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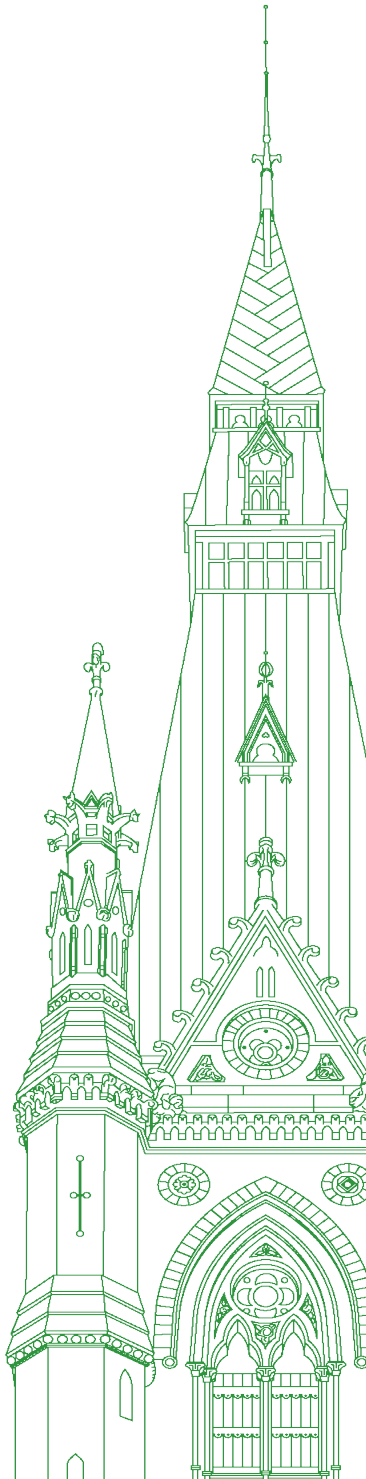

Chair: Mr. Sean Casey

Standing Committee on Health

Thursday, November 3, 2022

● (1100)

[*English*]

The Vice-Chair (Mr. Stephen Ellis (Cumberland—Colchester, CPC)): Good morning, everyone. I call this meeting to order.

Unfortunately, Mr. Casey could not be here today for personal reasons, so there's a new sheriff in town.

Welcome to meeting number 41 of the House of Commons Standing Committee on Health. Today we'll meet for two hours with witnesses 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, 2022.

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

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

All comments should be addressed through the chair. Additionally, screenshots and taking photos of your screen are not permitted. The proceedings will be made available via the House of Commons website. In accordance with our routine motion, I am informing the committee that all witnesses have completed the required connection tests in advance of the meeting.

Before I begin, I would like to advise members that the topic of today's meeting is childhood mental health. Some of the discussions may be difficult for viewers, members or staff. If you feel distressed or if you need help, please consult the clerk for information on supports available through the House administration.

There is one other housekeeping item before we get going. Just so you know, I will hold up a one-minute sign when you have one minute left. It will help keep us on track a little bit. Hopefully, it will be helpful and we can avoid cutting people off mid-sentence.

That being said, I will now welcome the witnesses who are with us via video conference this morning. Dr. Tyler Black is a clinical assistant professor at the University of British Columbia, and Ms. Wendy Digout is a psychologist.

Thank you for taking the time to appear today. You both have up to five minutes for your opening statement.

Dr. Black, I would invite you to begin. You now have the floor for five minutes.

Dr. Tyler R. Black (Clinical Assistant Professor, University of British Columbia, As an Individual): I thank the chair and the members of the committee for the honour of the invitation and this opportunity.

As an introduction, I'm a clinical assistant professor and subspecialist child and adolescent psychiatrist. I've been in practice for 14 years. I was a medical director for a major psychiatric emergency unit at B.C. Children's Hospital for over 10 years. You've already met my colleague, Dr. Quynh Doan, an emergency physician with whom I co-created the HEARTSMAP, a psychosocial screening tool for youth. I'm also the creator of the ASARI, a leading practice tool for the completion of suicide risk documentation.

I'm passionate about teaching, suicidology and mental health research, but most of all, I'm extremely committed to the health and well-being of the over 10,000 child and adolescent patients who I've seen in emergency settings and the children and adolescents who I'll never get a chance to see.

Though my opening statement will not focus on these, I have submitted a briefing note for your consideration. Instead of drowning this committee with more wordy words, I've chosen to deliver graphs that demonstrate important data-driven perspectives that I consider to be crucial and neglected knowledge. I've also included five graphs to demonstrate the complexity of the data we are seeing in Canada for youth with mental health changes since the pandemic.

As a quick aside, I never imagined that my experience in suicidology would lead me to be mired in political battles, but during the pandemic my advocacy has led me to correctly cautioning against the proclamations of increasing rates of suicide due to the pandemic. In fact, they have decreased. I have been in public responding to the horrific use of children's mental health and suicide by politicians and non-mental health experts to justify resisting protections against a pandemic that has killed millions and has created over 10 million orphans worldwide.

I have published and will publish more data that challenges the dominant moral panic narrative that there have only been mental health deteriorations in youth. Some youth have thrived and we need to understand why that is.

To the larger issue of mental health, my clinical work involves assessing children in the emergency department for mental health complaints and consulting with colleagues across B.C. The impacts of lack of service are readily apparent to me. A significant percentage of my patients and their families are wait-listed for mental health services at the moment that I'm seeing them, leaving me with only the daunting option of calling to advocate for expediency or telling these suffering youth to keep waiting. Children who present to mental health teams across Canada are rejected for service due to exclusion criteria or put on tremendous wait-lists because it's not severe enough only later to present to me with a suicide attempt after months of unaddressed suffering.

I deal disproportionately with youth in government custodial care or indigenous youth in Canada, knowing full well that the systemic barriers, racism and colonization are the reason that I see this disproportionate amount. The moral injury I suffer on a regular basis is incredible. I'm just glad to be the type of person who works hard to do my best during adversity because if I ever were to stop and just survey the bleakness of some of the things that I see, it might just crush me.

There are many things I think the federal government could do to improve mental health care and outcomes for children, and a non-comprehensive list would include improving the social determinants of health, like poverty, abuse, education and systemic barriers; ensuring the highest quality of care to children who are minoritized, underprivileged or living in remote areas; providing cost-free access for families to pharmaceuticals and therapies; eliminating exclusion criteria from youth services, which only further systemic discrimination; ensuring federal support for youth with disabilities for all neurodiversities; ensuring federal standards for early access and timely access to care; providing money to provinces with agreement to create treatment centres with day treatment, “step up step down” and neurodiversity focuses; creating standards for school safety; and establishing science-supported ways to make school less stressful for children.

Psychiatrists are trained in a bio-psychosocial model, and from day one we're taught the importance of the social determinants of health. Frustratingly, I have few ways to prescribe or modify the social determinants of health to provide programs that would deliver services to youth who need them or to affect on a large scale the effects of colonization on indigenous youth, but the government does have those powers.

On behalf of the children I work with and the families and caregivers who love them, for all the youth I don't get a chance to see, I'm so grateful this committee is tackling this issue and I really hope that serious and substantive change will come from the fruit of these labours.

Thank you.

● (1105)

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Black. I appreciate that.

I now invite Ms. Digout to begin.

You now have the floor for five minutes.

Ms. Wendy Digout (Psychologist, As an Individual): Good morning, and thank you for inviting me to speak to you.

My name is Wendy Digout, and I am a psychologist based out of Antigonish. I work in my own private practice in rural Nova Scotia, and I am also an associate with Hexagon Psychology.

Working in private practice, but also having past experience working in both school systems and mental health hospital settings, provides me with a unique perspective around children's mental health. However, trying to synthesize my thoughts on children's mental health into five minutes has been daunting.

The most obvious themes, however, when I think about children's mental health in Canada is around the gaps in service and ensuring that we keep in mind that in looking at children's mental health, we are also looking at families.

Accessibility, we all know, is a huge issue. Wait times in Nova Scotia are very significant. According to the Nova Scotia Health wait times website, 50% of all non-urgent child and youth mental health referrals can wait up to 77 days from referral to first actual treatment—that's actually the average for 50%, and there are many others that creep into several months.

If they're lucky enough to have financial resources and they either can pay per visit or have health insurance, many folks will look at private practice therapists as an option. However, thanks to the Association of Psychologists of Nova Scotia and the data they gathered in 2021, we know that even the wait-lists for private therapists are growing just as much. For the private practice psychologists in Nova Scotia who keep a wait-list, almost half have a wait-list of two to five months, and a further 35% have a wait-list of six months to a year. This is in the private system.

Living in rural areas, there are also functional issues regarding accessibility. Our local district health authority covers a large area from Cape Breton to Antigonish. Our regional hospital covers four counties. Some people have to drive for up to an hour or an hour and a half to get to the regional hospital for mental health services. That means a day off work, having to get child care for your other kids and gas money, which is substantive these days.

Although virtual services have been very helpful in allowing access during COVID-19, we still have issues of cross-jurisdictional practices between provinces, so this can cause accessibility issues. If you have access to a nationally based EAP program or to a private practice like Hexagon Psychology, you can only work with the people who are registered in your province. Nationally based referral programs are becoming more and more common in the last few years, so I think looking at cross-jurisdictional access is going to be more and more important.

