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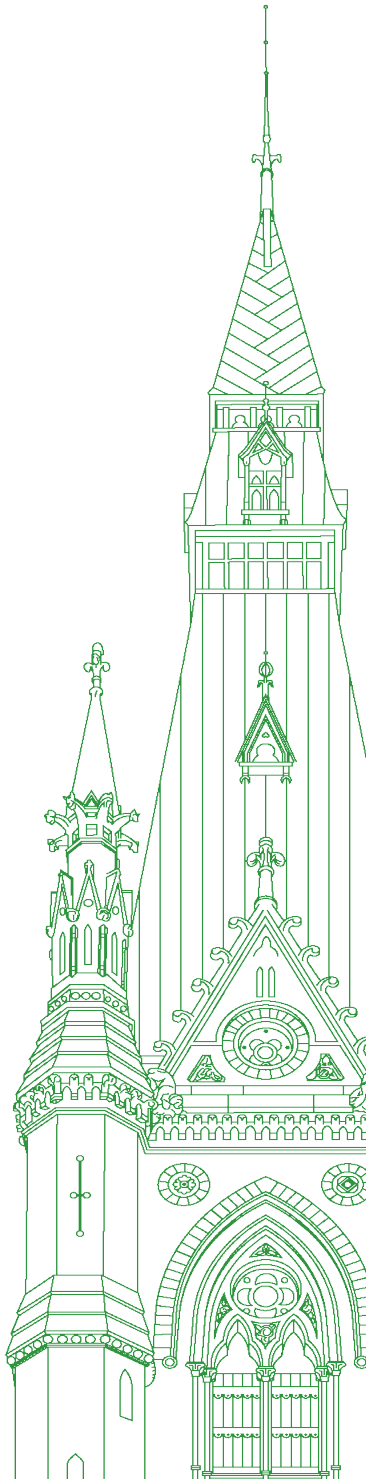

Chair: Mr. Ron McKinnon

Standing Committee on Health

Monday, November 30, 2020

● (1105)

[*English*]

The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)): I call the meeting to order.

Welcome, everyone, to meeting number 10 of the House of Commons Standing Committee on Health. The committee is meeting today to study the emergency situation facing Canadians in light of the second wave of COVID-19, with a focus on mental health aspects.

Witnesses, thank you for appearing today. You will have seven minutes for your presentations.

For the first hour we have, as an individual, Dr. Victoria Dawson, medical doctor. From the British Columbia Centre on Substance Use, we have Dr. Nadia Fairbairn, clinician scientist. From the Canadian Medical Association, we have Dr. Ann Collins, president, and from the Canadian Mental Health Association, Quebec division, we have Karen Hetherington, president.

For the second hour we will have, from Faces of Advocacy, Dr. David Edward-Ooi Poon, founder. From Movement Santé mentale Québec, we will have Renée Ouimet, director. From Stepped Care Solutions, we will have Dr. Peter Cornish, psychologist, and from Women's Health Research Institute, we will have Dr. Lori Brotto, executive director, and Dr. Gina Ogilvie, associate director.

Today's meeting is taking place in a hybrid format. I would like to start the meeting by providing you with some information following the motion that was adopted in the House on Wednesday, September 23, 2020.

As we are now sitting in a hybrid format, this means members can participate either in person or by video conference. All members, regardless of their method of participation, will be counted for the purpose of quorum. The committee's power to sit is, however, limited by the priority use of House resources, which is determined by the whips. All questions must be decided by recorded vote unless the committee disposes of them with unanimous consent or on division. Finally, the committee may deliberate in camera, provided that it takes into account the potential risks to confidentiality inherent to such deliberations with remote participants.

The proceedings will be made available via the House of Commons website. Just so you are aware, the webcast will always show the person speaking rather than the entirety of the committee.

To ensure an orderly meeting, I would like to outline a few rules to follow.

For those participating virtually, members and witnesses may speak in the official language of their choice. Interpretation services are available for this meeting. You have the choice, at the bottom of your screen, of floor, English or French. Before speaking, click on the microphone icon to activate your own microphone, and when you're done speaking, please put your microphone on mute to minimize any interference.

I remind everyone that all comments by members and witnesses should be addressed through the chair. Should members need to request the floor outside of their designated time for questions, they should activate their microphone and state that they have a point of order. In the event that a debate occurs, members should use the “raise hand” function. This will signal to the chair your interest in speaking and create a speakers list. In order to do so, you should click on “participants” at the bottom of the screen, and when a list pops up you will see next to your name that you can click “raise hand”.

When speaking, please speak slowly and clearly. Unless there are exceptional circumstances, the use of headsets with a boom microphone is mandatory for everyone participating remotely. Should any technical challenges arise, please advise the chair. Please note that we may need to suspend for a few minutes as we need to ensure that all members are able to participate fully.

For those participating in person, proceed as you usually would when the whole committee is meeting in person in a committee room. Keep in mind the directives from the Board of Internal Economy regarding masking and health protocols. Should you wish to get my attention, signal me with a hand gesture or, at an appropriate time, call out my name. Should you wish to raise a point of order, wait for an appropriate time and indicate to me clearly that you wish to raise a point of order.

With regard to a speakers list, the committee clerk and I will do the best we can to maintain a consolidated order of speaking for all members, whether they are participating virtually or in person.

We will now go to the witnesses.

Welcome, witnesses. We will start with Dr. Victoria Dawson.

Please go ahead, Dr. Dawson, for seven minutes.

Dr. Victoria Dawson (Medical Doctor, As an Individual): Thank you so much for inviting me today, honourable members of the committee, and thank you to all the witnesses.

I am Dr. Victoria Dawson. I work in rural Ontario in Wasaga Beach and Collingwood. I have a family practice. I'm here today to talk about the impact of the COVID second wave on our seniors primarily, since that's the majority of my population. I felt it was important to get the community aspect of what's going on. I do nursing home care, plus I have a clinic.

I had quite a number of meetings with my clientele. There's a lot of concern. There is limited help for seniors. I realize that a lot of virtual care has been going on with regard to mental health. However, unfortunately, my seniors are 80 and 90 years old and unable to access things like smart phones or Internet or even use a computer. Many of them have been left alone at their nursing homes because they're isolated from other members.

Our seniors have multiple health issues, such as dementia. They are unable to recognize people over video. They do better with in-person visitations. We have patients with COPD who are breathless, who can't necessarily hold a conversation on video or they can't make enough sound to be heard, so it's very difficult for them to speak on the phone or on virtual media.

Deafness is a huge one. I find that when I do telemedicine, my patients cannot hear me, so when they're trying to connect with other seniors or with their family members, they cannot hear anything, which is very problematic, and it's very difficult to overcome. There are even speech disturbances. It's very difficult sometimes to be heard, as we figured out with my microphone. With visual disturbances, they can't see their family members. Maybe they have a distance field deficit and they're not able to see their family members.

These seniors have communicated to me that they're very lonely. A lot of them are expressing suicidal ideation. They're wanting to die because they just can't face another month or two months without being able to communicate with or see their family members.

There are different community members who are trying to reach out to seniors and who have expressed some concerns as well. One of the concerns is about smart devices. They're unable to access care.

Fear is the other issue, because they don't have access to different resources, as you and I do, to tell them what's going on in the community. Unfortunately, the media is driving a lot of the fear. I'm finding that a lot of my seniors are not coming in to be seen or have their medical problems treated because they are just so scared to go. I had a really nice lady who sat with abdominal pain for eight months, and then we found out she had advanced cancer. Unfortunately it was diagnosed in the emergency department because she was too scared to go anywhere else for months.

With regard to COVID, there's a general lack of nursing home attendants protecting these patients. They've been completely neglected. In trying to protect them, we're also harming them.

I'm here to see if we can do something for these patients and try to find a balance so they're able to communicate with the outside world, create social circles for them because they thrive on being able to talk to other people.

I'm here to say that we need better mental health services for our seniors. A lot of the mental health is great, and I have referred people to virtual care like BounceBack Ontario. But seniors are not able to communicate through those devices, so they're often left with nobody to talk to. The nursing homes are understaffed. A lot of family members were going in and helping their seniors, whether it's cooking them meals or helping them get dressed, and now they're left in their rooms not able to communicate or get the extra help they need.

I'm here to speak for this forgotten population. In protecting them, we have also harmed them. I think that as a committee, as humans, as health care providers, we really need to reach out to that community and make sure they're well protected.

● (1110)

Many of them say to me that they have one or two good years, and they want to spend their one or two good years with family. How can we make that happen?

I know that I'm running out of time, and I also want to touch on our middle-class communities, working-class communities and family members who are not able to make ends meet. I've had a significant increase in this community in drug abuse and alcoholism. That's actually amongst the seniors as well, and people forget that this is how they're trying to deal with their problems as well. I understand why businesses are closed, but they have their entire lives invested in them.

We're seeing the reverberations in the children. The children are in turbulent environments. They're not able to cope with this. We're seeing a high rate of depression and anxiety in those as young as five or six years old when they're realizing what is happening to them. They don't necessarily understand what's going on at school. They understand about a virus, but they can't understand why mom and dad can't pay their bills, or why, not knowing where the next paycheque is going to come from, they have to go to the food bank this week.

I've also had some families who have become homeless during this, and there's no support for them. I'm really spinning my wheels in my community and trying to make sure that everybody is well taken care of, but frankly, I don't have the resources for these patients. I'm at a loss as to what to do. I've talked to other members in my community, and they're also expressing the same concerns. The high rate of suicidal ideation and the amount of mental health...coming in through the emergency departments are something that we can't even handle.

In the rural communities, we really need help. Seniors are number one. They're the ones who are suffering the most. I just want to highlight what we are dealing with from a family medicine perspective on getting these patients some help. Maybe it's financial assistance. We need something.

