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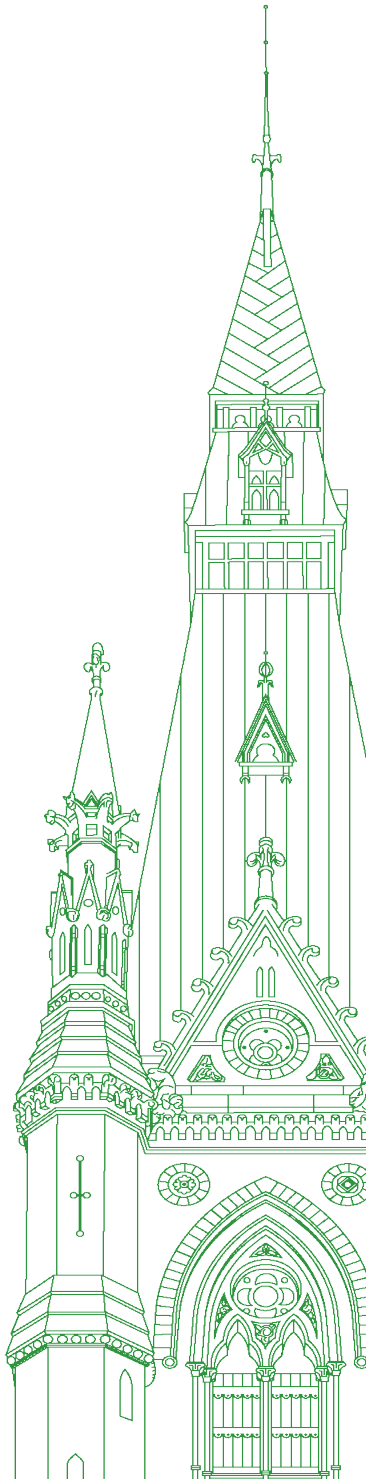

Chair: Mr. Ron McKinnon

Standing Committee on Health

Friday, January 29, 2021

● (1300)

[*English*]

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

Welcome to meeting number 15 of the House of Commons Standing Committee on Health.

The committee is meeting today to study the emergency situation facing Canadians in light of the second wave of the COVID-19 pandemic.

Today's meeting is taking place in a hybrid format, pursuant to the House order of January 25, 2021; therefore, members are attending in person, in the room, and remotely, using the Zoom application. The proceedings will be made available via the House of Commons website. So that you are aware, the webcast will always show the person speaking rather than the entirety of the committee.

Today's meeting is also taking place in the new webinar format. Webinars are for public committee meetings and are available only to members, their staff and witnesses. Members may have remarked that the entry into the meeting was much quicker and that they immediately entered as an active participant. All functionalities for active participants remain the same. Staff will be non-active participants only and can therefore only view the meeting in gallery view.

I would like to take this opportunity to remind all participants in this meeting that screenshots or taking photos of your screen is not permitted.

Given the ongoing pandemic situation and in light of the recommendations from health authorities, to remain healthy and safe, all those attending the meeting in person are to maintain two-metre physical distancing. They must wear a non-medical mask when circulating in the room, and it is highly recommended that the mask be worn at all times, including when an attendee is seated. As well, they must maintain proper hand hygiene by using the provided hand sanitizer at the room entrance. As the chair, I will be enforcing these measures for the duration of the meeting. I thank members in advance for their co-operation.

For those participating virtually, I would like to outline a few rules to follow.

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. With the latest Zoom version, you may now speak in the language of your choice without the need to select the corresponding language channel. You will also notice that the platform's “raise hand” feature is now in a more easily accessed location on the main toolbar, should you wish to speak or alert the chair. I caution that I actually don't see that on my screen, so that may be a promise yet to come.

For members participating in person, proceed as you usually would when the whole committee is meeting in person in a committee room.

Before speaking, please wait until I recognize you by name. If you are on the video conference, please click on the microphone icon to unmute yourself. For those in the room, your microphone will be controlled, as normal, by the proceedings and verification officer.

I remind everyone that all comments by members and witnesses should be addressed through the chair. When you're not speaking, your mike should be on mute.

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 would now like to welcome our witnesses.

We have, as an individual, Professor Ehsan Latif, professor of economics at Thompson Rivers University, British Columbia. We also have, as an individual, Dr. Samuel Veissière, assistant professor at the department of psychiatry and co-director of the culture, mind, and brain program at the department of psychiatry at McGill University. From the Hospital Employees' Union, we have Ms. Barb Nederpel, president; Ms. Georgina Hackett, director of occupational health and safety; and Ms. Maria Dreyfus, care aide. From the Kids Help Phone organization, we have Ms. Katherine Hay, president and chief executive officer.

Each witness group will have six minutes to speak. We will have a single round of questions once all witnesses have given their statement.

I would also advise that I will be using cards. One is yellow and one is red. I will display the yellow card when you have one minute left, and I will display the red one when your time is up.

Thank you.

We will now go to our witnesses' statements.

Professor Latif, if you please, go ahead for six minutes.

Dr. Ehsan Latif (Professor of Economics, Thompson Rivers University, British Columbia, As an Individual): Thank you, Mr. Chair.

It is my honour to appear before you today. My name is Ehsan Latif. I'm a professor of economics at Thompson Rivers University in Canada. I will be talking today from the perspective of economics. I have done primal research on the impact of decisions on mental health in Canada. I will try to connect my research findings with the current situation and also talk about some policy issues.

An economic recession impacts mental health in a number of ways. Unemployed people suffer the most, because of financial stress and loss of social status. Employed people also suffer from anxiety and distress because they feel they can lose their job any time. The mental pressure during the recession period may lead to excessive drinking, smoking and drug abuse. These unhealthy behaviours often lead to chronic health conditions like cancer, stroke, high blood pressure and cirrhosis of the liver. The mental health impact of a recession may not end with the end of the recession. Sometimes people may suffer for an extended period of time.

Using large-scale Canadian data from the Canadian national population health survey, I conducted a couple of studies on the impact of economic recessions on mental health, drinking behaviour and smoking. In one study, I found that the unemployment rate had a significant positive impact on weekly alcohol consumption and the probability of binge drinking. The study also found that the unemployment rate had a significant positive effect on the number of cigarettes smoked by daily smokers. The results suggest that the impact of the unemployment rate on drinking and smoking behaviour was more pronounced for males than females.

In another study, I found that the provincial unemployment rate had a significant positive impact on depression. This study further found that females, individuals with post-secondary education, individuals with college or university education and individuals below 54 years in age were more likely to suffer from depression from an economic downturn.

In all these studies, I used data from 1994 to 2009, the past recession, so let me connect this to what is happening here now.

The recession due to COVID-19 had a disproportionate employment-related impact on Canada's service sectors, including transportation, restaurants, accommodation, and arts and entertainment. Females and young people were the hardest-hit groups, as they predominantly work in the service sectors. The other hardest-hit groups were visible minorities, new immigrants and indigenous people. Among the employed people, essential workers and health care providers were very much vulnerable to the negative mental health impacts of COVID-19. In particular, health care workers had a greater risk of exposure to the virus and had to work in very stressful conditions.

A recent study by Statistics Canada found that the pandemic impacted the mental health of all Canadians. However, youth experienced the greatest decline since the pandemic began. The study reported that women were more impacted than men. The study also found that visible minority groups were more likely than whites to report poor mental health. The study found that those already experiencing poor mental health before COVID-19 were impacted even more by the pandemic. Finally, the study found that a substantial number of Canadians reported increases in their alcohol, cannabis and tobacco consumption.

