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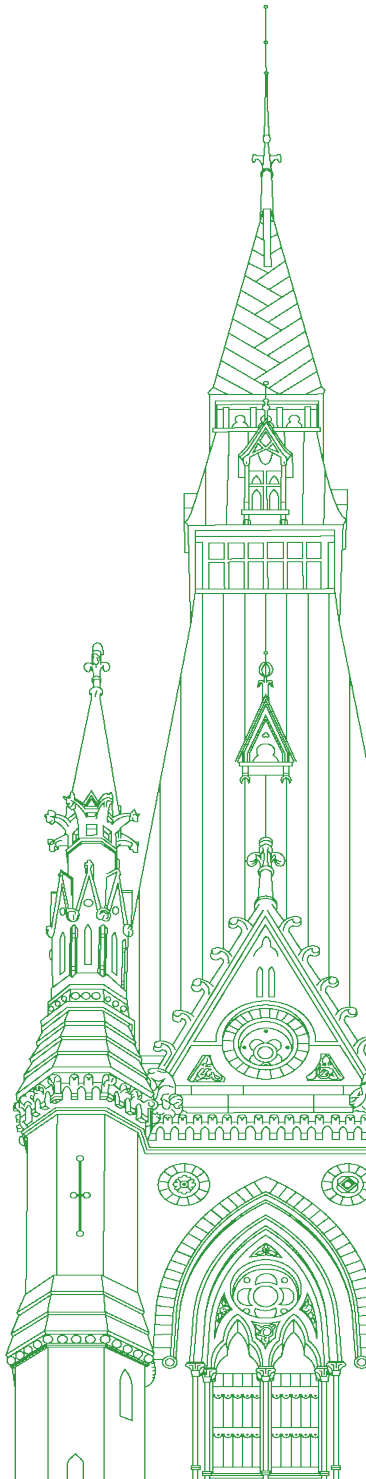

Chair: Mr. Sean Casey

Standing Committee on Health

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● (1105)

[*English*]

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

Welcome to meeting number 53 of the House of Commons Standing Committee on Health.

Today we will meet for two hours with witnesses for 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 have a couple of comments for the benefit of our witnesses today.

For those who are participating on Zoom, you have interpretation available to you, and we know now that it is working. You have the choice at the bottom of your screen of either the floor, English or French. For those of you in the room, of course, you can select the desired channel.

Please don't take screenshots or photos of your screen. These proceedings will be made available on the House of Commons website.

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

I would now like to welcome the witnesses who are with us this afternoon. We have Dr. Tracie Afifi, professor at the University of Manitoba, appearing by video conference. From the Canadian Counselling and Psychotherapy Association, we have Ms. Carrie Foster, president-elect, and Lindsey Thomson, the director of public affairs; and from the Offord Centre for Child Studies, we have Dr. Stelios Georgiades, director, and McMaster Children's Hospital chair in autism and neurodevelopment. He's with us by video conference.

Thanks to all of the witnesses for being with us today.

Each of you has up to five minutes for your opening statement. We're going to begin with Dr. Afifi.

Welcome to the committee. You now have the floor.

Dr. Tracie Afifi (Professor, University of Manitoba, As an Individual): Thank you.

The most recent UNICEF data on child well-being in high-income countries indicates that Canada ranks 30th out of 38 countries. This, along with our need to support children and youth to recover from the COVID-19 pandemic, emphasizes that now is when we need to fully invest in children and youth to foster healthy development and resilience. This requires several strategies.

First, it's recommended that we invest in long-term funding for youth and child health research. Second, it's recommended that we implement strategies to effectively translate this research into policy and practice. Third, it is recommended that we train and retain health care and social service professionals to develop a network in which systems can share information and collaborate. Fourth, we need to be able connect all children in a timely manner to health care and social services when needed.

However, we need to consider these recommendations within the context of children's environments, in which they live, grow, develop and learn. What does this mean? It means that for optimal health we first need to ensure that children's and youths' environments are both safe and stable. It requires an approach that includes addressing poverty, racism and violence.

Today, I would like to focus on violence and the home environment to demonstrate that healthy child development is actually not possible when children live in unsafe and unstable homes.

The Centers for Disease Control and Prevention in the United States indicates that safe, stable and nurturing relationships and environments are important for preventing child abuse and neglect and fostering resilience, but you might wonder why we need to prevent violence to improve health. The answer is that spanking and child maltreatment are associated with an increased likelihood of mental disorders, physical health conditions and many other poor outcomes. An individual cannot achieve optimal health if they experience violence.

How common is violence in homes in Canada?

Although we don't have representative data on spanking in Canada, we do know from community samples that hitting children as a means of physical discipline is common. We also know that conclusive evidence across decades and over thousands of studies indicates that spanking is related to mental disorders, physical health problems, substance use disorders and thinking about and attempting suicide in childhood and across the lifespan. Children who are spanked are more likely to experience severe physical abuse, sexual abuse, emotional abuse and exposure to intimate partner violence.

Our team has analyzed data from a nationally representative sample of Canadian adults who retrospectively reported on their childhood experiences. We found that 32% of individuals in Canada have experienced child abuse, including physical abuse, sexual abuse and exposure to intimate partner violence.

Let me repeat that: One in three Canadian adults has reported experiencing child abuse.

We further analyzed these data and found that individuals who experienced child abuse were more likely to have depression; bipolar disorder; generalized anxiety disorder; obsessive-compulsive disorder; panic disorder; post-traumatic stress disorder; phobia; attention deficit disorder; eating disorders; alcohol abuse or dependence; drug abuse or dependence; suicidal ideation; and suicide attempts.

Our research has also indicated that spanking, slapping, harsh physical punishment, child abuse and neglect are associated with increased likelihood of several physical health conditions, including hypertension, liver disease, diabetes, cardiovascular disease, gastrointestinal disease, obesity and arthritis.

Please recall the four recommendations that I began with: All these recommendations should incorporate violence prevention to achieve our greatest likelihood of improving health outcomes for children and youth.

To summarize, we have recommendation one: long-term funding for research.

We need ongoing data collection and infrastructure in place to be able to act quickly when evidence is needed, such as in the COVID-19 pandemic. We did not have these research mechanisms in place during the pandemic and we were not able to act quickly to produce the data to improve the health outcomes for children and youth. What is needed is ongoing, longitudinal nationally representative data collection that includes measures of health; violence; other social determinants of health; systemic barriers; access to care; and potential protective factors.

Recommendation two is for knowledge translation and mobilization to connect research to policy and practice related to improving health and preventing violence.

Recommendation three is for training and retaining. We need to train and retain health care and social service professionals and develop a network in which these systems can share information and collaborate.

Recommendation four is for timely access to health care and child protection for all children and youth when needed.

To conclude, violence prevention and early health intervention will yield the best outcomes for children, youth and families in Canada.

Thank you.

● (1110)

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

Next we're going to the Canadian Counselling and Psychotherapy Association.

Will it be Ms. Foster or Ms. Thomson?

All right. You have the floor for the next five minutes, Ms. Foster. Welcome.

Ms. Carrie Foster (President-Elect, Canadian Counselling and Psychotherapy Association): Good morning. *Bonjour*. I am here in the capacity of president-elect for the Canadian Counselling and Psychotherapy Association, or CCPA. I represent more than 12,000 members who provide essential mental health services across Canada.

I would like to speak today about the significant mental health trends affecting children and how the government can take immediate action to relieve some of the burden to Canadians of the cost of mental health care.

Children in Canada are desperate for and yet are struggling to access mental health support. There is clear and growing need for help, but our system is failing these children. Long wait times demonstrate that the demand for services outweighs the capacity of providers.

[*Translation*]

Counselling therapists and psychotherapists can and are willing to meet the demand. These mental health professionals have had to be the most available during the pandemic, compared to other health professionals.

[*English*]

Strengthening Canada's mental health care supports by increasing accessibility to providers is essential to pandemic recovery and to a thriving and healthy society. Despite health care being a provincially regulated matter, there are small, actionable, and yet impactful federal policies and legislation that can be amended in order to improve supply and access to qualified mental health care providers in Canada.

At present, counselling therapists and psychotherapists are the only regulated mental health service providers that must remit tax on their services. Physicians, psychiatrists, registered nurses, registered psychiatric nurses, psychologists, occupational therapists and social workers are all exempt from GST/HST on their psychotherapy services.

● (1115)

[*Translation*]

Counselling therapists and psychotherapists are excluded from this exemption. This contributes to reduced access to mental health services for children by creating unnecessary financial pressure.

[*English*]

The profession of counselling therapy/psychotherapy meets the threshold for tax exemption in the Excise Tax Act, as it is regulated in five provinces. However, because the profession does not regulate the same title in all five provinces—title being a provincial decision—the Department of Finance does not accept that counselling therapists and psychotherapists are the same profession in order to meet that minimum threshold.

The profession is the same in all but name. Counselling therapists and psychotherapists across Canada share a common scope of practice, abide by similar codes of ethics and standards of practice, have a comparable training and education profile, and have a commitment and obligation to ongoing continuing education. They are qualified, competent, and available to meet the skyrocketing mental health care needs of children in Canada, and yet the additional cost of GST/HST tax on their services is limiting their capacity to serve their communities and those seeking care.

[*Translation*]

To ensure universal access to all mental health professionals, services provided by psychotherapists and counselling therapists should be tax-free.

[*English*]

This exemption would enable a child seeking care to access a few additional sessions over the span of a year. These extra sessions could make the difference between a child's ability to fully integrate their learnings and positive changes and habits for improved well-being. We call on the committee to support CCPA's recommendation to the federal government to legislatively amend the Excise Tax Act through a financial bill that adds the profession of counselling therapy and psychotherapy to the list of GST/HST-exempt health care professionals.

[*Translation*]

Thank you very much. I'll be pleased to answer your questions in French or in English.

[*English*]

The Chair: Thank you very much, Ms. Foster.

Finally, we have Dr. Georgiades from the Offord Centre for Child Studies.

Welcome, Dr. Georgiades. You have the floor.

Dr. Stelios Georgiades (Director, Offord Centre for Child Studies): Thank you, honourable chair and honourable members of this committee.

Today, I join you from the authentic and resilient city of Hamilton and its surrounding areas, in the province of Ontario.

I am here to represent the members of the Offord Centre for Child Studies, which is a multidisciplinary research institute dedicated to improving the lives, health and development of children and youth. The Offord Centre is affiliated with McMaster University, McMaster Children's Hospital and Hamilton Health Sciences.

Today, I will position my testimony on one strategy for child and youth health that enhances all other strategies related to that.