In addition, many rural communities do not have consistent access to cell service or high-speed Internet. For example, people 10 minutes away from our university do not have access to cell service, and many do not have access to high-speed Internet. This makes virtual appointments not an option.

There are many other issues that I'd like to talk about, but I don't have time: the need for culturally responsive and appropriate services; the gaps in in-patient services for children; the gaps, in general, for children aged 16 to 19; issues of food scarcity, homelessness, unsafe homes and underserved populations; and the effects of COVID-19.

I want to spend my last minute or so talking about some potential solutions. I feel that we really need a collaborative approach that allows for the integration of services, where family doctors, therapists, psychiatrists, OTs, nutritionists and other specialists can work together to support families.

We also need to create, I think, a community-based case manager approach. We need someone who gets to know the family as a unit and their needs and can help them navigate through the system. We have some good examples like our cancer care navigators and the SchoolsPlus models in schools.

I think we also need to look at bringing regulated private practice professionals into a billing program such as the MSI billing program for doctors, and we need to look at cross-jurisdictional practice services.

In summary, I would like to ask that this committee continue to be creative in seeking a framework that can create equitable, accessible and timely mental health care for children and youth and their families in Canada that allows for enough flexibility that the strengths of communities can be utilized and areas of need can be addressed.

● (1110)

Please remember that when we're dealing with kids, we're dealing with families, so this really is a family and community issue.

Thank you.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Ms. Digout.

Both of our witnesses were bang on the time. Thank you very much for that.

We'll now start our round of questioning. Each party will have six minutes in the first round. We'll begin with the Conservative Party.

Ms. Goodridge, the floor is yours for six minutes.

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

Thank you to both witnesses. I want to start by thanking you guys for the work you do to provide assistance to kids and families in our country. It's spectacular.

Ms. Digout, one of the things you said, especially right at the end, was about how this really impacts the entire family. It goes beyond the child. I could really relate to some of what you were talking about, being someone that represents the riding of Fort McMurray—Cold Lake, a rural riding that has a few more challenges that are probably very similar to your own. In many cases, people have to drive long hours to get specialized care, and we don't always have Internet capacity to have even some of the digital options available.

What could you add to that? Do you have any solutions? Perhaps you could expand a bit on that.

● (1115)

Ms. Wendy Digout: Thank you for the question.

It's interesting when you talk about Fort McMurray, because I think we have several families that go back and forth between our communities, so there's a whole other family issue of one parent often working away.

Locally, our Nova Scotia government has been working hard to try to make sure there is access to Internet services. It's just not happening fast enough. I think that during COVID we saw the impact of that in terms of disparity and what people were able to access for school.

Even with the cell service, I think there are attempts, but I'm not sure how much that has been happening for the pockets in the areas around us that don't have it. I think it needs to become an initiative from the government. Just from a safety point of view, families need access to Wi-Fi and to cell service these days.

Mrs. Laila Goodridge: You touched on the fact that there are long wait-lists. Even private providers are having exceptionally long wait-lists. How does it impact children when they do not get the care in a timely manner?

Ms. Wendy Digout: I think they end up seeing someone like Dr. Black.

If we can catch the issues early enough, both within the family and for the child specifically, because they don't live in a silo, so the parents and family also need support.... When we don't have access to services for our children, they do end up in crisis. They end up self-harming. They end up with maybe more intensive eating disorders. Something that may have started as a bit of emotional eating can turn into a full eating disorder. They end up being suicidal, and they end up in our ERs. The ERs don't know where to put them because there are so many wait-lists to try to get them in to see people.

I think Dr. Black's work is really important for that.

Mrs. Laila Goodridge: That's fantastic. I guess I will open this up to either of you. I am the shadow minister for addictions, and I know that anecdotally we've been seeing more kids presenting with addiction issues at younger ages. I'm just wondering if you guys can touch upon that and if you have any possible solutions.

Dr. Tyler R. Black: Thank you for the question. I'll start.

Contrary to that sort of feeling, we're not seeing increases in youth addiction. In fact, kids are using less substances over time. It has been going down. When you do a survey of kids, the number of kids who use certain substances goes down by about 2% to 3% per year. Of course, during the pandemic, we had this counter-thing because of the toxicity of the drug supply, where some drug overdoses increased. Mostly, youth were spared from that, but obviously for those 20-plus it hit quite hard.

The substance use issue is always one of access. Whenever I have a child who has a substance use issue, there are very few places that do co-occurring work. If you have suicidality and you have an addiction, many places will say they can't help you because you're suicidal. If you have addictions and you become suicidal, you're removed from the program. We need a lot more of what we call “concurrent disorders” care, because, of course, addictions, mental health issues and physical issues all work together.

Mrs. Laila Goodridge: I think that you highlight an important piece. We have a spectacular facility in Alberta, CASA House, that treats children who have concurrent issues. I was lucky enough, as the MLA for my riding, to get to help a couple of little kiddos get down to CASA House to get the help they needed.

However, it became evident that we don't have enough of these facilities and enough of these people. Do you think there is an issue in terms of the number of people working in this field being able to address the issue at hand?

Dr. Tyler R. Black: We have lots of dedicated and hard-working people, and I think it would be fair to say that we need more.

I work in a tertiary hospital where there are a certain number of hospital beds, but there's a group of children who aren't sick enough to require full hospitalization. They are really struggling, such that it's hard to get their day-to-day work done. Programs like day treatment models, outpatient facilities, home-based care, for these kids who are in the middle—these families dealing with escalating crises—that's where there's a huge lack of services and beds.

Of course, we also need more hospitals.

● (1120)

The Vice-Chair (Mr. Stephen Ellis): Thank you, Dr. Black. We'll stop there. I appreciate that.

Now we'll turn to Dr. Powlowski.

Dr. Powlowski, you have the floor for six minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Following up on Laila's question, I'm going to ask a somewhat similar question.

Dr. Black, you talked about what to do with children who have both mental health issues and were suicidal. Somewhere in there was also addictions, because you were responding to the problem of addictions. As I think you know, a lot of overdoses in youth are by people who don't necessarily have mental health problems.

We're studying children's health. I have a lot of kids, but I have a 12-year-old and a 14-year-old, and I think for most of us who have teenage children, one of our biggest fears in terms of their health is that they're going to overdose.

It's not that my kids seem likely to do it. However, when you're a teenager these days and drinking in a place like Thunder Bay, which I hear—I don't know if it's true—has a higher per capita rate of overdose deaths than Vancouver even, there's certainly a concern that at some party they're going to do something. All it takes is one time. The stuff they're doing is laced with fentanyl, and that's it.

What can both of you tell us as to what parents, teachers, schools or governments can do in order to address this problem to try to prevent overdoses amongst youth?

Ms. Wendy Digout: I'll go ahead.

I think it goes back to early access. When it comes to drug use with teens, they're getting education within the school, but I don't think they often hear it. I think they need more real-life experience type of learning and hearing from people who have experience.

When children are starting to dabble, whether its marijuana or whatever, sometimes somebody puts something in what they're taking and that ends up in an overdose. We need to be able to have open conversations with them about using marijuana, and in a non-judgmental way so that they can have open conversations.

We have a woman out of Dartmouth here in Nova Scotia, who several years ago lost her daughter. It was her daughter's firs time ever taking a pill at a party, and she died. She didn't wake up the next morning.

She is doing a lot of advocacy work. Her name is Dale Jollota, and she's done lots of advocacy work in schools and with government. I'm more than willing to pass on her information, if that would be helpful for folks.

Dr. Tyler R. Black: I think when we're working with children, especially in the teenaged years, we often have to recognize how important it is at that stage of their life to figure out who they are, what they're doing and to have autonomy and responsibility. That means, as a parent, when you have those worries, you're making sure that your children have the information and the access, so that if they ever are in trouble, the people they call are the people who love them the most.

I encourage families and systems to work in models that are non-judgmental, that use the evidence base of harm reduction, and also to work with children at the stage they are in. A 14-year-old can't be told what to do, but they can be guided on what to do. If you're non-judgmental with your children, you approach them with a caring compassion that says wherever you are, whoever you are, I'm here for you if you need me, then if they ever get in a situation where they're in trouble, you've opened a door that they can come to.

Mr. Marcus Powlowski: I think that's good advice.

This is mostly to Dr. Black. I know you work in Vancouver. I'm sure there's probably a fairly large indigenous population as well as people who are from more outlying communities coming to Vancouver. I wonder if you could comment—and perhaps both of you may have some comment on this—on the success or lack of success of the western psychiatric system in dealing with either mental health issues or substance abuse within the indigenous community.

I'm on another committee, which is INAN. Certainly in that committee, we had a bunch of witnesses from the indigenous community asking for more funding for non-insured health benefits to allow people who were more indigenous healers, for example, to be part of the process, perhaps, along with people in the western psychiatric system.

Do you have any comments on that?

● (1125)

Dr. Tyler R. Black: Absolutely.

I think that psychiatry and medicine and, generally, colonizing society has to come to grips with the fact that there's been significant trauma and mistreatment delivered to indigenous families on the basis of care. Indigenous families need a voice at the table. It's really important in any treatment facility to have indigenous representation in the design, in the feedback and when working with indigenous families, to make sure they have access to important cultural care. Systems need to be set up for indigenous care.