During this COVID-19 period of physical distancing, virtual mental health services play a vital role in providing mental health care. Virtual mental health services allow better access to care for people living in rural and remote areas. Young people who are avid users of the Internet may find virtual mental health care more comfortable and attractive. However, many rural and remote areas lack access to quality Internet access. Further, marginalized groups, such as homeless people, may not be able to afford Internet facilities. Some groups, such as older people, are not familiar with modern technology. For complex mental health problems, virtual health care may not be enough, and patients may also need in-person care. In the coming days, we need to expand virtual mental health services. However, at the same time, we need to make it accessible to all groups, including people in rural and remote areas, indigenous people, homeless people and the older population.

● (1305)

During the pandemic, the Government of Canada launched a web portal called Wellness Together Canada, focusing on mental wellness. This web portal connects to peer support workers, social workers, psychologists and other professionals for confidential chat sessions and phone calls to deal with mental health issues. This publicly funded tool was certainly helpful, but people may not be aware. A recent study stated that only 11% of the people used the online system. We need more research on the impact of this tool.

People may suffer from pandemic-related mental health trauma for an extended period of time. For this reason, federal and provincial governments need to work together to reduce financial and other barriers to access to mental health care. In a 2018 report on mental health care in Canada, the Canadian Mental Health Association pointed out the lack of resources devoted to mental health support. The report noted that Canadian people have significant financial barriers in getting access to psychological support. The federal government can seriously consider this issue because in the coming days we have to focus more on mental health care and tackle this issue.

Thank you, Mr. Chair.

● (1310)

The Chair: Thank you, Professor.

We go now to Dr. Veissière.

Please go ahead, for six minutes.

Dr. Samuel Veissière (Assistant Professor and Co-director of the Culture, Mind, and Brain Program, Department of Psychiatry, McGill University, As an Individual): Thank you, Mr. Chair and members of the committee. It's an honour to be here.

I'm Samuel Veissière. I speak as a behavioural scientist and professor of psychiatry who specializes in the study of the impact of screen time on mental health and in youth mental health generally. I also speak to you as a parent and a professor who is very concerned for the mental health of our youth, as Professor Latif mentioned.

Because there is little time, I want to specify that the take-home message is that there are really two pandemics going on at the same time, with almost diametrically opposed risk and protective profiles. As we know, old age is by far the biggest risk factor for mortality and complications linked to the COVID-19 disease, while young age is the primary risk factor for poor mental health, but not for mortality and complications due to the COVID-19 disease.

In the acute early phase of the pandemic, I participated in a study led by Professor Rébecca Robillard at the University of Ottawa, where we surveyed 6,000 Canadians on pandemic-related stress, anxiety and worsened mental health. I'll mention some of the risk factors that we found, and then I'll go on to talk about some missing data that would really help us identify at-risk populations and also identify prevention strategies.

What we found is that the biggest risk factors for worsened mental health during the pandemic were, of course, pre-existing mental conditions and female sex, as Professor Latif mentioned, although it's important to point out that women are more likely to report mental health problems. Men, unfortunately, are less likely to report mental health problems until it is too late. We know that they suffer from significantly higher suicide rates, particularly in the context of an economic recession and job loss, but also divorce. We know that family relations have often been very negatively impacted by the pandemic. We also found that alcohol consumption and drug consumption were associated with worsened mental health. Certain personality traits like extroverts and people who suffer from neuroticism....

Interestingly, and very controversially, we found that a very strong predictor of more COVID-related anxiety was left-wing political beliefs. The point here is not a partisan political point. It is an empirical observation. The understanding of the crisis has unfortunately been very polarized and very politicized, with COVID-denying positions associated with the right, leading to a certain bias in the liberal media for more “alarmist” perspectives, thereby perhaps conferring higher anxiety for people who are on the left of the political spectrum. We know, however, that this is a predictor.

What else did we find? We found that poor family relations predicted worse mental health, as did less time spent exercising or engaging in artistic activities. We found, however—although we're still looking at the data—that socio-economic status did not necessarily predict mental health in the way that we thought it would. We found that people from the upper-middle class and higher, particularly younger people, often seemed to suffer from more anxiety, so it may be that people who are working remotely have a different sort of stress profile and perhaps worsened family relations.

That was an interesting finding, because we found that by far the strongest predictor was age. People under 40 and people in their twenties reported much worsened mental health. We also found that increased screen time and social media consumption—even reading political news—was associated with worsened mental health.

I will point out that many of us in the mental health research community were already very concerned with the mental health of our youth prior to the pandemic, in that a confluence of risk factors, many of which are associated with increased screen time and isolation, were a cause of major concern prior to the pandemic and have been gravely accentuated.

It would be very helpful for us in planning prevention strategies to have better public statistics on the incidence of suicide, of psychiatric emergencies, of drugs and alcohol consumption and so on.

● (1315)

To conclude, because I really want to leave time for discussion—I could go on at length to shed more light on these risk factors—given the diametrically opposed risk profile, it is important from a mental health perspective to find focused protection strategies and to restore opportunities for youth that we know are conducive to better mental health: human touch, participating in collective activities, participating in the community and in religious and athletic activities, finding safe ways for those who are not at risk to return to class, particularly for university-age populations. It has become a public health emergency.

I think that's about the gist of what I want to present. I'll be happy to answer any questions.

Thank you again, Mr. Chair and members of the committee.

The Chair: Thank you, Doctor.

We will go now to Ms. Nederpel, president of the Hospital Employees' Union.

Please go ahead for six minutes.

Ms. Barb Nederpel (President, Hospital Employees' Union): Good afternoon.

I am Barb Nederpel, the president of the Hospital Employees' Union, also known as HEU. Our union represents more than 50,000 health care workers across the province, including 20,000 who work directly in seniors care.

Joining me today are Maria Dreyfus, a care aide in a Fraser Valley long-term care home; and HEU's occupational health and safety director, Georgina Hackett.

Thank you so much for the opportunity to speak with you about the devastating impact COVID-19 has had on those working on the front lines of this pandemic, which is, in addition to everything we've heard so far, for the general public.

Health care work is largely women's work. About 85% of our members are women, and this workforce is also highly racialized. Our members were exhausted, stressed and at a high risk of injury well before the pandemic. COVID has shone a light on the very difficult working conditions in long-term care especially, and it has exacerbated this situation immensely.

On March 7, a resident at Lynn Valley Care Centre in North Vancouver passed away from the COVID-19 virus, the very first COVID-19-related death in Canada. Since then, there have been hundreds of outbreaks in B.C. care homes, and the majority of the 1,172 COVID-19-related deaths in B.C. have been of care home residents.

We know that the impacts of stress on mental health are cumulative, so 11 months of working long hours, being short-staffed, living in fear and in worry, and seeing so many of their residents die and their co-workers test positive for COVID have taken a serious toll on our members' mental health.

On top of everything else, our members in long-term care are working in a sector that has been racked by privatization and contracting out under the former B.C. Liberal provincial government. Wages and benefits vary greatly across the sector, a circumstance that forces workers to hold multiple jobs just to make ends meet. In fact, one in every five workers in our care homes holds two or more jobs in the sector. While the province has levelled up wages as part of its public health order to limit workers to a single site, many workers still have inadequate paid sick leave. Lack of access to decent-paying jobs and inadequate sick leave are also causing stress for our members.

As we saw with the SARS outbreak 17 years ago, we are seeing only the very tip of the iceberg at this time. Mental health impacts can last for years, and our members are really struggling. We are concerned about what the future holds for them, about our ability to retain workers in this sector, and about the impact on employee benefit costs.

Maria is here to tell you about her first-hand experience with being on the front line.

● (1320)

Ms. Maria Dreyfus (Care Aide, Hospital Employees' Union): Good afternoon. My name is Maria Dreyfus. I am a care aide in a long-term care facility in B.C., where I have worked for 12 years.

My facility has had two outbreaks during the COVID pandemic. The first one was in May and was very small. The second one was in November, when more than 150 people contracted COVID—93 residents and 63 workers—and 26 residents passed away.