The late Dr. Dan Offord, founder of the Offord Centre for Child Studies, believed that tracking children's life trajectories was vital to improving their health and well-being. To Dr. Offord, a clinician and researcher who worked at McMaster University—the birthplace of evidence-based medicine—data were key. Data help us identify and understand problems, and lead to evidence that helps formulate, deliver, evaluate and refine solutions.

Our recommendations for the Standing Committee on Health's study on children's health reflect the belief that everything we do to improve, support and sustain the physical and mental health of Canada's children and youth can become more efficient, effective, equitable and sustainable through evidence that builds on high-quality research and data.

The recommendations in this brief are a single, overarching recommendation in five parts. A strong national commitment to research in child and youth mental and physical health needs to build on an infrastructure capable of supporting that commitment. I'm glad these recommendations overlap with the ones noted by Dr. Afifi, earlier today. This is the best strategic path to achieving a significant and sustainable impact on all aspects of child and youth health. That impact can be pervasive, enhancing programs and services at the federal, provincial, territorial and municipal levels, and within not-for-profit institutions nationwide. A single strategic decision can generate multi-faceted and lasting benefits for our children and youth.

I'm now going to outline five high-level recommendations.

Number one, establish long-term funding for research on child and youth mental and physical health as part of a national child and youth comprehensive health strategy.

Number two, establish a national research network to collect, coordinate and harmonize data related to child and youth mental and physical health in a research-accessible system.

Number three, invest in training researchers and frontline staff who can conduct research, translate research into policy and practice, and deliver care that reflects and contributes to research.

Number four, adapt our existing data-gathering practices to accommodate the specific needs of children and youth.

Number five, develop a learning health system in child and youth health to better connect research findings and evidence with the design and deployment of policy, care and training.

To conclude, we currently have inadequate information on a spectrum of health outcomes and factors ranging from child and youth mental health to race, ethnicity, child maltreatment and parental health. Many of the witnesses who testified before this committee have shared this.

Canada needs to invest in the coordinated effort and infrastructure required to generate the essential data, research and evidence leading to evidence-based policies and practices that foster healthier children and youth, a healthier society and reduced inequities. This kind of national investment—one that coordinates data gathering and analysis across provinces and territories—is a mandate that only fits with the Government of Canada. It is very timely within the larger context of the dialogue happening in our country, right now, in relation to health.

● (1120)

As a nation, we need to expand and enrich our ability to coordinate data collection, management and analysis. Then we need to embrace evidence-informed policy and practice to bridge the gap between research and the design and delivery of policy and practice that can improve the lives of children and youth and their families in this country.

I want to end by thanking all of you for your time, commitment and all you do for Canada's children and youth.

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

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

Dr. Ellis, you have six minutes, please.

[*Translation*]

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Mr. Chair, with the agreement of the other members of the committee, I would like to take a little time to acknowledge the tragedy that took place yesterday in Laval. I think it's necessary to do that given this committee's mandate, which is currently looking at children's health.

The Chair: I agree. We'll observe a minute of silence for the victims of the Laval tragedy.

[*A moment of silence observed*]

Thank you, colleagues.

Mr. Ellis, the floor is yours again.

[*English*]

Mr. Stephen Ellis: Thank you, Mr. Chair.

Thank you, colleagues, for that moment to reflect. I certainly think it's germane given the difficult topics we're talking about here and that we continue to discuss at the health committee.

Chair, I would like to start with Ms. Foster, specifically about the removal of GST and HST with respect to the services of counsellors and psychotherapists.

Could you just give us a brief idea of how that may affect accessibility and also how it may affect a practice? In my province it's 15% extra. Some people might not find that difficult. In my mind the argument is that sometimes the people that need the help the most are those who are suffering the most financially as well.

If you could provide some comments on that, I'd appreciate it. Thank you.

Ms. Carrie Foster: I think that in this day and age every penny counts with the increasing cost of food and all that. I think that 15%, which it is in my province of Quebec as well, will make a difference. I have clients phoning all the time asking for that.

It's one piece of a larger picture that still needs to be looked at in terms of accessibility to mental health care for all Canadians on an equal basis. Fifteen per cent is a lot for some.

I would suggest that it's an important piece that would allow, at least perhaps, those who can't afford 15%.... It means less to you perhaps than to the clients I work with. I work with victims of violence. I also work with indigenous folks. I work for the federal NIHB program for indigenous and Inuit folks. That makes a huge difference to them.

I think it's one piece—an easy ask—that would allow those who can't afford it more access.

Thank you.

Mr. Stephen Ellis: Thank you for that.

Through the Chair, can you talk a bit about the coverage for services?

As we know, many different services of health care providers are covered through the public system. Moreover, for some people who are fortunate enough to have private insurance plans, there's coverage.

Can you talk a bit about the membership of your organization and what percentage of your clients may have coverage through other programs?

● (1125)

Ms. Carrie Foster: I can't give you the exact number, but I know that counsellors and psychotherapists nationally—and it differs from province to province—aren't necessarily all on par with the insurance companies that are out there. We are working with the the Canadian Life and Health Insurance Association to try to get them to include psychotherapists as much as they include psychologists and social workers.

Our membership, our indigenous folks.... There are creative arts therapists, there are those who work in social justice contexts and in schools. Not all of them will have access to counselling. That's a huge piece. That's a huge ask. We're not even asking for that today, but it's a big piece that needs to be looked at, in my humble opinion, as to how people can get access.

Yes, there is some availability. Not all counselling therapists and psychotherapists are admitted into all of the programs. At this point, we have been removed from the NIHB program. We were added during the pandemic. Presumably when and if the pandemic ends, we'll be taken out again.

That means that indigenous folks who work with us who have their Canadian certified counsellor permit will not be allowed to work in their communities, with their people, because they're CCCs.

I think it's really important that we look at what that is, so that we have not just early access to mental health, but also.... That gentleman in Laval...perhaps if he'd had help earlier on and had had access to services, he wouldn't have been doing what he was doing.

Mr. Stephen Ellis: I understand. Thank you.

Once again, this is through you, Chair. In my mind, we have a mental health crisis in this country. Perhaps a third of people are suffering with difficulties with their mental health.

How impactful do you think it would be if the Liberal government of the day actually transferred the $4.5 billion promised in the Canada mental health transfer? How transformative could that be to the delivery of mental health care services and, obviously, to the mental health of Canadians?

Ms. Carrie Foster: I'm not a financial expert, and I don't think it would be my place to answer that question. All I would say is that I think those parties involved in getting access for kids, access to mental health and youth access to mental health.... That's the important part. I will let you guys work out how you do it.

Did you have anything to add to that, Lindsey?

Ms. Lindsey Thomson (Director, Public Affairs, Canadian Counselling and Psychotherapy Association): Can you repeat the question, please?

Mr. Stephen Ellis: Absolutely. I'd love to.

Certainly, we understand that in Canada, there's a significant mental health crisis, with almost a third of Canadians suffering with their mental health. We know that the Liberal government has continued to promise a $4.5-billion Canada mental health transfer, which has not been actioned. In my mind, that type of money could be transformative, not only to the delivery of services, but obviously to the lives of the many Canadians who are suffering.

I wonder if you had a comment on how that may affect the delivery of services and the lives of the people you serve.

Ms. Lindsey Thomson: Absolutely, I can add to that.

I think the impact that it can have is beyond what we can possibly imagine. Some of the biggest issues that we're seeing are wait times. We know, depending on whether we're urban versus rural, we can be waiting for children's services for up to two and a half years. This is not to be dramatic, but this can literally be a life-or-death situation. We're seeing that the number of mental health struggles among children has increased exorbitantly due to the pandemic, lockdown and isolation and all they cause, as we are very social beings.

With that, it could help to increase standardization of service across the system. We know right now that there are some things that different governments are doing. For example, in Ontario, there's the structured psychotherapy program, which provides short-term psychotherapy and CBT, specifically. It's an amazing program, but let's see how we can bolster that and fill in the gaps.

For me, this is, absolutely, a great idea. It's a starting point to help increase the standardization of access to different services, while also ensuring that we're not only providing certain types of therapies. We have to be able to give people the choice they want. Just because a particular therapist is available, it doesn't mean that they're going to jibe with that client.

Therapy is all about that human connection and that relational connection. It's very different from what we might experience with going to see a physician who does a diagnosis of physical symptoms. We want to make sure it's not just, “Okay, this person is in front of you. Figure it out”, but giving them options to determine what's best for their needs, whether that's cognitive behavioural therapy, arts therapy, sand therapy or whatever that might be.

The Chair: Thank you, Ms. Thomson.

Next we have Mr. Jowhari, please, for six minutes.

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

Right away I want to acknowledge my colleague's early intervention about the event that happened yesterday and thank him. I also thank you for the moment of silence.

Welcome to all of the witnesses today.

This is a very important topic. It's very important to me as the founder of the all-parliamentary mental health caucus. I am very much invested in this.

I'm going to start with Ms. Foster.

In your opening remarks, you talked about demand outweighing capacity. Naturally, when we look at the study that we are doing, the demand that we are focusing on is children, especially children at the early stages, and the capacity is now where I want to focus. Often when I talk to different professional service providers, especially on mental health and mental wellness, what they're talking about.... If we look at capacity in a much broader sense rather than just the psychotherapist or the counselling therapist and include intervention at the early stages, then we may not be in as bad a situation as we are.

I would like to know your point of view on that.

● (1130)

Ms. Carrie Foster: I think the earlier we can intervene, going down the road, the less....

I work with kids and families as a couple and family therapist. If I can intervene when they're four, five and six.... I have clients who have had trauma at that age, as the Laval kids will have at this point.... If we can intervene now, then perhaps when they're 12, when they're 20, when they're 40 or when they're 50, they won't need those many services.

The earlier we get to it, the less chance there is of children or young adults reaching a crisis level of need for therapy and not being able, once again, to get the service. Hopefully, in the long-term picture, we can reduce the number of sessions required per capita, if you want.

Mr. Majid Jowhari: Ms. Thomson, you talked about bringing in other practitioners. You talked about a cognitive behavioural therapist. You talked about art therapists. I also consider those to be part of the capacity which that demand falls into.

Can you give us your point of view in looking at capacity in a much broader sense rather than just the psychotherapist or just the psychologist?

Ms. Lindsey Thomson: Absolutely.

I will share that I am also a registered psychotherapist who has been in practice for many years.

I think we need to get a little bit more creative in how we look at psychotherapy practice. A big part of that, of course, is education of the public about the different therapeutic modalities that are offered. From the research I've done, there are over 200 different types of therapy that we could have available, and that is so important to what's available for Canadians.

As an example, I provide cognitive behavioural therapy. Carrie works with children, so it's going to be a little bit of a different angle. It's all about what works for your individual personality. I am a type A, so CBT works for me and for the clients I work with. Some other individuals might prefer to work with—I'll try to give an example—narrative therapy or internal family systems. I'm happy to provide definitions of what all these different therapies mean, because there are many.

