay attention and their social interactions. Sometimes just to connect at a greater level is so important when establishing relationships with your patients.

I think there will continue to be a need for both. What I've started doing with some of my patients is deliver every second visit virtually. Those kids who are on medications need to have their blood pressure checked and their height checked and their weight checked on accurate scales. So there is a need for both, but there is a great potential to reduce time and cost for both families and the system.

Mr. Larry Maguire: Dr. Roy, do you have any comment?

[*Translation*]

Dr. Marie-Claude Roy: We need to interact with children personally. While the diagnosis may be easy to establish, even virtually, we should not lose sight of the human aspect of medicine in our dealings with parents when explaining a diagnosis and the serious consequences thereof. That's my concern about all of this.

As for the frequency of follow-ups, we need to take stock of the patients' circumstances, evaluate them at regular intervals, and schedule appointments between follow-ups. Frequent follow-ups are required for proper adjustments to be made. While it's easy to communicate a serious diagnosis virtually, it must not be forgotten that human contact, proximity and hearing from the parents in person are all extremely important and always will be.

● (1255)

[*English*]

Mr. Larry Maguire: I'll make the comment as well that it may actually be easier to do those diagnoses for seniors, except they aren't the ones who are online as much in those areas.

There's a priority here. I was just at a hospital foundation dinner on Saturday night in my own constituency, so it's very pertinent for me to be able to ask these questions here. I come from a largely rural area. People have to travel distances, sometimes a couple of hours, to get to a major facility or a major hospital. There are rural hospitals. I'm wondering what your experience is with nurse practitioners. It came up in my experience in the Manitoba legislature. We were dealing with nurse practitioners and trying to promote them as doing quite a bit of the work that doctors do today.

Is there a greater need for people like nurse practitioners in some of those rural areas versus our major hospitals to be able to alleviate the shortage of physicians we have, which is directly proportional to the needs and care of youth? Can you comment on that? There are regulations and things that we've talked about for online, and yes, it's nice to be able to do that, but is there anything that a nurse practitioner couldn't do for youth development that doctors are presently doing in those areas? How would nurse practitioners be able to help alleviate the shortages we have across the country today?

[*Translation*]

Dr. Marie-Claude Roy: Medical practice has to be decompartmentalized. Services are provided by pharmacists, and nurse practitioners are already collaborating, at least in Quebec. What we're looking for is a clearly established line of attack that will give children rapid and effective access to a health professional. The nurse practitioners will definitely help us do that.

Le président: Thank you, Dr. Roy and Mr. Maguire.

[*English*]

The last round of questioning today will come from Mr. van Koeverden for the next five minutes.

Mr. Adam van Koeverden: Thank you very much, Mr. Chair. I appreciate the opportunity to ask a follow-up. My preamble unfortunately took a long time in the previous round.

Dr. Feldman, I would like to go to you and focus in a little bit on the preventative measures that I think are necessary and prudent. With regard to any further expenditure in terms of transfers, I think it would be prudent to meet those with efforts to ensure resiliency in child populations. I personally am very focused on physical activity and sport in my work, but there are many other ways to ensure that kids develop that resiliency.

Can I have comments from you on how we can ensure that fewer kids need to access mental health supports in the future?

Dr. Mark Feldman: It's a great question.

I'd love to see universal day care. I think that's going to be a wonderful thing. Exercise is key. In the patients I see, I'm heavily involved in managing kids with school and learning and development attention problems. With good evidence, I can confidently say, exercise has been shown to have a demonstrable benefit in terms of attention span and reduction in anxiety. A recent study showed that just 20 minutes a day of aerobic exercise for kids can have significant benefits. That's huge.

For many of these kids, we may be able to prevent some of the mental health challenges. Nature and nurture are both important, though. Some kids are born with a propensity for mental health issues that may not be preventable but can be treated. So both will be important—prevention and treatment.

Mr. Adam van Koeverden: Thank you very much.

Very briefly, not considering those two things, prevention and treatment in two silos necessarily, but concerning exercise, exposure to arts and programming and lots of other social interventions, if you'd call them that, for people living with mental health challenges and illnesses, has there been proven—not talking about prevention so much—management? Is that also a preventative measure that could kind of—I hate to use such a crude term—slow down the tap a little bit on the number of people experiencing so many challenges or the severity of those challenges?

● (1300)

Dr. Mark Feldman: Yes, I think that there are so many different things that we can do that Dr. Roy talked about, in particular, looking at exposure to social media. The Canadian Paediatric Society has a statement that we could provide that makes recommendations—best opinion recommendations, because it's an area that needs to be researched—about the limitations and how we should participate with our children's online experiences to keep them safe. These are cutting down on time spent in the virtual world, getting out, doing more exercise and getting involved when possible in team and extracurricular activities that make kids social again. We are social animals.

[*Translation*]

Mr. Adam van Koeverden: I see that you agree on that, Dr. Roy. Do you have any comments?

Dr. Marie-Claude Roy: Only to say that would be a perfect ending. I fully agree with what my colleague just said.

Mr. Adam van Koeverden: Thank you.

[*English*]

I cede my remaining time to the chair, then, in that case.

The Chair: Thank you very much, Mr. van Koeverden.

That concludes the rounds of questions pretty much right at the top of the hour.

Please stand by, colleagues. I'm going to bid goodbye to our witnesses, then I have one small item of committee business to deal with.

To all of our witnesses, thank you so much for being with us today. We were fortunate to have one witness cancel, which allowed us to really get into the issues at some depth, and we very much appreciate the patient and professional way that you have handled all of the questions and the thoughtful presentations.

It will be of great value to us as we proceed along this route of the children's health study, which has a very broad range. We know that you're extremely busy, and we very much appreciate how generous you've been with your time today. Thank you, one and all.

Colleagues, I have one quick housekeeping matter to raise with you. When we embarked upon this study, we did not set a deadline for the receipt of briefs, and if it's the will of the committee to establish a date, I would suggest perhaps a month from today, which would give people lots of time, and it's also unlikely that we will be completely done hearing all of the witnesses by then.

The floor is open.

Mr. Michael Barrett: Mr. Chair, based on the trajectory of the committee's work and the expectation that we have some legislation coming our way, if you haven't had the opportunity already, could we check with the analysts if that's going to provide us sufficient time, even though we'd still be receiving briefs in advance of our conclusion of hearing witnesses?

The Chair: Sure, I'm happy to chat with the analysts. It wouldn't be unusual for the deadline for briefs to happen before all the viva voce evidence, but I throw it open to the analysts.

I see Mr. Davies in the room as well, so perhaps we can hear from the analysts and then Mr. Davies.

Mr. Michael Barrett: I concur, Chair. I'm just wondering if the date should, in fact, be earlier than four weeks. That's my question.

The Chair: That's understood.

Ms. Sarah Dodsworth (Committee Researcher): I think we are happy with the month deadline. I think it will still give us time to review those briefs and include them in the report, if it's the committee's will, with that deadline set.

The Chair: Go ahead, Mr. Davies.

Mr. Don Davies: I'm in favour of the month.

The Chair: Is there any further discussion?

Do we have consensus to set the deadline for the receipt of briefs for this study for October 27?

Some hon. members: Agreed.

The Chair: Is there any further business to come before the meeting?

We are adjourned.