It is difficult to describe how very scary it has been for all of us working in long-term care during the pandemic, but when the big outbreak hit our site, it was totally devastating. Residents whom we have known and cared for over many years were dying. We are their care providers, but also their family and friends, so this was very emotional and stressful.

I myself tested positive for COVID–19 and had to self-isolate. There are three other full-time workers living in my household, and they had to self-isolate as well. My biggest fear was that I was going to pass it on to my family. What were we going to do if we all had to be off work?

Fortunately, I had very mild symptoms and was eventually able to return to work, but not all my co-workers were so lucky. One of my co-workers who tested positive is a young mother. She infected not only her husband, but one of her young children. Another co-worker who tested positive recently found out after she returned to work that her internal organs have been badly damaged. This news was incredibly difficult for us to hear. We all cried when we received her text.

This cannot happen again. A quicker response was needed. There's so much fear and anxiety. We needed better communication about the virus and about the PPE required to protect us to the fullest, and we all should be able to apply for workers' compensation benefits and not have to worry about not having enough paid sick leave available to us.

Thank you.

The Chair: Thank you, Ms. Dreyfus.

We will go now to Kids Help Phone and Ms. Katherine Hay, president and chief executive officer.

Please go ahead. You have six minutes.

Ms. Katherine Hay (President and Chief Executive Officer, Kids Help Phone): Good afternoon and thank you, Mr. Chair and members of the Standing Committee on Health, for inviting us to speak here today.

I am going to start with a stark and sobering statistic for us all. Last year, Kids Help Phone conducted over 4,000 active suicide rescues. Research tells us that for every suicide, 125 people are directly impacted, so not only did we save over 4,000 youth in Canada, but we spared half a million people in Canada from traumatization from grief and loss of a loved one dying by suicide.

The reality of the first wave of the pandemic hit youth very hard. The second wave is just as difficult. The third wave is real—it's the mental health pandemic.

I am here because mental health is one of the most significant crises facing young people today. If we do not find solutions, if we do not ensure that young people can access support, we will lose multiple generations. The future of a strong Canada relies on the well-being of the youth of Canada today.

For over 31 years, Kids Help Phone has been Canada's only national 24-7 e-mental health service for young people in French and English, in every province and territory. In 2020, we interacted and connected with more than 4.5 million people in Canada, typically from age five to age 27, but also adults. That's an increase of 137% from 2019.

I do want you to remember that the clinical teams at Kids Help Phone are on the front lines 24-7 doing a tremendous job, and that is taking its toll.

In addition to being an essential service provider, we use real-time data to inform our decisions and the mental health landscape. We're the only mental health service in Canada combining clinical expertise with AI and machine learning for triaging to deliver better outcomes when young people reach out for support.

We see the impacts of COVID-19 every single day. Throughout the pandemic, conversations about grief have increased, as have conversations about eating and body image, by more than 80%; about gender and sexual identity, by more than 65%; about isolation, by more than 50%; about abuse, by more than 45%, and the list goes on.

I also want to take a moment to recognize that not all youth in Canada are equally served by this system. The underserved, remote, rural and racialized youth in Canada do not have equitable access, which is why Kids Help Phone is so important in addressing this reality.

We are especially worried about the far-reaching effects on some of our most vulnerable young people, including indigenous youth, Black youth, youth of colour, youth in rural and remote environments and youth identifying as LGBTQ2S+. We hear from them every single day. The percentage of young people reaching out to us about racism and discrimination doubled after the murder of George Floyd and the heightened social injustice.

These young people who text us every day are some of the most distressed young people, second only to those young people who fear harm from someone in their own home. When they speak about racism, they are also more likely to speak about suicide. We need to do more—Canada needs to do more—so that these young people do not get left behind.

I think we all agree that it is clear that COVID-19 has been profoundly hard on people's mental health—on youth in particular. At Kids Help Phone, it led to immediate record surges in demand back in March, and it has continued to do so to this day. There were 4.5 million connections in 2020.

Kids Help Phone faced enormous pressure to increase service, as well as grapple with uncertainty around our financial stability, similar to other charities. We are grateful to the Government of Canada, which, over two years, made a significant investment of $7.5 million in our essential services. That critical contribution has ensured that we remain open and that service has been uninterrupted even with record-breaking demands. We did not go dark, not for one minute.

Our work is nowhere near done. It will not be done when COVID-19 is a thing of the past, which we all hope is soon.

● (1325)

Everyone would agree that Canada's mental health sector is somewhat fragmented and struggles to meet the growing needs of Canadians. This is where Kids Help Phone can add value. We are pioneers in virtual care. We continue to expand our e-mental health platform to provide more youth with more seamless access to a continuum of virtual supports. We will work with our partners in the sector and governments to continue filling the gaps. We are leveraging our data, Canada's only real-time data showing what young people are facing, in their words. We speak to them every day. The reality is that we all know that the state of youth mental health was in crisis before the pandemic. It is exponentially amplified.

In closing, as I've said before and we all know, this pandemic will not come to an end when vaccines roll out, or even when the country returns to a new normal. There is no vaccine for the significant implications to our mental health. Canada must be ready to handle the long-term mental health effects of the pandemic.

Kids Help Phone is a trusted partner. Continued partnership between Kids Help Phone and the Government of Canada will play a critical role in providing e-mental health solutions for all the young people in Canada and in leveraging data to better inform policies and health system solutions. This is imperative. The future of Canada is anchored on the well-being and mental health of our young people today. It is on us to right tomorrow for them.

You need to know that Kids Help Phone will always be there for the kids who need us. We will be there 24-7, in every province and territory, in both official languages, for all who need us.

Thank you, Mr. Chair, members of Parliament and members of the standing committee.

● (1330)

The Chair: Thank you, Ms. Hay.

We will now start our questioning. We have time for one round of questions.

Mr. Maguire, please go ahead for six minutes.

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

I want to thank our witnesses for their presentations today.

To start, Ms. Hay, thank you very much for your presentation. These are pretty stark numbers. There's been a 137% increase from 2019. I wonder if you could comment on the emergency helpline my colleague Todd Doherty has brought forward in the House. It would be another opportunity to help in that regard.

Obviously, you're pointing out the use of your line and the fact that you've helped prevent 4,000 suicides. Can you expand on the mechanism that's involved there?

Ms. Katherine Hay: First of all, I do want to acknowledge the importance of increasing access for anybody in crisis, so a three-digit access point, where Kids Help Phone would most definitely be good partners too...through technology. It should not be the problem of someone in crisis to figure out where they need to reach out. We stand as partners with our colleagues for that.

You talked about our active rescue protocols and process. Kids Help Phone is national. We have professional counsellors in counselling centres, now remote, in Montreal, Toronto and Vancouver, as well as remotely in every province. We also have more than 2,200 active crisis responders every single month on our platform. I give you that background because it's not so easy to just call 911 for support. We might be in Toronto and the person in crisis might be in Sioux Lookout. We have an incredibly good relationship with the RCMP. That would be our first point of contact to connect us to local police services.

I also want to point out that we need to do work in this country, and we are doing work, on what the right step is for active rescues. It is sometimes not the right thing to do to send police into a highly charged environment. In some communities, it might not be the right thing to do. We're working in Saskatchewan right now with a pilot on wellness teams responding to active rescues.

Mr. Larry Maguire: There are a lot of cases where it's very important to make sure you're sending the right people to the situation. You're absolutely right.

I want to touch base with you, Ms. Nederpel and Ms. Dreyfus. Thank you for your presentation. This is a highly charged area.

Ms. Dreyfus mentioned the PPE required for this process. Can you provide us with greater certainty about what the quality of PPE may be that the Liberal government is purchasing for front-line staff? Do you have any recommendations for the government in regard to a more thorough job of inspecting those shipments of PPE? You talked more specifically about shortages, so perhaps you could reply to that first.