The situations I get in the emergency department are often big-time crises. When they happen, we invoke things such as the Mental Health Act. We invoke things such as section 28, under which the RCMP bring children in, so—

The Vice-Chair (Mr. Stephen Ellis): Dr. Black, I'll stop you there.

Thank you very much, sir. I appreciate that.

[*Translation*]

Next up is Mr. Champoux.

Welcome to the Standing Committee on Health, Mr. Champoux. You have the floor for six minutes.

Mr. Martin Champoux (Drummond, BQ): Thank you, Mr. Chair.

It is my turn to thank the witnesses who are with us today.

Dr. Black, I understood just now that you said we had not necessarily observed an increase in drug use among young people.

Did I understand your statement correctly?

[*English*]

Dr. Tyler R. Black: If we're referring to the percentage of children who use substances, that number has been steadily coming down for years.

[*Translation*]

Mr. Martin Champoux: Right.

Let's talk about teenagers in general, for example. My colleague Mr. Powlowski was just talking about his teenagers, and I have some of them at home too. We know that teenagers, by nature, are tempted to do all sorts of experimenting. We have all gone through that.

Dr. Black and Ms. Digout, have you observed, in your own practices, any change or increase in drug use among adolescent clients since marijuana was legalized in Canada and certain substances have been somewhat de-demonized?

Have you observed that more young people are turning to those products rather than alcohol, which might have been more easily accessible at the time, whereas now it's easier to get hold of marijuana?

[*English*]

Dr. Tyler R. Black: Marijuana remains inaccessible to children, even under legalization, but of course, children, since the dawn of marijuana, have had access to marijuana through other routes. The statistics we're starting to get—and, of course, legalization is a recent phenomenon—suggest that we have a continuation of fewer and fewer kids using marijuana.

[*Translation*]

Mr. Martin Champoux: Mr. Chair, I am told that the French interpretation is not working at the moment.

Okay. It's back.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Is it working now?

[*Translation*]

Mr. Martin Champoux: Yes. The interpretation is working now.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Please continue.

Dr. Tyler R. Black: Should I start again?

The Vice-Chair (Mr. Stephen Ellis): Just pick up where you left off. I think that's fine.

Dr. Tyler R. Black: Numbers have been coming down.

What I see typically is that every generation, every new wave of kids I work with seems more responsible, more connected, more socially engaged and more caring about outcomes. I know there's a feeling sometimes that things are getting worse and worse, but that's never been borne out in the data. This generation of kids use the least amount of drugs, have the least amount of sex under 13 and have the least amount of violence. Some of the moral tropes that go on about kids are not reflected in the data that we see with kids.

[*Translation*]

Mr. Martin Champoux: Right.

I'm going to come back to the more specific question about youth mental health. You said you want there to be more mental health programs and standards everywhere in Canada. My colleagues and I regularly reiterate that health falls under the jurisdiction of Quebec and the provinces.

Dr. Black, I won't ask you to comment on all the provinces, but do you trust the British Columbia government to manage the health care system? How is it working in British Columbia?

● (1130)

[*English*]

Dr. Tyler R. Black: Every jurisdiction that I've known, including B.C., struggles with wait-lists and access to care. I don't think I'm aware of a Canadian jurisdiction that is completely nailing it. I do think, overall as a country, we spend less per capita on mental health than do most developed nations. Mental health especially for children is a foundational element that will impact the rest of their lives. It would be a really good return on investment for governments to put more money into the well-being of our children.

Generally, it would be hard to look at the wait times that families report and the lack of access to care that families struggle with and give any jurisdiction, including B.C., a high mark on a report card.

[*Translation*]

Mr. Martin Champoux: Ms. Digout, how is it working in Nova Scotia? Do you trust the provincial government to manage the health care system?

[*English*]

Ms. Wendy Digout: I agree with Dr. Black in that what we're seeing with the wait times is that things aren't being well managed. I think our government is trying hard to look at alternatives. One issue I'm seeing in colleagues, both within the formal mental health system in the hospital system and in private practices, is burnout. We need more bodies and we need more bodies doing the type of work that they are good at. Instead of throwing people in and expecting them to jump in, we need people doing what they are trained to do. I think that's one of the issues within the system.

[*Translation*]

Mr. Martin Champoux: I could not agree with you more about that.

My question is for both of you, Dr. Black and Ms. Digout.

If the federal government gives money to Quebec and the provinces for health care with conditions attached, might that complicate things further? Would it not be simpler to do as all the premiers are asking? There are radio campaigns going on from one end of the country to the other begging the federal government to stop attaching conditions to health transfers and to increase them to 35%.

Would that not enable Quebec and the provinces to manage the money better and spend it on specific types of health care, in particular children's mental health, that are in urgent need of investments?

[*English*]

The Vice-Chair (Mr. Stephen Ellis): I'll have to ask both the witnesses to keep it to two or three seconds each, or we can come back to it.

Dr. Tyler R. Black: I'll leave those decisions to those with the expertise. I would say more money is good.

Ms. Wendy Digout: I concur.

The Vice-Chair (Mr. Stephen Ellis): Very well done. Impressive, in fact, I might say.

That being said, I'll try to avoid commentary here.

Mr. Davies, you now have the floor for six minutes. Go ahead, please.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair.

Dr. Black, if I may I will start with you. In an August article in Scientific American you stated that pediatric suicide and mental health crisis rates increase sharply when school is in and ease when school is out. You noted that this pattern is also found in other jurisdictions such as Japan, Germany and Finland.

Can you explain to us why that is?

Dr. Tyler R. Black: The why is always challenging. We notice this. Anyone who works with children knows that they are more busy during the school year. When school get's out, there's just less busyness. I think it has a lot to do with the fact that school is like a job for kids. School has your co-workers, your boss, your supervisor, your overtime, which is homework, and your hours. What you don't get often and what kids fail to recognize are the benefits, which are like wages.

School is a big deal. A study in 2014 showed that 84% of children reported that school causes them anxiety. There are so many things that schools could do better. There are things like changing the hours of service, lessening the amount of homework, providing access to mental health curriculum, creating safe spaces for kids who are neuroatypical and those types of things. There are so many things that schools could do.

I think you could just ask a random sampling of 10 kids what they think schools could do better and you would get a host of responses. School is just a really stressful thing for kids. We see a 60% increase in suicides during school days. In the ERs we see 100% to 150% more kids on school days than on non-school days.

● (1135)

Mr. Don Davies: Thank you.

In a 2018 “Ask Me Anything” Q and A interview, you said the following with respect to mental health wait times in Canada, and you touched on it in your testimony today. You said, “Your 6 months wait is unacceptable to see a psychiatrist if you are struggling with a possible illness”. Is there any research you're aware of on a connection between lack of access to care and increased suicide?

Dr. Tyler R. Black: To develop evidence like that would be challenging. If we want causal evidence, we usually do things like randomized control trials, and it would be pretty unethical to put people on wait-lists and see. I think what we typically see, though, is that many of the patients I see in the emergency department had issues that.... Maybe I'm just coming off as an expert who looks backwards or something like that, but I always think, "You know, eight months ago, I could have really helped a lot easier with this than in the situation I'm in right now."

What we know for sure is that unaddressed, untreated mental health issues, untherapized mental health issues...and for kids I have to say that therapy is super important and even harder to access than medications from a family doctor or psychiatrist. These things, if they're not addressed early, they fester. They grow. Many of us know adults who struggle with major mental health issues because of childhood issues that were never addressed. It's just one of those things that is really important.

Mr. Don Davies: It reminds me of that phrase that we don't need research to tell us that water is wet.

Dr. Tyler R. Black: Yes. It's challenging to do.

Mr. Don Davies: I guess you would agree with the proposition that the longer we wait and deny children access to necessary therapy.... I think as a general proposition it would increase the risk of suicide. Would that be a fair thesis to suggest?

Dr. Tyler R. Black: Absolutely.

Mr. Don Davies: Okay.

Madam Digout, you touched on this. I wonder if you could outline how social determinants impact childhood mental health in Canada, maybe if I single out poverty as an example. Is there a link between poverty and mental health problems in children?

Ms. Wendy Digout: I don't know the exact research studies, but I'm sure they're out there. I think that even just common sense.... I have families who have to make a decision on whether they can afford to take the afternoon off work to take their kid to therapy, or whether or not they can afford their child's medication, choosing between rent and medication if they don't have service, but I think just even accessing....

One anecdote is that I worked with a young adult years ago, and I remember that one day.... His parents were in survival mode. They literally were going day to day trying to get food on the table and trying to provide the basic necessities, and this kid was very engaged in therapy. I remember that one day he walked 20 minutes in the pouring rain, on his own, to get to his therapy appointment.

Kids want it. They don't always have the opportunity to get it, and the barriers are just huge when it comes to the poverty aspect. Nutritional food and the ability to get out and do active living is sometimes very difficult for families.

Mr. Don Davies: You actually anticipated where I was going next.

Dr. Black, I just wanted to ask you, are you aware of any research on the connection between poverty and childhood mental health issues?

Dr. Tyler R. Black: Absolutely. We know that the socio-economic determinants of health are correlated. I'm happy to forward some links to the clerk to share with the committee. There's recently been a study even linking suicide rates in children and adolescents to poverty. It is a variable that we consider.

Again, will we ever establish cause with evidence? Probably not, but it will be compelling evidence when it's seen.

