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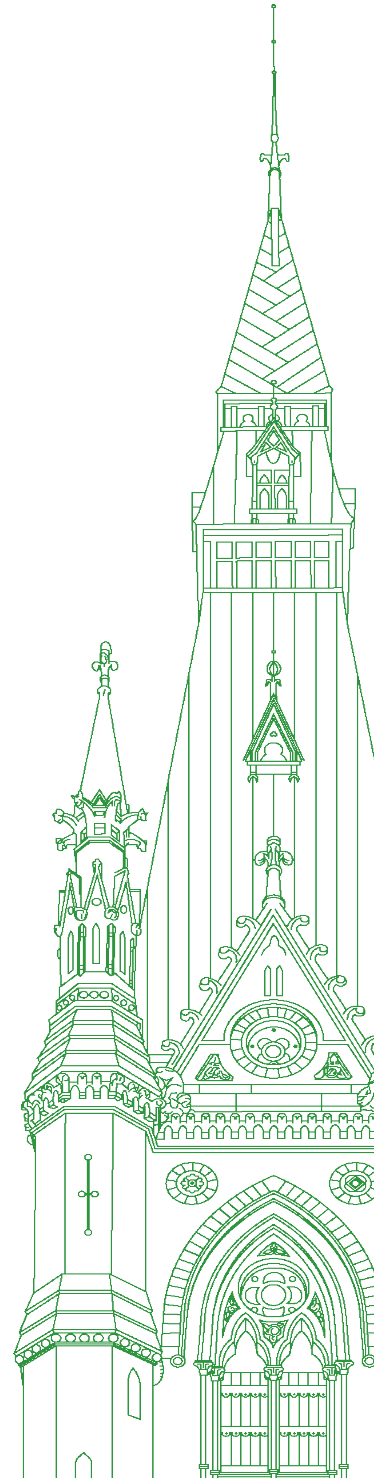

Chair: Mr. Ron McKinnon

Standing Committee on Health

Monday, December 7, 2020

● (1100)

[*English*]

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

Welcome, everyone, to meeting number 12 of the House of Commons Standing Committee on Health. The committee is meeting today to study the mental health aspects of the emergency situation facing Canadians in light of the second wave of COVID-19.

I want to thank you, witnesses, for appearing today. You will have seven minutes for your presentations.

For the first hour, we have Dr. Kim Lavoie, professor, as an individual. We have Dr. Jitender Sareen, physician; and from the Overdose Prevention Society, we have Sarah Blyth, executive director.

I would like to start the meeting by providing some information following the motion that was adopted in the House on Wednesday, September 23, 2020.

The committee is now sitting in a hybrid format, meaning that 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, and so you are aware, the website 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. It is good to point out that if you are speaking in French and you have the English selected, sometimes it is difficult for people to hear what you're saying because the translation will tend to override you, so make sure you choose the proper channel for how you want to speak. Before speaking, click on the microphone icon to activate your own microphone. When you are finished 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. Any member who wishes to intervene on a point of order raised by another member should do likewise.

In the event of a debate, if a member wishes to intervene, they 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 the list pops up, you'll 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 a headset with a boom microphone is mandatory for everyone participating remotely. Should any technical challenges arise, please advise the chair and please note that we may need to suspend for a few minutes in such a case 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 the 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.

I should also note that I have a couple of cards. I will display the yellow card when you have one minute left, and I will display the red card when your time is up. When you see the red card, please wrap us as soon as you can and we will proceed.

With that, we will now go to our first witness, Dr. Kim Lavoie.

Professor, please go ahead. You have seven minutes.

Dr. Kim Lavoie (Professor, Department of Psychology, Université du Québec à Montréal, As an Individual): Thank you very much, Mr. Chair, and thank you so much for the invitation and the opportunity to be here. If I get any formalities wrong, I apologize. This is my first time, but it's a real pleasure to be here.

I'm going to go through each of the questions that were sent to me and respond to them in turn. I will basically be speaking about the results of an ongoing study that I'm leading here in Montreal. It's an international study called iCARE and I'm going to focus primarily on the Canadian data.

I'm going to report on what we've been seeing from the study basically since the outset of the pandemic in late March. We have data currently on 6,000 Canadians through a representative sample, and we have data on over 14,000 Canadians from a convenient sample.

The first question I'm going to address is any sex differences in the mental health impacts among Canadians. An analysis of our data reveals that women appear to be shouldering more of the emotional and behavioural burden of the pandemic, as well as experiencing greater job and income loss. As a result, they may or seem to be experiencing greater negative mental health impacts.

From the start of the pandemic through to the end of November, more women than men believed that adhering to public health measures is very important. This is when I'm speaking about the emotional burden. They also have greater COVID-19-related concerns, whether we're talking about the health impacts to self or others, personal financial impacts of the pandemic and its policies, or socio-economic impacts, for example feeling socially isolated and separated from family.

However, this potentially explains why women appear to be twice as adherent to public health measures or public health policies relative to men. When I'm speaking about the public health measures, I'm speaking about the big ones—handwashing, social distancing, avoiding social gatherings and self-isolating if they have COVID-19. This is what I'm referring to when I speak to the emotional and behavioural burden.

Now I'll speak more directly to the mental health impacts. Between June and November, significantly more women than men reported experiencing severe mental stress. By this I mean anxiety, depression, loneliness and frustration, as well as interpersonal stress. In our study, this was defined as experiencing more verbal and physical fights with family.

Rates are twice as high among women across all of these variables and appear to be getting worse over time. Again, I'll remind you that the period is between June and November. Significantly more women than men have cancelled medical appointments or avoided presenting to the emergency room due to concerns about COVID. After the first wave, more women than men reported losing their job or having their job hours cut.

To give you an example of the absolute percentage differences between men and women, in June 25% of women reported experiencing severe anxiety—and this is in the upper quartile—versus only 12% of men. In November, 27% of women reported experiencing severe anxiety versus 14% of men.

Speaking to how it is impacting various vulnerable groups, the pandemic seems to be exacerbating pre-existing health, mental health and socio-economic disparities across many vulnerable populations. This was evident in our study in June and has persisted or worsened through November.

Young people—I mean the 18-25 group, compared to those over age 25; visible minorities—that is, non-white; and those living under the poverty line, defined as having a total household income of less than $60,000 a year compared to over $60,000, report experiencing significantly more severe mental stress, such as anxiety, depression and loneliness, and higher interpersonal stress, such as verbal and physical fights with family.

To give you a sense of what this is among young people, in June, among those aged 18-25, 31% were in the upper quartile for anxiety, versus 23% of the 25-50 age group and only 10% of the over-50 age group. Across the board, rates of severe mental stress among young people are more than three times those of people over age 50, and it is worsening over time. Significantly more young people, visible minorities and those living under the poverty line also report consuming more drugs and alcohol, and this is again in the upper quartile range.

● (1105)

Significantly more young people, visible minorities and those living under the poverty line have had trouble or reported having trouble accessing non-COVID-related medical care. The same three groups report having lost their jobs, having their job hours cut or losing income and having trouble paying for housing. Again, these are all the upper quartile extremes.

It's unclear how accessible or well adapted mental health services are for these groups, but I suspect there are probably considerable knowledge gaps about what services may be available.

In terms of the next question, the availability of programs that can support mental health services and provide mental health services to people across Canada, what I want to speak about is the survey of psychologists in Quebec. This was run by the Order of Psychologists of Quebec. Across the board, psychologists here have been reporting that their patients are more distressed, that there's more anxiety, more depression, more requests for emergency services and a lot of requests for consultations for drug and alcohol abuse. Seventy per cent have been contacted by former patients, and 34% have increased their hours since the start of the pandemic. However, what I wanted to highlight is that 50% reported being willing to provide emergency services, and it was estimated that 7,000 hours per week could be added to aid the population.

This was done in the context of Quebec, but it brings me to the next question: How could virtual or teletherapy perhaps be leveraged to meet the needs of Canadians? Offering teletherapy options could be done, given the fact that there are so many psychologists in Quebec. We have a high volume of clinical psychologists in Quebec, and maybe we could consider leveraging the availability of these specialists to expand the reach and accessibility of needed services across Canada.

The last thing I want to mention is a program called Wellness Together Canada. This is a federally funded program to provide mental health services to people across the country. In my speaking notes, which I shared with the committee earlier today, I wanted to mention that it's something that I think we could do better at leveraging to get more of these needed services to people across Canada. As it stands, only 10% of Canadians surveyed had any awareness whatsoever that this program existed, so I think we can do a lot better there.

Thank you very much.

● (1110)

The Chair: Thank you, Doctor.

We go now to Dr. Jitender Sareen, physician.

Dr. Sareen, please go ahead for seven minutes.

Dr. Jitender Sareen (Physician, Department of Psychiatry, University of Manitoba, As an Individual): Thank you so much, Chair. It's a pleasure to be here.

Thank you, Dr. Lavoie, for your comments.

I think my comments will build on many of the comments that Dr. Lavoie has mentioned.

I'm a psychiatrist. I'm the department head at the University of Manitoba and provincial specialty lead. What I'm going to present is based on funding from CIHR.

The main summary of what I'm going to say is that we absolutely need a public health approach to manage the mental health sequelae of the COVID-19 pandemic. We need to look at it from universal strategies as well as targeted strategies for our vulnerable groups. As Dr. Lavoie was saying, there are lots of opportunities to enhance our virtual mental health care services, not only for elective services, but especially for our emergent services.

We also need to invest in appropriate infrastructure for isolation in the community for vulnerable groups. Success will only occur where there are strong partnerships among federal, provincial, community and private sectors.