Ms. Barb Nederpel: I'll pass that over to Georgina, as she's the expert in the OH and safety field.

Mr. Larry Maguire: Thank you.

Ms. Georgina Hackett (Director, Occupational Health and Safety, Hospital Employees' Union): To comment on the experience in British Columbia, one of the major challenges we found is that our long-term care sector is fragmented in terms of who owns, operates and runs those facilities. If you were working in a long-term care facility that was owned and operated by a health authority, there was greater coordination in terms of purchasing personal protective equipment and the standards that it came under.

In the early days, the privately run long-term care facilities and affiliate-run facilities were left to source a lot of their equipment. We had experiences where we needed to escalate PPE delivery to some of these facilities during outbreaks where they were caring for COVID-19-positive residents without the equipment they needed, or to facilities that found a source from a supplier that wasn't meeting the standards required for health care, and finding that we were even needing to ship this by taxi to those facilities.

One of the things that helped along the way was a centralized supply hub that the province set up, but again, the time it took for that to be established across all of the sector and all of the different owners and operators.... It took a significant amount of time during the crisis.

● (1335)

Mr. Larry Maguire: You're basically getting into where I was going with this. In the early days, the government threw out the emergency stockpile of PPE that we had and then had a planeload of our PPE sent to China.

You've just made reference to the shortage of PPE in those early days. That caused a lot of stress and anxiety. I know that right here in my own constituency there were front-line care people phoning our office about that. Are you hearing any concerns from your members about shortages of PPE? You referred to the earlier ones, but where are we at now?

Ms. Georgina Hackett: We had concerns raised as recently as November, when different facilities were trying to access supplies: masks, non-medical masks, medical masks from different suppliers, goggles and glasses, and visors. It seems to have settled out in the last few weeks, but as recently as November there were issues.

The Chair: Thank you, Mr. Maguire.

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

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you, Mr. Chair. Six minutes are probably not going to be anywhere near enough with this group of witnesses.

First of all, I want to take a moment to thank all of you for being here. Ms. Nederpel, Ms. Hackett and Ms. Dreyfus, please take back to your membership the thanks of all the people on this committee for the incredible work that you and your members all do. We're so very thankful.

Ms. Dreyfus, I'm so glad you made a recovery from COVID. It is so nice to see you here, and thank you very much.

I'm going to go to you, Ms. Hay, if I could. Your statistics were alarming. The work you do is overwhelmingly impressive. Thank you.

I'm a father of two teenagers. When we think about how the schools and the programs for youth were all shut down during the first wave, I was so glad to see that we did invest over $7 million with the Kids Help Phone.

I also want to take a quick second to thank Tony Van Bynen, because we wouldn't be having these conversations if it weren't for Tony pushing so hard for this study, and it's so important. It's the pandemic within a pandemic.

I'm sorry that I'm taking so long before I get to a question, but this is pretty important stuff to me.

We see a light at the end of the tunnel with vaccines, but we're so far from being out of the woods yet. I think about social isolation, and I think about virtual-only learning for students across the country and the lack of in-person activity. It's a major issue. It was a major issue before COVID, and it's going to be a lingering issue long after COVID.

What can we do better to support this generation of youth right now and into the future?

Ms. Katherine Hay: Thank you for that question, Mr. Fisher. I could not agree with you more. You know as a father of two teenagers—I'm a survivor of the teenage years, thankfully—that what we are seeing right now with young people is an enormous amount of loss and grief.

My colleague from McGill University talked about touch and the lack of in-person interaction. It is important to create an environment where virtual care and virtual supports—multiple different ones, because one-size-fits-all doesn't fit anybody well—are integrated and seamless. I cannot say that enough, about the seamlessness. It is critically important that we build a system for young people where they are not left behind. For the work of this and other governments across Canada focusing on mental health and young people, the time is now, and we cannot let them get far behind.

I could give you a list of things that Kids Help Phone could partner with that would directly impact young people, but for today I just want to implore this committee to make sure that you push all of us in the sector, and yourselves, to make sure it's seamless, that we are not fragmented and that we're not assuming the gaps are small, because the gaps are large.

● (1340)

Mr. Darren Fisher: Thank you for that.

This will probably run out my time, but as a parent I think about this a lot. Many parents wouldn't be able to tell the difference between a child just having a bad day and a child going through mental distress.

We talk about the virtual learning. We talk about Zoom life. As members of this committee, we all live on Zoom. We live in rooms with bad chairs and we live with bad lighting and bad backgrounds, but when we think about our children, this virtual learning is not working. I shouldn't say it's not working, but sometimes it's not working. My son did the first semester but wasn't willing to go back for the second semester and won't go back to school now until it's in person, because they're missing out on that quality of life, that touch, as the professor said earlier.

What are the signs that parents and guardians should look for when they're seeing a young person who may or may not just be having a bad day?

Ms. Katherine Hay: We need to remember that mental health did not begin with COVID. The things that worked for you before as a parent, teacher or community member are really important to put at the forefront now. Watch for a young person's change in behaviour. More isolation, distress or even overamplification of cheerfulness could be an indicator.

My best advice—it's Kathy Hay advice, not professional advice—is to be actively involved with your young person or a young person in your life. Watch what's going on. Don't assume everything is okay, because if you're feeling the stress of COVID, which we all are, I can assure you that young people are feeling it even more.

If I could put one final note forward, I would ask people in communities to please watch out for young people, because abuse is increasing. Kids are in homes that might not necessarily have been safe before, but they would have received support in their schools or community environments, which aren't available to them now. Keep your eyes open. Kids Help Phone does mandatory reports every day, and we work with young people and parents in those environments.

Mr. Darren Fisher: Excellent. Thank you so much.

Thank you, Mr. Chair. I know my time is up.

The Chair: Thank you, Mr. Fisher.

[*Translation*]

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

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

I want to thank all the witnesses for their contributions. This gives us food for thought and helps us find solutions to better manage these types of situations created by the pandemic.

Dr. Veissière, I first want to address the issue of psychosocial consequences as collateral damage of the pandemic.

Throughout our meetings, witnesses have warned us about the collateral damage of the pandemic, particularly for patients who don't have COVID-19. This includes offloading, late screening and cancellation of surgery. Without exaggeration, we can expect to see cases where, as a side effect, COVID-19 will result in the death of some patients or will have a very serious impact on their health, in addition to their mental health.

Last week, when you participated in a consultation conducted by the Quebec government, you clearly stated that, as part of the collateral damage of COVID-19, the psychosocial impact on the mental health of families was among the missing pieces of information that we would need to address.

Could you elaborate on this? If you feel inspired, could you give us some solutions?

Dr. Samuel Veissière: Thank you for the question. I'll respond in English.

[*English*]

It's an excellent question.

As you point out, we strongly suspect that excess mortality has been a problem. Excess mortality in turn is likely associated with a further psychosocial or mental health toll on those families negatively impacted by missed surgeries or by increased mortality not related to COVID or related to cancellation of hospital services.

The one dimension that is closest to my own area of expertise that I do want to speak on as well in terms of missing data is that there's a dire need for better evidence-based research on the impact of isolation, increased screen time and virtual and distance learning on the psychosocial emotional development of youth and on their mental health.

The last thing I also wanted to mention in response to the previous question—what can we do to help our youth?—is that we knew before the pandemic that the figures were alarming and that our youth are in distress. There's a confluence of factors that contribute to the increased erosion of resilience among younger people. One of them is increased screen time. We know this from the research.

What I would like to implore our government to do, because we cannot rely on big tech companies to do this for us, is to, at some point, treat screen time like a controlled substance—like tobacco, cannabis or alcohol, substances that we know negatively impact development—and have clear, evidence-based guidelines for its regulation.