● (1115)

The Chair: That's seven minutes, Doctor. Could you wrap up quickly?

Dr. Victoria Dawson: Yes, thank you. I'm done.

The Chair: Thank you very much.

We go now to Dr. Nadia Fairbairn, clinician scientist at the British Columbia Centre on Substance Use.

Go ahead, Dr. Fairbairn, for seven minutes.

Dr. Nadia Fairbairn (Clinician Scientist, British Columbia Centre on Substance Use): Good morning, Chair Ron McKinnon, Vice-Chairs Luc Thériault and the Honourable Michelle Rempel Garner, and members of the Standing Committee on Health.

My name is Dr. Nadia Fairbairn. I am a clinician scientist and an assistant professor in the department of medicine at the University of British Columbia. I am here on behalf of the British Columbia Centre on Substance Use, a provincial organization with a mandate to develop, help implement and evaluate evidence-based approaches to substance use and addiction throughout the continuum of care, from prevention to treatment to harm reduction to recovery.

I've been invited to speak here today with regard to the impact of COVID-19 on mental health and substance use for Canadians. I will focus on substance use, while acknowledging the intersectional impacts of this pandemic on population levels of depression, anxiety, domestic violence and adverse childhood experiences, among others.

Let's look at alcohol, our most commonly used substance in Canada and one that was responsible for $15 billion in health and social costs in Canada in 2018. Alcohol intake in excess is linked to increased mortality, cancer risk and other chronic conditions, although many Canadians and clinicians are unaware of Canada's low-risk alcohol drinking guidelines.

A recent Nanos poll found that pandemic-related alcohol consumption is increasing across all age groups in Canada. A recent CIHR study found that nearly one in four respondents reported consuming more alcohol, both in quantity and frequency, during the pandemic. The issue is particularly pronounced among 18- to 34-year-olds, with nearly half reporting an increase. Nearly one in 10 Canadians who drink alcohol says that they have had issues with controlling their ability to stop drinking since the start of COVID-19.

Due to time limitations, I'm not able to comment on other legal drugs, such as tobacco or cannabis, but these are also responsible for mounting health and social costs and harms during COVID-19. We know with certainty that increased consumption of substances is associated with an increased burden of social harms, health harms and dependency.

Why is this happening? Consuming substances like alcohol is a way for some people to manage or control their stress, as well as symptoms of depression or anxiety, during the pandemic. In addition, recognizing our societal dependence on alcohol and fearing the fallout from restricting access to alcohol during times of public health lockdown, most provinces, except P.E.I., declared liquor retail an essential service. This was a sound decision, given that, without proper care, alcohol withdrawal can be a life-threatening condition. In order to ease the financial burden on the hospitality industry, municipalities also relaxed restrictions on access to liquor by permitting restaurants to offer alcohol for takeout with takeaway food. Retail markups on liquor were also reduced.

In the case of illegal drugs, the situation is dire. The overdose crisis continues to have a significant impact on Canadian communities and families. With an average of 11 deaths and 13 hospitalizations every day between January 2016 and March 2020, it is one of the most serious public health crises in Canada's history.

During COVID-19, overdoses and fatal overdoses across Canada are occurring at the highest rates ever recorded. Deaths in British Columbia hit new highs over the spring, including a monthly record of 181 illicit drug toxicity deaths in June. Five years into the declaration of the public health emergency in the province, the province is now on pace to see the highest number of overdoses in one year. Alberta revealed in September that 301 people in the spring died due to overdose—also a record. In Ontario, overdose deaths jumped by nearly 40% in the first months after COVID-19 hit the province, on pace to extend to 2,200 overdoses—the highest on record. Overdoses have taken far more lives than COVID-19 has in these three provinces, which are the hardest hit by the opioid crisis, yet our response has been muted in comparison. Even more so than with mental health, the unmet needs, already large, are increasing.

On a personal note, this has been the most challenging time to practise addiction medicine. I have had to make several calls to families and loved ones following the loss of a patient to overdose during the pandemic, and my heart goes out to each of them who are suffering and grieving. It is every community in Canada that is being affected.

There are many reasons why overdose deaths have gone up during the pandemic. First, contamination of the illicit drug supply with synthetics, fentanyl and its analogues, as well as other poisonous substances, such as the very potent benzodiazepine etizolam, has driven the overdose crisis in Canada since 2016.

● (1120)

During COVID-19, changes in the illegal drug supply, as supply chains have been disrupted by travel restrictions and border measures, have led to further poisoning of the drug supply in Canada. At the same time, there has been less access to supports and services for people who use drugs, as well as hesitancy to seek treatment through the health care system due to concerns regarding COVID-19 risk in health care settings.

This has led to reductions in the use of harm reduction services such as supervised consumption sites, as well as reduced access to treatment services such as detox and recovery beds. Substance use, including relapse rates, has increased as many struggle to cope with stress during this difficult time.

There are a number of actions that can mitigate the increasing harms we're seeing due to substance use during the COVID-19 second wave in Canada.

We need to raise awareness of the potential harms of alcohol use and encourage people to follow safer consumption and lower-risk drinking guidelines.

We need to understand and anticipate that the pandemic may lead to an increased risk of relapse for those in recovery from substance use disorders. We need to improve screening and treatment of people at risk for relapse to substance use and to improve access to evidence-based treatments and recovery-oriented services as part of a comprehensive system of care for addiction.

There is a pressing need for more evidence-based clinical guidance and more training of health professionals to equip them with the knowledge of care for substance use and addiction to build capacity in the health system. Access to pharmaceutical alternatives is needed to prevent overdose and other severe harms caused by a contaminated illicit drug supply.

Finally, I agree with the chief public health officer of Canada, the Canadian Association of Chiefs of Police, and Moms Stop The Harm, a network of Canadian families impacted by substance use-related harms and deaths, that to mitigate the pressing harms of substance use and in order to be able to treat addiction as the medical condition it is, the decriminalization of people who use drugs is essential, as was unanimously endorsed by Vancouver City Council just last week.

I would like to thank Ms. Cheyenne Johnson and Dr. Perry Kendall at the BC Centre on Substance Use, B.C. Minister of Health Adrian Dix and B.C. Provincial Health Officer Bonnie Henry for their leadership in B.C. during this time of need.

Thank you very much for your attention.

The Chair: Thank you, Dr. Fairbairn.

We go now to the Canadian Medical Association, with Dr. Ann Collins, president.

Dr. Collins, please go ahead. You have seven minutes.

Dr. Ann Collins (President, Canadian Medical Association): Thank you, Mr. Chair.

It's my honour to appear before you today. My name is Dr. Ann Collins. In a three-decade career, I have taught family medicine, run a full-time practice, served with the Canadian Armed Forces and worked in nursing home care. Today, as president of the Canadian Medical Association, I am proud to represent our 80,000 members, so many of whom have been working all out for over nine months and counting.

Our health systems and the people who work in them were stressed well before then. Now we are at a tipping point. I am deeply concerned about the mental health of Canadians. I am deeply concerned about my physician colleagues and health care providers who work alongside them. Psychological trauma is anticipated to be the longest-lasting impact among health care workers in the post-pandemic environment. After almost a year on the front lines in untenable circumstances, burnout is a grave concern. We are sounding the alarm.

When Canadians banged their pots and pans, they shouted their support for those risking their lives on the front lines. The pots are now nestled in the kitchen drawers, but the pandemic has not stopped. It's worse. The risk to front-line workers persists.

At the pandemic's onset, a lack of coordination of emergency supply stockpiles among federal and provincial governments led to inadequate deployment of such supplies as ventilators and a widespread void of sufficient PPE for front-line health care workers. Physicians were faced with the ethical dilemma of being unprotected while treating patients and potentially putting their families at risk, in addition to having to make decisions about allocating life-saving intervention.

The explicit anxiety haunting front-line physicians is palpable. They are at high risk of developing symptoms of burnout, depression, psychological distress and suicidal ideation. Gruelling work hours, uncertainty, fears of personal and family risk, experiences with critically ill and dying patients—these conditions create unprecedented anxiety.

Physician burnout was a nationwide challenge long before the COVID-19 pandemic emerged. In 2018, 30% of physicians reported high levels of burnout. The outcomes of human health resource issues, system inefficiencies and overcapacity workload create a culture of sustained burnout. No amount of therapy, yoga or mindfulness will make it go away. The consequences reach much further. They lead to bad patient outcomes.

We are calling on all levels of government and health authorities to work together to protect Canadians and health care providers during the second wave of COVID-19 through a series of four strategic investments and actions.

The first is that all governments recognize and raise awareness of the need to support health care providers as part of their public education messaging on COVID-19. There is nothing benign about remaining mute on this subject. Patient safety depends on the mental health stability of medical professionals.

The second is that the federal government invest in the creation of a mental health COVID-19 task force that mobilizes national mental health associations and professionals to support the mental health needs of care providers during and following the resurgence; and that the government increase funding to jurisdictions, enhancing access to existing, but strained, specialized mental health resources for health care providers.

Third, our vulnerable populations and people living in rural and remote areas are disproportionately affected. The federal government must fund and implement sustainable, evidence-based mental health services and supports to respond to the increased demand for mental health care resulting from COVID-19. We must also intensify access to critical social support services and embed virtual care. We welcome the commitment to expand broadband across the country. It has the capacity to create equitable access to virtual care. But the success of digital health care relies on not only broadband expansion but also the development of digital health literacy programs and measures to ensure equity of access for marginalized populations.

● (1125)

Lastly, we simply cannot ignore the risk of a health care shutdown. Avoiding this is absolutely critical. Following public health measures is needed, as well as federal investment. A health care and innovation fund of $4 billion in federal funds would address the backlog of medical services, expand primary care teams and boost the capacity of public health.

These measures don't exist in a vacuum. It is their combination that blazes a path to Canadian health security.