I'm going to tell you the story of a 15-year-old boy living in a rural community in Manitoba who loses a friend suddenly in an accident. He is brought to the nursing station by his grandfather because he is suicidal. He has also been in contact with someone who is COVID-positive. He needs an emergency mental health assessment, but he does not want to travel to Winnipeg for that assessment, which is hundreds of kilometres away. Pre-pandemic and during the pandemic, the person would have to be brought to Winnipeg, stay in the hospital for a few days, and that would increase the risk of COVID transmission. I'm going to come back to the case in a few moments.

The COVID pandemic has impacted all Canadians. During the pandemic, Canadians have had an increase in distress, fear, anxiety, alcohol and drug use. We have to invest in appropriate media campaigns that focus on mental wellness strategies and remind people of the low-risk guidelines for alcohol and substance use. These media campaigns are extremely important to invest in because, as Dr. Lavoie says, people actually don't know some of these important strategies.

We need to improve pathways to accessing care. In Manitoba and other provinces, it is extremely difficult for a person to access mental health care in a timely manner. Whatever we can do to simplify access is going to improve the system.

We need to invest in virtual mental health care using a stepped care approach, using online screening tools, phone supports, and then having people be able to access services virtually, either individual or group therapy, based on measurement-based care. We need to appropriately staff these virtual mental health care resources, and we need to pivot towards measurement-based care so we're actually monitoring people's outcomes as they are going through the treatments.

I want to focus on the crisis in emergent population, which is at high risk. People in crisis often wait for long periods of time in the emergency department for a mental health assessment. Rural sites face greater access barriers for emergency assessment than urban sites, and during the pandemic, fear of acquiring COVID-19 in a hospital may prevent people from getting life-saving treatments.

In Manitoba, we have pivoted towards doing more emergency virtual mental health care. In partnerships with federal, provincial and community partners, we have implemented a pilot where there's a youth telepsychiatry emergent service that provides service across all rural EDs as well as rural first nations. The goal is simply to reduce the transfers of youth for assessment and reduce the need for hospital admissions. Over the last three months, we have already reduced one transfer to Winnipeg per week.

The adult crisis response centre has also transformed the majority of their crisis services for urgent mental health addictions assessment to a virtual platform, and we have also developed virtual wards where people can get daily assessments and supports at home with appropriate supports from their families so we can try to minimize the exposure to COVID.

● (1115)

Our University of Manitoba Ongomiizwin-Health Services has developed COVID rapid response teams that are designed to go into first nations communities to support the community leadership in identifying contact tracing, helping with isolation procedures and helping with rapid point-of-care testing to reduce the spread of COVID-19.

The last important project I'll talk about in Manitoba is the alternate isolation accommodations. We know that people who are exposed to COVID in homeless shelters and cannot isolate appropriately, as well as seniors and health care workers, are at significant risk of spreading COVID. Alternate isolation accommodations in hotels and apartment buildings have been utilized to help with isolation and health supports. Over 800 people in Manitoba have utilized these to reduce the transmission of COVID. The At Home/Chez Soi project that many of you are familiar with uses a harm reduction approach for our homeless population. That approach is also being used in our communities.

I'm going to come back to the story of the 15-year-old boy. He had come to the first nations community, in crisis, with his grandfather. He was exposed to COVID. He got a virtual telehealth assessment from Winnipeg, so he did not have to travel to Winnipeg for an assessment. There was no need for an immediate psychiatric admission. He was able to stay in his home community and be isolated in a hotel for a few days until the test results came back.

I'll end there.

I look forward to the questions.

The Chair: Thank you, Dr. Sareen.

We go now to the Overdose Prevention Society and Sarah Blyth, executive director.

Please go ahead, Ms. Blyth. You have seven minutes.

Ms. Sarah Blyth (Executive Director, Overdose Prevention Society): Thanks a lot for having me today. It's really an honour to be able to speak to you—

The Chair: Ms. Blyth, there's something wrong with your sound. It's very weak.

Can you check to see if the proper mike is selected?

Mr. Don Davies (Vancouver Kingsway, NDP): Mr. Chair, if I may, I can hear her fine. I'm wondering if the problem might be your headset, because she is coming across very strong and clear.

● (1120)

Hon. Michelle Rempel Garner (Calgary Nose Hill, CPC): I can hear her perfectly as well.

The Chair: Maybe it's just me.

Please go ahead, and while you speak, I'm going to check to make sure all my cables are plugged in properly.

Please go ahead for seven minutes.

Ms. Sarah Blyth: Thank you so much.

My name is Sarah Blyth. I'm representing the Overdose Prevention Society. We opened an emergency safe injection site in order to deal with the emergence of overdoses in the Downtown Eastside and all of the deaths that were happening in 2014.

We see up to 700 people daily in the Downtown Eastside. The OPS in the Downtown Eastside have collectively saved 6,000 lives in the past four years. Unfortunately, the drug supply continues to get more contaminated, and that contamination has spread across Canada. Overdose prevention saves lives in emergency situations, but in order to save lives we need to take immediate action or more people will die.

COVID has only complicated the situation. We are telling people to stay home, but more drug users are dying of overdoses than of COVID. In order to keep people home, we need to give them a safe supply, something that they're not buying from drug dealers on the street. It's something that doctors can prescribe so that they are not dying in their housing alone, so that they can stay home and so that they don't come out of hospitals. We've had a lot of people go into hospitals, then hotels, and then come right back out to the street with COVID to look for drugs because they're not getting what they need. It's just further causing harm and a difficult situation.

The overdose prevention site has become sort of a one-stop-shop for everything because of COVID. A lot of services have closed down. For any person who is homeless and using drugs, they come to us for housing support. We help people get housing. Once a week we usually get someone housing, though I have to say that there isn't really any housing right now. It's a very difficult situation. It's also really hard to go home at the end of the night and have people stay out in the cold, so we do what we can. Working on the front lines, as you can imagine, is very challenging right now.

We provide medical support. We deal with helping to clean wounds, provide wound care and all kinds of things. We also deal with mental health support. A lot of times people go in to get their mental health support from the hospital, but then they have to leave an hour later. It's the same with medical support. Usually they come to us, and we do our best to help people, but we're one of the only places. We distribute information. A lot of people don't have cellphones or television access.

We now distribute clothing, food, blankets and mats to sleep outside at night. We do pretty much everything as an overdose prevention site. I just wanted you all to know this because I think it's pretty important to know what these front-line services are doing and how much we're taking on due to other services shutting down.

I'm just going to tell you what we need from the federal government. We really need some sort of a national housing plan that would take immediate action. We need housing, and right now I can't get people into housing no matter how hard I try. Because I'm on the front line with people, I spend a lot of my time side by side with people who are crying, who are sleeping outside and who are getting sick needlessly.

We also need support. The City of Vancouver and council have passed a motion regarding decriminalization, and they need support. They understand the challenges. I really believe that the city council that we have, with Mayor Kennedy Stewart, understands the challenges that we're facing. We really need to—

● (1125)

The Chair: Pardon me, Ms. Blyth.

The clerk has informed me that your mike is just a little too close. It makes popping noises.

Could you move it away?

Ms. Sarah Blyth: Oh, I'm sorry, guys.

Is it better now?

The Chair: I'm not a judge, because I've had potential issues, but let's try that.

Ms. Sarah Blyth: Okay.

Mainly, it's just getting support for the City of Vancouver. I'm sure cities across Canada are facing this with COVID, especially since a lot of people who were near homeless used to be able to stay at other people's houses. Now, there is no way to have visitors, especially in social housing in the Downtown Eastside. There are hundreds of people who are out on the street who didn't use to be, so we're facing a really serious situation here and [*Technical difficulty—Editor*].

We really need safe supply. We need people to be able to stay home. All of these things may seem controversial, but really, in the end, if you do the right thing, you're going to save lives, and you're going to be proud of that in the work you do. You're going to make some big changes, and other parts of the world are looking at us to see what we do in these situations.

We can be proud of what we do, or we can let things on the overdose crisis stay as they are, and not be able to sleep at night. I don't know how people can sleep at night with so many people dying. You guys can do something about it, so we're asking you to help us.

It's desperate. I've come to the last one, where we weren't as desperate, but now we're really desperate. I am desperate. I am out on the streets helping people all day. It's every day. A lot of people aren't even social distancing or anything, because they have so many more problems than just COVID—housing, health care, all those things.

We can do a lot in many simple ways. I am willing to help. If any of you want to meet with me to try to come up with a plan, I am willing to do that. I am willing to be part of the solution. You can contact me.

That's basically it. We need your help. I think you can help us, so I am putting it out there that I am willing to be part of that.

Thank you.

The Chair: Thank you, Ms. Blyth.

We'll start our rounds of questions. I believe we will have time for one round of questions.

We will start with Mr. Barlow.

Mr. John Barlow (Foothills, CPC): Thank you very much, Mr. Chair.

I want to thank every one of our witnesses for their honest testimony and for painting us a pretty bleak picture of the state of Canadians' mental health as a result of COVID.

Dr. Lavoie, you were saying that only about 10% of Canadians know about a program. I missed the first part of that. Can you tell me which program you were talking about? It was near the end of your presentation.

Dr. Kim Lavoie: It's called Wellness Together Canada, and it's a very well-funded federal program that's been in place since the end of the summer. In my speaking notes, which I gave to Mr. Pagé, I provided the web link.

Mr. John Barlow: I know the program.

Dr. Kim Lavoie: I just got it from a collaborator on our study, and he provided some information about the user statistics and things so far in the first few months of the rollout. One of the most startling things was just how few people were really aware of it. There is a lot of money that's already been pumped into this online program, so there is still a lot to be done to promote it and make it available to those people who need it.