In the short term, we can also communicate those guidelines, through family physicians and through our educators, for responsible screen time and responsible screen use. This, many of us in the community believe, is a public health emergency. It already was before the pandemic, and it is considerably worse now.

Thank you for your question.

● (1345)

[*Translation*]

Mr. Luc Thériault: You're talking about guidelines. Could you give us some ideas?

Dr. Samuel Veissière: Are you talking about guidelines for responsible screen time?

Mr. Luc Thériault: Yes. What does responsible screen time mean to you? In what context does it apply?

We're currently in a pandemic situation. As a result, virtual consultations are the preferred option. I imagine that, in your practice, this has certain advantages, but also disadvantages. You're in the process of compiling the differences that you're seeing on a therapeutic level. There are limits to what you can do when you meet with a patient virtually rather than in person.

In general, what could you say about these guidelines? In what situations should remote consultations be the preferred option? Can this practice be expanded? Will this create side effects or side issues?

Dr. Samuel Veissière: Thank you for the question.

[*English*]

I think it's important to point out that the work done by Ms. Hay, for example, is wonderful, and it is needed. There is in fact research showing that tele-therapy can confer some benefits for some patients who might otherwise have mobility or accessibility issues. It's important to continue to focus on these strategies. However, it's important to focus on prevention strategies as well. If we know that over one quarter of our youth prior to the pandemic required mental health care, this is a sign that our society is broken, in some sense. We need to focus on the strategies so that they do not need those services. Of course, those services are great, but hopefully people would be healthier.

Less screen time and more face-to-face activity would be better, as would good regulations for the amount of screen time on a developmental schedule, such as zero screen time for youth under six and then up to one hour a day with supervision, but also good guidelines for the kinds of content people consume and the kinds used. For example, we know that active communication with loved ones with social media is good. It's associated with increased well-being. Passive, mindless scrolling of anxiogenic information is not good.

There are plenty of those guidelines, but unfortunately, as I expressed to the National Assembly of Quebec last week, most of the protective factors that we can recommend do not presently apply under the current public health guidelines, which we know are required to protect our vulnerable population. However, moving toward, focused protection strategies targeting different groups with different risk factors where we know that young people really need these opportunities to connect, in particular in school and in universities, has also become an emergency.

● (1350)

[*Translation*]

The Chair: Thank you, Mr. Thériault.

[*English*]

We go now to Mr. Davies.

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

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

I'd like to thank all the witnesses for their powerful testimony. I want to direct my questions to the HEU.

Ms. Nederpel, Ms. Hackett and Ms. Dreyfus, I'd like to thank you in particular for your fierce advocacy on behalf of not only your members and those working on the front lines but also the patients they take care of. I'd also like to thank you for the service you're doing. It's well known that north of 70% of the deaths in Canada due to COVID occurred in long-term care facilities. It's your members, the staff and employees, who have been on the front lines of this, putting their health and their families at risk. I want to thank you for the incredible work you've done and the sacrifice you're making for all of our health.

Ms. Nederpel, it's been said that the conditions of work are the conditions of care in the long-term care sector. I'm just wondering what suggestions you have for the federal government to help prevent a health human resources crisis that I think is developing as a result of pandemic burnout.

Ms. Barb Nederpel: That is such a critical question, Mr. Davies. Thank you for that.

I have to say that right from the get-go, deep fragmentation happens here in British Columbia. There are hundreds of different collective agreements. Many facilities don't have any agreements whatsoever. It also changes from province to province. The impact of COVID has been pretty wide-ranging. Regardless, it has been devastating.

We have to go to the basics. We absolutely need to have national standards across this country about working conditions and the caring conditions that our residents are living in. That means we need to increase the federal transfer funds to provinces so that they can provide the dignified, unrushed care that our residents desperately need. Of course, those transfer funds must be provided, but with accountability attached to them. That's absolutely imperative. We need to address the very basics so that when emergencies such as COVID, SARS and other instances come along, we have the capacity to pivot as quickly as possible.

On top of that, we need to figure out how we provide sick pay for workers. I'm not sure if it's federal or provincial; you all need to figure that out. In the public sector agreement, workers get as many as 18 days a year for sick time. However, in the fragmented long-term care sector, we're lucky if they have five to seven paid sick days. One instance of where they have even one single symptom of COVID can wipe out their sick bank. Then what do they do? We're putting them in an untenable position where they have to feed their family and can't afford not to go to work. That's not okay, especially in this sector.

We need to have a strong sick pay plan. I think it's important to point out that new hires get none. A new hire during COVID works full-time hours alongside a fellow worker. They're getting no sick time. That's where we should really start.

Mr. Don Davies: Thank you.

You sort of anticipated where I was going next, which is that my party, the New Democrats, have been calling for national standards in the long-term care sector, working in partnership with the provinces and territories to establish minimum standards on the minimum number of hours of care per day, increasing the wages and benefits and working conditions of everybody working in the LTC sector, and similar things.

We're hearing back that there is a noticeable difference in terms of the working conditions and care standards in for-profit versus non-profit or government care homes. What can you tell us about what you're noticing in that regard?

Ms. Barb Nederpel: I think it's important to really point out the difference between the private sector and the public sector, where we've had significant contracting out and contract flipping, which was designed to drive the wages and benefits down for workers. That has resulted in a dramatic gap in the wage between the public sector and the private sector, of as much as $7 an hour. That's not even including the disproportionate impact on their benefits and pensions.

What happens is that you have this recruitment and retention problem. As I mentioned earlier, we had a crisis in long-term care long before COVID even started, because of the significant wage gap.

Again, this province has done a good job, in the sense that it has brought the wages up so that everybody gets paid the same, but that is something that absolutely needs to stay permanent. But it's not just wages; it's all of the benefits. They have to be equal right across the board in this sector.

● (1355)

Mr. Don Davies: Ms. Dreyfus, the last word goes to you.

What would mean the most to you and your fellow workers to increase the morale and your enjoyment and your feelings of protection in the sector you work in? What advice would you give us?

The Chair: Go ahead quickly, please.

Ms. Maria Dreyfus: It would really mean a lot to us if we were able to do our job, direct care, without being rushed at work, and were able to spend time, quality time, with our clients.

The Chair: Thank you, Mr. Davies.

Thank you, witnesses, for sharing with us your time today, and of course for your expertise and basically all the labours of love you put in every day.

I would also advise that if you have any further information you would like to offer the committee, please send it to the clerk, and that will be incorporated into our study as well.

With that, we'll bring in the next panel, so we will suspend. Thank you very much, everybody.

● (1355)

_____(Pause)_____

● (1404)

The Chair: The meeting is resumed.

Welcome back, everyone, as we resume meeting number 15 of the House of Commons Standing Committee on Health.

The committee is meeting today to study the emergency situation facing Canadians in light of the second wave of COVID-19.

For the witnesses just joining us, I'd just like to remind you that you may speak in the official language of your choice. Interpretation services are available in the meeting. You have the choice, at the bottom of your screen, of floor, English or French. With the latest Zoom version, you may now speak in the language of your choice without the need to select the corresponding language channel.

With that, I will introduce our witnesses.

From the Camrose Women's Shelter, we have Ms. Nora-Lee Rear, executive director; from the Canadian Grief Alliance, we have Ms. Maxxine Rattner, member, and Mr. Paul Adams, member; from Homewood Health Centre Incorporated, we have Dr. Carlos Lalonde, executive vice-president of national medical services and chief of staff; and from the Mental Health Commission of Canada, we have Ms. Louise Bradley, president and chief executive officer.

Each witness group will have six minutes to deliver a statement. I would note that I will show a yellow card when you are at the five-minute mark, and a red card when you're at six minutes.

With that, we will start the statements, if you please.