Mr. Don Davies: Thank you.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. Davies.

Thank you, Dr. Black. That ends the first round of questioning.

I will just bring to the attention of the witnesses that there are differences in time. I will make you aware of that as the members begin their rounds. For round two, I would like to welcome Mr. Vidal to our committee on health.

Mr. Vidal, you have the floor for five minutes.

Mr. Gary Vidal (Desnethé—Missinippi—Churchill River, CPC): Thank you, Chair. Thank you for having me here today.

Like Dr. Powlowski, I typically sit at the INAN committee, so I am bringing that flavour to this.

I quickly looked at the motion last night and the sense of disparity in access to health service for rural, indigenous and lower-income folks. As an MP who serves the northern half of the province of Saskatchewan—71,000 people over about 350,000 square kilometres or about the size of Germany—I think I bring some of that flavour to the table. I appreciate the opportunity today.

I appreciate the witnesses and their testimony. There are a couple of quick question that I would like to get to in my time.

Obviously, remoteness and distance from services are a big deal to communities like mine, and access to professional services. One thing I heard last week from some leaders in my riding is that during the pandemic they had access to remote mental health services. They were doing it via virtual meetings and that type of opportunity, and they're very concerned that it is going to end.

My question for you is a bit twofold.

Is that concern valid in the sense of losing that? Obviously that's significant. Can you speak to the opportunity, or the quality or ability, to actually provide those services virtually? That's a big deal deal when you're six or eight hours away from the nearest professional.

I would quickly go to both of you, if you don't mind.

● (1140)

Dr. Tyler R. Black: I'll try to be very quick, to give time for our other witness.

The virtual care is crucial. We had it generally before the pandemic. Obviously, the pandemic forced us all to be doing it. In 2022, despite most of our patients having the physical ability and COVID ability to come in, many patients still choose virtual because of the ease for them.

In psychiatry, there are occasions that I need to do physical exams, take measurements and see people in person. I will always need an office to be able to do that, but the delivery of virtual care safely is really important. It would require making sure that we have the infrastructure, that patients and families understand the importance of privacy during those times, and that we have good audits to make sure that the quality of care doesn't decrease.

However, I can say without question that most of my patients and families prefer virtual appointments in 2022 over in-person appointments. I think we have to consider why that is.

Ms. Wendy Digout: I would agree that many of my clients are continuing to request virtual. Some kids are just more comfortable with the screen as well, which I think is important when we're doing assessments and working with kids.

I don't know, in terms of the formal systems, whether or not they will be continuing. I hope they will, because I think it's become vital for accessibility.

Mr. Gary Vidal: I appreciate that, because that confirms for me the sense of advocating for those two remaining.... That was the purpose of my question.

Ms. Dugout, I have a quick question for you.

You talked about food security in your comments. Again, I'm going to reference this particularly to my riding. I have communities where they pay $14 for a gallon of milk, $9 for a dozen eggs and $12 for a kilogram of apples. It's obviously a huge issue in some of the very remote communities, because of freight and those kinds of costs.

Can you make the link for me...or flesh out a little bit of the food security connection to mental health and how that might affect people in those more remote regions who face those very high food costs?

Ms. Wendy Digout: I think food security is an issue in all communities. I think it's probably worse in remote communities like yours, where it's much more expensive.

I go back to the idea that a calorie is an energy unit. We need to provide kids with energy and the nutrients they need to grow. Their brains need it. Their bodies need it. To me, it's integral to good mental and physical health to be able to have food.

Families are not always able to.... There are some great community opportunities to provide community fridges and things, which can help as well.

Mr. Gary Vidal: Thank you.

Dr. Black, I have a really quick question, because the chair is going to cut me off.

You talk about this ASARI tool that you developed. I'm really curious if that is able to be used—I don't know much about it—in rural and remote settings virtually. How can that be used by other people?

Dr. Tyler R. Black: The ASARI is different from a lot of assessment tools. It's not intended to score risk. What it is intended to do is to allow the clinician to completely document what they're thinking and to communicate what they're thinking about suicide risk.

It's accredited. It's used in places all over Canada, and it can be used in any location. It's available for free at the website that I set up at ASARI.ca.

● (1145)

The Vice-Chair (Mr. Stephen Ellis): Thank you, Dr. Black. I appreciate that.

Thank you, Mr. Vidal.

We'll turn now to Mr. van Koeverden.

You have the floor, sir, for five minutes.

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

It's nice to follow Mr. Vidal, as I used to when we were on INAN together. I hope his work continues to be rewarding and productive on INAN. I'm sure it is.

Thank you to our witnesses today, not just for being here and providing really good testimony but also for your extraordinary work. I don't need to tell you, but I do want to emphasize, how important your extraordinary efforts are in society. You save lives every day. Thank you.

My first question is for Dr. Black.

It's about the first thing you mentioned with respect to the attacks you've experienced with respect to misinformation and disinformation. I think misinformation and disinformation should be differentiated. There's intentional misinformation. There's information that goes out because people are ill-informed. There's a very important divide here based on intent. A lot of people who are spreading misinformation are doing it in an effort to help. A lot of others are doing it with the intent to harm. I think those need to be differentiated.

I was hoping you could elaborate a little bit on your experiences and on what our government could do to counter misinformation, disinformation and malinformation. What do you think our obligations are in that regard?

Dr. Tyler R. Black: Thank you so much. This is a question I've thought a lot about. I've been in the online space doing advocacy. Online the amount of disinformation and misinformation is tremendous. I think we have to start really considering the weaponization of disinformation as a threat to Canadian lives. Many people have died of COVID because of disinformation about COVID and the vaccines. Many people have not done what they could to protect themselves due to disinformation that was spread.

Disinformation on vaccines goes back well before COVID, when intentional actors chose to spread disinformation for either personal gain, political disruption or anti-authoritarianism and those types of things. The threat is to people who are marginalized and who don't have the ability to know what all of the latest science shows. Disinformation online can be very compelling. I think the government has a strong obligation to fight disinformation.

I'm part of a group called ScienceUpFirst, which is led by Tim Caulfield at the University of Alberta and Senator Stan Kutcher. We work really hard to distribute information that counters disinformation. I think the government does have to take seriously—knowing that we have freedom of expression and not freedom of speech—the threats associated with disinformation. As far as misinformation goes, you know, people will think things. I'm used to myths. It's okay to battle myths. Disinformation is intentional. It's subversive and it's extremely alluring to people for very important psychological reasons.

Mr. Adam van Koeverden: Can I just ask one specific question about that?

When I think about misinformation and disinformation, I also consider the relationship between an act of omission and an act of commission. An act of commission is saying something vis-à-vis how vaccines are very good and you should get vaccinated—I just made an appointment for my flu shot today—whereas an act of omission might be a reluctance to say such a thing, given an extraordinary platform.

Can you speak to that at all?

Dr. Tyler R. Black: It's challenging.

What we do and what we don't do obviously impact the outcomes we care about.

Many physicians, unfortunately, have chosen to be silent in the face of disinformation. I think disinformation requires us to be active in fighting it, not just by putting out pamphlets or saying, “I'm a doctor. Come talk to me”, but by actually fighting disinformation.

I think there need to be serious ramifications for doctors who use disinformation. We're starting to see doctors having judgments in the United States. I think there have been some interesting developments in Canada. It's very important.

Mr. Adam van Koeverden: Thank you.

I have one quick last question. It's around physical activity. I'm an advocate for kids getting enough physical activity. I see the rates of that declining.

This is for both Dr. Digout and Dr. Black. I recognize and appreciate your pragmatic optimism with respect to the state of affairs of Canadian kids. Have mental health practitioners investigated things that you can perhaps prescribe in the meantime when there is that unfortunate lag time around physical activity and being able to get outside? Can you speak for as long as you can about the positive impacts physical activity has on youth and mental health?

Go ahead, Dr. Digout. I don't have long.

● (1150)

Ms. Wendy Digout: Again, there's tons of research on this. We do know the importance of getting out and being active. I think for some of our neurodiverse clients it's even more important to be able to get out, get active and get moving.

The Vice-Chair (Mr. Stephen Ellis): I'll stop you there, Ms. Digout. Thank you for that.

Thank you, Mr. van Koeverden.

The next round of questions goes to Mr. Champoux.

I'll underline for our witnesses that it's for two and a half minutes.

[*Translation*]

Mr. Champoux, you have the floor.

Mr. Martin Champoux: Thank you, Mr. Chair.

Two and a half minutes is very short, so I'm going to try to ask a question that won't call for too long an answer.

My question is for both witnesses.

Do you draw on practices in other countries?

Do you think other countries are having better success than Quebec and Canada when it comes to mental health and prevention, particularly among children and youth?

Could you give examples of countries that are having better success?

What are they doing differently?

[*English*]

Dr. Tyler R. Black: I'll quickly go and then give Ms. Digout a chance.

For me, I care about standards. Many nations have taken the issue of health standards more seriously. In fact, often we borrow from U.K. and Australian guidelines because Canada doesn't have it's own specific.... We provide health care, yet we leave it very much open to health care providers on how to do so. It's very important that we have standardization.

When I think about NICE in the U.K., for example, it's something that really helps guide people for treatment, and it's very scalable. That would be one example.

[*Translation*]

Mr. Martin Champoux: Ms. Digout, do you have any examples for us?