I do want to add one other thing—coming back to something Dr. Sareen said, which is really important—which is the idea of providing stepped care. This kind of online Wellness Together program would be good for a lot of people who are having trouble coping, who are having a new onset or an increase in anxiety or depression or feeling isolated. However, there is a difference between providing care to those who might have an exacerbation of a pre-existing psychopathology—those who might have mood and anxiety disorders that may or may not have been well treated pre-pandemic, and what kinds of services those folks need—versus those who are developing new psychopathology, that is, clinical levels of anxiety and depression, and who can't get services, versus those who are just more stressed out and having trouble coping with day-to-day life.

This kind of stepped care idea is really important. I think we need to make sure that.... Some of these counselling-type online programs might not be suitable for those with more severe psychopathology. I'd be interested to hear more from Dr. Sareen, but I just wanted to clarify that.

● (1130)

Mr. John Barlow: Sure. I appreciate that.

With that in mind, with regard to the Wellness Together program and with so few Canadians knowing about it.... The United States put in its 988 program as a suicide helpline. It has received a lot of publicity, and most people know about it.

Would something like that work here in Canada? We don't have anything along that line, but it just seems like everybody knows 911, so 988 would be that gateway, let's say, if you were in a mental health stressful situation. Would a program like that help as something that would be easily recognizable and that everyone would be able to get? Maybe it could be an introduction to the Wellness Together program.

Dr. Kim Lavoie: Absolutely. I think anything that has quick brand recognition.... Everybody knows what to do and where to go, and then the program will direct you to the services that you need as a function of your initial assessment. Absolutely, that would be a fantastic idea.

Mr. John Barlow: It's my understanding that, with the program we have now, it's different in every region, and it's just an answering machine. I don't think that, in this crisis situation, what anyone wants to hear in an emergency situation is “Please call back” or “Leave your name and number”.

Dr. Kim Lavoie: Absolutely.

Mr. John Barlow: We saw the results from the Canadian Mental Health Association survey that came out on Thursday or Friday, and the numbers were quite staggering.

The one that really caught my attention—and, Dr. Lavoie, you mentioned it briefly at the beginning of your presentation—was the impact that COVID has had on women. The number, I think, was that close to 13%—off the top of my head—of parents are now scared of domestic violence in some way.

Is that a significant increase from what you would traditionally see? Has COVID caused that much of a sharp rise in that issue?

Dr. Kim Lavoie: Yes, and I think it's also one of the reasons why we're seeing a huge increase in the number of separations and divorces. You can just imagine how stressful a divorce is in normal times; imagine trying to work out separating, finding a new home, and child custody. It's absolutely shocking how much separation and divorce is happening.

I think it is really being fuelled by the fact that a lot of couples, who are used to a certain balance in their relationship, are now being thrown together, spending 24 hours a day together. All the gender roles are getting mixed up. You have moms and dads at home with kids who might be doing online learning. Certainly, there are the effects of the widespread lockdown that happened more in the first wave.

All of that is to say that I would suspect that it's probably more than 13%, because I would suspect that those who are probably experiencing it the most and the worst are not the ones who have the time or the luxury to respond to some of these surveys, so I—

Mr. John Barlow: I'm sorry, Dr. Lavoie. I only have a few seconds left, and I just want to ask a quick question of Dr. Sareen.

You were talking about access to psychiatric help and accessing the resources we have there. Would that 988 number work on that? Would that be a way, as well, to have those professionals be working as part of that program as a first step for Canadians to access that type of assistance?

Dr. Jitender Sareen: Absolutely.

I think the 988 approach is excellent, but having the next steps is really important at the provincial level.

In China, they also implemented online screening so that you can have.... We're used to ordering food online. We should be able to do some level of online because the volumes are just going to be out of control. You can't build a system that has enough people on the phone. You have to integrate it with online self-assessment, self-screening tools, and then have the next pathways to care after the assessments. They have to be integrated, or people will not show up to the line because they'll say, “Well, you know, I didn't get an answer” or—

Mr. John Barlow: Or “I'm scared to go the hospital because of COVID....”

Thank you very much. I appreciate it.

The Chair: Thank you, Mr. Barlow.

We go now to Mr. Van Bynen.

I understand that Mr. Van Bynen will be splitting his time with Mr. Kelloway. I will show you the yellow card at three minutes.

Go ahead. You have six minutes.

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Thank you, Mr. Chair. I will be splitting my time with Mr. Kelloway.

I'd also like to say thank you to our witnesses for joining us today and for sharing their perspectives and expertise on what I believe is an incredibly important topic.

Dr. Lavoie, I was a bit taken aback by the fact that only 10% of the population is aware of the Wellness Together website. When I see that 680,000 Canadians have already used the service, with close to 1.8 million separate web sessions, it really does give me an important scope and a scale of the crisis we're faced with, so I appreciate your bringing that forward. We need to find ways to make sure that more people are aware of that program.

I will be asking Dr. Sareen my question.

Dr. Sareen, since the beginning of the pandemic, it has become clear that COVID-19 impacts certain communities disproportionately and that race, gender and socio-economic status are some of the factors that can amplify these impacts. Based on your experience with first nations communities, could you please share with the committee some of the mental health effects and challenges that indigenous peoples are facing as a result of the pandemic?

● (1135)

Dr. Jitender Sareen: Some of the key things are what every Canadian is facing, which are fear, anxiety and stress. The additional barriers, if people are living in on-reserve communities, are poor access to sites in urban settings, and stigma if somebody has had COVID. Right now, we know that having COVID increases the stigma for all people who have had COVID. There is more stigma and there is discrimination that can also be faced.

Coming back to Dr. Lavoie's point, I think many people are scared to get care for chronic health conditions unrelated to COVID, and that can also have a major impact as far as mortality goes. We know that our first nation communities have significant health disparities. People are less likely to come for appropriate care. We have the tools to be able to provide telephone or video conferencing assessments, and we really need to do this so that people can feel safe to access care in their home communities.

Mr. Tony Van Bynen: Thank you.

When you appeared before the committee in 2017, you mentioned that you were working with a team of researchers who were examining the impact of trauma and PTSD among Canadians. The current COVID-19 pandemic has taken a physical and emotional toll on many people in Canada and across the globe, particularly on our health care workers and first responders, whose jobs during this pandemic have been essential but also more demanding and emotionally draining than usual.

Do we currently have any research that shows the impact of the pandemic on their mental health, and what can be done to support those on the front lines?

Dr. Jitender Sareen: There are groups that are working on understanding the health impacts. We know that health care workers, as well as first responders, are at a higher risk of developing mental health difficulties because of their daily stress, as well as seeing the traumatic events. There is work that is being done to look at those interventions.

In Manitoba, we have also developed prevention trials, where we are providing a randomized trial to look at cognitive behaviour therapy to reduce depression and PTSD among well public safety personnel. That's a trial that we've been doing because it's really important to try to prevent mental health difficulties in our population.

The Chair: Thank you.

Mr. Tony Van Bynen: Have I hit my three minutes, Mr. Chair?

The Chair: You're well over.

Mr. Kelloway, you have a minute and a half.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thank you, Mr. Chair.

Thank you to the witnesses for being here today and to MP Van Bynen for his advocacy and leadership on the mental health supports for Canadians.

Dr. Sareen, my question is for you. About a month ago, our government announced the rapid housing initiative. That's a program of $1 billion to help address urgent housing needs for vulnerable Canadians. Given your expertise with vulnerable populations, I'm wondering if you can speak to the importance of a housing initiative like this and how it will address mental health needs for Canadians, especially on our path to a COVID-19 recovery.

● (1140)

Dr. Jitender Sareen: Yes. I think we know, as Ms. Blyth mentioned, that housing is extremely important in terms of helping our people with severe mental illness. I was involved with the At Home/Chez Soi project, which really showed that providing housing, along with harm reduction approaches and mental health supports, is extremely important.

The alternate isolation accommodation in Manitoba, led by Sharon Kuropatwa, is really based on exactly that model. People who are being tested for COVID or who are COVID-positive and are homeless have difficulty being able to isolate, and we need to provide them appropriate supports. I think housing is a major issue. As Ms. Blyth said, that's the biggest challenge for our most vulnerable Canadians.

We could do a lot around virtual mental health care. I always say that in Winnipeg we don't spend a lot on PPE in mental health. If governments can support virtual care platforms, appropriate electronic health records and appropriate outcomes, we would save a lot of PPE and people would get care at home. Housing is extremely important in being able to support people in their own homes. Otherwise, they're going to be coming to the emergency rooms. They're going to have negative sequelae.

Mr. Mike Kelloway: Thank you.

The Chair: Thank you, Mr. Kelloway.

[*Translation*]

Now it's your turn, Mr. Thériault.

Go ahead for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you, Mr. Chair.

I wanted to thank all the witnesses for contributing to our understanding of the mental health impact of this pandemic.

I'll start with a brief comment.

Ms. Blyth, I'd like to express my gratitude and admiration for the harm reduction work you're doing on the ground despite very limited resources. We see that mental health problems and mental illness aren't a recent phenomenon, according to Dr. Lavoie's studies and the many interviews she has given. Her contribution during the pandemic has been remarkable.

Prevention, first and foremost, is the key to improvement. It's also the primary determinant of health in general, but one would think mental health has always been the poor cousin of health systems. The pandemic has had a mirror effect, putting this reality squarely in our face and making it seem worse.

What are we to do about that? We have Dr. Lavoie's compelling data. However, I'd like to take this a little further. We'll have to make decisions as legislators.

