Docket: T1340/7008

CANADIAN HUMAN RIGHTS TRIBUNAL

B E T W E E N:

FIRST NATIONS CHILD AND FAMILY CARING SOCIETY OF CANADA and ASSEMBLY OF FIRST NATIONS

Complainants

- and -

CANADIAN HUMAN RIGHTS COMMISSION

Commission

- and -

ATTORNEY GENERAL OF CANADA
(Representing the Minister of Indigenous Services Canada)

Respondent

- and -

CHIEFS OF ONTARIO,
AMNESTY INTERNATIONAL and
NISHNAWBE ASKI NATION

Interested Parties

AFFIDAVIT OF RYAN GIROUX, M.D.

I, Ryan Giroux, M.D., of the City of Toronto, in the Province of Ontario, **SOLEMNLY AFFIRM THAT:**

1. I am a Métis General Pediatrician carrying out a clinical practice with the urban Indigenous community in Toronto and Scarborough. As such, I have personal knowledge of the matters hereinafter deposed to save and except for those matters stated to be on information and belief and where so stated, I believe them to be true.

2. I have reviewed the Affidavit of Dr. Valerie Gideon ("**the Dr. Gideon Affidavit**"), affirmed on March 14, 2024, filed on behalf of the Respondent Indigenous Services Canada ("**ISC**") in this matter.

My background and qualifications

3. I am a member of the Métis Nation of Alberta. Most of my clinical work is with the urban Indigenous community in Toronto and Scarborough, Ontario. Since 2021, I have been an Indigenous Educator with the Royal College of Physicians and Surgeons of Canada. I have been the Post Graduate Medical Education Indigenous Health Faculty Lead at the University of Toronto's Temerty Faculty of Medicine since 2022. I have been a member of the Canadian Paediatric Society's First Nations, Inuit and Métis Health Committee since 2017 and am currently its Co-Chair. As part of this work, I am a collaborator on an academic study on pediatricians' knowledge of and experiences with accessing Jordan's Principle. I was President of the Professional Association of Residents of Ontario from 2020-2021 and, in that capacity, participated in negotiations with the Government of Ontario during the COVID-19 pandemic.

4. I received my MD from the Temerty Faculty of Medicine at the University of Toronto in 2017. I received my specialty in Pediatrics from the Royal College of Physicians and Surgeons of Canada in 2021.

5. I practice as a pediatrician in the Department of Pediatrics at St. Michael's Hospital in Toronto, Ontario. Since 2021, I have provided consultative care and primary care to Indigenous families in three separate clinics in the Toronto Area, through the Inner City Health Associates, as well as through an additional clinic at St. Michael's Hospital. In my practice, I have written letters of support for First Nations children seeking to access products, services, or supports from Indigenous Services Canada through Jordan's Principle. I have seen the life changing impact Jordan's Principle can have for First Nations children when it is properly implemented, and the disadvantage that persists, and can worsen, when it is not.

6. All of the above experience has made me familiar with the federal government's implementation of Jordan's Principle and with the health and social needs of First Nations children.

REPLY TO THE AFFIDAVIT OF DR. VALERIE GIDEON

Failure to recognize and account for social prescribing

7. Paragraph 13 of the Dr. Gideon Affidavit describes how Jordan's Principle is receiving requests for socioeconomic supports such groceries, rent payments, mortgage payments, requests for new homes and renovations, items such as personal vehicles, and recreational requests like sports camp fees. Paragraph 15 stipulates that Jordan's Principle may be used as a temporary relief measure to address immediate risk factors to children and that it is not intended to displace government income assistance programs. Paragraph 24 asserts that some items requested through Jordan's Principle were "likely misclassified" as urgent, such as bicycles, glowsticks, social/recreational activities such as movie passes and gym memberships, sporting equipment, and more. Lastly, paragraph 26 of the Dr. Gideon Affidavit asserts that while therapy services may be "objectively urgent" in the context of a child who recently experienced caregiver death or a community impacted by a state of emergency, an "unrelated product, service or support (for example, a gaming console)" in that context is "likely non-urgent".

8. By way of reply, in my opinion, the information presented in Dr. Gideon's affidavit fails to recognize or understand the importance of a practice known as social prescribing.

9. For clarity, the internationally-accepted definition of social prescribing is "a means for trusted individuals in clinical and community settings to identify that a person has nonmedical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription—a non-medical prescription, to improve health and wellbeing and to strengthen community connections". This description is drawn from a 2024 Commentary authored by Caitlin Muhl, Susan Bennett, Stéphanie Fragman and Nicole Racine ("**Muhl et al. (2024)**"), titled "Social prescribing: Moving pediatric care upstream to improve child health and wellbeing and address child health inequities" A true copy of this Commentary is attached as **Exhibit "1"** to my reply affidavit.