Canadians need the confidence that their health care system is there for them, that the physicians and front-line health care workers are in good shape. With burnout becoming the most significant challenge to the health care system, we face a degradation of care for our patients.

Every tipping point needs a steadying hand. Canada is reaching out for it. Great victories require two elements: a common enemy and solidarity. We have a common enemy—it's viral—but without solidarity there will only be more harm and loss. This virus doesn't care about politics. It doesn't recognize federal, provincial or territorial lines, and it doesn't care about a perceived stake. These case numbers aren't numbers; they are lives, and we must fight for them, all of us, together.

Mr. Chair, let me thank the committee for the invitation to share the convictions of Canada's physicians.

The Chair: Thank you, Doctor.

We'll go now to the Canadian Mental Health Association, with Ms. Hetherington, president.

Please go ahead for seven minutes.

[*Translation*]

Ms. Karen Hetherington (President, Canadian Mental Health Association – Quebec Division): Good morning, everyone.

Thank you for the invitation to appear before you today.

I'll speak in French, so I hope the interpretation is working.

I'm the president of the Canadian Mental Health Association. I'm here to speak on behalf of the Quebec division.

I won't waste my time talking about statistics, since Dr. Fairbairn, Dr. Dawson and Dr. Collins have explained the effects very well. I'll focus on what we can do. I'll talk about possible solutions to the crisis we're experiencing.

Everyone is affected by COVID-19, but everyone is affected in a different way. The question is how can this be changed to have an overall effect on the Canadian population. In 2019, the Canadian Mental Health Association released a document entitled “Cohesive, Collaborative, Collective: Advancing Mental Health Promotion in Canada”. In our view, mental health promotion is the final frontier. It is the file to be explored and developed.

Promotion differs from prevention. Prevention focuses on reducing symptoms. Promotion focuses on positive mental health. Positive individual and collective mental health must be cultivated. These interventions must be made throughout the lifespan. This includes all populations, including youth and seniors with different life experiences. Promotion can take place in different settings, such as schools, local settings and workplaces. The good news is your mandate. The federal government has that responsibility. It can provide focused leadership in the current crisis.

Mental health promotion is inclusive. It reaches the rich, the poor, people already diagnosed with mental illness and people at risk. It allows for the development of a campaign that respects these differences and addresses the issue of the ever-changing nature of this crisis.

● (1130)

At the beginning of the pandemic, people across Canada posted rainbows, and people often said, “It's going to be okay”. It was very comforting in March, April and May, but December is tomorrow. Is it as comforting?

Mental health promotion is a complex thing. What speaks to me may not speak to you and may not speak to the most vulnerable population.

At the Quebec division of the Canadian Mental Health Association, we believe that a community mental health approach is needed to ensure that the campaign will reach the most vulnerable in many different ways. Community organizations have an intimate knowledge of the vulnerability of individuals, families and communities. They have experience with the other layer of exclusion that these groups are currently experiencing. The speeches of all the witnesses before me are proof of this. The most vulnerable people in our community are experiencing another layer of exclusion that is really difficult.

What can be done?

In our opinion, the only way is through community organizations. We already have campaign models. Mental health week has been carried out by the Canadian Mental Health Association for 70 years now. Five years ago there was the get loud campaign. This year, because of the pandemic, we feel we really need to talk about it. There's a need for comprehensive campaigns and very targeted interventions that reach out to the different needs of the population. The only way to do that is through mental health promotion and through community organizations across Canada.

For example, Quebec has the Vieillir en bonne santé mentale program. People can't stay connected or they don't have access to technology. You really have to be innovative. As I said, it's a complex issue. You have to mobilize community agencies that can respond. All community movements have an advantage.

● (1135)

[*English*]

They can change on a dime, and this COVID virus gives us the opportunity to live continuous uncertainty and we need to turn on a dime.

[*Translation*]

My recommendations are very clear. The government must commit to mental health promotion. It must not be limited to impact. It has been proven that it will have an effect, not just on the impact of COVID-19, but on the entire health care system and health care needs.

Therefore, I recommend that the federal government support community mental health across Canada with a specific mandate to develop mental health promotion programs that are innovative and adapted to the current context.

These programs should foster positive mental health through positive messages delivered to our diverse communities and promote the connectivity of citizens, whether at home, at school, in the community at large, or at work.

Thank you.

The Chair: Thank you, Ms. Hetherington.

[*English*]

We will start our questioning now, but we will only have time for one round of questions on this panel.

We will start with Ms. Rempel Garner.

Please go ahead for six minutes.

Hon. Michelle Rempel Garner (Calgary Nose Hill, CPC): Thank you, Chair.

I had a bunch of questions prepared, but I have to say that what I just heard, particularly from Dr. Fairbairn and Dr. Dawson, is very sobering. I would frame what I heard from the two of you this way. First of all, I acknowledge that COVID-19 is serious and we all have to work together to prevent it. I'm not putting any question there, but the prolonged impact of the measures we've seen has had significant corollary health impacts. I heard everything: mental health issues, isolation and suicide risk, opioid deaths, increase in substance abuse, the delays in surgery, increase in domestic violence and increased rates of depression. However, I think the line that stuck with me the most is “In trying to protect them, we're also harming them.”

This is what's been keeping me up at night as a policy-maker. How do we protect the public from COVID-19 and at the same time understand that we may be causing harm? It's an area I don't know how to talk about as a legislator because I don't want to diminish the severity of COVID-19, but at the same time there's a serious problem here.

I'm going to divide my time between the two of you, Dr. Fairbairn and Dr. Dawson, because you're on the front lines right now.

For each of you, what are three short-term recommendations? I know, to what Dr. Collins and Dr. Hetherington said, we need longer-term solutions to deal with the health care system in Canada. I couldn't agree more. But Dr. Fairbairn and Dr. Dawson, if you were sitting in my role right now, what are the three things you would do to make a short-term change to get to that nexus where we're protecting people from COVID-19 but also addressing some of the concerns you raised?

I will start with you, Dr. Fairbairn. I only have four minutes, so if you could keep your comments very short that would be helpful.

Dr. Nadia Fairbairn: Thank you so much for that question.

It does feel as though COVID-19 has pulled back a layer of what was already not adequate within the addiction treatment system. When it comes to areas of urgent need at the intersection of COVID-19 and addiction, first we need an urgent scale-up of service access to evidence-based services for addiction. That includes harm-reduction services, like supervised consumption sites and naloxone. That also includes detox and recovery beds. I've had numerous clients who want to access detox who relapsed during COVID-19, and those services are all scaled down because of COVID-19 precautions. Scaling up all services that are needed for addiction treatment would be first.

Second, we need an expansion of access to pharmaceutical alternatives to the drug supply. Fentanyl is not going away. The contaminated drug supply has only gotten worse with COVID-19 and this is not going to miraculously resolve itself. We really need to be able to offer people who want to prevent overdose and fatalities for themselves, and the impacts on their families and communities, urgent access to these medications.

Third—

● (1140)

Hon. Michelle Rempel Garner: Dr. Fairbairn, I have only two minutes left—I've been going so fast—and I want to give Dr. Dawson a chance to get in with her perspective on rural and remote treatment right now.

Dr. Nadia Fairbairn: Sure.

Hon. Michelle Rempel Garner: As Dr. Fairbairn said, what are the most urgent things at that nexus between the COVID policies that we have right now and the corollary health impacts? What could change? What could we be doing differently right now to stop some of the issues you're seeing?

Dr. Victoria Dawson: I think we really need to start connecting our seniors with some sort of mental health care and try to do it in a safe way by accessing rapid testing so that people can actually go in and see these seniors. They live for their families. We need to reconnect them. We need to get counsellors or anybody to see these patients face to face.

Unfortunately, unlike those of us who are in the digital world and can connect with people, seniors never grew up with this. They maybe were introduced to this 15 years ago. That's not enough. They need to be able to connect, to see people, to see facial expressions and to see their grandkids or their family members.

I think it's about accessing the rapid testing so that this can happen, and about creating a safe bubble community for our seniors: having five or six people that they once again can connect with safely. Once again, it's about using things like rapid testing. Fifteen minutes in their world is fine, but we can't wait days, weeks or months for testing to come back.

I am seriously concerned about the amount of alcohol that is being used by seniors. Just as younger persons are, they are using it to deal with this. Patients have come to me—they finally broke down and came to the office—and have said, “Dr. Dawson, I can't do this anymore.” They saw an article and they say, “I want to be referred to MAID because my whole life is my family.” They see those articles and they say, “I don't want to live anymore.”

What do you do with these seniors who can't reach out? They can't use BounceBack in Ontario because they don't have a computer. We really need to try to create a group for them, whether it's a social-distancing coffee hour for seniors to talk about things or getting them connected with their families, to try to stop that wheel of fear.

Family members don't want to go visit grandpa and grandma because they're scared of causing them to die. The realistic aspect is that they'll probably die sooner from something else other than COVID, especially if we put proper checks and balances in place.

The Chair: Can you wrap up your answer, please?

Dr. Victoria Dawson: Thank you.

Hon. Michelle Rempel Garner: Thank you to you both.

The Chair: Thank you, Ms. Rempel Garner.

We will go now to Mr. Fisher.

Mr. Fisher, please go ahead. You have six minutes.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you very much, Mr. Chair.

Thank you so much to all of our experts here today. We really appreciate your testimony and your opening statements.

I'm going to focus my comments and questions on Dr. Collins, a fellow East Coaster.

Thank you, Dr. Collins, for your service in the Canadian military.

It's so clear that mental health issues have spiked during COVID-19. I'm wondering, Dr. Collins, if you could talk about some of the key populations you're most concerned about and how the government can better support these people during COVID-19.

Dr. Ann Collins: Thank you very much for the question.

First, I am here representing the 80,000 members of the Canadian Medical Association, who have been on the front line tirelessly for the last nine months. I want to thank them and acknowledge their service and commitment.