[*English*]

Ms. Wendy Digout: I don't really.

I often go to the U.K. psychological.... I can't remember the name of the website. I continually look at their standards, and there are a few programs in the U.K. that I often turn to when I'm looking for ideas for things.

However, I really don't know much about other countries and what they're doing right now.

[*Translation*]

Mr. Martin Champoux: I will continue with you, Ms. Digout.

Do you think the schools are playing their role well enough? Do teachers have the right tools for providing children with information?

[*English*]

Ms. Wendy Digout: Many teachers do. Certainly, Senator Kutcher has done a lot of work, working with schools in Nova Scotia. He's set up some great programming for teachers to learn about mental health and the language around mental health.

It's coming. I think it's a matter where some teachers are very comfortable talking about mental health and some are not.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Ms. Digout.

Thank you, Mr. Champoux.

We'll now go to Mr. Davies for two and a half minutes.

Mr. Don Davies: Thank you.

I've seen statistics that say about 32% of Canadians have no access to dental insurance, but it's about 50% of low-income Canadians who don't have access to dental care. This is one of the few areas of health care where the effects of poor health are visible. They're on our face. I know it's well documented that dental issues cause pain, but they also cause embarrassment and shame.

With respect to children, is there any connection between poor oral health and facial disfigurements and mental health? Would you recommend that we address that gap in our health care system as a means of dealing with children's mental health issues?

Dr. Tyler R. Black: Yes, absolutely. Children are very sensitive to the ways in which.... I would say that the newest generation is much better at not teasing or picking out differences in kids, but kids are still kids, especially in middle school. It makes it very hard.

When I think about this, I think there's a neglected population in neurodiversity. I work with a lot of children who have autism, who have neurodevelopmental disabilities and intellectual disabilities. Many times they are hospitalized with severe aggression, hurting themselves very severely because of poor oral care. When you can't express where pain is coming from, it can result in headbanging and a lot of injuries. We certainly see oral care relating to hospitalizations. I've had many hospitalizations where the solution is to consult a dentist, and I'm in a mental health facility. Certainly, oral health matters.

When we think about what makes kids feel confident, we realize that if they're having pain or have some form of deformity, that makes it obvious this is going to impact their mental health for sure.

● (1155)

Mr. Don Davies: Ms. Digout, do you have anything to add?

Ms. Wendy Digout: The only other thing I would add is that in the neurodiverse community, there are often some difficulties around performing even daily oral care because of sensory issues. I think it's a really important role for mental health clinicians, and occupational therapists particularly, to work with kids who have sensory issues. It's even painful for them to brush their teeth, and they can't get past it. There's the way that things look, but there's also a big issue around ensuring proper care.

There are other mental health issues where dental care becomes an issue, when the kids can't take care of hygiene. In early psychosis, that's one of the things we see regularly. We start to see some of those pieces not being done daily.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Ms. Digout.

Thank you, Mr. Davies.

At this time, we'll return to Ms. Goodridge.

You have the floor for five minutes.

Mrs. Laila Goodridge: Thank you, Dr. Ellis.

I want to go back to something I asked earlier about children's substance use.

Earlier in the study, we had Bruce Squires from McMaster Children's Hospital in Hamilton, Ontario, come before the committee. One thing he shared with our committee is that they had seen a 90% increase in admissions for eating disorders and a doubling in admissions for substance-use disorders among the kids coming into their space at McMaster. To me, those numbers are extremely troubling.

Dr. Black, you then shared that it is actually going down, from what you've seen in the statistics. I'm wondering if you could table with the committee the statistics you referenced. It's either doubling or it's going down, but I think this is highly problematic that we perhaps don't have all the right information.

Would you be willing to table that with the committee?

Dr. Tyler R. Black: Yes. If I may, Ray et al. published, in the Journal of the American Medical Association, a study of Ontario admissions for overdose and self-harm. We have the McCreary Centre reports that I'd like to enter so that you can have access to some larger Ontario data.

Mrs. Laila Goodridge: Thank you.

I will note—and I'm hoping that all members have done the required sound checks before participating—that it doesn't appear you're using the House of Commons headset, and there is some challenge in hearing you.

Do you by chance have that headset, so we can make sure we're protecting the health and safety of our interpreters?

Dr. Tyler R. Black: Certainly I can use it. I did the sound check and they said it was good.

Mrs. Laila Goodridge: Fantastic.

It's one of the interesting challenges we've been having at the House of Commons, especially as we've gone to hybrid sittings. There have been injuries to our interpreters due to people not using the appropriate headsets. It's just something that I think is good practice.

I apologize for not catching that earlier, but better late than never. It might prevent an injury to one of our interpreters.

You talked about the need for more harm reduction. Do you believe that there are enough treatment spaces available for children who have substance-use disorders in this country? Do you believe that treatment and recovery should be put before harm reduction?

Dr. Tyler R. Black: Harm reduction is an element that comes first.

Certainly we need treatment when it's needed. You need a child who is willing to do treatment, who is in a state of change where treatment will be fruitful. Of course, when things are in crisis, we need acute access to treatment and withdrawal management, and those types of things as well.

Harm reduction is an overall philosophy that starts even at the family kitchen table and works all the way through to the hospital environment. Harm reduction is the model that can apply at any stage—even early.

● (1200)

Mrs. Laila Goodridge: Thank you, Dr. Black.

I would argue that would be more in the education and prevention aspect of those conversations, and they're critically important. I don't think, as a society, we do enough to alarm our kids about the risks of addiction and substance-use disorders as a whole. I would hope that each and every one of us can be champions for reducing substance-use disorders. I know that it's disproportionate in many of our rural and isolated communities, which often will end up having a suicide crisis because they do not have adequate support.

Ms. Digout, perhaps you could highlight what you're seeing in rural Nova Scotia when it comes to this issue with addictions.

Ms. Wendy Digout: I agree with Dr. Black that the harm reduction philosophy is kind of.... I guess that's the standard with which we have to start, but we don't have enough treatment facilities when they are required. With regard to harm reduction, there's actually a very specific way to use harm reduction in therapy. It is a proactive, a family and an educational issue, but within therapy, it's very specific, looking at ways that children or youth can start examining their own use, whether it creates harm in other ways that they might want to reduce, and whether they are interested in reducing harm and able to see it. There's the therapeutic modality of harm reduction as well as the philosophy that kind of is the overarching ideal.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Ms. Digout.

Thank you, Mrs. Goodridge.

I'll turn to Dr. Hanley.

You have the floor for five minutes, sir.

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much, Chair.

I would like to thank both of the witnesses for their testimony today and, like Mr. van Koeverden said, for their amazing work.

The general theme, I think, in my questions is addressing our previous study, which we're just analyzing the report on, and that's the health care workforce crisis with a lens around mental health needs and how we get better not only on the prevention side but also at maximizing access to service. It's in that vein.

Dr. Black, briefly, to follow up on Mr. Vidal's question on the use of the ASARI tool, are we doing well enough in risk assessment in the emergency department amongst our health care providers? Between the HEARTSMAP tool and the ASARI tool.... Are these tools that are already helping us, perhaps, be more consistent in how we do risk assessment and communicate that risk assessment? Maybe you could elaborate on that a little bit.

We're not hearing you now.

The Vice-Chair (Mr. Stephen Ellis): Dr. Black, we don't have any audio, and by the visual, it says you are on mute.

Dr. Tyler R. Black: I've just switched back. I'm still trying to figure out the headset because I didn't test this one—my apologies.

The ASARI and the HEARTSMAP tools, when used, can be really helpful in both documenting risk and communicating it—as well as the HEARTSMAP tool in its psychosocial assessment. The HEARTSMAP tool actually calculates what an emergency physician could consider next as a course of action and who to consult with, not just with regard to mental health but for social and physical needs, youth health needs and these types of things. It would be really helpful to be used.

As for risk assessment in general, it's very hard to predict who will die by suicide and who won't. In fact, there is no risk prediction system that gets better than a positive predictive value of 1%. Therefore, risk assessment is often trying to figure out what the risk factors are that make suicide more likely and what the protective factors are that make it less likely, trying to cut away as many risk factors as possible and add as many protective factors as possible. This is something that every human working with kids can do. I see a lot of efforts zeroing in on prediction, and I wish the science were there, but it's just not. However, risk reduction and protection increase are very achievable goals in any setting, including emergency departments.

● (1205)

Mr. Brendan Hanley: Thank you. That's very helpful.

Ms. Digout, I'm hearing from private clinics in my territory that there are long waiting lists. They often have to provide pro bono services to those who don't have coverage. They're short-staffed and often overwhelmed due to the public mental health and addiction service itself being backlogged due to demand. You've spoken about this, and I'd like you to elaborate a bit. I think you mentioned the possibility of advocacy for MSI coverage for your cadre, and I know I've heard that.

Maybe you could speak about how you think it would help improve access to mental health services if your cadre of service was actually covered under the public health insurance plan.

Ms. Wendy Digout: I know that there's currently debate in Nova Scotia around how to make that work, because our government is strongly looking at a way of billing private practitioners. On the difference between clients who have private health insurance, who I can direct bill, compared with the people who have to pay up front and then get reimbursed or are paying out of pocket, the ability to not get stressed over the finances of this is really important. From a practice point of view, taking that financial stress off the client and the family is really important.