10. Caitlin Muhl is a doctoral candidate in Health Quality at Queen's University, whose doctoral work is focused on social prescribing. Dr. Susan Bennett is the Director of Social

Pediatrics at the Children's Hospital of Eastern Ontario. Stéphanie Fragman is the Executive Director at the Eastern Ottawa Resource Centre. Nicole Racine is a clinical psychologist and Assistant Professor at the University of Ottawa's School of Psychology. In particular, I recognize Ms. Muhl as an expert in the field of social prescribing and Dr. Bennett as an expert in the field of social pediatrics.

11. Social prescribing is a global movement. It has been developing in the Canadian context, including through the Canadian Institute for Social Prescribing, which is funded by the Canadian Red Cross and the Public Health Agency of Canada.

12. In the pediatric context, Muhl et al. (2024) note that social prescribing may include:

a. Supports for basic needs (e.g., income, food, housing);

b. Physical activity (e.g., exercise classes, team sports, individual sports);

c. Arts and culture programs (e.g., dance, museums, music);

d. Social activities (e.g., hobby groups, camps, mentorship programs);

e. Time in nature (e.g., parks passes, nature clubs, community gardens); and

f. Volunteer opportunities.

13. While the term social prescribing in pediatrics is somewhat new, recommending social-related supports in order to meet the needs of a child's physical, emotional, and mental health is not new. Rather, recommending social-related supports stems from the recognition of how social determinants of health impact the wellbeing of children. For First Nations children, health inequities are inextricably linked to various factors that extend beyond the walls of hospitals or clinics, such as poor housing, lack of educational opportunities, or underfunding of critical services that lead to family poverty. Social related supports (i.e. social prescribing) are a key tool for redressing those health inequities.

Social prescribing in clinical practice

14. In clinical practice, there are many instances where paediatricians recommend social-related supports, including the examples of supports outlined in Dr. Gideon's affidavit, as part of our clinical recommendations.

15. For example, in my own practice, I may recommend enrolment in a sports camp for a child as part of management for childhood obesity. I may also recommend the removal of mold or carpet in a home in which a child who has poorly controlled asthma lives. Both of these examples would be within the treatment guidelines for these conditions and fall under the concept of social prescribing.

16. Furthermore, in those two examples, paediatricians can look further upstream for the root causes of higher obesity rates and higher rates of asthma in, for example, First Nations communities – and we may find that poor access to healthy foods, poor access to centres that promote activity, and inadequate housing can be the root cause of the higher rates of obesity or asthma.

17. These upstream factors are, at their core, part of the historical disadvantage resulting from the colonization of First Nations communities.

The concern about "likely misclassified" urgent requests or unrelated requests

18. As outlined above, in her affidavit, Dr. Gideon asserts that some requests are "likely misclassified" as urgent when they may be non-urgent, citing requests for glowsticks as one example among others (at paragraph 24). Dr. Gideon also asserts that an "unrelated" product, service, or support such as a gaming console may not be urgent.

19. It is certainly possible that some items requested through Jordan's Principle are misclassified as urgent.

20. However, in my opinion, a holistic understanding of a First Nations child's individual needs through social prescribing brings to the forefront that many of these needs may be urgent. For example, a child with Autism Spectrum Disorder may have sensory needs that include visual stimulation in order to self-regulate. For that child, a glowstick may be a tool used by their family

to calm them. Additionally, a gaming console that provides a displaced teenager with the ability to reconnect with their online gaming community may provide stability and mental wellness in a time of crisis.

Social prescription is a necessary tool for addressing health inequities

21. As a paediatrician, I see how social prescribing is a necessary tool to address health inequities for First Nations children.

22. Furthermore, as a professional who supports First Nations families in their Jordan's Principle applications and participates in Indigenous community advocacy, I am of the opinion that the information presented in Dr. Gideon's affidavit, on its face, fails to recognize, account for, or understand the importance of social prescribing.

23. I affirm this affidavit in support of the Caring Society's position on the within Jordan's Principle non-compliance motion and for no improper purpose.

AFFIRMED BEFORE ME over video teleconference on this 27th day of March 2024, in accordance with O. Reg. 431/20, *Administering Oath or Declaration Remotely*. The Commissioner was in Ottawa, Ontario and the affiant was in Toronto, Ontario

Commissioner for taking affidavits

David P. Taylor
LSO# 63508Q

RYAN GIROUX, M.D.