Dr. Lavoie, based on your experience, why do you think psychotherapy isn't universally available? Why is it that investing in mental health and mental health promotion isn't considered necessary, when we know very well that mental disorders can cause physical disorders and chronic diseases such as cardiovascular diseases, obesity and so on?

What, in your view, are the reasons why that investment hasn't been made, and is it a mistake to continue underinvesting in mental health prevention?

Dr. Kim Lavoie: Thank you very much for your question.

[*English*]

I'm going to speak in English, because I said I would. I hope that's okay. It's weird whenever I'm addressing someone in French, but I can speak in French as well. I just want to make sure it's okay with the translator.

The main reason is the availability of funds and, to some degree, bias that still exists in medicine that a lot of mental health is in your head and doesn't affect the body. There's a disconnect there, but by and large, it's something we've been struggling with for years.

I'm a clinical psychologist. One thing that still exists to this day—and there's a particular problem in Quebec—is that we have a lot of interns, who are the equivalent of medical residents, who do not get paid for their psychology internships, which is not the case in other provinces. The only explanation I can really give you is that it hasn't been prioritized all this time. It has certainly been deprioritized when you look at the funding set aside for mental health services, and I think more needs to be done.

As someone said earlier, this pandemic has only accentuated the disparities and the gaps in the available services for people who need them in terms of mental health services.

I couldn't agree with you more. It's great to have great physical health, but without mental health.... I'm sure everyone would agree that it's the primary reason a lot of people actually consult their doctors. They don't feel good; they aren't sleeping and they can't function in daily life.

I don't have anything more than that we're dealing with a history of bias and a history of deprioritizing mental over physical health. Definitely, more needs to be done.

● (1145)

[*Translation*]

The Chair: If you want to speak French, please do. We have good interpreters.

We are listening, Mr. Thériault.

Mr. Luc Thériault: Mr. Chair, would you please tell me how much time I have left?

The Chair: You have a minute and a half.

Mr. Luc Thériault: You said the message has to be much clearer, more perceptible and comprehensible, for measures to be appropriate, effective and efficient. There are differences in the way the age groups comply with health measures.

What might be an effective message to send to people both over and under 25 years of age?

Based on past experience, people will definitely let their guard down as the holidays approach.

Dr. Kim Lavoie: That's an excellent question.

It reminds us that people don't comply with health restrictions for the same reasons. What concerns young people doesn't concern older people. Young people are asked to make greater sacrifices than the ones I'm asked to make.

Telling young people not to go to university, not to see their friends and not to go out with boys or girls at this time in their lives is a lot to ask. You have to understand what motivates people and what young people's concerns are. We need a specific approach and messages targeting those people to make them understand that, if they comply with health restrictions, their social lives, university and jobs will all come back.

I think what they hear focuses too much on protecting the health of their families, the elderly and the sick. That doesn't resonate with young people. The message needs to be changed.

The Chair: Thank you, Mr. Thériault.

[*English*]

Mr. Davies, please go ahead for six minutes.

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

Thank you to all the witnesses for their testimony.

I also want to add my voice to Mr. Thériault's, to Sarah Blyth in particular, for the outstanding work she does every day with very limited circumstances and in trying conditions. I know you're saving lives, and that's an astounding statistic that your overdose prevention site has saved 6,000 lives in four years.

I'm going to direct my questions to you, Ms. Blyth. I think you mentioned that you've been in operation since 2014. Do I have that correct?

Ms. Sarah Blyth: Yes, you do.

Mr. Don Davies: I'm a big believer that the social determinants of health—having access to secure, affordable housing, basic income, nutritious food, etc.—are very important components to overall physical and mental health.

My first question is about housing. Have you seen any significant increase in federally funded affordable housing since 2014?

● (1150)

Ms. Sarah Blyth: No, I have not. There are so many empty buildings on our block. I think there are about 800 units that were formerly available with the region—with The Balmoral, with The Stanley, at 58 West—that are now gone.

Also there's the fact that people generally stay with each other. A lot of people in social housing will have a guest who is homeless come and stay with them. They help each other. But now, because of COVID, people aren't doing that and sometimes aren't allowed to do that. It makes it more difficult.

Mr. Don Davies: Right.

In terms of your overdose prevention site facility, has the federal government provided any funding or other resources to assist in the work that the OPS is doing?

Ms. Sarah Blyth: We haven't received any money for our site.

Mr. Don Davies: Has the federal government provided any resources to support the mental health and well-being of you and other harm reduction workers that you are aware of, either in Vancouver or anywhere else?

Ms. Sarah Blyth: No, we haven't had any support; we're pretty much on our own. To be honest, it's very challenging because we just know we have to go on and there's no choice. We don't think about our mental health, really, unfortunately.

Mr. Don Davies: I know that dealing with the trauma that you're dealing with on the street is equally as affecting for those who are working as for those who are suffering. I think it's a community trauma we all experience.

Ms. Blyth, have you seen an increase in the number of people who are using drugs alone since the outbreak of COVID?

Ms. Sarah Blyth: Yes. We've definitely seen people.... At the very beginning, a lot of people stayed home. They're starting to come back out again, just because the numbers are so high in overdoses compared to COVID deaths. I haven't heard of anyone dying of COVID in the Downtown Eastside—well, maybe a few people.

However, there are hundreds of people—thousands of people—who have died of overdoses, so we're trying to make sure that message gets across to drug users that actually you're more likely to die of an overdose than you are of COVID, and that using together in a safe manner, and teaching people how to use in a safe manner, is really important.

We saw that with the—

Mr. Don Davies: I'm going to end with—

Ms. Sarah Blyth: Go ahead.

Mr. Don Davies: I'm going to end with a three-part question and let you answer.

You referred to the toxic street supply, and I think you mentioned Vancouver city council. Here's my three-part question. Why has the illicit drug supply become increasingly toxic during the COVID pandemic? How important is it that we decriminalize all of these drugs so that people don't have to get their drugs from organized crime on the street? Finally, do you have any advice to the federal government about the request from the Vancouver city council to issue a section 56 exemption to allow the decriminalization of possession of all drugs in Vancouver?

Ms. Sarah Blyth: I think that right now we have to do something really serious in order to stop these deaths. Really, if we don't, people will continue to die.

The drug users and community groups—people who are on the front lines—have all come together and said that decriminalization is one of the things that are really going to save lives. It's now up to you to make those changes with section 56. I think if you make those changes, you're going to be changing the way we do things, which will actually save lives and make a huge difference in what happens in the future.

I think, again, that if we don't do something significant, people are going to continue to die. Really, you may not see it yourself, but I see it with parents every day. I have mothers and family members contacting me every day with their relatives dying.

Decriminalization is something significant, as is safe supply. Getting people something that's not going to kill them is hugely significant, especially with COVID. The contamination is way worse, because they're not getting the drugs they used to, which were brought into Canada. Now they're just using whatever is under the kitchen sink, and if doesn't kill them, it damages them and could cause long-term health problems and mental health problems that are going to cause more problems in the health care system. Long-term costs are going to be huge.

I think we can do a lot to change things.

I'm sorry. I think we're out of time here, and I'm sorry if I didn't answer all the questions.

● (1155)

The Chair: Thank you, Mr. Davies.

That does wrap up our questions.

I want to thank the witnesses, all of you, for sharing your time with us today and for sharing your expertise and your knowledge. I wish everyone well going forward.

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

We are suspended.

● (1155)

_____________________(Pause)_____________________

● (1155)

The Chair: We will now resume the meeting.

Welcome, everyone. We are continuing meeting 12 of the House of Commons Standing Committee on Health. We are meeting today to study the mental health aspects of the emergency situation facing Canadians in light of the second wave of the COVID-19 pandemic.

I'd like to thank all the witnesses for appearing today. You will have seven minutes for your presentations.

I'll go over a few housekeeping items. You may certainly speak in the official language of your choice. Interpretation services are available for this meeting. You have the choice, at the bottom of the screen, of floor, English or French. Before speaking, click on the microphone icon to activate your own microphone. When you are finished speaking, please put your microphone on mute to minimize any interference.

Just as a reminder, all comments by members and witnesses should be addressed through the chair. 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.

For this hour's panel we have, as an individual, Dr. Nick Kates, chair of the Department of Psychiatry and Behavioural Neurosciences at McMaster University; from the British Columbia Teachers' Federation, Teri Mooring, president; and from the Canadian Association for Long Term Care, Jason Lee, treasurer.

Thank you, all.

Dr. Kates, we will start with you. Please go ahead. You have seven minutes.

● (1200)

Dr. Nick Kates (Chair, Department of Psychiatry and Behavioural Neurosciences, McMaster University, As an Individual): Thank you very much, Mr. Chair.

I speak today as a psychiatrist as well as chair of an academic department. COVID-19's second wave is posing some different challenges from wave one for the mental health and well-being of Canadians who are already feeling tired, frustrated, angry, scared, depressed or anxious. It is placing additional demands on health and mental health systems that are already having difficulty coping and where demand outstrips the available supply.

While we are better prepared for wave two and have learned much that has helped us to lay a foundation for what lies ahead, including our rapid adoption of virtual care, many Canadians are tired. The longer the pandemic and the isolation, distancing, lockdowns and uncertainty continue, the more the symptoms of stress become anxiety and the losses lead to depression.

The Chair: Pardon me, Dr. Kates.

I wonder if you could lift your microphone a little bit. We're getting popping noises.

Dr. Nick Kates: Sure. Is that any better?

The Chair: Let me hear what Peter Piper picked.

Dr. Nick Kates: Peter Piper picked a peck of pickled peppers.

The Chair: To my ears, that's perfect. Thank you.

Please go ahead.