I also want to emphasize and acknowledge what they are currently dealing with. They have already had high levels of burnout, as we showed earlier in 2018. However, during this pandemic, they've had to deal with uncertainties around PPE, and we hear that this still exists in some parts of the country. They have concerns for their families and for themselves. They care daily for people with COVID-19, but also for people impacted by what you've heard from previous speakers about COVID-19.

For them, we call upon government to establish a COVID-19 virtual care task force to look at their impacts, and to make a strong commitment with public education messaging around the need for support for health care providers.

Other populations that have been profoundly impacted—and you've heard most eloquently from previous speakers—include our seniors.

I want to put some emphasis on our youth. In my practice, in the last 30 years, I saw an increasing level of anxiety among adolescents and even pre-adolescents. That impacted their schooling, their relationship with family and their relationship with friends. I and their parents struggled to find adequate resources to serve their needs.

I can only imagine what COVID-19 has done with that age group in terms of the disruption in the types of schooling they're having, in terms of loss of social contacts with concern about the pandemic, and in terms of who's in and who's not in their bubble and whom they can or cannot see.

Again, we're calling upon enhanced social supports and services in a coordinated way, between all levels of government and health authorities, to service this population, as well as seniors, our indigenous communities, and people living in rural and remote Canada.

● (1145)

Mr. Darren Fisher: Thank you, Doctor.

One of the first things this government did, during the renegotiation of the health accord, was invest an additional $5 billion over 10 years specifically dedicated to mental health.

Are you seeing the results of this investment yet in health care systems across the provinces and territories?

Dr. Ann Collins: We support investments that have been made to support mental health in the past, and investments that have been made to support what's happening now in the pandemic and what's been happening since March.

Our need today is to emphasize—regardless of what's been done in the past—what's happening now, and to be very acutely aware of what's happening with our health care providers, as well as our vulnerable communities and Canadians across the country, in general. We need to look at ways, collectively and collaboratively, to improve the delivery of service, access to service, and the number of professionals providing that service.

First of all, we need to look to now, in part to control what's going to happen from the mental health perspective, but also, let's not forget, to control the transmission of the virus right now, and what the needs will be in the short term and the long term as a result of this.

Mr. Darren Fisher: Dr. Collins, the outbreaks and deaths in long-term care homes across Canada are one of the greatest tragedies of the pandemic, and likely one of the greatest tragedies of our lives.

The mental health impacts on those in long-term care must be profound. How can we support not only those living in long-term care but also those working in these facilities?

Dr. Ann Collins: That is a critical point in terms of those health care providers and all those who work alongside them.

Again, it's to have enhanced services within provinces, within those areas, to target the type of support those providers need. We need those people to be in good shape; we need them to carry on. They need to know they're supported; we need to show they're supported by putting boots on the ground and providing access to the care they need.

The Chair: Thank you, Mr. Fisher.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Mr. Chair, I missed what you said. Since I was listening to the interpretation when you switched to French and your voice was very low, I didn't understand you.

I suppose it's my turn to speak?

● (1150)

The Chair: Yes, it's your turn, Mr. Thériault.

Mr. Luc Thériault: Thank you very much, Mr. Chair.

I'd like to thank all of you.

We have a general idea of what is going on in the mental health field. There are people around us who are depressed or anxious. We go out a little bit, though, and we get phone calls in our constituency offices. This morning, I found that reality was hitting hard.

In the first wave, witnesses told us that the pandemic was highlighting what we didn't do well, which was working on the first determinant of health: prevention. Our shortcomings are now jumping out at us.

If we want to engage in positive promotion, we have the opportunity to get our act together and make things right. We are in the middle of the second wave, and we should have a clear signal.

All you need are resources; it's not just a matter of coordination. Over the last 25 years, funding for health care systems has really deteriorated. Where there were always cuts was in mental health prevention. Mental health has always been overlooked in health care systems.

I imagine that you will be calling loud and clear on the federal government to give a clear signal now to restore health care networks and rapidly increase health transfers. There needs to be some catching up in this regard.

Please feel free to say so. This isn't playing politics. In our constitutional framework, the people who provide care are in the territories, in the provinces, in Quebec. These people have to be able to plan things.

Ms. Hetherington, you have great ideas, but it takes money to make them happen. Do you agree with me that the government should announce today, in its economic update, that it will significantly increase health transfers? It doesn't make sense anymore.

Who wants to respond to my remarks?

Ms. Karen Hetherington: You didn't ask a question.

More resources are needed. As I said, prevention and promotion programs will help to improve our health care system.

Our health care system is overwhelmed. We need to invest in prevention and promotion before the mental health of workers deteriorates completely. It is clear, plain and simple: the provinces need more money to provide services to the population. All prevention programs fall under provincial jurisdiction, and the provinces should have the money to deliver them. Promotion is a provincial responsibility, but it is also a federal responsibility.

I completely agree with you, Mr. Thériault. More money needs to be transferred to the provinces so that they have more resources. This time, it must be clear: we must invest in prevention and promotion.

Mr. Luc Thériault: We're talking about transfers, and people might say that a lot of money is being spent on COVID-19, but we need sustainable and structuring investments that will allow our networks to get back on their feet and correct the mistakes that have been made. We have the opportunity to start from scratch, to get back on the right foot.

Ms. Hetherington, in the document we received this morning, around 10:00 a.m., you say that one in five people will personally experience a mental health problem or mental illness. Your organization says the following:

> The Mental Health Commission of Canada (MHCC) estimates that the direct annual cost attributable to mental health problems and mental illness—health care, relevant social services, income supports—is at least $42 billion. By contrast, total direct costs for cancer care in Canada, which includes hospital care, was in 2012 estimated at $7.5 billion, while direct costs for heart failure are estimated at $2.8 billion per year. These costs parallel those in peer jurisdictions such as England and at the global level: the World Health Organization…

It's really not insignificant.

● (1155)

The Chair: Mr. Thériault, you have 30 seconds left.

Mr. Luc Thériault: Medical students are told that prevention is the number one determinant of health. But here are some figures that show that we would make very significant savings and efficiency gains if, once and for all, we turned the tide by investing squarely in prevention and, to do so, by increasing transfers.

Ms. Karen Hetherington: I absolutely agree with you. It's an opportunity we can take advantage of. The COVID-19 situation is very difficult, but it's also an opportunity for change. It gives us the opportunity to redirect trends and focus on prevention and promotion. There's not enough investment in this; it's clear, simple and specific. It's time to change that. Yes, it's time.

The Chair: Thank you, Mr. Thériault.

[*English*]

We go now to Mr. Davies.

Mr. Davies, go ahead for six minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you to all the witnesses for being here today and for their riveting and, I think, quite sobering testimony.

Dr. Fairbairn, I will start with you. It's been said quite often in the last little while that there isn't one pandemic in Canada; there are two. We, of course, have the COVID pandemic, but we have an entrenched opioid overdose crisis that has taken over 15,000 lives in the last four years alone in this country. Not to equate them, but that is more lives lost to overdoses than we've currently lost from COVID.

On October 28, Dr. Fairbairn, you co-authored an op-ed in the Canadian Medical Association Journal that said the following:

> Swift and decisive action has been crucial to Canada's success limiting COVID-19. The same emphatic response is needed now [to] combat the overdose crisis.

Could you please outline what an emphatic response to the overdose crisis would look like in Canada?

Dr. Nadia Fairbairn: I completely agree. It's the stigma regarding addiction and the lack of acceptance of it as a medical condition that has resulted in chronic underinvestment in services for people living with addictions. All over Canada we are losing people who are very young to overdose.

We need investments within the health care system, which includes developing, for the first time, a comprehensive addiction system of care where we work up the silos, where prevention, treatment, harm reduction and recovery are all coordinated and people can access the system rather than consistently butt up against the system.

We need expanded access to pharmaceutical alternatives, given the fact that it's a poisoned drug supply. We need a real conversation, real consideration, regarding the decriminalization of drugs. We need to be able to fully move substance use out of the criminal justice system and treat it as the medical condition that it is.

Amendments regarding the Controlled Drugs and Substances Act are important. There were some really important amendments that were made at the beginning of COVID-19 to support people to access, for example, medications for opioid agonist treatment, so that was done quite quickly at the beginning of the pandemic. The revisiting of other ways that the CDSA can be amended to support people who are critically at risk for imminent death due to overdose is also really important in order for us to be able to have an addiction treatment system that people can come into.

Mr. Don Davies: Thank you for that.

Have you noticed any increase during the COVID crisis in the number of people who are seeking treatment?

Dr. Nadia Fairbairn: Yes. We have noticed increased relapse rates. I should note that this includes people who are elderly, who are in the geriatric population. It's all ages. We are seeing increased relapse rates due to stress and isolation related to COVID, and we're seeing a downscaling of services for people. The combination is resulting in people increasingly butting up against the system without any services available for them. That includes treatment and recovery-oriented services, including harm reduction services, which are so crucial in preventing overdose every day.

● (1200)

Mr. Don Davies: I think it's relatively commonly accepted now that addiction has a unique feature to it, which is that when someone seeks recovery, there's a very limited window in which to get that person into recovery. Treatment on demand, I think, is something that is commonly accepted as required in order to tackle this issue. Can you give us a bit of a flavour of how Canada is doing in terms of access to treatment on demand?

Dr. Nadia Fairbairn: Unfortunately, treatment on demand remains the exception to the types of substance use services that are offered. Most of the time, if people are looking to access particular detox or recovery services, there can be a considerable wait. Those delays can result in adverse harms and deaths during the waiting period, given the crucial importance of having services available when people try to access them.