This is **Exhibit "1"**
to the affidavit of
Ryan Giroux M.D.
sworn before me this 27th
day of March, 2024

David P. Taylor
LSO# : 63508Q

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Commentary

Commentary

Social prescribing: Moving pediatric care upstream to improve child health and wellbeing and address child health inequities

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ABSTRACT

Social prescribing is a means for trusted individuals in clinical and community settings to connect people who have non-medical, health-related social needs to non-clinical supports and services within the community through a non-medical prescription. Evaluations of social prescribing programs for the pediatric population have demonstrated statistically significant improvements in participants' mental, physical, and social wellbeing and reductions in healthcare demand and costs. Experts have pointed to the particularly powerful impact of social prescribing on children's mental health, suggesting that it may help to alleviate the strain on the overburdened mental health system. Social prescribing shows promise as a tool to move pediatric care upstream by addressing non-medical, health-related social needs, hence why there is an urgent need to direct more attention towards the pediatric population in social prescribing research, policy, and practice. This demands rapid action by researchers, policymakers, and child health professionals to support advancements in this area.

Keywords: Child health equity; Social pediatrics; Social prescribing.

The COVID-19 pandemic has detrimentally impacted children's mental health and consequently triggered a notable rise in pediatric emergency department visits for attempted suicide, self-harm, and suicidal ideation (1). Child health professionals are now faced with the seemingly impossible task of meeting an even greater demand for an already overburdened mental health system.

The pandemic has also exacerbated child health inequities (2). Health inequities arise from disparate social, economic, and environmental conditions that manifest from the unequal allocation of power and resources, otherwise known as the determinants of health, such as income, education, housing, and early child development (3). They also stem from structural inequities that organize the distribution of power and resources differentially across dimensions of identity, such as race, gender, class, and sexual orientation, resulting in unique combinations of discrimination and privilege. Child health inequities not only detrimentally shape child health and wellbeing—they have impacts across the life course (4,5), hence why addressing child health inequities is the most effective means of improving health and wellbeing in society (6).

Health is often described using the metaphor of a stream, with upstream factors having downstream effects (7). Upstream solutions (changes to community conditions) address the causes of health inequities at the community level, whereas downstream solutions (medical interventions) address the effects of the causes of health inequities at the individual level. As the downstream manifestations of the impact of the causes of health inequities at the community level, non-medical, health-related social needs create a "middle stream", and present opportunities

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for health professionals to intervene at the individual level. With increasing recognition of this "middle stream," the introduction of social interventions into medical settings has grown exponentially in recent years, particularly in Paediatrics (8). Social prescribing is one type of social intervention that is gaining traction globally (9), with notable impacts on children's mental health (10–12).

In this commentary, we provide an overview of social prescribing, outline our efforts to launch the first social prescribing program in Canada with a pediatric focus, describe the global landscape of social prescribing in pediatrics, and put out a call to action to researchers, policymakers, and child health professionals to support advancements in this area.

SOCIAL PRESCRIBING—WHAT IT IS AND WHY IT MATTERS

Social prescribing is "a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription—a non-medical prescription, to improve health and wellbeing and to strengthen community connections" (13). Social prescriptions are tailored to individual needs, strengths, and interests. Examples include supports for basic needs (e.g., income, food, housing), physical activity (e.g., exercise classes, team sports, individual sports), arts and culture programs (e.g., dance, museums, music), social activities (e.g., hobby groups, camps, mentorship programs), time in nature (e.g., parks passes, nature clubs, community gardens), and volunteer opportunities. Social prescribing shifts the conversation from "what is the matter *with* you" to "what matters *to* you" (9). In doing so, this holistic approach to health and wellbeing supports the Quintuple Aim—an internationally-recognized framework for optimizing health system performance, by advancing health equity, enhancing participant experience, enhancing provider experience, reducing costs, and improving population health (9,14).

SOCIAL PRESCRIBING IN PEDIATRICS—THE VANIER SOCIAL PEDIATRIC HUB

Across Canada, advancements are being made in social prescribing research, policy, and practice. All of this work is linked through the Canadian Institute for Social Prescribing. While there is significant momentum around the social prescribing movement in Canada, social prescribing efforts to date have largely focused on adults. At the Vanier Social Pediatric Hub in Ottawa, we recently launched the first social prescribing program in the country to focus on the pediatric population.

The Hub embraces the community social pediatrics model that was developed by Montréal paediatrician, Dr. Gilles Julien. Social pediatrics is "a global, holistic, and multidisciplinary approach to child health—it considers the health of the child within the context of their society, environment, school, and family, integrating the physical, mental, and social dimensions of child health and development as well as care, prevention, and promotion of health and quality of life" (15). There are many parallels between social pediatrics and social prescribing, with notable similarities being that they are both holistic, person-centred, and community-based approaches to health and wellbeing that embody the principles of the United Nations Convention on the Rights of the Child, give children a voice in their own care, and draw on children's strengths as well as those of their family and community.