Dr. Nick Kates: It has created stress in many areas of our life, and we have experienced multiple losses, including of loved ones under circumstances that have made grieving more difficult. It has changed our family and social relationships and social cohesiveness, led to a deterioration of pre-existing mental health problems and led to worries about our physical, emotional, financial and social future well-being. There are also some specific syndromes that have been identified, such as lockdown fatigue, COVID anxiety, COVID insomnia and, in a different context, Zoom fatigue.

For some, these have been transient and we have adjusted and moved on, but almost 50% of us are reporting significant changes in our mental health. For many, they have led to clinical symptoms of depression, anxiety and even suicidal ideation, while pre-existing mental health and addiction problems have worsened.

Of particular concern has been the impact of the trauma experienced by so many Canadians in many different walks of life, including the moral injury from being forced to make decisions that are incompatible with one's values, beliefs or culture. These have often been exacerbated by pre-existing inequities in income, housing, education, employment and work conditions, history and culture, race or ethnicity, family situations or stigma, and it is the overlap of these factors, often referred to as intersectionality, that further increases the risk of developing mental health and addiction problems. This happens at a time when the pandemic has exposed gaps in our existing mental health services and reduced access to many supports.

It has affected different populations in different ways. First nations, Inuit and Métis communities face particular challenges, often resulting from pre-existing inequities such as inadequate housing, lack of services, lack of public health infrastructure or existing mental health services, geographic isolation and stigma. Members of racialized communities are also likely to experience additional issues because of systemic racism or bias.

Children may be at particular risk as they may be dealing with anxiety about going to school, making a relative ill, loss of contact with their friends or valued family members. We've seen child maltreatment rates increase. One of the greater long-term concerns is that adversity in childhood increases the likelihood of physical and mental health problems in later life and highlights the importance of early years interventions.

Young adults are likely to be struggling with limitations based on social activities and often feeling like their future has been put on hold or even taken away. Seniors, whether living in congregate living situations or living on their own, are showing increased cognitive decline and increased symptoms of depression and anxiety only highlighted by the isolation and concerns about going out.

We've witnessed an increase in alcohol, cannabis and other drug consumption, as well as opiate-related deaths, and in compulsive gambling. Other populations are at risk: those who've lost their jobs, because we know the psychological impacts of unemployment; those who are homeless, already dealing with multiple social and economic challenges; and individuals living with significant psychiatric and physical disabilities, like autism spectrum disorders, and their families. Services and supports have been closed. Access to treatment is more difficult and in-house supports have often ended.

In terms of the impact of gender, we're seeing an increase in intimate partner violence, perhaps inevitable when individuals often living in dysfunctional relationships are on top of each other 24 hours a day without the normal outlets of social activities, and this is often fuelled by increased access to alcohol. A second gender-related issue is increased child care demands, where the bulk of responsibilities still fall to the mother. Many working parents are anxious about children being back at school, but even more so about what might happen if the schools were to close.

The evidence also suggests that in terms of virtual care, whether by video, audio, email or even text, both providers and patients find it more convenient with equally good outcomes, but we need to remember that many individuals still don't have access to computers or even phones, and we also need to identify for which clinical situations and populations and for which therapies virtual care is superior to face-to-face.

● (1205)

When we look at how we respond to these unprecedented demands, while there is no single situation, we are looking at common approaches that could benefit all. We need to think about smaller changes, which could be introduced more easily, and also about targeting our interventions at particular populations.

I have divided my suggestions into three areas.

The first are services and supports for individuals and families. First, we need to strengthen our existing mental health systems. Ways to do this would include developing a plan in conjunction with the provinces and territories that outlines shared purpose, guidelines and goals to guide the work taking place across the country; gathering data on the current needs to inform future service priorities; developing a mechanism to share ideas that are working in different parts of the country that could be adapted or adopted elsewhere; and continuing and formalizing billing codes for virtual care.

There is also going to be a need for existing resources to support targeted interventions. We need to adapt our models of care to respond to the current challenges with a focus on early recognition and also on prevention and proactive screening. For example, in primary care, family physicians could be calling seniors to find out how they are doing and identify those who may be at greater risk. We need to emphasize shorter-term care—including single-session treatments—a wide range of treatments for PTSD, and system navigation.

We need to build new partnerships across the system, with our systems working more closely together to pool their resources and support one another, and we need to better support self-care and management by providing resources and assistance for individuals to better look after their own well-being. This can include access to interactive or curated educational resources, developing a list of most useful sites for providers, developing accessible guides and blogs about specific—

The Chair: Dr. Kates, could you wrap up, please?

Dr. Nick Kates: Sure.

There are two last points I would like to highlight. One is the importance of expanding the capacity of our mental health system by increasing training for front-line providers, expanding the role of primary care and also providing peer support, looking at the model that is currently being piloted for the RCMP.

The other is to continue to address systemic and socio-economic changes, inequities, systemic barriers and stigma. We need to provide additional supports for families and children, maintain income for low-income Canadians while the pandemic affects their work, and expand access to high-speed broadband to remote or isolated communities.

I thank you for your time.

● (1210)

The Chair: Thank you, Doctor.

We go now to Ms. Mooring, president of the British Columbia Teachers' Federation.

Please go ahead, Ms. Mooring, for seven minutes.

Ms. Teri Mooring (President, British Columbia Teachers' Federation): Thank you, Mr. Chair.

Thank you for the opportunity to speak with you today on the issue of safeguarding teachers' mental health through the second wave of COVID-19.

I'd like to begin by acknowledging that I am speaking to you from the traditional ancestral and unceded territory of the Coast Salish peoples, specifically the Squamish, Tsleil-Waututh and Musqueam nations.

I represent the 45,000 members of the British Columbia Teachers' Federation, all the public school teachers from kindergarten to grade 12 and adult educators. Our challenges and concerns are not unique. They are echoed by teachers from coast to coast to coast.

As a member of the Canadian Teachers' Federation, the BCTF, alongside other teachers' unions from across the country, acknowledge and appreciate the critical work of teachers and education workers across Canada, who continue to exemplify essential front-line service and professionalism during this critical and difficult time in our collective history.

While the mental health of teachers and indeed everyone in Canada has been dealt a serious blow by the coronavirus, these problems far predate the pandemic for Canadian teachers. Increasingly difficult working conditions have been straining teachers' mental health and resilience for decades. At the same time, we are also witnessing rising rates of mental health challenges among our students, and this is truly heartbreaking.

As public education budgets have declined in the past two decades, public expectations of our school systems have risen. As education is an essential part of long-term solutions to many of society's challenges, including the raising up of Canada's next generation of leaders and citizens, such expectations are understandable.

One of our favourite BCTF slogans is “Kids matter. Teachers care.” That really is at the heart of why we are called to the profession. Kids do matter enormously, and we do care deeply. Teachers and schools are only one element of what must be a collective social effort to support young people's diverse aspirations and needs. Strong and focused federal leadership, coordination and resources must be a part of this national endeavour.

When schools were closed in B.C. on March 17, teachers had less than two weeks to respond to the enormous challenge of transferring their classroom practices and skills to online remote learning. Adding to their stress was the knowledge of the toll the pandemic was taking on our most vulnerable students. The digital divide, food and housing insecurity, family violence, racism and other traumatic experiences limited or completely diminished some students' ability to truly access their education.

In B.C. we've returned to full in-class learning. Our research shows that the inadequate implementation of health and safety measures is taking a critical toll on teachers' physical and mental health. “I feel scared, isolated, lonely and very sad”, said one teacher in a BCTF survey conducted this fall. Another stated, “The stakes now are just so much here—I can't protect my kids from a potentially life-altering disease.” These are among the deeply concerning words expressed by teachers regarding their current mental state.

It's also important that we recognize gender inequality at play in a feminized profession. More than 70% of public school teachers in Canada identify as women. The emotional labour of caring for their students as well as their own children while also often providing eldercare for family members is an extra burden shouldered disproportionately by women teachers during this pandemic.

What actions can the federal government take to reduce teachers' distress and support them in their critical roles as front-line and essential professionals? Our members told us that consultation, communication and co-operation are key. Teachers feel less vulnerable to mental and physical risk when a critical majority within their school community understand and abide by health and safety protocols and when those protocols are deemed to be adequate.

I refer you, Mr. Chair, to the recommendations in our brief. They outline the ways the federal government may catalyze informed, constructive, transparent improvements and collaboration regarding teachers' mental health.

The $2 billion in federal funding provided to provinces and territories was appreciated and necessary to ensure basic school safety protections. Unfortunately, it wasn't enough to allow schools to reduce classroom density to facilitate physical distancing. There also need to be measures in place to ensure that federal funds are used to directly improve the safety of classrooms. More needs to be done when we are witnessing the COVID-19 cases in B.C. and many other jurisdictions continue to rise unchecked.

● (1215)

Another stressor for teachers is their economic stability. Teachers who have been exposed to the virus and are required to isolate use up their entire allotment of sick leave for the year. With many teachers already running out of sick leave, the federal benefit, as is, is inadequate, as it necessitates too large a reduction in pay for teachers who already live in one of the most expensive jurisdictions in Canada.

Additionally, for the most precarious workers, teachers teaching on call or replacement teachers, who can potentially work with hundreds of students across many schools every single week, there is no contractual sick leave. Teachers should not have to choose between their health and their ability to make a liveable income.

To conclude, COVID-19 has put into stark relief what happens when the mandates of austerity and efficiency meet a national crisis. B.C.'s public education system, like others across Canada, has endured deep cuts and chronic underfunding for decades.

This struggle is the backdrop to our current reality. It's also a primary reason Canada still enjoys an envied position as one of the best education jurisdictions in the world—our commitment to high levels of professionalism and expertise, and to equitable access to high-quality education for every student in every constituency, in every community.