I would say that, in general, there's a huge gap there in terms of treatment on demand throughout the country. That delay has worsened during COVID-19. People aren't even able to become eligible for wait-lists, for example, because services are at capacity, given they're not able to accommodate as many clients as they would have been able to even before COVID-19. Treatment on demand remains highly limited. That includes evidence-based treatments like pharmacologic agents that can be really life-saving for people—methadone, buprenorphine, morphine formulations, etc.

Mr. Don Davies: Thank you.

As you may know, the New Democratic Party has had an official policy of favouring decriminalization of drugs for some time. In July, both I and NDP deputy health critic Jenny Kwan sent a letter to the federal health minister requesting the implementation of a Canada-wide exemption from the Controlled Drugs and Substances Act to decriminalize personal possession of illicit substances as an urgent interim health measure. I think you made reference to the fact that the Vancouver city council recently sent a similar request for an exemption for the city of Vancouver.

How urgent is it, in your view—

The Chair: You're at six minutes. Can you wrap up, please?

Mr. Don Davies: —that Canada move towards an official policy of decriminalization so that we can treat substance use and substance use disorder as a health issue? There seems to be a resistance to do that at the federal level.

Dr. Nadia Fairbairn: I think it's urgent. I think it can be considered as part of the urgent second-wave COVID-19 response to be looking at decriminalization as a way of addressing the contaminated drug supply that's poisoning Canadians.

The Chair: Thank you, Mr. Davies.

That brings us to the end of our questioning.

To the witnesses, thank you for sharing with us your time and expertise today. Thank you for your excellent answers.

With that, we will suspend while we bring in the next panel.

Thank you very much.

● (1200)

_____(Pause)_____

● (1205)

The Chair: We will now resume the meeting.

Welcome, everyone.

For this second hour we have, from Faces of Advocacy, Dr. Poon, founder and medical doctor; from Mouvement Santé mentale Québec, Madame Renée Ouimet, director; from Stepped Care Solutions, Dr. Cornish, psychologist; and from Women's Health Research Institute, Dr. Brotto, executive director, and Dr. Ogilvie, associate director.

We'll now start with witness statements. Each group will have seven minutes.

Please go ahead, Dr. Poon, for seven minutes.

Dr. David Edward-Ooi Poon (Medical Doctor and Founder, Faces of Advocacy): Thanks very much, Mr. Chair.

Mr. Chair, my name is Dr. David Edward-Ooi Poon and I'm the founder of Faces of Advocacy. We are a grassroots Canadian organization with over 9,500 members, established to safely reunite families in Canada during the COVID-19 travel restrictions. From my understanding, we are directly responsible for the extended family travel exemptions announced on October 2, 2020.

As Canadians brace for a second wave of COVID-19, government policies must ensure that families are reunited and kept together in order to abate the shadow pandemic of a mental health crisis.

These are the unedited statements from members suffering due to COVID-19-related family separation:

“Life doesn't feel worth living...fixing it is out of my control. I don't know how long I can keep going.”

“After 225 days apart and no history of mental health issues, my most recent panic attack was last night.”

“As a healthcare provider I have never fully understood addiction until the separation from my partner. The constant feelings of despair, hopelessness, sadness and anxiety [since March] gave me this unwanted lesson.”

“I cry. My son cries. He thinks it's his fault.”

“2020 is a rough year for all. Imagine going through it without your family.”

In our Faces of Advocacy mental health index, we surveyed the mental health of over 1,200 of our members using validated clinical tools. The survey showed a near doubling of suicidal/self-harm thoughts due to COVID-19-related family separation. Sixty per cent to 70% of respondents showed moderate to severe symptoms of anxiety, depression and/or PTSD, where 49% of respondents had never been diagnosed with a mental illness prior to the family separations. Only 34% felt they had adequate mental health support during the pandemic, and 84% responded that their mental health decreases the longer they are separated from their families.

A coordinated federal strategy must be implemented for all Canadians, including permanent and temporary residents. Our briefing includes six recommendations. I will highlight four.

Number one is Donna's rule. Donna McCall was a Canadian nurse and mother whose American children were not allowed into Canada as she died. She said goodbye to her children on FaceTime. The mental health sequelae of that moment spans a lifetime. Family reunification must be prioritized to protect the mental health of Canadians. This can be done through the ministry of health, alongside IRCC, Public Safety and other departments, to offer a reasonable path for family members to reunite at a time of crisis.

Number two is the last goodbye protocol. There must be a federal guideline ensuring reasonable accommodations—

● (1210)

The Chair: Excuse me, Dr. Poon. Could you slow down a bit to allow the translators to keep up with you?

Dr. David Edward-Ooi Poon: My apologies.

In the last goodbye protocol, there must be federal guidelines ensuring reasonable accommodation for Canadian families to have an appropriate bedside presence. Even if families are allowed in the same city, hospitals do not have a uniform bedside process, particularly at the end of life.

In our briefing, we have a first-hand account of an ICU nurse detailing the mental health pains that families go through from this lack of clarity at end of life. Provided that sufficient resources such as personal protective equipment are available, hospitals must allow culturally sensitive and safe opportunities for some family to be present for critically ill patients.

The basic idea is that during COVID we had patients whose family maybe were in the hospital but could not say goodbye to their family member. We have PPE now. We can educate patients on how to do this safely. The mental health outcomes of not being there for a proper last rites ritual have long-standing repercussions and must be addressed for the mental health of Canadians moving forward through COVID.

Number three, there must be a federal mandate for virtual care under the Canada Health Act. This would protect virtual/phone billing codes for primary care and mental health physicians to ensure accessibility, comprehensiveness and portability of mental health care for Canadians. This mandate must consider that physicians licensed to work in Canada may be displaced during the pandemic but are still able to provide virtual treatment.

For example, a physician in Saskatchewan is able to call patients in Saskatchewan. If that physician is displaced during the pandemic and is in Ontario, that physician should still be able to call the Saskatchewan patients in order to provide care. This will ensure continuity and consistency with the Canada Health Act. So far, Saskatchewan operates like that, but Ontario doesn't. That is why there must be a federal mandate.

In point number six in our recommendations are the end-of-the-tunnel health strategies. What we require is a federally mandated and federally managed national COVID-19 vaccine program. Provincial distribution would be subject to possible inequitable distribution amongst the most vulnerable, and when that is seen by numbers of Canadians, that can really adversely affect mental health. We already see how the mental health of Canadians deteriorates given that they see other people flouting public health guidelines or not following masking mandates. Imagine what will occur if there is not a transparent, equitable process for a national COVID-19 vaccine program.

Immunizations for COVID-19, when available, must be equitably distributed at no cost; this includes the elderly and the immunocompromised. This must be paired with a modern country-wide surveillance system to ensure proper calculations of response and attack rates, immunity and outbreaks. The reason it is federal and not provincial is to ensure transparency as well as consistency across the entire program.

The other part of the end-of-the-tunnel health strategy is that, once COVID-19 testing is proven to be reasonably accurate, a federal inquiry into testing must be considered as a replacement for the 14-day quarantine. It is one of the largest barriers to family reunification at the moment, as some people are unable to take a full two weeks off to see their family member. A federal inquiry into the efficacy and usefulness of testing is needed.

Family is essential in life and in death. COVID-19 forces us to face mental health challenges in both. This briefing recommends strategies to reunite families safely and reasonably and to accommodate end-of-life reunification in a considerate manner while simultaneously promoting and protecting mental health.

Thank you, Mr. Chair.

● (1215)

The Chair: Thank you, Dr. Poon.

We're going to Mouvement Santé mentale Québec.

[*Translation*]

Ms. Ouimet, you have seven minutes.

Ms. Renée Ouimet (Director, Mouvement Santé mentale Québec): Good afternoon.

Thank you for inviting us to appear.

I'm going to bring you to the field of mental health promotion and prevention.

We are a group of community organizations dedicated to promotion and prevention. We have member groups across Quebec and have been around since 1955.

Our mandate is to create, develop and strengthen mental health, that is, to take action to try to maintain a mentally healthy population at all times, whether in the population as a whole, in the workplace or elsewhere.

I didn't hear the witnesses speak earlier, but there's one thing I'd like you to keep in mind as you leave this meeting. Mental health is a good, positive thing; it's not mental illness. When we talk about mental health, we're talking about an individual and collective wealth. The World Health Organization tells us that without mental health, there is no health. It's important to remember this.

Mental health is a dynamic balance between the different areas of our lives. Clearly, these days, it isn't an easy balance to maintain. However, promoting mental health is really working to increase the collective well-being, on a daily basis, and to help the population develop its mental health robustness factors. It is happening all the time, everywhere, throughout the life course, from childhood to old age.

The pandemic has shown us that there are already many people who aren't doing well. There were many young people going to school with distress and intense anxiety, many teachers who lacked resources, and many people in the health care system who were out of breath. The pandemic allowed us—perhaps this will prove to be positive—to look at the situation through a magnifying glass and discover that many things weren't going well in our society. There are people who are bouncing back very well in this situation, but there are others for whom it is much more difficult.

Many people say we're in the same boat, but we are not. We're all on the same ocean, but there are people who have tiny little cardboard boats, and there are people who are on ocean liners. Even in the pandemic, we aren't all equal, in the same situation. It's important to remember that.

I hope lessons will be learned from this pandemic. In the area of promotion, there are two areas where it is important to act. First, there's action on the social determinants of health. Currently, we know that the poorest and most vulnerable people have more mental health problems. The fight against poverty and access to education must be tackled. It is also necessary to pay attention to political interventions so that they are always universal and to design public policies that integrate mental health. As I said at the beginning, without mental health, there is no health at all.

At Mouvement Santé mentale Québec, we've developed seven tips. We have described, in simple words, what we call the robustness factors in mental health. You'll find them on our website, in French and English. An American researcher did research with American soldiers who had been in prison for eight years and who came out of prison without post-traumatic shock. He wanted to find out what helped them, after suffering and being imprisoned, to avoid post-traumatic shock. What comes out of this is these protective factors, which involve taking action and creating important bonds, which are fundamental, as Dr. Poon mentioned earlier, to recharge, to discover, and so on. I invite you to visit our site to learn about all these protective factors that need to be integrated into our lives, in our policies, in our schools, with seniors, at all times.