For us as practitioners, there's nothing more heartbreaking than having to turn someone away because you don't have space in your schedule, or you already have five people who you are seeing pro bono and you just physically or financially can't continue to do that. It's heartbreaking. We talk about burnout, and those are the types of things that burn out psychiatrists, psychologists and social workers. It's not the work when we're helping. It's when we can't provide what we know should be there.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Ms. Digout.

Thank you for that, Dr. Hanley.

That concludes two rounds of questioning.

The third round of questioning will go to Mr. Vidal for the Conservative Party for five minutes.

Mr. Gary Vidal: Thank you, Mr. Chair.

I want to follow up on a couple of things that were said earlier. One was said by Dr. Hanley, who talked about the staffing issues we're seeing here in facilities and whatnot.

As a bit of an example, there's a facility that was announced and built in my riding. It's a facility for the treatment and recovery of those dealing with mental health problems and addictions. It's a 20,000-square-foot facility, and $16.1 million was invested in this 24-bed facility. It was announced and opened in June, and I had the privilege of touring it in July. Much to my chagrin, it was empty. There wasn't a patient in the facility, because they don't have the staff.

I'm just curious to hear your response. What level of frustration would that indicate for you in your worlds when we build a $16-million facility, but we don't have the wherewithal to actually staff it?

Dr. Tyler R. Black: It's very frustrating. This happens in hospitals, where bed decisions and treatment decisions are changed based upon staffing levels. This is something that we encounter regularly.

You can make a space, but it needs bodies, as Ms. Digout was mentioning. We need people doing what they do. We've had a tremendous amount of burnout. We have a number of people leaving. It's very hard to replace people with experience. We're finding that many facilities are struggling with staffing issues on a daily basis.

It's not just about providing a space but about making sure that space includes the humans inside it, and that requires an ongoing commitment. If you look at it relative to other things people could be doing with their time, sometimes it becomes very disheartening to work in mental health, which always seems a bit neglected compared with other areas of health.

● (1210)

Mr. Gary Vidal: Ms. Digout, do you want to make a quick comment, or do you want me to move on to my next question? I can come back to you with it if you want.

Ms. Wendy Digout: You can just move on.

Mr. Gary Vidal: Thank you.

One of the other comments you made in your opening five minutes—and I know you were very limited there—was about culturally appropriate services, in contrast to the facility, which would be culturally appropriate as well if it were actually open and serving people.

I want to give it that credit, but there's another facility that is looking for some really small levels of funding. They would provide very culturally appropriate land-based treatment and, I would add, which you also mentioned, services that would include the whole family. I think it's absolutely central to us in solving the issue of mental health and wellness and addictions recovery that we include the whole family, yet an organization like that, which already has a facility and needs some really small investments, can't seem to get those investments.

I don't mean the question to be one about the negatives around the investment, but can you speak to how important that combination of culturally based, land-based and family-centred treatment would be in the context of mental health and addictions, please?

Ms. Wendy Digout: I think having the opportunity to provide clients different types of therapy—whether it is land-based, specific to their own culture or more western-based medicine—is really important, because sometimes people will surprise you.

When you make the mental health treatment about the one child, what happens is they become.... Everything seems to be around what they're doing wrong, instead of setting up what's happening within the family. Sometimes we can do that family work better when we're outside of the therapy room, doing home visits, doing something constructive and looking at the ways the family interacts and communicates with one another.

Mr. Gary Vidal: Dr. Black, do you want to comment on that as well?

I have 30 seconds left, so I'm not going to start another question.

Dr. Tyler R. Black: I'll try to be brief then.

Any time we have an opportunity to listen to indigenous voices and develop programs that work for indigenous people, we should embrace it. We should fund it. This would be an anti-colonial approach of centring power in indigenous hands. I would be in support of it.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Dr. Black.

Thank you, Mr. Vidal.

Mr. Jowhari, you now have the floor for five minutes.

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

Thank you to the witnesses for your testimony and for your hard work on and advocacy of mental health, specifically children and mental health.

Dr. Black, I'll start with you. In your opening remarks you talked about federal standards for early care as one of your recommendations. Madam Digout also talked about early access. I would like to open up the conversation and the line of questioning to your recommendation of federal standards. How can we collaborate with the provinces to ensure that those standards are not only implemented, but measured and reported?

If you could demystify what those federal standards should be and give us some recommendations for collaboration, I would really appreciate it.

Dr. Tyler R. Black: It's probably well known that, politically, wait times are a thing. The publishing of surgical wait times and ER wait times is something that has a tremendous amount of political power. This generates ideas to improve the situation from all members of politics.

In the same way, I think there could be standards that would really.... When a child is in trouble, how long should it take for them to see a mental health professional? That's an example. The publishing and the encouragement of shorter wait times is something that could be not only a national standard but something that is well known. It relies on advocacy groups to talk about it. In Ontario, I think about three years ago, they published that some kids were waiting more than two years for treatment. We need these standards.

They should be based on tiers of care. When things are early, it doesn't require a tertiary emergency psychiatrist like me. There are many professionals in many areas who have excellent training and all sorts of therapies, but when they need help, they should be able to access help. When that group needs help, they should have access all the way up to the tertiary services that are the rarest and most expensive.

Scaling these in a way that works with tiers of service would greatly reduce wait times. I spend time assessing children who don't need to see me. Establishing standards of how to access care in a timely way would be really helpful.

● (1215)

Mr. Majid Jowhari: Thank you.

Go ahead, Madam Digout.

Ms. Wendy Digout: I agree with the importance of a tiered system.

Some examples from when I was thinking of early access.... Sometimes early access means a child who is starting to get some anxiety going to school, so it's being able to learn what that is, how that feels in their belly when they can't go to school and then some coping strategies around it.

That's a fairly quick intervention if we catch it early. If you wait too long, that child will have full school refusal. They may start engaging in withdrawing and become depressed because of isolation and withdrawing. If we can catch some of those things early, we have some amazing early intervention programs for children with developmental disabilities.

Getting speech therapy early on is crucial when we look at outcomes from a behavioural point of view and academic success. It's ensuring that when we need it, we can get it and with the appropriate person. A kid starting to get anxiety and a sore belly going to school definitely does not need to see Dr. Black. They need to learn some coping strategies.

Mr. Majid Jowhari: What I'm hearing is that access to the right care, in the various steps and a structured point of view, could shorten the wait time, which is a standard we are trying to recommend or measure. The standard is a multi-dimensional thing.

I only have about 30 seconds and probably 15 seconds to each one of you.

I want to get your feedback around a concept of integrated youth services. In a direct way, both of you talked about social determinants of health, social services and mental health support. What are your thoughts on that and whether there should be direct funding from the federal government for it or not?

Dr. Tyler R. Black: We have a model in B.C. that accesses some federal funding called the Foundry. It's building integrated drop-in centres for youth that include health and wellness as well as mental health access. I think it could be a really good role for funding, yes.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Dr. Black.

Thank you, Mr. Jowhari.

[*Translation*]

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

Mr. Martin Champoux: Thank you, Mr. Chair.

I have to take issue with the questions asked by my colleague Mr. Jowhari, who suggested that the federal government should attach standards to the funding provided to the provinces.

Dr. Black, you answered very honestly, I agree, but it is a good idea to recall that 50 years ago, the federal government funded 50% of the cost of the provinces' health care services. Now, it's 22%. The premiers of all of the provinces and of Quebec and the territories have been calling unanimously, for a long time, for the federal government to increase health transfers to 28%, then to 35% of the costs, to restore some balance.

Dr. Black and Ms. Digout, you know, as do I, that the provinces' problem in managing health care systems is underfunding by the federal government. It is a lack of money. All the standards that the federal government might require in connection with increasing health transfers are already included in Quebec's and the provinces' ideas.

So the answer is not very complicated. It is not to attach standards to an increase in health transfers or allow the federal government to involve itself as it might like in the administration of health care services in Quebec and in the provinces and territories. It is simply to send the money to the people who have always managed the health care systems.

I just wanted to point this out, because we all want shorter wait times in emergency rooms. We all want better and faster treatment for patients and people who have mental health problems, in particular, who are often perceived and judged negatively and misdiagnosed. We all want these things. We all hope to have a more effective social safety net. However, I don't think we get that through discussions or standards that the federal government might impose on the provinces and Quebec for sending money here and there as it sees fit.

I also wanted to tell you that I support and admire your work. It is essential, and you are doing it in horrible conditions, in my opinion. You should be getting much more support, and that is what I hope we take away from this meeting. The money has to be sent to the right place and managed by the right people, based on the priorities and the urgent needs and specific needs in each of the regions of Canada, which are not all the same from one end of the country to the other.

This may be the last time I have the opportunity to speak to you today, so I will congratulate you and thank you very much for being with us and for your essential work.

I hope we will be able to provide you with better support.

● (1220)

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. Champoux.

[*English*]

Now we'll turn to Mr. Davies for two and a half minutes.

Mr. Don Davies: Thank you, Dr. Black.

Again, in the 2018 “Ask Me Anything” Q and A interview, you touched on the concept of misconceptions about suicide risk, and you touched on that here today.

Can you tell us what you think some of the key misconceptions about suicide risk are, and maybe on the flip side, what the key risk factors are?

Dr. Tyler R. Black: Sure.