Thank you again for the opportunity to share the experiences, perspectives and counsel of B.C.'s public school teachers.

The Chair: Thank you, Ms. Mooring.

We will now go to the Canadian Association for Long Term Care and Jason Lee, treasurer.

Please go ahead. You have seven minutes.

Mr. Jason Lee (Treasurer, Canadian Association for Long Term Care): Thank you, Mr. Chairman.

Members of the committee, I want to thank you for inviting CALTC to appear again before you today to discuss seniors living in long-term care and the supports that residents require to protect their mental health.

My name is Jason Lee and I'm here today as the treasurer of the Canadian Association for Long Term Care, also known as CALTC.

As the leading voice for quality long-term care in Canada, our members advocate on behalf of our residents at the federal level to ensure seniors can age and live with dignity.

Our conversation today is focused on mental health. This has no doubt been an extraordinarily difficult and painful time for everyone involved, including residents, their families, front-line staff and those who operate long-term care homes. In my limited time, I want to focus specifically on residents' mental health. If needed, I am happy to come back to the committee with more information on the effects of COVID-19 on mental health in families and staff.

Studies have shown that social isolation has a negative impact on health, especially in seniors, and that this increases the overall cost of our health care system. Moreover, social isolation in the senior population can even occur in care homes where there's an abundance of residents and staff. We know that those who are more connected with their families and friends lead longer, happier and healthier lives. COVID-19 has presented unique hurdles in residents' mental health, as physical isolation is required in outbreak situations.

Since the beginning of the pandemic, governments, public health officials and the long-term care and continuing care sectors have faced challenges that are not only unprecedented, but also ethically and emotionally complex. Perhaps the most significant has been the issue of family visits.

Family members or close companions are a vital part of the care team within long-term care and are crucial to the residents' experiences. When visitations were restricted earlier in the year, many residents experienced an impact on their overall quality of life, despite the best efforts of staff. While such restrictions were and still are necessary for keeping residents and staff safe, we also understand how important it is to be physically and emotionally close to those who are important to us, particularly as we age.

Staff in homes across the nation have been nimble, innovative and dedicated in trying to connect families with their loved ones with the use of phones, technology and other measures to protect their communications.

While directions for families and other visitors vary across the country, depending on the rate of COVID-19 in the community, many of the new approaches to connecting residents and their families during this turbulent time require new and updated technology, enhanced use of personal protective equipment, upgrades to home infrastructure and additional staff to ensure safe visits.

This is why CALTC called on the federal government in September for immediate and stable funding in the amount of $2.1 billion over two years to cover personal protective equipment, staffing and other costs associated with COVID-19. I would like to acknowledge and thank the federal government for investing the first $1 billion of that ask through the safe long-term care fund just last week.

However, mental health challenges in long-term care, like other challenges exposed through the coronavirus, are not unique to this moment. Further long-term care investments are required to support structural changes that bring the infrastructure and training that homes and staff need to provide the level and type of care seniors deserve.

Specifically, investments need to be made in the retrofitting and rebuilding of new long-term care homes to create environments that live up to modern design standards, especially with respect to residents living with Alzheimer's disease and other forms of dementia.

● (1220)

Additionally, a vital component of success in the provision of health care, from individual care plans to facility operations to government policy direction, depends on having the best information available that has been collected at the point of care. This is true for long-term care. Facility-level data that is comparable and shared across Canada can support policy-makers and health practitioners in improving the quality of care, and therefore the quality of life for long-term care residents.

Finally, it is time to modernize the Canada health transfer to include dedicated demographic top-up that reflects the increased costs of aging populations. We can only hope to appropriately address mental health for residents through the appropriate funding of all aspects of their home life and their care, and there is a role for the federal government in ensuring access to the appropriate mental health supports.

In closing, we cannot pretend that mental health care is somehow separate from other types of care received in homes, or even separate from other challenges the sector faces. It's easy to look at the current situation in long-term care homes across the country and say that long-term care is something to be avoided at all cost. It's easy to discuss and demonize long-term care homes as warehouses for the elderly. This, however, is not the long-term care that we as operators and staff know it to be.

There is not a home in this country that does not see itself as an extended family, one that includes its residents, their families, staff and the community in which they operate. Phrases such as “warehousing” are a real problem in mobilizing much-needed funding and support for the sector.

To truly address the systemic issues in long-term care and ensure that the effects of COVID-19 don't happen again, we need to stop discussing long-term care as a last resort for seniors and start thinking instead of how we can make the last years of someone's life vibrant and comfortable. How can we invest in long-term care homes, communities and wraparound seniors services to ensure that seniors who come into a care environment feel as though they are making a new home?

Thank you for this opportunity to speak to your committee.

● (1225)

The Chair: Thank you, Mr. Lee.

We'll go now to our questions and start with Mr. Maguire.

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

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

I want to thank particularly the witnesses who are here today for their presentations, which were very informative.

The issues are immense amongst all the different levels here, but I want to first approach it from the seniors' position. We looked at two-thirds of our youth being affected and a third of the seniors being affected, more by mental health issues, which is a smaller number but it's excruciating for those families who are in that position. Data has been mentioned by all of you as an important area. I wanted to focus a little bit on the additional stresses causing our mental health issues and contributing to some of the health issues and the staffing of our long-term care facilities.

Mr. Lee, I wonder if you could answer this first. Before the pandemic, recruitment and retainment of health care aides in facilities was under pressure and was already a challenge. Is there publicly available data to look at the turnover rate of health care aides in these long-term care facilities?

Mr. Jason Lee: That's a good question. Currently, we don't have a system in place across the country where data is collected at the source—in the homes—and gathered and shared in any way across the country so that we can easily answer that question. Anecdotally, the industry would look at turnover rates in the first year of employment in the area of 25% turnover, so it does have a high turnover rate. Again, I say that anecdotally, because the data system that I mentioned earlier does not exist. If we had such a system, your work as a policy-maker would certainly be easier.

Mr. Larry Maguire: Yes, thanks.

In long-term facilities, I know there seems to be a situation where there aren't enough full-time positions in some of those areas. Due to the pandemic, we have a lot of major problems here in trying to contain these outbreaks in the facilities, and now most provinces have said that the health care aides can't work in multiple facilities.

Moving forward, I wonder what concrete measures you would suggest or you can think of that the federal government should implement to encourage these long-term care facilities to offer more full-time positions, so that they don't have to work in multiple facilities. I know that the staff who are working there are very concerned about being the ones who might bring something into the homes.

Mr. Jason Lee: Absolutely, the last thing any staff member wants is to be the person who brought COVID-19 into their home. No matter how innocent it is, that's not what they want to see happen.

Specifically about the question of permanent full-time positions, the industry right now is in need of workers, and my experience has been that staff who are looking to work don't have any shortage of work available to them. Historically, we generally operate under collective agreements in the majority of these homes, and the number of full-time and part-time positions is normally written right into those collective agreements, some of which are 30 or 40 years old.

Certainly in our homes we offer a lot of full-time positions, but not all staff want that. A lot of staff are looking for a casual or part-time position because they have their own situations and they want that flexibility.

Mr. Larry Maguire: Yes, with families and that sort of thing, for sure....

One of the things that came up on the weekend.... A Harvard epidemiologist, Michael Mina, spoke out about the importance of rapid home tests and said that home testing could be a big game-changer. At-home rapid tests aren't available in Canada and haven't been approved in Canada yet.

I know staff members are pretty concerned about bringing COVID into their workplace, as I said, so to reduce the stress of employees in these situations, should the federal government be approving and distributing the rapid at-home tests to staff who work at these long-term facilities?

It may apply to other things like our school systems as well. I know that in Manitoba the premier has just indicated, Ms. Mooring, that they will have enough rapid tests for two tests a week for every teacher until the end of June.

Maybe I could get the two of you to comment on that, just on the home test kits.

● (1230)

Mr. Jason Lee: From the position of Canadian Association for Long Term Care, we're in favour of testing. We'd like to see more testing done. At times, there has been difficulty having access to the level of testing that we would like to have for our staff and residents in the community. Therefore, if this is a step towards more access and reliable testing, that would be a favourable step.

Mr. Larry Maguire: Thank you.

Ms. Mooring.

Ms. Teri Mooring: I would concur that rapid testing for teachers and home testing would be helpful. We've had some issues in B.C. around the length of time it takes to get the results of a test, and during that time, of course, teachers need to remain off work. While that has improved, certainly access to rapid testing at home would also be helpful for teachers in terms of, as you say, reducing stress and ensuring that they're safe and that, if they have questions about their health, they can get a quick answer.

The Chair: Thank you, Mr. Maguire.

We 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 to all the witnesses. An awful lot of information was given to us today, and I thank you all for that.

I want to direct my first question to Dr. Kates.

Although it seems as though there's a light at the end of the tunnel now with multiple vaccine candidates under review, and we're hearing very good things about them, we know that Canadians are still struggling to cope with public health measures designed to keep them safe.

In August, after wave one, you were quoted in the Hamilton Spectator as saying:

> I think people are generally feeling a lack of motivation, anxiety and stress and are looking to kind of break out, rather than move out smoothly.

Could you tell us what the specific challenges were that Canadians faced mentally as they looked to go back to old routines after coming out of that first wave? What can we learn from that as we look to our future post-COVID-19 second wave in Canada as we start to roll out the vaccines?

Dr. Nick Kates: It is a real challenge, because we are asking people to go again through something that.... When they went through it the first time, they thought that would be it and then they could move on. There's also fatigue, and people have to some extent exhausted some of the things they were doing early on when they were in lockdown or in isolation or needing to follow some of the distancing measures. There's a general feeling of frustration. There's a timelessness, a sense of “When is this going to end?”