I have read several pieces of research on mental health promotion in the context of the pandemic. One of the things that I've found, which I'm sure you've heard of, that stands out and is very protective of mental health is having confidence in our authorities.

● (1220)

During the first wave, there was less distress in Canada and Quebec than in the United States or other countries because people trusted the authorities. It is important to maintain this trust.

We must always have access to accurate information. According to research, having a strong sense of coherence protects our mental health. A strong sense of coherence is when we are able to understand what is happening to us, to have the information to deal with and make sense of it, and to decide what measures to take.

It's important to remember that we can all foster a sense of coherence in people by providing them with accurate information and examples of what makes sense, and by helping them find solutions when they cannot do so on their own.

Emotions have often been talked about. Recently, I heard a researcher talk about the importance of welcoming our emotions, whatever they may be, before they blow up in our faces. This is a protective factor in mental health. You also have to listen to other people's emotions, because they are like a barometer. Emotions reflect a need, and we have to respond to them. Sometimes there is social anger and we intervene. This has a positive effect on the public's mental health. There are many other emotions.

During the pandemic, it is important to nurture positive emotions and talk about people who are doing well. Some companies stand out and are finding innovative and extraordinary solutions. They are putting in place really interesting policies and it is important to name them, to ask—

The Chair: Ms. Ouimet, your time is up.

Ms. Renée Ouimet: Let me finish by stressing the importance of having caring workplaces that protect our mental health. We know that psychological distress in these environments decreases by 24%. Another very important protective factor is to break social isolation.

Thank you.

The Chair: Thank you, Ms. Ouimet.

[*English*]

We will now go to Stepped Care Solutions.

Dr. Cornish, go ahead for seven minutes, please.

Dr. Peter Cornish (Psychologist, Stepped Care Solutions): Thank you very much.

I'm going to speak about the availability of mental health promotion programs, in particular focusing on Wellness Together Canada, which is a federally funded program that Stepped Care Solutions launched in partnership with Kids Help Phone and Homewood Health.

As a researcher, I'm also going to speak to the role of virtual care and increasing access during the pandemic. Having worked with provincial, territorial and federal governments, I'm also going to speak to the role the federal government could play in supporting provinces and territories.

My non-profit company, Stepped Care Solutions, is the lead partner for Wellness Together Canada. Our diverse team comprises psychologists, social workers, IT experts and, perhaps most importantly, people with lived experience of mental illness.

We originally developed the Stepped Care 2.0 model in Newfoundland and Labrador, and it is now scaled across the province, both in population health and in clinic-based settings. We're working now with the Northwest Territories to do the same kind of implementation. The model informed the development of Wellness Together Canada, which was implemented in April over a period of 10 days, a very rapid implementation of a virtual portal. We're now working on improving the user journey as informed by the stepped care model. The original structure being implemented very quickly was...really, we just wanted to get tools and counselling into the hands of Canadians.

We realize, in the virtual world, how important the experience of being on a portal is. How the portal looks and feels is really the equivalent of what we call in mental health the importance of the common factors for producing good outcomes, which have a lot to do with the relationship or, in more colloquial terms, the bedside manner. What we really want to emulate is the romantic version of the rural physician, who, by very essence and personality, invokes a sense of “Things will be okay. You're under my care.”

Anyone in Canada who visits the Wellness Together portal will have the choice of 11 independent evidence-based and evidence-informed programs available 24-7, including immediate mental health crisis tech support, but also self-assessment and tracking tools so you can monitor wellness, self-guided tools based on cognitive behavioural therapy, peer-to-peer support, coaching and e-courses, and one-to-one counselling.

To date, almost 700,000 people have accessed the program. Of these, approximately 60,000 have registered for ongoing care. Seventy-eight per cent of users whom we surveyed through a random survey a few months ago indicated they would recommend it to a friend, which is an indication that they are satisfied with the program.

Some national polling indicates that people do have some concerns about privacy and fears that the programming on the portal would cost money. This is not true, of course—it's free—but we know those perceptions are out there. Around privacy, we discovered some fairly simple things when we asked people what could make the experience better, what we can do on the portal, and we are redesigning it to address those concerns.

I want to turn to the role of virtual care in general and increasing access during the pandemic. Some recent surveys on virtual clinic care experiences, including surveys on Wellness Together Canada, indicate that help-seekers like telemental health much more than we previously thought. Clinicians, my colleagues, psychologists, social workers, psychiatrists and physicians are not as pleased with virtual care. I think we will need to invest in more training and support to bring them along. The population likes it.

Another thing I want to emphasize around what we've learned through the pandemic is that virtual care has much more potential. It's much more than teletherapy.

● (1225)

Teletherapy is doing what we normally do, but using a system like Zoom, where we can deliver psychiatric or psychotherapy care. We're finding that it's just as effective, but there's so much more we can do in the digital world to accelerate long overdue system innovations, such as continuing to develop and invest in things like portals such as Wellness Together Canada, population health programs, and what we call “one to many” solutions, where you'd have a webinar that can be delivered to thousands of people at once.

There is also continuous wellness monitoring—we actually don't do a lot of this—and putting that data in the hands of users in our health care system. This could be scaled up nationally in clinic settings, as we're doing with Wellness Together Canada.

There is more rapid access to care. With Stepped Care 2.0, people get access to a variety of care immediately. On the portal, they get it immediately, whether it's a counsellor or using self-guided programs.

What we're finding through some polls is that virtual care appears to promote more equitable access. We're finding that there's a much more even distribution along gender lines on the Wellness Together Canada portal than we see in clinic settings. Racial representation of users is more representative of the population.

I want to conclude with a few points where I think the federal government could take on a continued role. It's in investing in technology infrastructure. We know that in the north and most rural areas, broadband access is difficult and is often delivered by satellite. We need to change that, because you cannot access the Wellness Together Canada programs as successfully in rural and remote places in Canada.

We need to continue scaling population-level programming and develop more and improved self-guided programming. People really like it. That's the thing they're going to the most.

● (1230)

The Chair: You're at seven minutes, Dr. Cornish. Please wrap up.

Dr. Peter Cornish: Finally, what I'd like to say is that the federal government can take a role in integrating municipal, provincial and national levels to fill the gap that exists with mental health. The gap is immediate care for people who need it most, including those who are homeless and suffering from addictions. This model and this portal can be expanded to provide that support.

The Chair: Thank you, Dr. Cornish.

We go now to Women's Health Research Institute.

Dr. Brotto or Dr. Ogilvie, please go ahead for seven minutes.

Dr. Lori Brotto (Executive Director, Women’s Health Research Institute): Thank you for inviting us to speak with you today.

I want to acknowledge that our work at the Women's Health Research Institute is situated on the traditional, ancestral and unceded territory of the Coast Salish peoples, which includes the Musqueam, Squamish and Tsleil-Waututh nations.

With regard to COVID-19, sex-disaggregated data reveals a higher case fatality rate for males compared to females. Of note, however, there are exceptions in some countries, such as India, where case fatality is higher in females. In a comment published recently in The Lancet Global Health, the authors speculated whether these higher rates in females might be due to factors related to their gender. We already know that pandemics can compound differential exposure and outcome for women, girls, sexual and gender minorities, caregivers, and other essential workers in gendered occupations.

The Women's Health Research Institute designed a two-part study that combined a survey and an examination of antibodies collected by dry blood spot sample. In our remarks today, we will only focus on a snapshot of the mental health outcomes.

I want to acknowledge our full team at the Women's Health Research Institute, colleagues from BC Children's Hospital Research Institute, all of the students and trainees, as well as funding from our BC Women's Health Foundation.

Dr. Gina Ogilvie (Assistant Director, Women's Health Research Institute): Thank you, Dr. Brotto.

A significant strength of our project is that it draws from seven existing cohorts that are representative of women in B.C., totalling over 40,000 individuals who've consented to be contacted for future research. These individuals received an email invitation that described the study's aims and obtained their e-consent.

The link then took them to the survey, which consisted of one core module focused on a comprehensive epidemiological survey on COVID-19-related symptoms and risks, socio-demographics, medical history and vaccine attitudes. They then proceeded to four modules that focused on substance use; psychosocial outcomes and gender-based violence; underlying comorbidities, including HIV; and economic outcomes and health care disruption. Where appropriate, such as with the psychosocial outcomes, we employed validated clinical scales.

At the end of the survey modules, participants were invited to send the survey link to another household member who identified as another sex or gender. They were also invited to provide their address to receive a dry blood spot kit to measure antibody responses, and those are being prepared to be sent out right now.

Participants were stratified into nine five-year age strata from 25 to 69, with a target for recruitment of about 750 participants for each of those strata, for a total of 6,750 participants. The data we're going to discuss today are based on responses from about 5,300 individuals, out of an approximate 15,000 invitations sent out, so we had a response rate of about 30%.

Just to be clear, while we administered the survey at one time point, for some of the questions we asked people to think about their experiences for three specific periods of time: the three months before the pandemic or pre-pandemic; during phase one of the pandemic, which was mid-March to mid-May; and phase two, which started after the middle of May. Going forward, we are continuing to collect longitudinal data.

I would like to share some of our results.

The mean age of participants was 51, and most of the respondents, 87%, identified as female. In terms of gender, we had 59 individuals who identified as trans or non-binary; 31% were essential workers, and over half reported chronic health conditions.

For this presentation, we will report on rates of overall depression, moderate and severe depression, anxiety, loneliness, distress, intimate partner violence, and alcohol and cannabis use in the defined three phases of the pandemic.