When we offer up the scope of the different types of therapies provided, we're giving more access to Canadians at whatever stage they're at, whether they're struggling with substance use, whether they're survivors of domestic violence or whether they've gone through traumatic events. There are so many different types of therapies that research demonstrates do match this particular and unique need.

Another thing I'd like to add to Carrie's earlier point is that if we focus on early intervention and preventative care, that's going to have a huge ripple effect on the cost to the government in the long run, not just the government but also the workforce in terms of absenteeism, the effects on families and how they're able to give back to the economy and be able to participate in Canadian life.

Mr. Majid Jowhari: Thank you.

I'm going to go to the partisan part of my question period.

My colleague Dr. Ellis asked how impactful that $4.5 billion could be. Indeed, it is impactful. However, having money thrown out there without having accountability, transparency and measures of where it's been spent has been a challenge. As you know, in 2017 our government spent $5 billion on transfers to provinces for mental health. You testified that you haven't seen any improvement in access. You haven't seen improvement in increasing capacity in dealing with that.

Therefore, I'd like to know your point of view on welcoming the $4.5 billion, as we agreed, and the types of measures you would really like to see that support transparency, accountability and, most importantly, access for our children.

● (1135)

Ms. Lindsey Thomson: Absolutely.

In terms of measures it's definitely about having some kind of structure and standardization in place, and a set level of criteria of whom the money is being made available to. It's making sure that a certain percentage of the funds are being earmarked directly for community services and agencies to be able to support those who need it most, who don't have the extra 15% on top of the session fee to be able to afford more sessions. For me, it's really about about having structure and oversight.

It's also about having flexibility, because the need province by province is very different. Ottawa as an urban centre is very different from rural Manitoba. It's very different from the state of affairs in B.C. with the opioid crisis there. We really have to make sure that there's structure, but also flexibility, to have a good flow with it.

Mr. Majid Jowhari: Thank you.

The Chair: Thank you, Ms. Thomson, and Mr. Jowhari.

[*Translation*]

Go ahead, Mr. Garon. You now have the floor for six minutes.

Mr. Jean-Denis Garon (Mirabel, BQ): Thank you, Mr. Chair.

I join my colleagues in offering my condolences and thoughts to the parents and loved ones of the victims and to the affected community in Laval. This reminds us that our children are our most important asset. We need to think about them and take care of them. I think we are all united in that thought today.

Ms. Thomson, I'm going to pick up on my colleague's question about the partisan part, it seems. I thought it was a very good question.

Are there any standards, rules or measures in Quebec regarding the provision of psychological care for children?

Ms. Lindsey Thomson: I don't know, but I can look into it and send you an answer in writing.

Do you want to add anything, Ms. Foster?

Ms. Carrie Foster: Mr. Garon, could you repeat the last part of your question so I understand?

Mr. Jean-Denis Garon: Are there standards for the services that must be provided to children? Is this a market where there are standards imposed by the Government of Quebec?

Ms. Carrie Foster: Yes, psychotherapy has been regulated in Quebec since 2012, which is very different from the rest of the provinces. It's regulated by professional order. So as a couple and family therapist, I'm a member of the Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec, despite the fact that social workers are—

Mr. Jean-Denis Garon: My question was more the following: are there any government objectives for services to children?

Ms. Carrie Foster: We'll have to get an answer to you about that later.

Mr. Jean-Denis Garon: It would be interesting if you could provide us with that information.

I've noticed that for a number of years people have been coming to Ottawa to ask for money, transfers and national policies in areas of provincial jurisdiction. That's true for psychologists, respiratory therapists, students and education. It's true in just about every field.

It seems to me that we've gotten into the habit of coming to Ottawa to ask for transfers because Ottawa is where the money is. Now, these transfers have policies and conditions attached to them to the provinces and to Quebec, with measurement tools and accountability, to try to verify if the money is going to the right place.

Don't you think it would be simpler if the money were in Quebec City and you went directly to Quebec City to say what you wanted and you would measure the results? Don't you think there's something wrong with all this?

Ms. Carrie Foster: That's a good question, isn't it?

Mr. Jean-Denis Garon: I always ask good questions.

Ms. Carrie Foster: That's for sure.

We're currently part of Canada and have to follow its ways of doing things. We make our requests to the federal government because it's the one that deals with this throughout Canada. If we can get this sorted out at once, it would be better for all counsellors and psychotherapists in the country.

Mr. Jean-Denis Garon: So sending money to the provinces would solve the problem all at once. That's music to my ears.

Dr. Afifi, I've read many of your research papers over the past few days. Among other things, you've studied the effects of traumatic experiences such as spanking on the long-term development of children.

Do you think that everything that has happened during the pandemic, such as the lack of socialization, school closures and delays in education, could have a long-term impact on children? What are the potential costs to the provincial health and education systems?

● (1140)

[*English*]

Dr. Tracie Afifi: We do know from the data that's been collected so far that the pandemic is definitely having an impact on children. Currently, it's shown mostly in mental health but there can be physical health problems as well. We have children who were born during the pandemic who haven't been adequately socialized and have delays in speech. We have a lot of increased anxiety and depression throughout that.

Early intervention is necessary, absolutely. Could it be ongoing and have an impact? [*Technical difficulty—Editor*]

[*Translation*]

Mr. Jean-Denis Garon: Dr. Afifi, we lost you for a few moments. Please continue.

[*English*]

Dr. Tracie Afifi: In terms of whether there will there be long-term impact, I would anticipate absolutely that there is going to be long-term impact, but again, what we need to understand and know how to respond to that is data.

We need to be able to be doing research. We need to be able to be provide evidence-based treatments for individuals, because if we don't intervene now when they are young, it has the potential for mental health problems to continue across the lifespan and become worse.

With that, we need to make it accessible to all children in a timely manner. We need to be making sure—

[*Translation*]

Mr. Jean-Denis Garon: If I may interrupt, I have a specific question about that.

There is a lack of acceptable public longitudinal data that should be collected by Statistics Canada. You've made that point, and so have other witnesses. Can you give us a concrete example of a research question about children's health during the pandemic that you are unable to answer today because of this lack of data from Statistics Canada?

[*English*]

Dr. Tracie Afifi: A concrete example is that because we don't have good data before the pandemic, it's hard to ask and answer questions whether or not the mental health of children has changed due to or after the pandemic.

If we had long-term data collection in place, we could simply ask the questions of whether or not depression and anxiety increased and we could measure it precisely with data, if we had baseline data to compare it to.

We don't have those data structures and infrastructures in place for children in mental health, and with that we don't have a lot of measures of other things that are important that are related to mental health, such as poverty, racism, violence. All of that was also increased due to the pandemic, and the pandemic influenced different people in different ways.

If we had data in place before the pandemic, then we could easily compare to see if things decreased. Without the before data, we can just say what it is now. Can we say that it changed? We can say that this is what it is now, if we collect the data now, but we don't have the ability to compare differences.

The Chair: Thank you, Dr. Afifi.

Next is Mr. Davies, please, for six minutes.

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

Thank you to the witnesses for being here.

I would like to add my voice to that of my colleagues on behalf of the New Democratic Party to express our deep sorrow and grief over the recent events in Laval. Our hearts go out to the parents, families and all those affected by that unbelievable tragedy.

I'm going to start, Dr. Afifi, with you.

How solid is the connection between corporal punishment, or hitting children as a form of punishment, and subsequent mental health issues?

Dr. Tracie Afifi: The evidence is 100% certain that if you hit a child, you're increasing the likelihood that they will have poor outcomes. That includes mental health and physical health. It also includes across the other domains of development—education, justice, etc.

Does that mean every child who is hit will have these outcomes? No. Some children will be more resilient, and we're learning about why that's the case, but with 100% certainty, there's no question with the decades of data and thousands of studies that if a child is hit, spanked, slapped, whatever word we use, you're increasing the likelihood of poor outcomes for that child. That child will be less likely to reach their full potential and less likely to be in optimal health. That's 100% certainty.

Importantly, there are no studies, not one study, that show that hitting a child is beneficial to the child.

● (1145)

Mr. Don Davies: Funnily enough, the Criminal Code of Canada actually authorizes parents, teachers and other guardians to use physical force or discipline to punish a child under their care. It is subject to a test of what's reasonable under the circumstances.

Domestic violence, by definition violence in the home, is self-evidently harmful with respect to partners. Why does it seem to be a persistent issue to apply that same approach when it comes to corporal punishment of children in the domestic situation?

Dr. Tracie Afifi: It's a problem that we have in Canada that we haven't repealed section 43 of the Criminal Code. The only people that we're allowed to hit in our country by law is our children. They're the most vulnerable and the ones that we need to protect the most, arguably, but we're still allowed to hit them.

We need to repeal section 43 for the important reason of.... It's not making it criminal and it's not putting parents in jail. That's not the reason and that's not what's happened in over 60 other countries in the world. We're behind on this.

It first happened in 1970—

Mr. Don Davies: We'd have to have a bill in Parliament to repeal that very section.

Dr. Tracie Afifi: Yes.

Mr. Don Davies: I'll go to the Canadian Counselling and Psychotherapy Association.

What portion of overall health care spending is currently allocated to children's mental health services in Canada? Maybe can you give us a general idea of how we compare to similar jurisdictions in the world.

Ms. Lindsey Thomson: That is a very good question that I did not prepare for today, so I will get back to you in writing.

Mr. Don Davies: Okay, thank you.

According to CIHI, more than one quarter of children and youth hospitalized for mental health conditions lived in the least affluent neighbourhoods in 2020.

I wonder if there is a link between poverty and poor mental health among children and youth.

Ms. Carrie Foster: In the research that I've read over the years, yes. Definitely immigrant populations, racially diverse or any of the cultures that aren't necessarily at a high economic standard.... Poor neighbourhoods tend to increase that.

Mr. Don Davies: Again according to CIHI, rates of mood and anxiety medication use by children and youth were twice as high for females than males in 2020.

I wonder if you can tell us a little bit more about perhaps some gender differences in mental health among children.

Ms. Carrie Foster: It's interesting because also, statistically, when they reach adolescence, boys are more likely to have a higher rate of suicide, especially in Quebec.

I think it's just perhaps how we socialize our girls and how we socialize our boys—the boys to be strong and the girls perhaps to.... There's a higher availability of sensitivity, perhaps, that we find. That's how we socialize. That's work that I certainly do in my practice with regard to self-esteem, here and in the other countries I've worked in.

Mr. Don Davies: We've talked a lot about upstream interventions. I think that is self-evident and that probably everybody in this committee would understand and agree with that.