Some of the big misconceptions that I deal with regularly are the close tying and connection of suicides to mental health. There's a myth out there that all people who die by suicide, or 90%—and many advocacy organizations still have this number—have mental health issues. The way that we know this is by a method called psychological autopsies. There are some challenges with that.

Whenever we do coroner reviews, and I've been a part of those.... If we look at the National Institutes of Health in the United States, we see that mental health is a factor in about 56% of suicides, so this close linking between suicides and mental health doesn't address all of the suicide concerns we have. Some people have suicides because of issues that aren't related to their mental health: physical health, disabilities, socio-economic determinants of health and those types of things.

Another myth about suicide that I always like to battle is this idea that when we talk, ask questions or screen for suicide, we're somehow introducing risk into people. In fact, talking openly about it and having—I see the sign—the ability to interact with people on a human level about suicide actually protects. We have good research showing that people benefit from that.

If we think about major risk factors, there is a laundry list, but I would like to posit that we have our mental health, our physical health, systemic racism and exclusion, and in youth, we have discrimination on the basis of gender and sexual minorities, which is a large factor.

Mr. Don Davies: Touching on that, my next question.... You'll probably have little time for much else.

For decades, mental health has been regarded as less critical to our overall health and physical health. Is it time, do you think, that we should add mental health treatment as an insured benefit under the Canada Health Act?

The Vice-Chair (Mr. Stephen Ellis): Answer in two seconds or less, please.

Dr. Tyler R. Black: It's more than time.

Mr. Don Davies: Ms. Digout.

Ms. Wendy Digout: Once again, I concur.

The Vice-Chair (Mr. Stephen Ellis): You guys are great. This is the easiest job ever.

Thank you very much, witnesses.

Thank you, Mr. Davies, as well.

Now we turn the floor to Ms. Goodridge.

You have five minutes.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

Again, I want to thank the witnesses. Having two witnesses for a two-hour meeting is a lot to ask.

I mean no disrespect in this, but one of the issues that has been very top of mind for me.... I'm a young mom. Through the course of this study and through the course of the last few months, I have on numerous occasions brought up the real, serious concerns that have been brought to me by a lot of parents—moms and dads, regular people, grandparents all across the country—who are struggling to find children's pain medication. We're at a crisis level. We're at a space where it's on the shelves in the U.S. in abundance—you can even pick your flavour—but in Canada, you can't find it anywhere. This is especially troubling in rural, remote and isolated communities, such as the one that I live in, because we're a long ways away from a children's hospital if something does go bad.

With that, I'd like to move a motion:

That the committee hold a meeting on Tuesday, November 15, 2022, to discuss the ongoing shortages of children's pain medications to include an hour with officials from the Department of Health and a second hour to include one witness from each political party represented on the committee.

● (1225)

The Vice-Chair (Mr. Stephen Ellis): Thank you very much for that, Ms. Goodridge. I'll just confer with the clerk to ensure it's all in order.

Thank you for that, Mr. Clerk.

Certainly, even though we would normally require a significant 48 hours for a motion, this is definitely related to the topic at hand. Certainly, it's something that affects everybody here, so I find the motion to be in order.

I now open it to debate.

Mr. Vidal.

Mr. Gary Vidal: Not being a regular on this committee, I think it's important that we hear from the right people when we do things like this. I would like to suggest an amendment that we include the Minister of Health to appear during the first hour of this meeting on November 15.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. Vidal.

I understand you're proposing an amendment to include not only officials from Health Canada but also the Minister of Health to appear during that first hour.

We now have an amendment on the floor. Is that correct, sir?

Mr. Gary Vidal: That is correct.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much.

There's an amendment.

We have multiple speakers. We have Mr. van Koeverden, and after that, Monsieur Champoux.

Mr. van Koeverden, you have the floor

Mr. Adam van Koeverden: Thank you, Mr. Chair.

I appreciate that this was distributed in advance, and Ms. Goodridge approached our side before the meeting started. We had lots of advance notice.

We're supportive of the motion, but we haven't had an opportunity to discuss the amendment. We would be in favour of having, like you said, officials and witnesses from each side, but we'll pass on having the minister at this time. We haven't had an opportunity to discuss it at all.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. van Koeverden.

[*Translation*]

Mr. Champoux, you have the floor.

Mr. Martin Champoux: Mr. Chair, what I wanted to discuss is not so much the motion or the amendment. Unless we really intend to start another round of questions, I propose that the committee release the witnesses who have stayed. If we plan to debate a motion and vote on it, it would seem to be polite to let them go.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Certainly as you mentioned, that was not about the amendment, but I could poll the room to understand that the witnesses may be free to go.

I see concurrence here.

I'd like to thank both witnesses for appearing today.

I appreciate your insights and how smoothly everything went, and your understanding with the new sheriff and the one-minute sign. I appreciate that and wish you well today.

Thank you very much for appearing.

Ms. Wendy Digout: Thank you.

Dr. Tyler R. Black: Thank you.

[*Translation*]

The Vice-Chair (Mr. Stephen Ellis): Thank you.

[*English*]

Ms. Goodridge, you have the floor.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

I guess to Mr. van Koeverden, when I prepared the motion, I hadn't really.... I'm still a relatively new member of Parliament, having been elected in the class of 2021. It wasn't something that I was initially contemplating, but I take the suggestion from my colleague Mr. Vidal. I think it's important to, whenever possible....

This is an issue that parents from coast to coast to coast are struggling with. Making sure that we have all of the answers as to what's causing it and what is being done to solve this, I think, would be beneficial to parents and would help to alleviate some stress.

One thing we heard from Ms. Digout is that children's mental health is a family issue. I would suggest that a lot of families right now are facing additional anxiety because they are unable to find basic over-the-counter pain medication in a first world country. This is something that is standard in a third world country. This is not something that's relatively standard in Canada. I think that it merits and is worth discussing.

I would hope that members of this committee accept that I am still a new member of Parliament and I think this is a very good suggestion.

● (1230)

The Vice-Chair (Mr. Stephen Ellis): Thank you, Ms. Goodridge.

Dr. Hanley, you have the floor.

Mr. Brendan Hanley: Thank you.

I appreciate Ms. Goodridge bringing the issue for committee to consider. I think this is important and that the timing would be optimal.

However, I disagree with including the minister. We want to sort out the story from Health Canada's officials' point of view. I wouldn't support the amendment, but I certainly support our having one meeting on this important issue.

Thanks.

The Vice-Chair (Mr. Stephen Ellis): Mr. Jowhari.

Mr. Majid Jowhari: I'm definitely in support of the motion. Thank you very much. It was distributed. We had the conversation. There is full support.

There are two things. Number one, the 17th is such short notice to be able to get the minister. Number two, I'm sure that supplementary (B)s and the department results are going to be out very soon, probably within the next few weeks. That's a great opportunity for us to ask the minister in that session the questions we want to ask. By then, we will have an understanding of what the department and the witnesses are saying, and we will also have data so that we could ask relevant and key questions of the minister.

I definitely support the motion as presented by our colleague, Madam Goodridge. On getting the minister here on short notice on the 17th without having heard all the other stuff, I will be opposing that.

Thank you.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. Jowhari.

Mr. Champoux, go ahead, please.

[*Translation*]

Mr. Martin Champoux: I understand the amendment proposed by my colleague Mr. Vidal and I would like to propose the following.

If the Conservatives want the Minister to be part of this committee meeting, I propose to postpone this subject for a few meetings and move on to the next study, which had been proposed by my colleague Mr. Thériault and deals with breast implants, a very important subject for Quebeckers and Canadians. Two meetings are scheduled for that study. I therefore propose that the date of the meeting that would include the Minister's appearance be changed. That would allow more time to invite him, so our Liberal colleagues might agree to that change.

I will let you discuss it.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): If I'm hearing you correctly, you haven't proposed an exact date but the subamendment would be to delay the meeting and have the minister appear at a time in the future on this particular subject.

It's always interesting to be here at the health committee. I've been informed by the clerk that any subamendment should really be directed toward the actual original amendment as opposed to subamending the subamendment.

I don't know how that translated into French.

Monsieur Champoux.

[*Translation*]

Mr. Martin Champoux: It was hard to translate.

I would note that it was a friendly amendment for my Conservative friends rather than an official subamendment.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Okay. Thank you very much for that.

Mr. van Koeverden.

Mr. Adam van Koeverden: Thank you, Mr. Chair.

Again, I would just clarify that we're supportive of having a meeting in short order. It is important.

● (1235)

[*Translation*]

It is very urgent.

[*English*]

That's a good day to have it.

I would reiterate that, on getting to the bottom of it, we should hear from our communities. I have talked to Ms. Goodridge off-line about this. I've called five or six pharmacies in my riding to check. Hearing from some pharmacists or from some experts in the country would be really helpful, and officials as well.

On a point of clarification, something struck a nerve a little bit. The term “third world” is outdated. It's a Cold War era term that we don't use anymore. It can be derogatory in some cases. Comparing Canada to the developing world doesn't do too much to highlight our challenges. We have some, but the ones in developing nations are different.

Thanks.

The Vice-Chair (Mr. Stephen Ellis): Mr. Davies, go ahead, please.

Mr. Don Davies: Thank you.

With the amendments and subamendments it was starting to remind me of the old adage that an elephant was designed by a committee.

We ought to get right back to the simplicity of this. I like the motion as it's drafted originally. Calling the minister unnecessarily politicizes an issue and probably won't add any more substantive information than we'll get from the health officials.