We have relied on collective goodwill and a collective sense of shared responsibility for looking after each other, and I think it's going to be so important that we continue to reinforce that, continue to reinforce the messages that you're doing this not just for you, but for the people around you.

Again, we have to be careful that we don't oversell the arrival of the vaccine. It is going to take time. We don't know what the effects are going to be. We don't know what happens if people are vaccinated differentially in terms of the activities we're looking at. Therefore, we have to help people continue to reset their expectations, whether it be about immediate events or social or other activities that they were hoping to participate in, and at the same time really focus on some of the benefits that people have noticed from having time to focus on other things, focus maybe on simpler rewards, realizing that there are some things that we had built some of our expectations around that aren't as important as they are at the moment.

Mr. Darren Fisher: Thank you very much, Dr. Kates.

My next question is for Mr. Lee—or is it Dr. Lee?

Based on some of the things you said in testimony, how important was the most recent announcement by Minister Carla Qualtrough of $23.2 million in funding for colleges and institutes in Canada to develop and implement an accelerated online program to train approximately 4,000 new personal support worker interns?

● (1235)

Mr. Jason Lee: Thank you.

I'm not a doctor and I don't play one on television, but it's a good question and it is a good announcement.

We see that funding as very helpful. We've talked about the need for more training and more staff. We'd like to see a national health human resource strategy that would incorporate training initiatives like that. What can we do through our immigration programs to bring more health care workers to Canada? How can we train them and make sure they're in the right sector and in the right provinces?

A more comprehensive strategy would be our request, but this is a very good piece of it. The one thing in that particular piece that we would have liked to see is an opportunity for not just the public institutions, but also the private training institutions to have access to that same program.

It's a good step in the right direction.

Mr. Darren Fisher: Thank you, sir.

Mr. Chair, I'm going to give my last bit of time to Mr. Kelloway.

The Chair: Thank you, Mr. Fisher.

Mr. Kelloway, go ahead.

Mr. Mike Kelloway: Thank you so much.

My question will be directed to Dr. Kates.

Dr. Kates, my constituents often face long wait times for mental health support. In saying that, though, I knew that my constituents would benefit from the Wellness Together app as it provided a direct line to important mental health resources at no cost.

In your view, are virtual platforms such as Wellness Together Canada the future for mental health services, as an effective means of providing support to individuals in need of mental health, especially now as we move toward the winter months?

Dr. Nick Kates: I would say, absolutely. One of the lessons that I hope we can take away as we move forward is the opportunity to rethink the way we organize and deliver mental health care.

I would say that two particular pieces are important. The first is to really stress, emphasize and support self-management by individuals of their own care. This is not original; it's something that is part of all care. I think the pandemic has taught us not only that this is a way of greatly expanding the reach of the mental health services, but that it's effective. We know that virtual care and online CBT can be as effective as face-to-face.

Providing resources and support, but in a targeted way because it's not one-size-fits-all.... Different populations, whether it be young adults or parents who are dealing with problems with their children, may need different kinds of resources and services.

The other way we can broaden the scope of the mental health system is to realize that there are many other people. One of our greatest untapped resources is health care providers who are not working to full scope. Another is families. I don't think we've taken advantage of not only the willingness, but the expertise of families to assist in the care of their loved ones, and similarly as supports for individuals.

If we can support families and also primary care providers, public health nurses, other community visiting nurses and people working in community agencies with simple stepped approaches.... We're not turning everybody into a mental health specialist, but we're saying that there are lots of things around lifestyle and dealing with stress and family relationships that anybody can be trained to deliver.

Let's rethink how we do that. Let's try to broaden the base of our mental health care system, so we can use more expensive and highly trained resources in a much more targeted way for those people who really need that expertise.

Mr. Mike Kelloway: Those are fantastic points. Thank you.

[*Translation*]

The Chair: Thank you, Mr. Kelloway.

We will continue now with Mr. Thériault.

Go ahead for six minutes, Mr. Thériault.

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

Mr. Lee, in September, you wrote a press release entitled "30 Years of Chronic Underinvestment has Created a 'Perfect Storm' in Long-Term Care". Some of my colleagues may think I suggested the title to you, but I can assure them we haven't met until today.

Many people have come and told us that all the pandemic has done is reveal the weak links in the health system and shed light on the vulnerabilities that chronic underinvestment in recent decades has caused in it.

Before returning to that point, I would first like to discuss the mission of the long-term care centres, the CHSLDs, and the role of families, particularly during a pandemic. In discussing a long-term care centre, we're talking about both a care centre and a living centre.

The living centre part concerns families, first and foremost. Over the years, responsibility for patients has been transferred to their families. As for the care aspect, that's provided by professionals. Families have been excluded during the pandemic as a result of a lack of personal protective equipment. That wasn't desirable, but it had to be done. If my understanding is correct, today you're saying we have to find other ways to ensure this separation doesn't occur. We have more resources with which to secure the CHSLDs, and we also have communication infrastructure that precludes our ever having to sever this family connection, which is necessary for the mental health of the patients as they approach the end of their lives. Lord knows the mental health of patients is essential in keeping them in good health.

Is that in fact what you said? Could you tell us more about those resources? Do you think the contribution of families should absolutely be preserved in the event of another pandemic?

● (1240)

[*English*]

Mr. Jason Lee: Thank you very much for your questions. I'll do my best to answer them.

I'll start with your reference to the press release back in September. This press release drew attention to the fact that the Canadian Association for Long Term Care has identified a number of issues, chronic issues, in the system. We've been speaking with the federal government and other levels of government for years looking to have these addressed. The silver lining of this pandemic is that it has shone a light on the sector of long-term care. It has everyone now looking at it, seeing that we can do better, and anxious to know what these corrections should be—must be—to ensure that we don't end up in the same situation again in the future.

We've talked about the need for staffing and a national health human resource strategy. That would be an important step toward ensuring that we don't find ourselves in this situation again. There's also the infrastructure of our homes. Hundreds of homes across the country need to be either completely rebuilt or refurbished so that they are better designed for infection control. If a virus like this were to present itself again, we then would be better equipped in these homes to deal with it than we currently are.

Earlier, I mentioned data as something we need to collect and share and give to policy-makers like you so that you can make good decisions about the sector. This has been an extremely difficult time for everybody, families and residents, across the country, and we really don't want to repeat this. We see that there are ways to avoid going through the same scenario. If another virus like this one went through our country in five years' time, we should have the infrastructure, we should have the staffing and we should have the information in place so that we can avoid—

● (1245)

[*Translation*]

Mr. Luc Thériault: Pardon me for cutting you off.

If there had been enough personal protective equipment from the outset, would the decision to remove families from the CHSLDs, the long-term care centres, nevertheless have been made? If so, given the effect that had on patients—dying alone is inhumane—what could be done in future to prevent that kind of separation?

[*English*]

Mr. Jason Lee: There was definitely a shortage of personal protective equipment in the early days of this pandemic. It's something we're still experiencing but to a much smaller degree currently.

If the stockpiles had been there in March or April.... We didn't even consider that as a barrier. As you know, it was talked about a lot in the early days of the pandemic as a concern, as a risk, as a barrier. Had we had larger stockpiles, we would have spent less time talking about personal protective equipment and probably more time talking about the other challenges we were facing.

[*Translation*]

Mr. Luc Thériault: Staff retention is related to working conditions. Better funding obviously fosters better working conditions and therefore helps retain staff. I imagine that dealing with the same people in a long-term care home has a positive effect on the quality of the care residents receive.

[*English*]

Mr. Jason Lee: Absolutely. Staff turnover results in residents seeing more unfamiliar faces. That continuity of care, knowing your caregivers and seeing them on a regular basis, is all part of what we're talking about here today. It's good for mental health because you become connected with your caregiver and they become part of your extended family.

Definitely, retention of staff is a priority of long-term care. Increasing wages and improving working conditions will help us do that.

[*Translation*]

The Chair: Thank you, Mr. Thériault.

[*English*]

We go now to Mr. Davies.

Mr. Davies, go ahead, please, for six minutes.

Mr. Don Davies: Thank you, Mr. Chair, and thank you to all the witnesses.

Ms. Mooring, a recent pan-Canadian survey conducted by the Canadian Teachers' Federation revealed that 46% of teachers across Canada are concerned about their own mental health and well-being. In a November 27th interview, you responded to that by saying, “It is stressful for all of us during this pandemic, but the fact teachers feel they don’t have what they need in order to keep themselves and everyone safe is particularly difficult”.

Could you tell us where you see the deficits? What do teachers want that they don't have and what do they need in order to improve their feeling of safety and mental health?

Ms. Teri Mooring: Thanks very much for the question.

Part of what we have outlined in our brief is the fact that teachers don't feel there are adequate preventative measures in place in schools right now. Two of these issues involve PPE. In B.C. at least—and this varies across Canada—there isn't a requirement for PPE to be worn in classrooms, just in common areas. That can be extraordinarily stressful, especially for teachers with underlying medical conditions, in terms of being able to keep safe, not only for themselves but also for their students. Teachers take a high level of responsibility for keeping their students safe, and it feels like that's difficult to do.

The other issue—and I think this is more similar across Canada—is that there isn't the funding to reduce classroom density. We know that physical distancing and mask wearing are important in terms of limiting the transmission of the virus, and neither is present right now in classrooms in British Columbia.

The other is data collection. We would like to see specific sector data as well. We don't have that right now. There is some information that is available publicly in B.C., but it's only a rolling clearing house of schools that have been issued exposure notifications. In B.C., there have been over 1,000 exposure notifications issued. What's happening is that parents are starting to collect that data online, and that's not the most reliable way to get that information. We need to hear that from the health professionals, so that data should be available.