Can you give us an example of a concrete, pragmatic, practical upstream intervention that you would recommend the federal government champion to start actually making that concept real?

Ms. Lindsey Thomson: Just let me confer for a second.

Can you verify what you mean by “upstream”?

Mr. Don Davies: I mean more preventative or early intervention. Is there a way to get better assessment and treatment among children, let's say in our primary schools?

If we want upstream interventions to reduce the rate of hospitalizations and kind of get to it early, how do we make that real? What do we do?

Ms. Carrie Foster: In this country, we have a heavy emphasis on diagnosis, as opposed to just assessment and evaluation. Counsellors and psychotherapists are able to assess. If we brought in that ability....

Guidance counsellors are also a part of the CCPA system. Perhaps if we can broaden that, then we won't have to wait for one psychologist per school board to make it to all the different schools. I think that would be one way of getting early diagnoses earlier on.

Clients call me looking for help for their children who have ADHD. For me, it's whether they need actual special input in the school and special parameters put around their learning and their learning difficulties so that they can achieve or is it that they just want to work on some of the psychotherapeutic things and need the counselling aspect. They can't see me for the diagnosis, but they can see me for the betterment and for the mental health care.

● (1150)

The Chair: Thank you, Ms. Foster and Mr. Davies.

Ms. Lindsey Thomson: I have one point, if I may add to that.

I would just further Carrie's point about absolutely increasing the availability of psychotherapists within the schools.

I have had the opportunity to do my bachelor's in education and actually be in schools. I learned that, as Carrie mentioned, there are guidance counsellors available, but often—at least in the context of my experience in Toronto—you'll have one guidance counsellor for five schools. If you have 500 to 1,000 children per school, how much one-on-one time are they actually getting? It's not just doing career counselling and seeing how their grades are, but seeing how they are actually doing in terms of their mental health. That's one piece.

The other piece I see, which would bring us in a whole different—

The Chair: Thank you, Ms. Thomson. We want to try to make sure that everyone gets a chance here, and we're well past time. You'll get a chance to come back to it, I'm sure.

Mrs. Goodridge, you have five minutes, please.

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

Thank you to all the witnesses. As has been the case in many of our panels, we have a variety of different witnesses with very different specializations. That makes it really difficult to try to figure out which angle we're going to go with this.

I think this is part of the struggle with this very vast study we have on children's health. Children are a large demographic in our country, and yet we're just studying children's health, which can be everything from autism to mental health to access to care and everything in between. I think it makes it very difficult for us as parliamentarians to figure out exactly how we're going to take this...because it's all important.

I'll start with you, Dr. Georgiades. I was reading the study that you produced in 2021 on screen use and mental health symptoms in children and youth. I thought that was extremely poignant. I'm just wondering if you could expand on that a little bit.

Dr. Stelios Georgiades: I want to start with your comment about how broad child health is and how challenging it is to come up with an action plan that may also attach to screen use and mental health, especially during the pandemic. I agree with that. I've been in Canada for 27 years. I have to say that, in my opinion, I have never seen a study like the one being undertaken by your committee right now. You have experts and witnesses who testify, but your committee and your teams now have information and testimony that can certainly guide us on the way forward. Even though it's broad and challenging, I am very encouraged by the work of this committee and the opportunities that may come out of this study.

In terms of screen use and mental health, that is not my expertise. That study was actually co-led by another Dr. Georgiades at McMaster, Dr. Kathy Georgiades.

Mrs. Laila Goodridge: My apologies. I will skip past that, then. I clearly did not prepare as well as I should have.

To go back a bit, you definitely are a specialist in autism. One thing we've heard very clearly is that early diagnosis is important. What are you guys seeing in terms of backlogs, especially in terms of COVID and how that has impacted being able to diagnose children earlier?

Dr. Stelios Georgiades: Autism is a great example of children with multi-faceted needs. We know, based on several studies, that early diagnosis and earlier access to intervention can certainly lead to improved and more optimal outcomes.

There is no doubt that the pandemic has limited the rate of diagnosis across our country, and the rate of diagnosis was already slow before the pandemic. I think some of your other witnesses talked about many of the issues being there prior to the pandemic and being exacerbated because of the pandemic.

At the same time, I will say that autism is also a positive example. It is one area in our country where I have personally experienced what collaboration and unity across scientists, clinicians, stakeholders, families and also politicians and policy-makers can do. There's a backlog. There's no doubt about that. But we are in the process of working with many stakeholders across Canada on developing a national autism strategy that will use innovative, effective and efficient ways to clear the backlog in the years to come.

That's an example of both a challenge and an opportunity in terms of what collaboration across jurisdictions, across political parties and across specializations can actually achieve.

● (1155)

Mrs. Laila Goodridge: Thank you.

I don't want to interrupt, but I think I have about a minute left.

No? All right.

The Chair: No, you had five, and that's five.

Thank you very much, Mrs. Goodridge.

Next we're going to Ms. Sidhu, please, for five minutes.

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

I want to express my condolences to the families and friends of those affected by yesterday's tragedy in Laval.

My first question is for Dr. Afifi and Ms. Thomson.

You talked about how for five schools, there's one guidance counsellor. What role can schools play? How can early childhood education programs be designed to help support healthy development and resiliency in children?

Ms. Lindsey Thomson: For that, I'll say I'm not an expert, so I'll be going based on the research that I've read and my experience in thinking about working with children from a mental health perspective.

The thing I can think of and that I've heard from our school counsellor educators through the CCPA is actually having part of the curriculum be learning about what it means to be human: how to be able to regulate our emotions; how to be able to communicate; how to be able to express anger, frustration in a healthy way. It's making some space for that type of education so we're not left until, "I realize I have an anxiety disorder. I don't know what I'm doing. I'm 30 years old and starting therapy for the first time trying to figure it out," while also managing maybe a single-income household with two kids.

Ms. Sonia Sidhu: Thank you.

Dr. Afifi, do you want to add to that?

Dr. Tracie Afifi: Sure. I think it's to make it extremely concrete and simple. Early intervention is key. We can access children through schools early. That's really important. It's evidence-based. We need to make sure we're putting programs in schools. There are many out there, the good behaviour game, for example, where you can implement evidence-based practices in schools to improve the mental health of kids.

Early intervention, evidence-based and access to care: those are the things we need for all children. This is equal for every child who needs it. If we can prevent things from happening before they happen, then we're going to have better outcomes. Those are the things we need to do, and that's where data is involved. We have to make sure—

Also, to a previous question, how do we know we're making progress? How do we know we're improving things? It's data. Everything is based on evidence and data. If we don't collect the data, then we don't know if what we're doing works.

The recommendations I've made actually try to incorporate many of all the things we're talking about today: evidence, early access and more access to care.

Ms. Sonia Sidhu: Thank you.

I understand there's a stigma in certain cultural communities. How can we reduce stigma and support a more open conversation about mental health? If you could both add on that point, and what do you think about integrated services as well?

● (1200)

Dr. Tracie Afifi: Yes. With that, we need to integrate our services. We can't be working in silos. I think that's really important. It's important across things like child protection and health. We need to have integrated services for sure. That's our best efforts. We need to continue to talk about mental health and reduce the stigma, but we also need to have those conversations early on with children.

As one of the other witnesses said, we need to be checking in on children. We need to be giving them the tools and the language and their own ability to identify when they need help. These feelings that they have inside might be anxiety. They might not be able to identify them as anxiety, so if we make it as normal...that we all have these feelings, and sometimes anxiety is healthy and helpful and sometimes it's too much and it makes things harder for us. Giving those children the tools to know that these things are normal and healthy reduces the stigma. It also gives them the ability to communicate to us instead of having it come up in unwanted behaviour or other problems. It might take some time for a teacher or parent to recognize that it isn't defiant behaviour, that the child is struggling with a mental health problem. Is it anxiety or depression? Whatever it may be, it's surfacing in perhaps a behaviour that is identified as unwanted.

Ms. Sonia Sidhu: Thank you for that.

Do you want to add to that?

Ms. Carrie Foster: Sure. Thank you.

Counsellors and psychotherapists are also trained in cultural humility. I think that's a big piece that needs to be addressed. That is just being able to speak, understand and inform yourself as to the cultural and ethnic background of your client so they are being addressed and helped in terms that meet their language and cultural values. I think that's a big piece.

Lindsey, is there anything else we wanted to say about that? That's it, yes.

Ms. Sonia Sidhu: Do you want to add on the integrated services, one-stop shop?

Ms. Carrie Foster: A one-stop shop?

Ms. Sonia Sidhu: The integrated services: the psychotherapist, psychiatrist, social services—

Ms. Carrie Foster: I think teamwork is always important in terms of who can do what. One stop hopefully is there, if it's a good fit, so if I'm needing a drama therapist as opposed to a psychiatrist, or a play therapist, I'm getting my needs met for my child or youth. It's not necessarily a psychiatrist who's going to be helping my child and being able to access their need through talk therapy, but there are other methodologies out there that we need to be including more of.

The Chair: Thank you, Ms. Foster.

[*Translation*]

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

Mr. Jean-Denis Garon: Thank you, Mr. Chair.

Ms. Foster, I'll continue with you. I have a 140-page document in front of me. It's the Quebec government's *Plan d'action interministériel en santé mentale 2022-2026 — S'unir pour un mieux-être collectif*. Area 4 covers all actions for children, youth and their families, actions over four years that include new funding.

You're in Quebec. I imagine that as a psychologist, you've read this document.

Ms. Carrie Foster: I'm not a psychologist, but rather a couple and family therapist.

Mr. Jean-Denis Garon: Right. You represent them.

Ms. Thomson, have you read this document?

Ms. Lindsey Thomson: Not in detail, no.

Ms. Carrie Foster: We work with a clientele—

Mr. Jean-Denis Garon: If it were a good, well-funded plan—there are 140 pages of it—that were ready to go, that would be the kind of plan that the Government of Canada could unconditionally fund, right?

Ms. Carrie Foster: I would like to follow up on this document. I promise that I will read it.

However, I hope that this includes private practitioners and couple and family therapists, because in Quebec, they aren't currently included.

Mr. Jean-Denis Garon: It's recommended reading.

I'm accused of always asking the same question, but we have this tendency in Ottawa to hear from people who think that the provinces don't have standards and that Quebec doesn't have standards. It almost implies that our children aren't important. Then, when we get here, we're told that standards are needed to monitor the provinces, but I have 140 pages of standards in front of me. It's not a lack of courtesy, but I would have found it interesting if we could have discussed this document here in Ottawa.

I have one last quick question for you. Does the Quebec sales tax apply to psychological services?

Ms. Carrie Foster: Do you mean psychotherapy? As a psychotherapist, I can tell you that it does.