We plan, in the future, to report on these analyses by gender, culture and ethnicity, including indigeneity and race, as well as other socio-demographic variables, once our target sample size is reached.

● (1235)

Dr. Lori Brotto: Thanks, Dr. Ogilvie.

Moving on to depression, first of all.... Comparing males and females, and consistent with what we would have predicted based on past pandemics, there was a significant increase in depressive symptoms that was quite a bit higher in females compared to males as we moved from pre-pandemic to phase one. As pandemic controls started to loosen, we found a decrease in those depressive scores.

When we separated the data by age and not sex, our data showed that the highest burden was borne by the youngest age group—those 25 to 30 years old—and among our sample of trans and non-binary individuals, the scores were clinically significantly higher than the females.

We then moved on to look at extreme depression. Females experienced a four times greater increase in their rate of extreme depression from pre-pandemic to phase one, which was clinically significantly higher than for males. With regard to the trans and non-binary group, their pandemic rates of severe depression also doubled from pre-pandemic to phase one.

Anxiety can be defined as the fear of the unknown combined with a loss of control, so using a validated measure of anxiety that taps into worries and anxiety, we found a very similar pattern to what was found with depression: significantly higher rates for females, and a significantly greater increase from pre-pandemic to phase one, with the highest burden being borne by the youngest age group, 25- to 30-year-olds. This was also found when we focused specifically on clinically significant anxiety: Nearly 20% of the females during phase one of the pandemic fell into clinically significant anxiety rates.

One facet of depression is loneliness, which we asked about in a separate question. Again, the sex-specific findings were replicated, and the highest burden was borne by the 25- to 30-year-olds.

With regard to intimate partner violence or IPV, emerging data do show that, since the outbreak of the COVID pandemic, reports of IPV have increased worldwide as a result of mandatory lockdowns. We asked about a list of behaviours like being hit, thrown, kicked, beaten, etc. Our data were based on only the female population in a relationship.

The Chair: Pardon me, Doctor. You're at seven minutes. Could you wrap up, please?

Dr. Lori Brotto: Thank you.

There was a near-doubling of rates of intimate partner violence from pre-pandemic to phase one.

Finally, among alcohol and cannabis groups, we found that one-third of the participants reported an increase in alcohol use, and 40% of the youngest age group reported an increase in cannabis use.

In summary, our data show significant effects of sex, with females being disproportionately more impacted when it comes to depression, anxiety, loneliness, overall distress and significant increases in intimate partner violence. We recommend a sex- and age-specific tailoring of mental health resources based on these data.

Thank you very much.

● (1240)

The Chair: Thank you.

We will start our round of questioning. We will have time for one round of questions, and we will go over the hour somewhat.

We will start with Ms. Rempel Garner for six minutes, please.

Hon. Michelle Rempel Garner: Thank you, Mr. Chair.

Dr. Poon, how many of your members do you think can afford to take the two-week quarantine period to reunite with their loved one?

Dr. David Edward-Ooi Poon: We are thankful that the Government of Canada has allowed family reunification to occur, although much later than we expected. The question is this, though: How many of them can afford the two-week quarantine once they arrive in Canada, as well as the two-week quarantine when they go back into their home country?

Now, this is not to be disparaging and to be flippant about the health and safety of Canadians. There must be a safe pathway to do so. That is why in our recommendations we believe that there must be an inquiry into alternatives to the 14-day—

Hon. Michelle Rempel Garner: Dr. Poon, my six minutes are going to go really quickly, so I'm just wondering—

Dr. David Edward-Ooi Poon: That's all right.

Hon. Michelle Rempel Garner: Do you think many of your members can afford that two-week quarantine?

Dr. David Edward-Ooi Poon: No, they cannot.

Hon. Michelle Rempel Garner: Look, this is probably the first time I have ever done this in my time in Parliament, but I will get personal for a second.

I didn't expect a tall, dark and handsome American to come into my life. I'm glad he did. However, even in my position of privilege, it was over five months that I was separated from my husband this year, and it was only because of the Alberta pilot project that we were able to see each other. It's really hard. I don't get to see my kids. I don't get to see my mother-in-law, who has stage 4 breast cancer. It's hard.

This is me as a legislator sitting in this committee right now. Everyone on this committee knows that I'm as tough as nails—I know some of the names the Liberals call me—but every night when I come home alone, it's hard, and this is me.

I'm wondering if there are alternatives to quarantine that have better public health outcomes, like if we could test everyone at the airport, as opposed to letting four million people come in untested who may or may not observe the quarantine. I know there were quarantine exemptions for that many people over the last several months.

I'm just wondering, given that you are a clinician, Dr. Poon, if part of your recommendation is to expand systems like the one we're seeing in Alberta to other airports and other border crossings across the country so that it can aid in family reunification.

Dr. David Edward-Ooi Poon: The system in Alberta, along with the pilots in British Columbia and Ontario for airport testing, will offer wonderful ways to increase the number of reunited families, particularly if we apply what's being used in airports to the land borders, which should be helpful.

Once again, we are not asking for open borders. We are just asking to be together and we want to be together safely.

Hon. Michelle Rempel Garner: Yes, I hear you.

I wanted to explore a little bit more your recommendations around family reunification for compassionate visits. I was particularly moved by a case in Manitoba recently. After months of begging and procedural work, somebody was granted an exemption to come to Canada to see a family member who was in the hospital, but then couldn't reunite with them before they passed because there was no exemption to quarantine, even if a test was administered.

Are there other countries around the world that are doing this and that we should be looking to for best practice?

Dr. David Edward-Ooi Poon: There are many countries in the world without the particular border standards or restrictions that Canada has. The compassionate exemptions have been worked in through different family reunifications on a case-by-case basis in other countries. For example, in the U.S. you can actually just fly over right now to see a loved one who might be passing away.

Donna's rule, which I am suggesting, must be a federal government mandate to prioritize family reunification in times of crisis. We must not have a family say goodbye to their mother through FaceTime when she is dying. There must be Donna's rule to prioritize family reunification at a time of crisis.

Hon. Michelle Rempel Garner: I think personal stories are important right now.

You're a clinician. Can you summarize what it's like, on behalf of everyone in your group as well as your experience, to be separated from a loved one for over half a year or for months at a time?

● (1245)

Dr. David Edward-Ooi Poon: I ask members of the committee to consider this: If there's a worldwide pandemic, who do you want beside you? The answer is, uniformly, your family.

Imagine the moments lost. How many miscarriages were taken alone? How many deaths were felt by oneself? How many tragedies were faced without the support of loved ones?

We understand that this level of pain needed to be worked out, but now that we are here and we are preparing for the second wave, we must not allow the mistakes that happened earlier in the year to create further family separations as we approach the second wave.

Hon. Michelle Rempel Garner: How critically do rapid testing and widespread availability of testing play into this?

Dr. David Edward-Ooi Poon: Rapid testing and rapid availability of testing are just more tools to allow family reunification, whether or not that's a mixture of quarantine and testing at the border or point of care. Anything we can do to bring families together on a case-by-case basis through broad exemptions is of the utmost importance during the second wave of COVID.

Hon. Michelle Rempel Garner: Thank you for everything you've done. My heart is with everybody in your group.

Thank you, Chair.

The Chair: Thank you, Ms. Rempel Garner.

We go now to Mr. Kelloway, please. You have six minutes.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thank you, Mr. Chair. I'll share my time with MP Van Bynen.

I want to thank all the witnesses for being here today. When we talk about mental health, it's usually talked about as a blanket subject that affects everyone the same.

As my colleagues know, I represent the wonderful people of Cape Breton—Canso. That riding encompasses the island of Cape Breton and northeastern Nova Scotia, which is predominantly rural. I know that many rural Canadians experience unique challenges when it comes to mental health. Other groups are impacted differently as well, such as seniors, women, indigenous groups, racialized Canadians, children and so forth.

This question is for Dr. Cornish. What can we do to ensure that mental health support in Canada is intersectional, to better support all Canadians, especially those with unique needs and challenges?

Dr. Peter Cornish: Thank you for that question. It's an excellent question.

Our current system has a one-size-fits-all approach. You can go to a physician, psychologist or psychiatrist. What we're learning with opening up the buffet of options is that it fits much more with the reality of our society that has people of all kinds of different identities and intersections on gender and race. What we find is that the typical access to care is often blocked by protocols that triage or try to diagnose at the front end and do a lot of heavy assessment, in which case, during a first point of contact, whether it be by phone or in a consultation room, the person doesn't walk away with any care at all because they're busy answering questions.

I have a personal story. My daughter tried twice, when she was a teen and in university, to get access to care. She walked away from the counselling centre saying that all they did was ask her their questions. They never actually asked her what she wanted. Then she went to the private sector, thinking she would get better care. Again, it was the therapist's questions. The therapist thought they knew better and they thought they had to ask everything, turn over every stone and ask every question to find out everything that was wrong with my daughter before they could help.

Physicians don't do that. When I go to my physician, they don't ask me about everything that's wrong with me. They ask me why I am there and what I want, and they make sure that I walk away with something useful.

We've never done that with mental health. We assume that experts know what questions to ask, and this is not appropriate, given that we have people of different gender orientations and different cultural backgrounds. We shouldn't make any assumption about what they need. We should start by asking, “What would be helpful today?” and trust that people in most cases can answer that question better than we could as professionals.

That's what we are doing with stepped care 2.0. That's what we are doing with Wellness Together Canada. We are giving mental health back to the people who are seeking support, rather than keeping it to a secret professional sort of assumptions about what will work for whom.

Mr. Mike Kelloway: Thank you, Dr. Cornish. Thank you so much for all the work you do.

I'll hand it over to MP Van Bynen for his questions.

● (1250)

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Thank you, Mr. Chair.

First, let me thank Michelle Rempel Garner for sharing her personal situation with us. I'm a member of the all-party mental health caucus, and each and every one of those individuals was brave enough to share their personal experience with us. I have to say it's heartbreaking, so it advances my commitment and emphasizes the importance of what we're discussing now.