For the Camrose Women's Shelter, Ms. Nora-Lee Rear, please go ahead for six minutes.

● (1405)

Ms. Nora-Lee Rear (Executive Director, Camrose Women's Shelter): Thank you, Mr. Chair, for the opportunity to address the committee this afternoon.

The COVID-19 pandemic has created a spike in domestic violence, meaning an increased number of people seeking support. The need for mental health support for our clients surpasses what the current programming and staff can offer, and other counselling resources in the community often have wait-lists or cost more than our clients can afford.

Experiencing abuse contributes to many negative mental health outcomes, including depression, anxiety and PTSD. The additional stress, uncertainty and rapid changes of the COVID-19 pandemic put further strain on the women and children using our services. Access to quality mental health care is an important part of an individual's journey towards a lifestyle free of abuse. One of our main hopes is that by offering our services and increasing mental health supports for these women and children, we will begin to break the cycle of trauma and support clients' transitions to safe and independent lives. Fostering positive mental health is beneficial for the community overall, as better mental health is correlated to better overall wellness and the ability to function within society.

To this end, our organization designed an evaluation to understand the qualitative changes resulting from our program. The evaluation focused on individuals recognizing that they are not alone in the world or in their struggles. We used thematic analysis to discover key findings, and we believe some of those findings are relevant to this discussion today. We chose clients who were active as of September 11, 2020, providing a pool of 52 possible respondents, the majority of whom had become involved in our program since March 1, 2020.

While safety from abusers is a key part of our shelter services, numerous clients also identified the women's shelter involvement as a form of suicide prevention. Often there is a deep sense of loneliness that accompanies leaving a relationship, even an abusive one. This, combined with the logistical and economic complications that most women face and compounded with the mixed messages received during COVID, has created the perfect storm for abusers to capitalize on. Shelters state that they are the safest place to be, even during COVID, while public health messages lock down victims with their abusers, making it more difficult for someone in an abusive relationship to flee to a shelter during social isolation, because their partner may be more closely monitoring or limiting their technology use.

One interviewee said, “Through this program, I went from feeling like committing suicide to feeling like I had a lot of hope.” They went from feeling helpless to feeling they were powerful, with choices and independence. This increased sense of control led to greater mental resilience and the ability to move forward in adverse situations, even during COVID.

Many clients expressed that they had gained the ability to take back their power. Before being involved in our programs, respondents could not speak for themselves or their children, but they now report coming back to who they were before the abuse. They went from feeling helpless to feeling they were powerful, with choices and independence. One interviewee said, “Knowing I have help gets me through mentally.” Another said, “I know that when things get worse for me, the women's shelter is always there.”

A number of respondents shared the difficulty of addressing societal misconceptions about abuse. Those experiences included conversations with friends and family who were uncertain about how to respond to disclosures of abuse and who just didn't “get it”. The common theme that united these experiences was trying to explain abuse to those who don't get it. One respondent expressed, “It is very frustrating, because within my family, who are supposed to support me, someone will say, 'You're a liar', 'That didn't happen', or 'It wasn't that bad.'” These frustrations range from the systemic level to the personal level and are particularly difficult for someone who is trying to relate the effects of abuse on their mental well-being when no one believes them.

● (1410)

Respondents also described their own barriers to accessing services. Abuse can skew an individual’s relationship to help, including feeling undeserving of the help or fearful that assistance will be withheld. Respondents identified a fear of being told “no” when asking for services. One respondent was afraid to access human services as she feared it would be used against her by her abuser. The constant fear of what will be used against our clients is an ongoing reminder of the control abusers have, and COVID has exacerbated that.

During times of COVID, while the public is hearing pervasive messaging to stay home and stay safe for their physical and mental health, women also need to know that, one, shelters serving abused women and children are open and are ready to help, and two, that you don’t need to come to a shelter to get help. As they have done throughout their history, shelters have been innovative in their approaches to reach and support women and to support their mental health.

What COVID has done is to shine a spotlight on the many cracks and fissures in the support networks that women need on their path to healing. We know we can make a difference in women’s mental health, as well as their children’s, now and in the very difficult times that we know are coming.

Thank you.

The Chair: Thank you, Ms. Rear.

We go now to the Canadian Grief Alliance and to Ms. Rattner or Mr. Adams to give a statement for their group.

Go ahead. You have six minutes.

Mr. Paul Adams (Member, Canadian Grief Alliance): Mr. Chair and honourable members, thank you for inviting the Canadian Grief Alliance to speak to you today.

We're a coalition of grief experts and more than 150 leading health organizations, including the Canadian Medical Association, the Canadian Nurses Association, and the Canadian Psychiatric Association. We came together last spring to ask all levels of government to urgently turn their minds to the issue of grief in the context of COVID-19 and in anticipation of the deadly toll we have seen since.

Almost every one of us has suffered grief in our lives: the loss of a mother or father, a brother or sister, or perhaps a child or close friend. As profound as our grief may have been, what most of us suffered was the usual response of human beings to profound loss. Most of us, with the help of family and friends and the passage of time, rejoined the trajectory of our lives, even if the ache of loss never entirely disappeared, but what the research tells us is that when grief is complicated, when its circumstances prevent us from having the space or the support to grieve, it can transform into depression or anxiety, dependence or addiction, and self-harm or the thoughts of it.

Today, we're suffering a pandemic of grief. Nearly 20,000 Canadians have died of COVID-19. The image of a nurse holding an iPad at someone's deathbed is now a familiar one. Robbed of the chance to be with their loved one at their deathbed, the grieving may have a funeral replaced with a Zoom call. Instead of a house filled up with family and friends, the grieving may have a frozen lasagna dropped off at their doorstep—socially distanced, no hug, no touch, no lingering visit.

Nowadays, much of this is also true of those who grieve for the 25,000 people in Canada who die of heart disease, cancer or anything else in an ordinary month. More than two million Canadians are estimated to have been touched directly by death in their circle during this pandemic, and their experience is anything but normal. It's complicated grief, the kind that we know can lead to enduring mental health issues.

Specific communities are especially affected. Health workers are exposed to a scale of suffering that even they are unaccustomed to. The CGA also recognizes the generations of grief that indigenous people carry as the result of colonization and structural violence, which are often overlooked in public health policy.

Our existing system is not well equipped to deal with grief, in part because it is rightfully not regarded as a form of mental illness. Indeed, mental health advice that is sound for those suffering from anxiety or depression may actually make matters worse for the grieving. The grieving need dedicated support that understands the nature of their grief and how to guide them. That's why we at the Canadian Grief Alliance believe it's time for a Canadian grief strategy, whose aim would be to help Canadians avoid succumbing to enduring mental health challenges that will diminish their lives and take a toll on our society and our health care system.

I'll ask my colleague Maxxine Rattner to take it from there.

● (1415)

Ms. Maxxine Rattner (Member, Canadian Grief Alliance): Thanks so much, Paul.

Specifically, we are proposing a three-part emergency-based response as the first steps of a Canadian grief strategy. First, Canadians need expanded access to grief services where they live. Grief services that were largely under-resourced before the pandemic are now bursting at the seams, trying to meet skyrocketing demands. In many parts of the country, there are long wait-lists or a complete absence of grief services. Without sufficient grief services, the risks for mental health issues to develop will increase. Communities disproportionally impacted by the pandemic, including racialized and indigenous communities, are also being disproportionately impacted by grief. Grief support services and programs led by and for these communities are essential.

Second, we propose a national public awareness campaign to increase Canadians' understanding of grief and provide education and strategies to help Canadians grieving in isolation to cope. Such a campaign would also acknowledge our collective grief as a country.

Third, Canadians have never experienced this depth and breadth of grief and loss before. We propose a rapid national consultation in the immediate term, and dedicated research funding in the months to come that would allow us to better understand pandemic-related and affected grief. We have a model that would allow us to complete such a consultation within about two months, as we are very connected to organizations doing this work and are engaged with diverse communities across the country.