Mr. Jean-Denis Garon: Okay. So your opinion is that, as part of the harmonized tax, that should be removed.

Is there a problem with the availability of psychological services in Quebec? I get the impression that we have a labour shortage and that we should have the means to train more people. There is currently a bottleneck in terms of availability.

● (1205)

Ms. Carrie Foster: Especially for psychologists and psychiatrists.

In Quebec, there are counselling therapists and psychotherapists who are ready to work and willing to become members of a professional body. However, the Government of Quebec's approach to professional bodies doesn't allow them to be admitted. So people don't have access to these services unless they pay out of their own pockets.

Mr. Jean-Denis Garon: So you feel there are enough resources.

Ms. Carrie Foster: This is unfortunate, and I hope that Quebec will change this soon.

The Chair: Thank you, Mr. Garon.

Thank you, Ms. Foster.

[*English*]

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

Mr. Don Davies: Thank you.

My information is that less than 20% of youth who need mental health services receive appropriate treatment. Does that jive with your practical experience?

Ms. Carrie Foster: Yes, and I can tell you that my waiting list is about two years long at this point in time.

Mr. Don Davies: I think it's fair to say that there's been a societal shift, and maybe—hopefully—a political shift in the last, say, 10 years, where we now recognize mental health to be a core part of overall health, and not any different, really, from physical health. Yet, we are not providing treatment to a huge number of our citizens. Of course, as we're studying children, who I think are often among the most important people in our lives, we're letting a significant part of their health go untreated.

My question is this: Is it time to bring access to mental health services under our universal health care system so that everybody can get treatment when they need it?

Ms. Carrie Foster: That's my dream. I think absolutely that's what we would hope for.

Mr. Don Davies: Ms. Thomson, you were nodding. Would you agree with that?

Ms. Lindsey Thomson: Yes, one hundred per cent.

Mr. Don Davies: Other witnesses, I'd like to open that up to you.

Dr. Afifi, would you agree with that?

Dr. Tracie Afifi: Absolutely, we need to do that.

Mr. Don Davies: Mr. Georgiades, would you agree with that?

Dr. Stelios Georgiades: Thank you for your comment. I think the big question is why wouldn't we include it?

Mr. Don Davies: How much time do I have left, Mr. Chair?

The Chair: You have one minute.

Mr. Don Davies: Interestingly, there was a large cross-sectional study conducted in 2020 of Canadian children, youth and parents, where 67% to 70% of children and adolescents experienced deterioration in at least one mental health domain: depression, anxiety, irritability, attention hyperactivity and OC disorders, but 19% to 31%, depending on the age group, experienced improvement in at least one domain.

Do any of the witnesses have any comment—perhaps, Dr. Afifi—on what factors might explain this heterogeneity of experiences among Canadian children?

Dr. Tracie Afifi: I can speak to that. It depends on what outcome you're looking at.

For some children, the home environment they were captured in, for lack of a better phrase, may have improved. They may have received one-on-one, undivided attention from their parents, who were able to stay home and take care of their needs. Some things may have increased. For some children, their needs might have improved being in the home environment through the pandemic and home-schooling.

When we think of the families with the least amount of resources who couldn't provide that and were struggling, trying to do their job and to find adequate care and education for their children, those children would have suffered the most during the pandemic and perhaps have been left behind.

I think it depends on the circumstances and what outcomes you're specifically looking at then saying what went up and what went down.

The Chair: Thank you, Dr. Afifi.

Mr. Don Davies: Thank you.

The Chair: Next we're going to Mr. Jeneroux, please, for five minutes.

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Thank you, Mr. Chair.

Thank you, everybody, for taking the time to be here today.

I'm hoping to get to at least two themes in the five minutes I have here, so I'll start with the first one.

Both you, Ms. Thomson and Professor Afifi, touched on the importance of intervention with our children and the reasons for doing that at an early stage. I've had discussions with some policy-makers about things like ADHD and dyslexia and whether or not certain education systems should be looking at making screening for that mandatory.

From your research, Professor Afifi, and then to you here in the room, I'm wondering if there is some of it that falls into your realm and that you have seen has been a success. It may not necessarily be here in Canada; it could also be elsewhere. Since Ms. Thomson is writing, I'll go to you first, Professor Afifi, and hopefully get some of your thoughts.

● (1210)

Dr. Tracie Afifi: I think we need to be careful with universal screening and not just implement it for a variety of things unless there's a proven reason that we should. First of all, screening needs to be done if we can adequately identify what the problem is.

Then, most importantly, if we're screening children, then we are obligated to connect those children who screened positive, for whatever it was, to services. If we don't have those services readily available and in place, the screening is for nothing, and it could cause more anxiety for families, because now we've identified that their child may have ADHD, but we don't have the resources at the school, in the province or in the community to support that, so now they have to wait two years to get access to care.

I think we need to think that through carefully. If early intervention connects to screening, then, yes, we should do it, but we should only do it if we are able to connect those services.

Think about for screening for cancer, for example. Imagine being screened for cancer, and you're told you have cancer, but then you're told that we can't give you services for two years and that you're going to have to wait. Imagine how much worse that situation is.

There's an obligation there, when we screen, to connect to services and make sure they're there. Again, all the recommendations tie together. Data, evidence-based...and translating the information into policy and practice. Train and retain people in an integrated system that talks to each other. Then make sure all of these services are accessible to every single child, not just a certain child or certain children, so that no one is left behind.

Mr. Matt Jeneroux: I don't think we're going to unpack all of that in the five minutes I have, but before I go to Ms. Thomson, I see Dr. Georgiades nodding.

I fear I might not get to you in this round, Dr. Georgiades, but certainly if there is more of that I welcome its being submitted to the committee. As a philosophical and ideological conversation about the importance of what we do, do we just live not knowing that a kid has ADHD, then, because we don't have the services for it? That also seems like it's not necessarily the compassionate answer.

Before I take up more of the time I'll turn to Ms. Thomson to perhaps finish this theme.

Ms. Lindsey Thomson: Absolutely. Thank you.

I definitely echo what Dr. Afifi is saying.

To add to that, among the psychological tools that are available for doing different mental diagnoses, we see that they're not all appropriate across the different cultural experiences and ethnic backgrounds. That's something we have to bring extra attention to. If this is something that would be implemented, we have to look at the makeup or the grouping of the children and their background. Is this going to be appropriate? Are we going to be pathologizing their experience that they might not necessarily identify with?

Mr. Matt Jeneroux: Great.

Maybe I do have time for Dr. Georgiades.

Do I have 30 seconds, Mr. Chair? Okay.

If you can wrap all of that up in 30 seconds, Dr. Georgiades, it would be great.

Dr. Stelios Georgiades: If we think in a limited way in terms of controlled capacity, resources and strategy, I completely agree with Dr. Afifi that we should be very careful.

In the Canada that we all envision—especially those who are here today—capacity, resources and a clear evidence-placed strategy would be in place where screening is as much a part as a diagnosis, as timely interventions, so that our children and youth can reach their full potential.

The Chair: Thank you, Mr. Jeneroux and Dr. Georgiades.

Next we'll go to Dr. Powlowski, please, for five minutes.

● (1215)

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

We're here to talk about child mental health, and we've already talked about some of the barriers.

I'm going to build on Don's question. Don had two and a half minutes and he got right to the punch line, but I'm going to provide some of the buildup to that.

What percentage of children you treat have the cost of that treatment paid directly by government-provided services?

Ms. Carrie Foster: Maybe 10%....

Mr. Marcus Powlowski: And under what programs would they be?

Ms. Carrie Foster: That would be under IVAC, victims of criminal violence. It's a provincially run program. That would be under the NIHB program. That would also be under the program for the Kahnawake Social Services Resource Center.

Mr. Marcus Powlowski: For what percentage of children would the cost of their psychotherapy be covered by insurance plans they have, and what percentage of the whole cost is actually covered?

Ms. Carrie Foster: I'm not a psychologist nor are my colleagues in my order—social workers. As a psychotherapist and Canadian certified counsellor, maybe 15% to 20% of my clients are covered through insurance plans. For the rest, if they are in financial need, I take that hit. I reduce my service fees given their paying ability.

Mr. Marcus Powlowski: Okay. I'll get back to that question.

Don asked the question, and you've already answered. You would support the government providing and paying for the costs of this psychotherapy.

Dr. Georgiades said, “why wouldn't we?”.

I think the obvious answer is cost.

Have you, or any one of you, figured out what the total cost would be if the government were to provide these services as part of health care plans?

Ms. Carrie Foster: We have looked at that here. I did some research, because I was called in to this meeting on Monday, and I had full clients. I had to switch them all so that my Thursday was free, so forgive me if I don't have in-depth details.

Basically for every dollar you spend you would be saving $1.37 to $1.78, I think it is, from memory. I don't even remember where those numbers are from, but I'm sure we could get those to you.

I think the important part to remember—and we've spoken to this earlier—is that the more preventative measures we take in the long term, the more we're cutting back on costs.

The other most obvious answer is whether we can afford not to, as was already said. How can we put a price on people's and children's health and well-being? I have a really hard time with that.

Mr. Marcus Powlowski: Now, I hate to bring this up, but it has come up—you brought it up—the 5% as being a barrier to access.

Ms. Carrie Foster: It's 15%.

Mr. Marcus Powlowski: Well, for the federal government, our part is 5%.

I think the obvious question is the other part of that: How much do psychotherapists charge children for psychotherapy?

Ms. Lindsey Thomson: The cost for psychotherapy services varies greatly depending on where that psychotherapist is working: if they're in private practice versus a government setting versus a community program. The more complicated answer is that it really varies. From what I've seen in my experience, it can range from $80 an hour to $180 an hour, depending on location, the type of treatment that's being offered, a family setting versus individual setting, right? It varies greatly. A lot of psychotherapists do, as Carrie mentioned, take a hit to their own personal finances and offer a sliding scale, too.

Ms. Carrie Foster: If I could just add....

Psychiatry is going cost more. Maybe not psychiatry because it's covered under the card, but psychologists definitely are up to the $200-and-something. If we can add more psychotherapists in, and if insurance companies can cover them, which they won't want to because it's more out of their pockets, then we're better off.

Mr. Marcus Powlowski: Maybe I'll go to the other two witnesses online if they have a few seconds to address this question: Is this a good expenditure of government money? Does it save us more money in the long term?

Dr. Tracie Afifi: Absolutely, it would save you more money. The cost of not doing this in the long term will have impacts on education. People will not finish their education. They'll not be able to get jobs. There are justice costs, child protection costs, and down the road there will be more mental and physical health costs to the health care system. Not doing it early will actually cost the government more money in the long run, and that's quite certain. We need to provide this investment now.

● (1220)

The Chair: Thank you, Dr. Powlowski.