Since 2017, the Hub has been delivering comprehensive, integrated health and social services to children who are 0 to 17 years of age, experiencing complex psychosocial issues, and either living or going to school in Vanier, which is one of the most underserved communities in our nation's capital. Through a grant from the Public Health Agency of Canada Mental Health Promotion Innovation Fund, the Hub has formalized and enhanced their efforts to address non-medical, health-related social needs by launching a social prescribing program. As a participant in the program, a child works with a connector to explore what matters to them. Together, they create a social prescription—a non-medical prescription for a child-friendly community activity, which is written on a social prescription pad. Finally, the connector supports the child to complete their social prescription and addresses any barriers they may face. The entire process is tracked and monitored in the electronic medical record. Through the use of quality improvement tools and techniques, iterative improvements are made to the program over time. A program evaluation is currently underway to explore the experiences of children, family members, Hub staff, and community stakeholders, as well as to understand the impact of the program on child health and wellbeing.

SOCIAL PRESCRIBING IN PEDIATRICS—THE GLOBAL LANDSCAPE

The social prescribing movement involves almost 30 countries, and this number continues to grow, which reflects the potential of social prescribing to support the achievement of global goals for health and wellbeing (9,13). Social prescribing research, policy, and practice has mostly focused on adults, but there is growing understanding of the importance of social prescribing in pediatrics and the added complexities of working with this population, which often requires taking a family approach (12).

A small number of outcome, process, and economic evaluations of social prescribing programs for the pediatric population have been conducted in England in recent years, demonstrating statistically significant improvements in participants' mental, physical, and social wellbeing and reductions in healthcare demand and costs, including reductions in primary care and emergency room visits and a social return on investment ratio of $1.66:$8.38 (currency converted to CAD) (10,11). Experts have pointed to the particularly powerful impact of social prescribing on children's mental health, suggesting that it may play a preventative role, support children on mental health waiting lists, act as an adjunct to medical interventions, and ultimately, help to alleviate the strain on the overburdened mental health system (10–12). Evaluations have also shown that social prescribing empowers children to engage in shared decision-making regarding their health and wellbeing (10). By fostering autonomy (the need to feel control over life and decisions), relatedness (the need to have meaningful relationships and to feel a sense of belonging), competence (the ability to influence outcomes and to be

capable and effective), and beneficence (the ability to give and to make a positive impact on others), social prescribing builds self-determination (9). While social prescribing in pediatrics is still in its infancy, the existing evidence base paints a picture of a promising intervention (10–12).

A CALL TO ACTION

Given the potential of social prescribing in pediatrics, there is an urgent need to direct more attention towards the pediatric population in social prescribing research, policy, and practice. This is a call to action for researchers, policymakers, and child health professionals to support advancements in this area. First and foremost, there is a need for more research on social prescribing in pediatrics, particularly in terms of what works, for whom, and in what circumstances. Second, there is a need for healthy public policies that not only promote social prescribing at the individual level but also build healthy environments at the community level. Lastly, child health professionals need to move pediatric care upstream, not only by incorporating social prescribing into practice but also by advocating for shifts in social policies and structures. Together, these actions will promote the health and wellbeing of the pediatric population.

CONCLUSION

Social prescribing shows promise as a tool to move pediatric care upstream by addressing non-medical, health-related social needs. Given the deleterious effects of the pandemic on children's mental health and child health inequities, the time is now to direct more attention towards the pediatric population in social prescribing research, policy, and practice. The adage "it takes a village to raise a child" rings true here—social prescribing enables child health professionals to leverage the power of community to support children to reach their full potential.

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POTENTIAL CONFLICT OF INTEREST

All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed. NR declares holding the CHEO Chair in Child and Youth Mental Health and being a part of the Faculty of Social Sciences at the University of Ottawa. Her work is funded by the Canadian Institutes of Health Research and the Social Sciences and Humanities Research Council. SF declares a $447,000 grant from the PHAC Mental Health Promotion Innovation Fund. SB declares an unpaid advisory position at the Landon Pearson Resource Centre for the Study of Childhood and Children's Rights and a $447,000 grant from the PHAC Mental Health Promotion Innovation Fund. CM declares a paid Social Prescribing Advisor role for the Vanier Social Pediatric Hub, a paid Coordinator role for the National Academy for Social Prescribing (NASP) International Evidence Collaborative (IEC), and an unpaid role as a Co-Founder and Co-Lead of the Canadian Social Prescribing Student Collective.

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