I do think that we have a practical issue, which is getting the witnesses. We would have to have the witnesses we propose in by the end of tomorrow, I would say, as a matter of function in order to give the clerk next week to get the witnesses, because it's the Tuesday when we come back. That's more a question of administration.

I would support the motion as drafted by Ms. Goodridge for the 15th as written. Also if this is an urgent matter, then delaying it seems counterintuitive to the urgency.

It also gives a chance even to discuss among ourselves what witnesses we may want to have. It's my understanding that the shortage of children's pain medication is a global matter. I'm not sure I can say it is every country, but almost every country is experiencing this. Also, I want to talk to industry a little bit. I happened to have a meeting this morning with a Canadian pharmaceutical manufacturer, in fact, the largest domestic manufacturer of pharmaceuticals in the country. He had some interesting information about this as well. It would be nice to have a broad array of witnesses in that second hour so that we can get a fulsome picture to find out what the potential solutions for this are.

My interest in this matter is understanding what the problem is, but more important, seeing what solutions may exist. My interest is not in politically attacking the government on this, but rather working practically to see what we can do to help.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. Davies.

Go ahead, Ms. Sidhu.

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

Thank you to my colleague Ms. Goodridge for raising this issue. I agree with all of my colleagues that it's an important issue. Let's deal with it. I don't favour an amendment or subamendment, but I'm in favour of the motion because it's important.

Let's have a meeting, as Mr. Davies said, on an urgent basis with Health Canada, the pharmacists and then witnesses from your riding.

We're all working collaboratively. Let's work collaboratively on the motion.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Ms. Sidhu.

Go ahead, Ms. Goodridge.

Mrs. Laila Goodridge: I appreciate the support I've received from my colleagues on this issue. It's critically important.

One anecdote I'd like to share, because I think it's important, is the number of young moms, particularly, who have reached out to me since yesterday when this was brought up in question period. This isn't about politicizing this issue. They wrote to me and said, “Thank you. I thought that I was crazy. I have felt like I was alone in this. I have been struggling. I didn't realize that this was more than just my problem or my community's problem.” It really made them feel heard.

Frankly, inviting the minister was not an attempt to further embarrass. It was simply to try to see what other political mechanisms we possibly have. It is not about bringing politics into this. Frankly, I don't want to see politics in this issue. I want to see this issue fixed. I brought this to the committee more than a month ago and, arguably, it's worse than it was when I brought it to the committee a month ago.

I, personally, haven't seen any children's pain medication on the shelves in my northern Alberta community since early this summer. This is something that's hugely concerning. We're five hours from a children's hospital.

I really think this is something that needs to be studied. I believe that the amendment coming from my colleague Mr. Vidal was not an attempt to bring this in to further politicize the issue, but to further get to the bottom of this problem to see what has happened, what will continue happening and what other mechanisms we have. I think we have been able to show that we have pretty much cross-party support on this.

Canadian families expect and deserve to see forward movement on this. I understand that many believe this is bringing politics in. This wasn't the intention and this isn't the space where it is. I would urge everyone to consider the idea of bringing the minister in, because I think parents would love to hear some of what he's done to hopefully make things better.

● (1240)

The Vice-Chair (Mr. Stephen Ellis): Thank you, Ms. Goodridge.

At the current time, our speakers list has collapsed. That would make it an appropriate time to vote on the proposed amendment put forward by Mr. Vidal that in the first hour, the Minister of Health appear as a witness.

(Amendment negatived)

The Vice-Chair (Mr. Stephen Ellis): We'll return to debate on the motion as proposed.

Mr. Davies, you have the floor.

Mr. Don Davies: I think it's an appropriate moment to make one observation. This is an opportunity to think of young parents. Ms. Goodridge has been very passionate, effective and brave in sharing her own experience with her child, who had pain from teething and couldn't get pain medication, and bringing up young parents across this country who can't get pain medication for their children.

It's appropriate to point out the policy symmetry between this issue and lack of dental care, because there are millions of children and parents in this country who go to bed every night with pain because they can't get access to dental care. Whether you're a parent who has a teething child and you can't get pain medication, or you're a parent with an adolescent child who's going to bed at night with the same pain because he can't get dental care, it's the same parental pain. It's the same frustration. I think it's the same health need.

It's an opportunity to remind all of us, as parliamentarians, about consistency. I'm hoping that this can serve as a good example for all of us around this table, from all parties, to work constructively to address this problem, not only for the temporary issue of pain medication, but also for the structural opportunity to fix the problem of ensuring that all children get access to oral health care in this country.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. Davies.

I see no more speakers.

Certainly I believe that on the original motion as distributed, there seems to be concurrence around the table that members would support that. Is that the will of the room as I see it?

(Motion agreed to)

The Vice-Chair (Mr. Stephen Ellis): Excellent. The motion is that the committee hold a meeting on Tuesday November 15, to discuss the ongoing shortage of children's pain medication to include an hour of officials from the Department of Health and a second hour to include one witness from each political party represented on the committee.

I've been informed by the clerk that we'll have to have those witnesses' names in by end of day tomorrow.

Mrs. Laila Goodridge: Why don't you specify the time? Is that 4 p.m., eastern standard time?

The Vice-Chair (Mr. Stephen Ellis): That is 4 p.m. eastern time.

Mr. Davies.

● (1245)

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

Having disposed of that, as I mentioned to the chair earlier with respect to our report on health care human resources we're working on, could I suggest that the analysts produce for us sometime by the end of next week a clean copy of the report with the changes that we've agreed to? We've gone through the text of the report and we've agreed to it. Even to have those changes highlighted would be helpful.

Then also could we maybe have in different highlighting the portions of the report that we've parked? One thing that comes to my mind is the jurisdictional section at the beginning in paragraphs 3 to 7, which we said we'd come back to. Maybe that could be done in a different colour, so that we're working from an updated copy of the report. That would be helpful, I think, for all of us.

The Vice-Chair (Mr. Stephen Ellis): Thank you for that, Mr. Davies.

I did have the opportunity to speak to our analyst on that.

Please provide your comments to the committee.

Ms. Sarah Dodsworth (Committee Researcher): I suppose our comments are that we will try our very best. There are other resources to consider, including translation capacity, which is something that we'll have to check in with our colleagues on.

My sense, from having discussions prior to this, is that the end of next week is unlikely to be an achievable target date, but we can work with them to provide it as soon as possible in advance of future discussions.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much.

Mrs. Goodridge.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

I believe the suggestion by Mr. Davies is going to be productive and fruitful for us going forward.

I would put forward a suggestion to the committee that we perhaps not return to reviewing this until such a time that the analysts are able to provide it, understanding that they have a busy workload and a lot of other things on their plate. Perhaps if that ends up taking a couple of weeks, I think that is a very reasonable suggestion. This is a study that's gone on in this committee for a long time, and I think that's a reasonable way to make sure that we're going through this expeditiously.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much.

Mr. van Koeverden.

Mr. Adam van Koeverden: Thank you, Mr. Chair.

I would just say that if we're going to get into a conversation about the report, we would usually be in camera doing that. I don't think we're at that point yet, but we usually go in camera when we're talking about these types of things. Usually we're comfortable talking about that in that context.

I would also just urge that I think we should get, collectively, that report out before Christmas. Now we have three, maybe four, maybe five or who knows how many weeks before Christmas, and we have a new day, which is important, to talk about this. We have a child health study. We have all of these concurrent things and if we don't....

Maybe it's just me and the way I organize my time. I want to finish one thing before I move on to another. I think we ought to get that committee report tabled. I'm not suggesting there aren't competing interests here; it's just a matter of time.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much.

I'll make sure that the actual chair understands your comments and how this should go forward.

Mr. Davies.

Mr. Don Davies: Thank you.

In terms of the point about being in camera, we're not actually talking about the content of the report. We're just talking about its structure, so I think we're okay.

The thing is that we have all been keeping notes as we've gone through the report, so I have my own—as I'm sure all of us do—annotated copy of the report. It doesn't mean that we need to hold up continued assessment of the report. Frankly, we're on the recommendations and we have to continue to pile through the recommendations anyway. I'm just saying that it would be helpful to have that copy so that when we do finish the recommendations and come back to the parts of the text that are parked, we know where they are.

I hear the analyst. As soon as reasonably practicable is fine. That's good, but I don't think it should hold up our continued work on this report because, again, like the pain medication issue, the HR or human resources issue has been called a crisis as well. It also has urgency to it.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much for that, Mr. Davies. Certainly, good old common sense may prevail in the end.

I think that our discussions have been fruitful and that we've heard the will of the committee that, as soon as it's possible, we'd like to have that updated copy with the multiple highlights, as per Mr. Davies' suggestion, if we could.

Mr. Davies.

● (1250)

Mr. Don Davies: I move to adjourn.

The Vice-Chair (Mr. Stephen Ellis): Is it the will of the committee to adjourn?

Dr. Hanley.

Mr. Brendan Hanley: Before we adjourn, as much as I've missed the voice of Dr. Ellis around the table, I'd like to congratulate his chairmanship today—easily one of the top two chairs I've worked with on this committee. Thank you.

Some hon. members: Oh, oh!

The Vice-Chair (Mr. Stephen Ellis): On that note, the meeting is adjourned.