Next, we're going to go to Mr. Kitchen, please, for five minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you to the witnesses for being here. I do appreciate your comments. Basically, we see practitioners versus academics and researchers at the table, and I do appreciate it. Having lived in that world before I became a politician, it's been very interesting. I was the registrar for the profession in Saskatchewan, as well as the president of the national regulatory body for Canada, so I understand a number of things.

I have so many questions I want to ask, but I'll start off with asking you, Carrie or Lindsey, this: Have there ever been any discussions with insurance agencies as to whether they would turn around...? When they say, for example, with $500 of coverage for psychotherapy, “We only cover the cost the practitioner charges and not the GST/HST”...? Has there ever been any discussion with those agencies at all?

Ms. Carrie Foster: No. There's been discussion with them, but not on that particular point.

Mr. Robert Kitchen: Okay.

That part would actually take that out. Where now the insurance companies are saying, “Okay, we're going to give $500,” ultimately someone who's charging $100 for an hour maybe gets five treatments versus four because of the GST/HST.

Ms. Carrie Foster: The bigger picture would be to get the insurance companies to cover psychotherapy and counselling.

Mr. Robert Kitchen: True, but I'm just throwing that out there.

Second—and perhaps not only for those on the committee here who don't understand it but even for the people who are listening or who are going to read the report—can you quickly explain the differences...and the educational levels you need to get to the level of training that you have? In other words, what programs do you go to? For example, if we're talking psychologists, psychiatrists, psychotherapists, counsellors, social workers, that aspect—they're all dealing with mental health—can you just quickly and very briefly explain it?

Ms. Carrie Foster: I can speak especially for Quebec.

In Quebec, you can have a master's in social work, a master's in couples and family therapy and a master's in psychology, counselling psychology. That will get you into the CCPA. That will get you your psychotherapy permit in Quebec, but only if you have enough psychotherapeutic training, so for couples and family therapists, 100% or 98.8% of them are psychotherapists as well.

For social workers, you just need to have a B.A. to be a part of that order. They will not have their psychotherapy permits to the level of deep work. The psychological work they can do is limited.

Counselling and counselling therapy programs across Canada are at the master's level for entrance into the Canadian Counselling and Psychotherapy Association. Accreditation to get your certified Canadian counselling certification requires extra hours and making sure that you have all those checkpoints. They're pretty much on the same level as many of the others. In Quebec, we have so many orders that do or don't get their psychotherapy permits, but they're on par.

I have two master's degrees, one in science and one the creative arts—the first being in couples and family therapy. Most people I know have their psych education and another social work degree or something. They have four years of master's level courses to be able to work, and we have ongoing regulations with the CCPA to make sure that we have all of those add-ons. Those add-ons are things you need: the ethics course, the cultural awareness and so on.

Mr. Robert Kitchen: Thank you.

Just for a correction, are they regulated in five provinces in Canada? Is that correct?

Ms. Carrie Foster: That is correct.

Mr. Robert Kitchen: Okay. Are they up for regulatory standards in the others and the territories?

Ms. Carrie Foster: Yes, that's all in process: in Newfoundland, British Columbia and Manitoba. We're all across the country.

Mr. Robert Kitchen: Okay. That's great. Thank you very much for that.

On the issue of looking at a number of things, ultimately when we talk about children and mental health, we're talking about those aged zero to 18. On the tragic incident that happened yesterday in Laval, obviously there's a huge impact, not only on families but also on those siblings, etc., those young children.

I come from Saskatchewan, where, as you're well aware, the Humboldt bus crash happened. Unfortunately, I lost a very good friend in that accident, the head coach. Also, a number of hockey players who were impacted were, not from my community in particular. Young Adam Herold, who was 16 years of age and passed away in that accident, was from Montmartre, Saskatchewan.

These are tragic things that have impacted a lot of kids. On Tuesday, we heard about the value of sport, the value it provides to the mental health of young people when they get involved and active. These are things we need to look at. As a coach, I used to travel by bus all over northwestern Saskatchewan. I know that children getting on buses today—hockey players and those in other sports—are looking at this and asking, “Could something like this happen again?”

We recognize the need for accessing treatment as quickly as possible, the fastest we can do that. We look at the government saying that $4.5 billion is being put to mental health, yet it appears not even to have got to that stage. In fact, I think I heard that there's $825 million that was not even spent by 2022.

Where does that money go? How do we get that money out to the practitioners on the floor so that we put boots on the ground, so we can have that access, as opposed to putting it out there where it sits and creates more bureaucracy?

● (1225)

The Chair: Ms. Foster, I'm sorry to do this to you, but Dr. Kitchen actually went past his time with that very verbose question—

Voices: Oh, oh!

The Chair: If you could, please give us a succinct answer. Go ahead. Take 30 seconds.

Ms. Carrie Foster: Go ahead, Lindsey.

Ms. Lindsey Thomson: Have an oversight committee, some kind of structure and oversight to actually have accountability, to see where the money is flowing and ensure that it's not being left in the pot and leaving Canadians high and dry, and have different hubs in different locations—rural and urban, right?—and some kind of structure to be able to look into that.

The Chair: Thank you.

We have Mr. van Koeverden, please, for five minutes.

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

Thanks to all the witnesses. I echo the earlier condolences of my colleagues about yesterday's tragic crash.

I'd like to start by saying that I've emailed back and forth with a practitioner named Kevin Greene, who is a big advocate for the removal of HST on psychotherapy in Canada. I've read his emails and the deck that he sent me.

I've also had some conversations with folks in Finance, trying to understand the costs. Any time that a tax is eliminated, it is an obvious cost to government, and sometimes the cost to government is way bigger than the amount they invested. I think that's an important consideration, if we're talking about millions or billions of dollars here or there. I think personally that social costs in the long term greatly outweigh any investments we can make in kids today.

My questions are going to be primarily around resiliency and building resiliency in the early years for children.

First, is there any research indicating the impacts of access to sport, physical activity and recreation and positive team experiences for kids? Is there any research that indicates a positive influence on children and their resiliency, particularly around mental health, when they have access to sport, physical activity and recreation programs?

Ms. Lindsey Thomson: Yes. I can speak to research in terms of the impacts that recreation and movement have on our mental health in general. I'll have to find you the exact reference for this so I can send it to you after.

Research has demonstrated that if we do a control group and an experimental group looking at the impacts of taking, let's say, medication for depression, versus a group to look at the impacts of movement, in the long term, sustaining regular movement—you don't always have to be going to the gym, just getting out for a walk—is actually more effective than medication alone. We can naturally translate that to the importance of being able to have recreation for kids.

Mr. Adam van Koeverden: I might turn to the researchers on Zoom for that same question.

Dr. Tracie Afifi: I've done work in that exact area, looking at what protective factors might be related, for those who have experienced trauma and adversity, to better mental health and substance use outcomes. We look at protective factors at the individual level, school, family and community as well.

We found in a number of studies that physical activity and a sense of belonging—it could be belonging to a sports team, having that sense of community—does have an impact on reducing poor outcomes. We see it for kids who have experienced trauma and maltreatment, but sometimes the effects can be greater if you have also experienced that trauma and maltreatment.

● (1230)

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

I'd note that it's Winter Health and Fitness Week right now. Tuesday was Ski Day on the Hill. I skied with...I would guess a 13- or 14-year-old girl named Ella. I asked her why she loves physical activity. She said exactly what you just said, that it helps her deal with anxiety and helps her set goals. She's met all of her friends through sport. It is that protective mechanism which I drew from that conversation.

Secondly, anecdotally, so perhaps more towards the clinicians—less on the research side, more in your experience—in dealing with kids who have equitable access to sport, physical activity and recreation, do you see better outcomes for those kids?

Ms. Carrie Foster: I worked at the Jewish General Hospital in Montreal, running a group at their day care program of 10-year-old boys using drama therapy. Definitely, the ongoing improvements that were seen by their teachers were clear.

I've also done drama therapy online, with young adults who were depressed during the pandemic. We did MRI scans through the University of Toronto. Those MRI scans proved that the work we were doing online, just the connection, was in fact effective. That's really great to hear.

I do somatic work as well. A lot of the somatic work that I do is actually getting people into their bodies so that that anxiety comes down.

Mr. Adam van Koeverden: Thank you.

Briefly, would you consider drama a form of recreation?

Ms. Carrie Foster: Drama, yes. Drama therapy has a therapeutic focus.

Mr. Adam van Koeverden: Very quickly, Dr. Afifi, you mentioned the legality of corporal punishment. You mentioned that the only legal way in the Criminal Code that people can hit each other is when parents hit their children.

I'd also note that there is a social permission in the game of hockey...which we're all allowed to watch and see. A lot of young kids really love hockey, and there's bare-knuckle brawling in the game. That's the main reason I don't watch NHL hockey generally. I find it incredible that grown men are punching each other and it's totally normal. If it happened in front of a bar, then they'd probably both be arrested. It's an interesting thing.

Mr. Robert Kitchen: What about boxing?

Mr. Adam van Koeverden: That's not bare knuckle. Thank you for the commentary, though.

Anyway, how does that impact young boys who watch hockey and love the game?

The Chair: Answer very briefly, please, Dr. Afifi. We're out of time.

Dr. Tracie Afifi: Very briefly, I agree.

It is assault on the ice in some cases, and it affects all people who watch hockey. I hate it as well. I wish that could be changed, but I guess that's up to the NHL and the NHL Players' Association at this point.

I completely agree. It's still assault on the ice, and it's violence that we shouldn't be watching.

The Chair: Thank you.

[*Translation*]

Go ahead, Mr. Garon. You have two and a half minutes.

Mr. Jean-Denis Garon: Thank you, Mr. Chair.

Mr. Georgiades, you mentioned earlier that this study was a good initiative and that we would then have a document that could guide policy. Do you have any other standards, documents, reports, studies of bills or other documents produced by the provincial governments—which are responsible for health in this area—that could be submitted to the committee to guide us in our thinking?

[*English*]

Dr. Stelios Georgiades: I am sure that we can identify those and submit them to the committee.

I'm going to go back to the example of autism, where I think the model there can be used for the development of a national strategy for child health more generally. That is based on consultations with provinces, with—

[*Translation*]

Mr. Jean-Denis Garon: Allow me to interrupt.

We've been told that this has never been done, that this is the first time a study has been done, that this is the first time a committee and a government have taken an interest in children's health. That's normal; we're in Ottawa, and it's not Ottawa's business. An expert comes and tells us that in committee.

He's before the committee, and I'm asking him if there are other documents, reports or studies of bills. Earlier, I referred to the Quebec government's 140-page document entitled *Plan d'action interministériel en santé mentale 2022-2026 — S'unir pour un mieux-être collectif*. The answer I get is that he could look at that eventually, when it suits him and, incidentally, it takes national strategies for this and for that.