The emergency measures that I have just outlined are necessary but not sufficient to quell the rising tide of grief and its anticipated medium- and long-term social, economic and mental health impacts on Canadian society. Current mental health spending does not include grief services. Grief is falling through the cracks. We urge you to implement a Canadian grief strategy that brings together federal government departments, provincial and territorial partners and NGOs to build a coordinated, sustained and evidence-based response to the growing needs of grieving Canadians.

Grief cuts across the government's work in health and public health, from dementia to substance use, indigenous communities and children. We envision the strategy as having a lasting place within the framework of government. A Canadian grief strategy will help prevent significant mental health outcomes for individuals, families and communities across the country now and in the months and years to come. Canada has the opportunity to be a true leader by being the first country worldwide to commit to a grief strategy in the wake of COVID-19. On behalf of an ever-growing number of grieving Canadians, we urge you not to miss this opportunity.

Thank you.

The Chair: Thank you, Ms. Rattner.

We will go now to Homewood Health Centre, to Dr. Lalonde.

Please go ahead for six minutes.

Dr. Carlos Lalonde (Executive Vice-President of National Medical Services and Chief of Staff, Homewood Health Centre Inc.): Thank you very much for this opportunity, Mr. Chair.

The COVID-19 pandemic has contributed to an ongoing and expanding mental health crisis for Canadians and for the systems, institutions and professionals that provide mental health care across the country. The mental health impacts of the pandemic are both pervasive and severe, and, as always, the most vulnerable people are suffering the most.

I trust that we all recognize the truth in those statements and recognize that the rates of anxiety, depression, addictions and other mental health conditions have been on the rise. Rather than reciting specific statistics today, I hope to advocate for practical, inexpensive measures that we can implement now to make a significant and sustainable impact on Canada's ability to address this mental health crisis and the ones that follow.

While I am the executive vice-president of medical services and chief of staff for Homewood Health, a national organization providing mental health and addictions care, I am also a member of the board of examiners for the Royal College of Physicians and Surgeons of Canada. I'm actively involved in undergraduate and postgraduate education within the Department of Psychiatry at McMaster University, and I am a practising psychiatrist with extensive experience in front-line in-patient and outpatient psychiatry.

With that background, I would like to speak about our front-line mental health workers. It's not just our systems, institutions and resources that are stretched by the pandemic—it's our people. At home, these people have been facing the same stressors as everyone else over the past year. In addition, they have been responsible for supporting those in need of intensive mental health supports while often being faced with increased risk of exposure to the virus on the front lines.

The pandemic has thus created a situation where our front-line mental health professionals—physicians, psychologists, nurses and other clinical staff—the people supporting our most vulnerable citizens and our exhausted medical professionals and essential workers, are also burning out at record rates. The result is that there are fewer qualified mental health professionals left to care for a growing number of patients. This has led to significant gaps in care and more burnout. I see it every day. In addition to the overall shortage of these professionals, these vital resources are distributed inequitably across the country. These individuals tend to practise more in urban areas and in certain provinces over others.

Concurrently, we are rightfully doing more to encourage people to seek help. Wellness Together Canada, for example, is serving thousands of Canadians and provides easy-to-access virtual and telephonic services within a stepped care model offering anything from peer support to short-term counselling based on an individual's unique needs.

Unfortunately, experience gained over the course of this pandemic has further highlighted what many of us already knew: that the needs of many individuals cannot be fully met within the current system and that there is critically limited access to higher-level mental health practitioners, specifically psychologists and psychiatrists. Across the country, the availability of psychiatrists is particularly limited. There is a desperate need for these professionals, who are uniquely qualified to diagnose and treat those with more severe forms of mental illness through utilization of evidence-based psychotherapies, measurement-based care and, at times, medications.

What can we do? There are certain things we can do from an organizational level, but larger systemic change and national support are needed. In the long term, we can commit to making historic investments in mental health. We can train more mental health professionals, and we can incorporate virtual care requirements into training programs. We can work towards these types of initiatives down the road, but we need practical strategies that we can implement now to address the current needs during this pandemic.

I have three suggestions.

First, we need to make it easier to deploy expertise where we need it by reducing barriers between provinces to make it easier for qualified mental health professionals to practise interprovincially. With clinicians and patients becoming increasingly comfortable with virtual care, a licensed practitioner should be able to help patients in Alberta, Ontario and Nova Scotia in a single afternoon.

Speaking from personal experience, even for a Canadian psychiatrist with full licensure in one province, the process of gaining licensure in another province is onerous and can take months. The process is similar for those in other disciplines who report to their own provincial colleges. I am in support of the recommendations of the Royal College's virtual care task force report, which spoke of the idea of a pan-Canadian licence.

Second, along with increasing accessibility to secure virtual platforms, I believe we should provide financial incentives for those services we need most, specifically consultations and the provision of virtual care, particularly in the most under-serviced areas of our country. I would also suggest that this incentive not be contingent on the use of a specific online platform like OTN, as is the case in Ontario for physicians.

● (1420)

Third, we can streamline the process for allowing foreign-trained mental health professionals to practise in Canada. Even highly experienced psychiatrists who have completed all of their medical education in the United States face significant obstacles to practising in Canada. This process seems unnecessary and can sometimes take years to complete, all during a time when our national need for these professionals is skyrocketing.

As a country, we need to take better care of the people working on the front lines of our mental health system. To help them help their fellow Canadians, we need to act swiftly to enhance our professional capacity and give those professionals the flexibility to practice where we need them most. If we can reduce interprovincial barriers, if we can increase access to secure virtual platforms and provide additional incentives for the most-needed services, and if we can accelerate the process of putting qualified non-Canadians on the front line, we will be better prepared as a profession, a system and a nation to help the people who need our help most.

Thank you.

The Chair: Thank you, Dr. Lalonde.

We'll go now to the Mental Health Commission of Canada, to Ms. Bradley.

Please go ahead for six minutes.

● (1425)

Ms. Louise Bradley (President and Chief Executive Officer, Mental Health Commission of Canada): Thank you, Mr. Chair and members of the committee, for having me here today. It's particularly timely, given that yesterday was Bell Let's Talk Day, about raising awareness about mental health. The year 2021 marks the 11th year for Bell Let's Talk, and it has a very different feel from what it had in previous years. Partly, that's because mental health has been top of mind since the onset of the pandemic, and the numbers speak for themselves.

A soon-to-be-released Leger poll conducted for the Mental Health Commission of Canada and the Canadian Centre on Substance Use and Addiction spells out some very real concerns. The number of people in Canada reporting strong mental health has dropped by 23%, a drop from about two-thirds of the population to less than half since last March.

While awareness may be higher, the extent to which people with substance use and/or mental health concerns are accessing necessary treatments and supports is not keeping pace. Just 24% of respondents with problematic substance use and 22% with current mental health symptoms have accessed treatments since March.

On the heels of Bell Let's Talk, I think we can agree that it's time for some strong action. Don't get me wrong—five cents a text adds up to important community mental health funding, but to truly put our money where our mouth is, we have to be willing to invest the kinds of dollars that move mountains, quite frankly.

That's why we at the Mental Health Commission of Canada were so pleased to see Parliament unified behind the need for a standardized national mental health crisis hotline. It may be one small step, but any journey begins by putting one foot in front of the other.

Perhaps, though, there is a means to accelerate our progress. While old-fashioned thinking is one means to an end, we'll race to a place of mental health parity more quickly if we're willing to hit fast-forward by leveraging technology, which has shown in many instances to be as effective as face-to-face interventions.