My question is for Dr. Cornish. There are many people who do not normally experience mental health challenges who are reporting them because of the impacts of the COVID-19 pandemic, but some may not feel comfortable asking for help in these challenging times. How can we break some of the stigma associated with mental health issues and encourage them to seek help?

Dr. Peter Cornish: I think that, again, the one-size-fits-all thing has to be abandoned. What we're finding with veterans, first responders and front-line workers is that quite often the culture in these workforces is such that you shouldn't ask for help or your job might be in danger if you disclose a vulnerability.

What's proving to be very successful with those populations is peer support, communities of support. What I think the federal government can do is set up an infrastructure. Peer support works with the support of technology, because you can scale it. You can scale it in a way that's anonymous, because part of the concern when reaching out for care is that it might be somebody you know in the neighbourhood or rural area, especially with peer support, but with technology, you can make that anonymous, and you can also scale it to the point that there are enough people available to provide support and a listening ear.

What we find with peer support programs in volunteer workforces is that the turnover is high. This is not a problem, because when you train a peer support workforce, they may not work for a long period of time, but they're still within our population, able to provide informal support because they've learned skills on how to help each other.

The point of scaling, because the turnover is high, is that you need to have an infrastructure in place that continually replenishes and teaches mental health first aid for peer support workers.

Mr. Tony Van Bynen: Thank you.

The Chair: Thank you, Dr. Cornish and Mr. Van Bynen.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

I would like to thank all the witnesses for their valuable co-operation and their enlightening testimony. Having said that, we have received few briefs and speaking notes. I invite them to submit them, since they will be very useful to us.

Ms. Ouimet, you indicated at the outset that your organization is working to create, develop and strengthen mental health, particularly in the workplace. However, I am concerned about a new reality that is affecting workplaces as a result of the pandemic. I am talking about telework.

One study was conducted at Laval University by Caroline Biron and her collaborators. It is based on a sample of 1,259 people who were employed in Quebec during last spring's lockdown. The study found that 55% of the female workers and 41% of the male workers were suffering from psychological distress. Clearly, being able to work is better than being unemployed. I'm not talking about health care and doctors, but many companies are celebrating telework. However, we can see that telework has imposed and intensified isolation.

Could you tell us about that?

Ms. Renée Ouimet: I would like to clarify that Ms. Biron's research was not only about telework. That said, telework isolates workers a great deal. They receive less social and technical support. Therefore, new ways of doing things need to be established.

Workers can no longer talk to their colleagues about the difficulties they face or about a host of other situations. They find themselves more isolated. There are no more breaks together, no more opportunities for conversation, apart from general meetings. In addition, there is significantly less technical support. So we must create new structures, provide time for conversation between colleagues and determine what support they need. They need to be able to talk about what they are experiencing, not only about the technical aspects. It is important to check what technical support they need.

We need to create new meeting rituals between workers and managers. We also know that, even for those who physically come to work, the reality is more difficult because of the distancing and all the ensuing demands.

● (1255)

Mr. Luc Thériault: The percentage is 55% for women and 41% for men. Is that difference a constant? Is the variable always the same?

Do you have any answers to that?

Ms. Renée Ouimet: I did speak with Ms. Biron. She said that there had been no specific research on that. However, we know that women still carry a heavier burden at home even today. The work-family balance is more challenging for them. There is a great deal of responsibility. This affects women's mental health.

Mr. Luc Thériault: Is that what is called the “mental load”?

Ms. Renée Ouimet: Yes.

Mr. Luc Thériault: So we are talking about the workplace, which is also the environment in which we live, experience the mental load, the isolation and the lack of tools to express the pressure. The person is isolated, but must still perform as required.

Ms. Renée Ouimet: Yes, and women work more often in supportive, service settings, which has an effect on their mental health.

Mr. Luc Thériault: Under the circumstances, a lack of resources increases the tension.

Ms. Renée Ouimet: There are also concerns related to the pandemic. When you provide care or when you work in public services, such as grocery stores, you are in environments where you are confronted with it on a daily basis.

Mr. Luc Thériault: I would like to talk to you about the mental health of young people.

According to an analysis published in October, 46% of Montrealers aged 18 to 24 say they experience symptoms similar to generalized anxiety disorder or major depression. Elsewhere in Quebec, the rate is 31%. Nearly one in four Montreal adults, specifically 23%, report that their household has suffered major financial losses as a result of the pandemic.

The Chair: Mr. Thériault, you have 30 seconds.

Mr. Luc Thériault: Okay.

What can you tell me about that in a few seconds?

Ms. Renée Ouimet: Yes, this is the age when young people enter the job market and organize themselves as adults.

There was already a lot of distress in educational settings such as universities and CEGEPs, and that has increased. There has been more isolation and less socializing with friends and family.

Mr. Luc Thériault: What can be done?

Ms. Renée Ouimet: Employment is still important.

We need to find strategies to enable social encounters, which does not mean face-to-face meetings. However, solidarity must continue. Listening to our young people and our loved ones is essential. We must make them aware of all the available resources, since they are unfortunately not widely known. We receive many calls from people who do not know where to turn for help.

Mr. Luc Thériault: Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

I'd like to comment regarding documents. All documents we receive will be distributed to the committee once they're translated.

We'll now go to Mr. Davies.

Mr. Davies, please go ahead for six minutes.

Mr. Don Davies: Again, thank you to all the witnesses for being here.

Dr. Brotto, I had a feeling you had more to say when you were summarizing the findings, so I would like to turn it back over to you to complete your thoughts on some of the major findings from your study on the impact of COVID on women and gendered Canadians.

● (1300)

Dr. Lori Brotto: Thanks for the opportunity to emphasize the importance, first and foremost, when we're doing research and considering mental health among Canadians, of taking both a sex-based approach, with sex defined as male versus female or birth assignment, and also, importantly, gender. Gender is your sense of yourself as woman, man, non-binary, trans, two-spirited, etc. Sometimes when you ask a person about their gendered experience of mental health, it might look different from what we might assume our sex assignment tells us. It's a really important first conclusion that we keep both sex and gender in mind.

I think a major conclusion, based on our data, is that, when we consider the burden of depression, anxiety, stress and loneliness, we see magnified rates, sometimes three to four times higher, of those psychosocial outcomes for females compared with males. That's likely a combination of biological factors, such as being more predisposed to anxiety, and gendered aspects related to the fact that women are more likely to be front-line health care workers; serve in industries that continue to work throughout the pandemic, such as service industries, and work as janitorial staff; and bear a higher burden of home child care and domestic activities.

This leads us to conclude that when we consider mental health resources, we should keep sex and gender at the forefront of making decisions.

Second, and this was asked in the previous question, we saw a very significant effect of age. As Ms. Ouimet was illustrating, the highest burden was borne by our youngest age cohort, the 25- to 30-year-olds. They reported very high rates of loneliness.

We didn't have time for this data, but hopefully you'll see in the slides that we also took a very intersectional approach. We know that individuals living in rural communities, indigenous women, women with disabilities and women identifying as sex and gender minorities see all of these burdens as magnified.

Mr. Don Davies: Thank you.

On November 24, just days ago, the Women's Health Foundation published a new report series called “Unmasking Gender Inequity”. Was the report informed by your data?

Dr. Lori Brotto: Thanks for that question.

Yes, the BC Women's Health Foundation, which we work in close partnership with, conducted a separate survey that was intended to look at women's experiences in the province and the impacts of COVID on their health and well-being and on help-seeking services.

While it did not draw from our research dataset, we worked very closely with the foundation to share findings, to set priorities and to ensure that an equity lens was placed whenever we asked questions that pertained to women's health.

Mr. Don Davies: I have a kind of double-barrelled question here. One of the most acute and disturbing impacts of the COVID pandemic was revealed when you described the impact on gender-based violence. It has been referred to as a shadow pandemic.

Do you have any recommendations for steps the federal government could take to address that aspect of the pandemic? I'll leave it at that and ask this question first.

Dr. Lori Brotto: Indeed, we saw a near doubling of the self-reports of intimate partner violence among women from pre-pandemic to phase one with the highest pandemic controls. This is not surprising. Past pandemics found the same thing, and early data out of China showed us a three times higher rate of intimate partner violence. The real concern here is that women are often trapped and isolated with the perpetrators, so even if they wanted to ask for help, they simply can't.

We need a multipronged approach. First of all, we need to raise awareness about the fact that intimate partner violence rates are unacceptably high, and they increase directly in response to stress.

Second, we need to ensure that health care providers, front-line health care providers, are equipped with how to ask those sensitive questions of women in a safe way at their general wellness visits, which I understand are largely done through virtual care.

Third, we absolutely need more resources, so that when women do ask for help—and I emphasize that only a small minority of women ask for help when they're in an intimate partner violence situation—resources are available for them. We should be thinking about how resources can be available online, coming back to Dr. Cornish's really important points about virtual care, and how we can ensure that those resources are available to women.

Finally, the last thing I'll say about intimate partner violence is that we know it is disproportionately experienced by indigenous women, women living in rural communities, and women who experience other sex- and gender-based intersections. We need to ensure that when we do have resources, they are absolutely tailored to those communities that are most likely to be experiencing it.

● (1305)

The Chair: Thank you, Mr. Davies.

Thank you, everyone. That wraps up our questioning for this panel.

To all the witnesses, I really do appreciate your sharing your time and expertise with us today. It was very helpful.

Before we adjourn, I would like to make particular note of the translators. The translators, day by day, minute by minute, work tirelessly behind the scenes to make this work for us. I understand they had a fairly chaotic day today, so I would just like to acknowledge them and thank them in particular—today and every day.

Thank you, everybody.

Thank you to all the members and witnesses.

We are now adjourned.