So I'll ask the question again to get a yes or no answer: before telling us that the work has never been done by anyone, including the governments whose jurisdiction it is, have you done the research? What is the basis for what you told us earlier?

● (1235)

[*English*]

Dr. Stelios Georgiades: Absolutely. Many provincial studies and governments have produced guidelines for child health. I think what we're lacking in Canada is learning from each other across provinces and regions in a national scope.

That's what's lacking here, and I think that's why this committee is here today.

[*Translation*]

Mr. Jean-Denis Garon: So the provinces have already done some of the work we're doing today, contrary to what you told us earlier.

[*English*]

Dr. Stelios Georgiades: The different pieces may be there that we can build on. The committee is here today to learn from each other, so that all kids across Canada can benefit from evidence and learning. That is my point.

The Chair: Thank you, Dr. Georgiades.

Next we'll have Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: Thank you.

Dr. Afifi, you touched on this issue of the exposure of people to imagery.

I'm curious about the association, if any, between the Internet and social media exposure of children to, say, age-inappropriate images, acts or concepts, and whether there's been any work done to link that to increased mental illness or psychological dislocations in children.

Dr. Tracie Afifi: Is that in terms of the social media content that they see generally or in terms of bullying via social media? I just want to clarify that.

Mr. Don Davies: Anything, I suppose.

I'm just wondering about this one difference between children growing up today and most of us in this room—if not all of us—in that children today are growing up with access to the Internet and exposure to images, acts and concepts that may be age-inappropriate.

I wonder if there's any link between that and—

Dr. Tracie Afifi: Yes.

There's research on content that they see that has an impact on self-image, which is not my research. There's research showing increases in anxiety and depression related to content that they see on social media.

The work that we've done in my lab is looking at how social media is related to peer victimization and bullying. If they see and hear bullying online, whether that's through texts or through social media, all of those things increase poor mental health and substance use among youth and children.

Mr. Don Davies: To the association, I'm curious as clinicians what trends in childhood mental illness you're seeing. Are there any significant increases in disorders that you're able to tell us about?

Ms. Carrie Foster: There's ADHD and eating disorders, definitely. There's also compulsion. I have a lot of clients with OCD, aged five to 12. There's also depression and anxiety.

Mr. Don Davies: Ms. Thomson?

Ms. Lindsey Thomson: Absolutely, there are eating disorders. I work with women who experience eating disorders on the spectrum. From the clients who I've worked with, they said they've struggled with this from a young age. Bringing that back to social media, social media is a huge cause of eating disorders amongst young women.

The Chair: Thank you, Mr. Davies and Ms. Thomson.

Next is Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis: Thank you very much, Chair. I appreciate it.

I really appreciate the interesting discussion around the table.

I had a question for you, Dr. Georgiades.

My colleague talked a bit about transparency and accountability in funding, and its being the reason, of course, why $4.5 billion has not been sent with respect to the Canada mental health transfer. Anyway, I have a whole bunch of comments about that. I'll keep those to myself.

That being said, do you believe that at the current time we can find areas of interest in place that have enough data whereby we could actually stream funding to them that would make sense? Obviously, there's a significant need for funding in mental health. I find it difficult to believe that there are no mental health areas in the country that are transparent and accountable that could actually use money. I think there are lots out there that could, and they could fill that bill very quickly.

Do you have comments on that, Dr. Georgiades, please?

Dr. Stelios Georgiades: In principle, I think that making sure funds are allocated to address the needs of children across the country should be a priority.

I understand the point about transparency and accountability, but I don't see those as limitations. That is something that can be worked on. There are definitely ways—if there's will and collaboration—for us to increase the resources and take targeted steps so that we can actually support children and families on the ground.

● (1240)

Mr. Stephen Ellis: Dr. Georgiades, to be clear, at the current time if the government said, we're going today to fund the Canada mental health transfer to $4.5 billion, you feel there are systems out there that could readily accept that money with transparency and accountability?

Dr. Stelios Georgiades: I would say there are stakeholders that could come together and form a network of systems that could actually implement something like that, with a rigorous way in transparency and accountability.

Mr. Stephen Ellis: Through you, Chair, Dr. Afifi, we talked a bit about violence in hockey in particular. That is interesting. There are many other sports that are violent.

One of the concerns I've had as a family doctor for many years is the violence in video games. I would suggest that many more children are exposed to violence in video games, especially and, very sadly, in an isolated setting. What I mean by that is they would be playing video games and be often alone experiencing those things.

I'm certainly not sitting here arguing for violence in sports. That's not what I'm suggesting.

What I would suggest is that experiencing that very graphic violence in an isolated setting is perhaps something that is even more damaging, if there is such a thing.

Do you have comments on that, Dr. Afifi, please?

Dr. Tracie Afifi: I understand how violence in video games can very commonly be accessed by children and that many children do play those games, whether it be in isolation or online with their friends. These can be very graphic and real in certain cases.

Whether or not one is worse than the other in terms of watching hockey versus video games, we don't know. We don't have data. We couldn't comment on that.

I think most importantly it's really about understanding home environments. That's what I mentioned in my opening comments. We have to do all of this work within the context of understanding the environment in which a child lives, works, learns and plays. That is included in that. We need to understand the relationships and focus on not only the violence they witness or are exposed to, but more importantly we need to focus on violence they experience at the hands of caregivers and other people in their lives. The entire context of violence is important.

Mr. Stephen Ellis: Thank you very much, Dr. Afifi.

Through you, Chair, the other day I was watching television in French. I noticed very clearly that on French television, there were commercials talking about violence in the home. Normally, I watch English television. I live in Atlantic Canada, and we don't see any of that advertising there explaining the inappropriateness of it and seeing the very straightforward messaging.

Do you think that style of messaging is important? Should that be something we see in both official languages, and of course in languages that would be appropriate for marginalized and racialized communities as well?

Dr. Tracie Afifi: I think we need a multi-faceted approach. That could be a universal approach to explaining what is and isn't appropriate. Connecting families to resources that support them would be great. Repealing section 43 is one part of that. There are many things that we need to do. Education is one of those things.

So yes, I think it would be helpful along with many other things that would be needed for violence prevention. I think we could actually make great progress with a national plan. Over time, I think, if we could reduce or eliminate violence in childhood, that alone would show improvements in child health, both mental and physical, over the long term.

The Chair: Thank you, Dr. Afifi.

Dr. Hanley, you have five minutes.

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

I want to thank everyone for coming today. This has been a really interesting discussion.

I want to pick up on the funding question and how that might follow through. We know that with the previous $5 billion transfer...or we don't know; I think the question is that we don't know a lot about where that money went. I haven't heard anyone, including the Prime Minister or the Minister of Health, say that we don't need more funding into mental health. It's a matter of how we ensure that it gets there and gets to where it's needed.

I for one am really looking forward to the bilateral health negotiations. I imagine that mental health will be identified as a priority area for most jurisdictions, if not all, when it comes down to that.

I'd like to follow up on some of the discussion about coverage with a question for Ms. Foster and Ms. Thomson, very briefly.

Do you think it would be reasonable to have access to counselling and psychotherapy on the table as part of what should be covered in universal health coverage when it comes to bilateral health negotiations?

A voice: Yes.

Mr. Brendan Hanley: It brings up another question. I know that when I talk to some clinics in my jurisdictions in the Yukon in settings that are similar to yours, they are facing similar circumstances. People who do not have coverage are taking a hit. That in turn seems to affect their ability to resource themselves. If they did have access to increased public health coverage, it might enable them to increase and build their capacity to meet the needs of the community—in other words, hire more people and have a fuller roster, as it were.

Would that reflect your own experience?

● (1245)

Ms. Carrie Foster: Yes. I would also add to that “appropriate”, especially in the Yukon and northern territories where there are a lot of indigenous folks. It would be really important to be able to have a good fit therapy-wise to allow people to then be able to re-engage in community and be functional.

Mr. Brendan Hanley: Thank you.

That anticipates my next question. I think it would really bring into importance the concept of both mental health literacy and tiered care. Who gets what level of care? How do people know how to access that? How do we have the most efficient delivery of mental health care and also tools for self-management and family management?

I wonder if you might comment on that area, just briefly.

Ms. Lindsey Thomson: Stepped care is a model that is currently being implemented. I can speak to at least the context in Ontario.

A lot of research has been done in the U.K. to be able to determine where someone is in terms of their needs. Can they do bibliotherapy, which is maybe doing self-directed learning? Do they need to work with a psychotherapist or a social worker for talk therapy? Do they need medication management for a more severe mental health diagnosis?

That's absolutely something that we would like to see as part of that system.

Mr. Brendan Hanley: Thank you.

You brought up the subject of NIHB. Of course, that's a very important area in my jurisdiction. You mentioned there is coverage during the pandemic for psychotherapy and mental health services—

Ms. Carrie Foster: It's for psychotherapists and certified Canadian counsellors [*Inaudible—Editor*]

Mr. Brendan Hanley: You would like to see that continued, and that NIHB continues to—

Ms. Carrie Foster: I'd like to see it reinstated, because it was present up until 2017, I think. We'd like it reinstated permanently.

Mr. Brendan Hanley: Permanent reinstatement would be beneficial for our first nations and indigenous children. Thank you.

I would like to turn to Dr. Afifi. You mentioned almost in passing a relationship between childhood stress—toxic stress, I believe—and chronic disease outcomes later in life.

Could you comment on where we are in the research and understanding of that relationship, because I'm not sure it's very well known or understood?

Dr. Tracie Afifi: There's a lot of research that has been done in looking at how stress has an impact on the body and whether or not.... Some stress in certain situations is adaptive, healthy and good, but the thing is that we need to....

For some children, they experience chronic stress. They don't get relief from it. They don't have someone to help them process that stress or relieve that stress, so they're in a current state of hyperarousal or their nervous system is always engaged, so they always have that hyperarousal. When you live in that state, your heart rate is elevated, your blood pressure is elevated and you have many different impacts on your physical health and your mental health. Living in that constant state has a long-term impact on health.

There is a lot of evidence to show that it can have an increased likelihood not only of physical health conditions, but also of mental health conditions. Often, children who live in a home where they experience violence are always in that hyper state of arousal of chronic toxic stress.

● (1250)

The Chair: Thank you, Dr. Afifi.

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

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

Again, thank you to the witnesses.

When we were talking about the importance of sport and activity in children, it triggered something that's been pretty active in the news as of late. It's the very serious allegations of abuse that have been coming up, specifically around Gymnastics Canada.

Particularly, Ms. Thomson, when you were talking about eating disorders.... We've heard of so many situations from which some of this abuse has led to lifelong eating disorders in some of these gymnasts. There are allegations of sexual abuse.