The measures we're putting in place in classrooms in order to protect students are also impacting the way teachers teach. Because there isn't PPE, students are required to be more stationary than we would like. This is also having an impact on teaching and learning.

● (1250)

Mr. Don Davies: Following up on that, you mentioned the lack of safety protocols regarding mask wearing and physical distancing. You said they're not being applied in classrooms and school places.

What role would you like to see the federal government play in that? Could you imagine, say, the Prime Minister or the federal government perhaps issuing a national directive in that regard, or should this be left to the provinces? I'm just curious as to how you think that should be addressed.

Ms. Teri Mooring: There already are recommendations from the federal health office around wearing PPE, and that's for students 10 years and older. We would like to see that be more consistent.

We would certainly like to see, at a minimum, encouragement federally for greater consistency across Canada in terms of some of the preventative measures that are in place. Similarly, physical distancing is one of the most problematic measures. We're just not able to physically distance in classrooms of 30 or more students as well as all the adults in the room—teachers, support staff, etc. These are crowded rooms.

We have concerns that as the community spread of the virus is increasing—and that certainly is happening in B.C., especially in certain communities—those in-school transmissions are going to be inevitable. We're going to see the closure of schools instead of keeping them open.

Mr. Don Davies: I'm going to try to squeeze in one more quick question, if I could.

Teachers are well placed to monitor the health of their students. We heard that when children were home-schooled, this had a number of positive but also negative impacts on them. I'm just wondering. Has the return to in-person classes had a positive impact on students' mental health, or are you seeing challenges in that regard as well?

Ms. Teri Mooring: I think overall the impacts are positive, especially for students who are more vulnerable, but there are challenges, of course. You know, everyone is concerned about their safety.

We also have thousands of students who actually didn't return and are engaged in remote learning. That is very difficult to support when teachers are working full time in their classrooms. I would say that more investment is needed in terms of supporting students' mental health. Simply coming to school isn't enough. There need to be additional counsellors and counselling time for students, many of whom had really negative experiences during the school closure, especially, again, students who experience housing and food insecurity, family violence, etc.

There we would like to see more supports directed to supporting students' mental health. We're not seeing any increased investment in that regard.

Mr. Don Davies: You mentioned that $2 billion was made available by the federal government to the provinces, but you were concerned about leakage, that not all of that money would be used for the purpose for which it was intended.

What advice would you give this committee—to, in turn, give the government—to help ensure that the federal funding announced for a safe return to school is being used for the intended purposes?

Ms. Teri Mooring: We would like to see some accountability structures in place.

The Canadian Teachers' Federation is proposing a temporary ad hoc intergovernmental task force to take a look at sustainable operations of schools and how the money is being spent. We don't have any idea in B.C. about how school districts chose to spend that money. There needs to be some accounting of where it's gone, and that certainly hasn't been forthcoming yet. We think there is a need to ensure that the money is going to the purpose it was intended to go to, and that is keeping schools and classrooms safe.

Again, we're struggling with some of the preventative measures in B.C., including putting up barriers for teachers who have to teach hundreds of students every single week, and for teachers who have underlying health conditions.

There are still a number of health measures that should be in place but are not, as well as the additional safety measures that we think should be in place in schools.

● (1255)

Mr. Don Davies: Thank you for your testimony.

The Chair: Thank you, Mr. Davies.

We have a very short time left. I'm going to try to squeeze in one-minute rounds, one minute for each party.

The next person on my list, from the Conservative party, is Ms. Rempel Garner.

Ms. Rempel Garner, please go ahead for one minute.

Hon. Michelle Rempel Garner: For the witnesses, I'm concerned about the impact of the impending holiday season on mental health. It might exacerbate the effects that we're already seeing and that you've described.

Briefly, can you provide recommendations? Maybe you can run through one each or table with the committee recommendations that on an emergency basis the federal government could take on to deal with some of the perhaps exacerbating issues that might happen over the holidays with regard to mental health and COVID lockdowns.

That's for anybody to answer or just to make a commitment to table that with the committee.

Dr. Nick Kates: I'm just going to say that I think the message has to be a very simple one. It's short-term pain for long-term gain, and the more we can follow the limitations that are being asked of us, the more quickly we're going to come out.

The second thing, I think, is to see this as an opportunity to create memories that are different memories, not to compare Christmas or the holidays to any previous ones, but just to say that this is completely different, so let's completely suspend what happened in the past and let's get the most out of everything we do this year, because it is, hopefully, just going to be a once-in-our-lifetime event.

The Chair: Thank you, Ms. Rempel Garner.

We'll go now to Dr. Powlowski.

Please go ahead. You have one minute.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I have a question for Dr. Kates.

I think a lot of people have been under a lot of stress in seeing their elderly relatives sick and possibly dying without their family being around. I can see this causing long-term problems for people—just the guilt of having to live with this.

What are your recommendations with respect to people who are facing this kind of issue to help them get through it, and hopefully get through it a little less scarred than they might otherwise be?

Dr. Nick Kates: I would say a couple of things.

The first is to just validate that this is something that anybody in that situation is going to be experiencing and not to blame themselves. There's a simple kind of five-letter formula: listen, inquire, validate, explain and support. I think that if those of us who are health providers can just follow that very simple kind of acronym, it can be helpful.

I think peer-to-peer support can also be helpful for people, whether it be through groups or one-to-one facilitated peer support where they can connect with each other. It can be very helpful.

I think the last is just to acknowledge that this is just an unimaginable and horrific experience that we've been through, and that just the opportunities to talk about what it's like rather than to lock it away or try to put it into the past is the way we move through it, using all available supports and involving all family members, including younger children as well, who have a different perspective but have been affected.

The Chair: Thank you, Dr. Powlowski.

[*Translation*]

You have one minute, Mr. Thériault.

Mr. Luc Thériault: Mr. Lee, Quebec and the provinces form a common front in favour of a catch-up whereby health transfers would increase from 21% to 22% to 35%. The purpose of that is also to cover slightly more than the system's costs with a 6% indexation for subsequent years, since they have established that system costs are at 5.2%. That would cover the costs of the aging population.

I imagine you support those recommendations.

● (1300)

[*English*]

Mr. Jason Lee: Yes, I would say that we would approve seeing an increase to the health transfers, but our recommendation would be that those transfers be targeted specifically for seniors and in some way recognize the aging population and how that varies across the country.

[*Translation*]

The Chair: Thank you, Mr. Thériault.

[*English*]

Mr. Davies, go ahead.

[*Translation*]

Mr. Luc Thériault: How would you do it?

[*English*]

Mr. Don Davies: Thank you.

Ms. Mooring, you touched on the fact that teaching is still a significantly feminized profession. I'm wondering if you would be able to speak to what you've observed about how COVID has impacted teachers who identify as women, and what additional supports and provisions might be recommended to support their particular mental health needs at this time.

Ms. Teri Mooring: Teaching has become a much more feminized profession over the years, and recent graduates are even more predominantly women. Teaching has absolutely become much more feminized.

Along with that, obviously, not only women teachers but also women generally in our society disproportionately bear the burden of supporting families, as well as, in this case, supporting our students, so there need to be some things...including the fact that if teachers who are women have children who perhaps can't go to day care or can't attend school because they have symptoms, more and more women need to take that time off work in order to care for their children.

This means they are going to be using up their sick leave and other leave provisions in a much more intense way than perhaps others are, so increasing the federal benefits would really help women teachers in particular to buffer the loss of income they see when they have to take unpaid leave in order to provide family care.

The other issues are the additional stress put upon teachers who are women just because of the additional burdens, which means that they are carrying much more in terms of those stress levels with them into their teaching. Again, having those safety precautions in place, preventative precautions in place in classrooms, would absolutely help support teachers' peace of mind, including the fact that teachers are keenly aware that if they get ill—and this is true across Canada as well—we will have a national teachers shortage.

We also know that when teachers have to be away from their work, there isn't always someone to fill that space. That means their colleagues need to fill in to teach their classes, which means that important services are removed from students who need that support, diverse learners, and students who have their own medical needs.

There is a bit of a snowball effect that happens due to the disproportionate burden on women when they're in classrooms. It has a lot of consequences.

Mr. Don Davies: Thank you.

The Chair: Thank you, Mr. Davies.

Thank you to all of our witnesses. It has been a great panel. Thank you all for your time today and for sharing with us your expertise. It's a real help for our study.

I'd like to advise the committee members that I was unable to get all the pieces to align, all the parts to align, for doing Bill C-210. I'm still hopeful we will be able to do it after our two panels on Friday. Stay tuned, and we will get back to you.

Thank you, everybody—

Mr. Tony Van Bynen: Mr. Chair, just as a point of clarification—I did have my hand up. I thought I heard a member opposite indicate that there were no rapid tests made available. My understanding is that over 7.4 million rapid tests have been deployed to the provinces and territories, including over 964,000 to B.C., 2.3 million to Ontario, and 143,000 to Nova Scotia.

That's just for clarification.

Mr. John Barlow: Just on a point of clarification, he said home-based testing, not rapid testing.

Mr. Tony Van Bynen: My concern was that the inference was that there weren't any being distributed.

Mr. John Barlow: No, he specifically said home-based testing.

Mr. Larry Maguire: It was home-based testing, Mr. Van Bynen.

Mr. Tony Van Bynen: Thank you.

The Chair: Thank you, gentlemen, for your interventions.

Again, thanks to all of you for your time today and for all of your great work.

I'll see you all on Friday.

With that, we are now adjourned.

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