I wonder as much as, yes, activity is very important for kids, in situations like this one when extreme abuse is being reported and alleged...how does it impact children?

Ms. Lindsey Thomson: It makes things worse. When we're talking about the context of organized sport, I guess what I didn't say was that we're assuming that it's a safe environment. We're assuming that it's an environment for growth and development. Absolutely, building off what Dr. Afifi was just talking about, if you're in this constant state of fear and you have all this cortisol constantly running through you, it's going to lead to a lot of mental health challenges.

The piece specifically around eating disorders, which is very common, is that everything in my life is so chaotic and I have no control. Food is the one thing I have control over, to take back some of that autonomy. That's some of that self-determination.

That gives you a bit of insight and is a bit clearer on where that link comes from between those two parts.

Mrs. Laila Goodridge: Okay.

Would you be supportive of the idea of having an investigation by the Government of Canada into the allegations against Gymnastics Canada?

Ms. Lindsey Thomson: Absolutely.

Mrs. Laila Goodridge: What about you, Ms. Foster?

Ms. Carrie Foster: Absolutely.

Mrs. Laila Goodridge: I'll open it to the other witnesses.

Dr. Tracie Afifi: Any time children are at risk, we need to protect them. I would always support any time we think that children are at risk, whether it's any organization at all. We need to protect them.

Dr. Stelios Georgiades: Can I add to those comments as well?

Mrs. Laila Goodridge: It's nice to have some commonality around the table on this, because I think this is something....

As a parent to a young child, my little guy is still too little to be involved in any organized sport, but it's something that's very top of mind to me. What sport would I want to put him in?

My happy spot as a kid and my happy spot now as an adult is at the top of the slopes with skis strapped to me. That has always been my way of getting out, de-stressing and connecting with nature.

However, there are so many allegations of abuse and there are so many cases coming up of kids being abused by their coaches and sexually abused by their coaches, I think that makes parents...at least it makes me very nervous. What am I putting my child into? As much as I know there are tons of benefits, in the cases where there is abuse, I don't think there could be a single benefit.

Can you guys touch on that a bit?

Ms. Lindsey Thomson: I'm trying to think about what else to add, because I'm 100% in agreement with you. That's something we need to look at.

Also, the impact of parents' mental health, and being able to think.... If I were a parent, would I want to put them in a sport, at all? There's so much risk with hockey, gymnastics, dance and ballet. What is safe to put kids into, these days?

Ms. Carrie Foster: I think that speaks to those associations' gatekeeping. How do we check to see whether their checks on who's who, and who comes from where...?

In all sports and many educational institutions, that is something that falls short.

Mrs. Laila Goodridge: Is it troubling to you that the Government of Canada is still providing funding to many of these organizations, in spite of...?

Ms. Carrie Foster: It's not troubling to me. It's troubling to know children are suffering, as a result of that.

I think that's perhaps inside work for those associations—to look at that. I think sports are generally good. I don't think all coaches are.... If that were the case, then, yes, I think the government should get in there, but the associations need to take responsibility for those whom they bring in to coach [*Inaudible—Editor*].

● (1255)

Mrs. Laila Goodridge: I find it exceptionally troubling that there have been allegations that these organizations are covering up some of the abuse. To me, that is part and parcel of the issue.

Ms. Carrie Foster: It speaks to the same thing that went on in residential schools, and that goes on in educational schools for settler folks here in Canada, as well—private or public schools. There are always people who infiltrate. It speaks to families with abusers within the family. I think it's systemic. It will take a lot of work, insight and working together among psychologists, psychotherapists, counsellors and so on to help—and for all the governments across Canada to work in sync on that.

I would also add this: Put the information out to the counsellors and therapists. When they print 140-page things, make sure we are getting access to them, so we're more aware, publicly, about where funding is going, who's being funded, and how we're getting access to the information. Is it bottom-up or top-down? I would hope it's bottom-up.

The Chair: Thank you, Ms. Foster.

The last round of questions for today's meeting will be posed by Mr. Jowhari.

Mr. Majid Jowhari: Thank you, Mr. Chair. That's a great opportunity for me to ask a second round of questions.

The question is going to Professor Afifi.

In 2011, you co-authored a paper with—I believe—Professor MacMillan, which identified protective factors that may affect a child's resilience. These factors were organized into individual-, family- and community-level protective categories.

From your perspective, what are some of the most important protective factors that affect a child's resilience?

Dr. Tracie Afifi: That was a review paper we did in 2011. Since then, we've published many papers in the area. We focused on the children within their environments, because protective factors can come at many levels.

We also focused on things we can change. What is something we can change? At the individual level, it's important for children to feel they can be optimistic, in control and positive about their future—to have a plan. That's important, so they can envision their life in five years, instead of feeling they have no control in their life. That's very important.

We also find that parenting relationships are very important. Telling your children you love them, giving them hugs and spending quality time with them is very protective. Having an adult is very protective. That can even be found in a school. It can be a teacher, or a positive person in sport. If they are providing that supportive, healthy relationship, that is very resilient for for them, as well. Feeling safe in your neighbourhood and environment is very important for resilience.

We're starting to look more at neighbourhood- and society-level factors. That hasn't really been looked at yet. We're trying to look at all the factors at different levels, so we can understand the child within the entire context to which they belong and focus on protective factors at all of those levels.

Mr. Majid Jowhari: Thank you.

I saw a lot of nods from Mr. Georgiades.

Can you comment on that, as well?

Dr. Stelios Georgiades: Absolutely. I echo Professor Afifi's comments.

The idea of taking an ecological approach to health and resiliency is about not thinking about children as individuals who are isolated from family, community, peers and the larger society. It's thinking about them in a developmental way. That why what we call longitudinal studies, at the national level, are becoming more important, especially in light of this pandemic.

Taking an ecological and developmental approach to understanding health and functioning as well as resiliency and how that can be promoted is very important.

Mr. Majid Jowhari: Thank you.

You both talked about the emphasis on research and how research could guide us around some of the policies that we could develop, whether it's on regulation or government policies for providing better access to services.

Can you talk about some of those policies—specifically federal government policies? How could we marry the research that you've done, specifically around resiliency and protected categories, with federal government policies?

You both have about a minute and a half to go.

We can start with Professor Afifi.

● (1300)

Dr. Tracie Afifi: Thank you.

I think it's really important that we translate the data into policy and practice.

How do we do that? We do that with having open partnerships with the people who are going to use the data. We develop the research questions at the very beginning with the community organizations, the decision-makers and the policy-makers, so that we're producing the questions that are relevant to those who need to use the data.

When I started research, I was just the researcher. I did the work, I published it and I walked away. That's not my job anymore. My job is now to take the data and put it into the hands of the people who can use it and make it come to life.

We still don't have that connection very well between doing the research and translating the research into both policy and clinical practice.

There are lots of mechanisms in place now where we can build those relationships so that we're all working together to produce the information that we need. Then when you ask me how we know if kids are doing worse because of the COVID-19 pandemic, we'll know this because we have data. Researchers are answering the questions that the policy-makers and the decision-makers want to know, so we can turn that data into policy and into practice.

The Chair: Thank you.

Mr. Majid Jowhari: Thank you, Mr. Chair.

I know I'm over five minutes, but I'd appreciate feedback, if time allows, from Mr. Georgiades as well.

Dr. Stelios Georgiades: Very quickly, I echo Dr. Afifi's comments.

I am just going to say that I've lived in Europe, I studied in the U.S. and I live in Canada. I can tell you we have some of the best scientists and clinicians in the world.

My hope—and I'm very encouraged by the meeting today—is that our representatives in all levels of government, especially the members of this committee, will continue to work together, take the information in the testimonies of all the experts and stakeholders, and do something with it so that Canada can become the best country in the world to grow up in and for children to become useful and healthy citizens who contribute back to their community.

The Chair: Dr. Georgiades, I'm really glad we gave the extra 30 seconds. That was an excellent note on which to finish. Thank you so much for that.

Thank you, to all of our witnesses, for sharing your expertise and experiences on the front line. It will be of significant value to the committee.

There are a couple of administrative matters that I need to raise with committee members.

Witnesses, you are welcome to stay, but you're free to leave. We're very grateful to you for your attendance today.

I have three things to raise with you, colleagues. I know Mr. van Koeverden has something.

First of all, yesterday another private member's bill, Bill C-293, was referred to us. I know that our plan is to complete the work on this study before we consider whether we're going to private member's bills, but just so you know, we now have three that are waiting.

The second thing is, during the meeting today I received a notice from the whip that the Board of Internal Economy is going to be meeting on February 16, which will bump our committee out of its time slot. How that's going to be resolved is not yet determined, but I just wanted to let you know that there may be a problem with the meeting on February 16. We'll work on it between now and then. That's just for awareness.

Mr. van Koeverden, you had something.

Mr. Adam van Koeverden: Thank you very much, Mr. Chair. I appreciate the indulgence.

I have two things, very briefly.

The first is just a point of clarification for all members of the committee and anybody else. All federal funding for Gymnastics Canada and Hockey Canada has been frozen by the Minister of Sport in light of those allegations and investigations that are under way by the Office of the Sport Integrity Commissioner.

Second, this was an observation I made earlier in the meeting. I feel that when we have hybrid meetings with witnesses both online and in person, the natural inclination for us as MPs is to focus on the people here in the room, which is normal, but it puts people online at a disadvantage.

I would recommend that in the future, if possible, we dedicate one hour to the people who are online and one hour to the people who are in the room, or only host meetings that are online or in person, because it was challenging sometimes to engage. I know that hybrid meetings have their advantages, but it's an observation that I just make today and pose to the committee.

● (1305)

The Chair: We've opened the discussion and I can't very well terminate it without hearing from others who want to speak, but just be conscious of the time.

Mr. Garon and Ms. Goodridge want to speak to this point.

[*Translation*]

Mr. Jean-Denis Garon: My intervention is on another topic. It's not related to what Mr. van Koeverden said.

My whip's office tells me that it would be possible to hold the next meeting next Thursday evening. Has that been discussed with you, or is it still being discussed?

[*English*]

The Chair: There are problems with that. I don't think we need to address them now. I'm aware of that suggestion, but in my case, it means I have two committees at the same time and there are other people with issues there. Let's try to resolve this off-line and then come back. I think that is best. I'd rather not get into a prolonged discussion on it now.

Ms. Goodridge.

Mrs. Laila Goodridge: Mr. Chair, I would suggest that if we have conversations around the formatting of meetings, it would be appropriate to have them in committee business, as is the typical practice of this committee and others.

With that, I move to adjourn.

The Chair: Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: Thanks everyone.

The meeting is adjourned.