Before we talk about virtual care and e-mental health, two game-changers the commission is strongly advancing, we need to realize that given the complexities of mental illness, there will never be one single adequate solution. We can't separate the mind from the body, nor can we divide mental wellness from the experiences that have formed each of us. As humans, we aren't made up of neat compartments that can be assessed and evaluated in isolation from each other. We tend to be a bit messy and complex, a mixture of biology and psychology, very heavily influenced by social determinants of health such as income, education, race, exposure to trauma, and the list goes on.

The question of equity is going to be central to any truly meaningful progress, and that means shining a light on gaps and building the bridges to span them. With a dearth of culturally appropriate care, dwindling broadband signals in rural and remote communities, tech hesitancy among seniors, and lack of access among people living in poverty, we cannot expect e-mental health to hurdle systemic societal problems that need to be addressed at the root cause.

That doesn't mean we should throw our hands up in the air—quite the contrary. Take Wellness Together Canada, which has just been mentioned. It is built on a framework championed by the commission and is an important example of how partnerships across jurisdictions can translate into meaningful services. Today, we can access free mental health supports through online services that were developed to meet a need, and this happened almost overnight. If we can accomplish that, a feat once thought impossible—if even imagined at all, in fact—imagine how bright the future could be. To date, half a million people have accessed that site, but we know the need runs deeper.

● (1430)

Pre-pandemic, 1.6 million people in this country reported an unmet need for mental health care. Given the precipitous drop in mental wellness, I think it's safe to say that this need has only grown. Yes, it's true that symptoms of anxiety and depression and suicidal thoughts are increasing, but that does not mean that we must accept an echo mental health pandemic as inevitable.

If ever there has been a time to knit a tighter safety net, it is now. Whether we focus on standardizing virtual care or investing in accreditation of mental health apps, there is a critical role for all of you to play as decision-makers with the capacity to champion innovation.

Our late board chair, the Honourable Michael Wilson, put it best when he said, “There needs to be significant funding earmarked for ramping up access to services, community care and suicide prevention. But there must also be latitude for proving the sound economics of creative approaches.” These creative approaches include leveraging new technologies to keep pace with our counterparts in New Zealand and Australia.

COVID has underscored the importance of mental health, highlighting the precariousness of our well-being.

I hope that you will engage in further collaboration and innovation. We look forward to partnering with you in these initiatives.

Thank you kindly.

The Chair: Thank you, witnesses, for all of your statements.

We go now to questions. We will have time for one round of questions.

We start with Ms. Rempel Garner.

Please, go ahead for six minutes.

Mr. Chris d’Entremont (West Nova, CPC): I'm going to be taking her time.

The Chair: Okay. Go ahead, Mr. d'Entremont.

Mr. Chris d’Entremont: Thank you very much.

I want to start with the Grief Alliance for a moment.

Nova Scotia is the province I live in, and I know there are a number of us who are Nova Scotia-based: Mr. Fisher and Mr. Kelloway. Nova Scotia has been experiencing a lot of grief, whether due to the Portapique murders, or the six people we recently lost here from the southwest in a vessel, and we just lost a couple down in our neck of the woods as well. So, it's been a lot.... Even beyond the COVID issue, there's been a lot of very public grieving—or the lack thereof.

I want to understand what a grief service might be, because we don't have one here. Beyond the community and a few community members coming together to bring families and groups together, I don't know what a grief service actually is.

Ms. Maxxine Rattner: Thank you so much for that question.

There are definitely organizations across the country. I know that there's a wonderful provincial bereavement lead in your province, actually, as well. They are people who have the specialty and expertise and who are serving people on the ground. I'm from Toronto, and I can tell you that there are organizations such as Bereaved Families of Ontario, and a lot of hospices offer bereavement support.

You're right. There's a patchwork of grief services across the country. This is an under-resourced area that really has affected all of humanity prior to the pandemic. You can imagine that this patchwork of services that has been there pre-pandemic is just bursting at the seams, as I said, because they are hidden. They're things that people don't know about or access until they are affected.

When someone dies in a long-term care home, as so many thousands of people are doing across the country, there is no follow-up bereavement support. When someone dies in a hospital, there is no follow-up bereavement support. I will say, as a proud member of the palliative care community and as a hospice social worker for the past 10 years, that in most palliative care contexts there is no follow-up bereavement support. Hospices are one of the sole places where that happens, for about a year, but any grieving person can tell you that one year is not sufficient in many instances, and with the immense amount of grief and loss happening in your province, that's what we're thinking about when we think about complicated grief.

Complicated grief happens when a person, a community, or a family experiences multiple losses in a short amount of time or a long amount of time. Loss upon loss gets amplified. In many ways, I would never want to project onto your community, but I imagine that there are some manifestations of complex and complicated grief because of these multiple instances of trauma and loss happening around you.

Those are the examples we're speaking of, but, yes, I can look at my list to see who we have. Hospice Halifax would be offering bereavement support, but you're right, it's not like a grief service.

● (1435)

Mr. Chris d’Entremont: We're three hours away from that, so it's a big challenge.

Ms. Maxxine Rattner: Yes, exactly.

Mr. Chris d’Entremont: It's a big challenge, and since COVID is here, we're not travelling as we should be and we're not going to get the services that we should be getting, so that's adding to it.

In the three-point plan that you have, or the request you have, have you gone to governments? I'm going to guess that it's a health issue, and each province is a little different and there's a federal component. Who have you gone to and what kinds of commitments have you gotten at this point?

Ms. Maxxine Rattner: We have been meeting with some MPs who have been open to that. One of my colleagues within the CGA has met with the Minister of Health in Thunder Bay. I think all of us have been working off the side of our desks as a volunteer effort in trying to get attention for this urgent need.

I'm happy to have my colleague Paul add to that in any way, if that would be helpful.

Mr. Paul Adams: We've interacted at the moment principally with the federal government. We've been trying to get our message out through media.

What you were saying really touched me. I lost my wife four years ago to cancer. I was able to be at her bedside. We had a funeral. Family and friends came. We were able to travel to be with other family members. All of these things are denied people. As you were describing, in a situation of irregular and really profound loss, it's very difficult to imagine that people have the resources at hand to get through this.

Mr. Chris d'Entremont: I have a minute left. I want to go to Dr. Lalonde for a minute.

When we talk about the transfer of doctors and locums and being able to at least transfer these experts from one province to another, does it not sometimes fall upon the shoulders of the self-regulated college of physicians or what have you? How do we deal with that as a country when we have so many of these self-regulated organizations or colleges?

Dr. Carlos Lalonde: I think it's a great question, one that I don't have a simple answer to. One of the few benefits of the COVID situation currently is that it has increased the sense of community and collaboration across the country and between organizations and such. This is a topic that's been spoken about for years, and, again, even prior to this pandemic there was talk by some about a pan-Canadian licence.

It would require collaboration and communication amongst the different provincial colleges, whether we're talking about the college of physicians for the various provinces or other professional governing bodies, to essentially communicate and collaborate. It wouldn't be that difficult because we already have to register most of our documents and most of our other qualifications online. It would essentially just be a matter of provincial colleges co-operating and coming up with some type of formula to be able to make this work. It is something that could happen very quickly. Take a process that takes currently a couple of months and whittle it down to something that could take a couple of weeks, or maybe even a couple of days. The requirements are almost identical across all provinces. These boundaries that we've formed over time just need to be broken down so we will be able to provide the services to the people who need them.

Again, there was a survey last year of Canadian physicians, which showed that 90% of the doctors in Canada thought it would improve access to care across the country if we were able to do this, and about 50% of those physicians would be willing to do locums in various provinces, with a similar number of people willing to do virtual care.

Mr. Chris d'Entremont: Thank you for that.

Thanks for all the presentations.

The Chair: Thank you, Mr. d'Entremont.

We go now to Mr. Van Bynen.

Mr. Van Bynen, please go ahead for six minutes.

● (1440)

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

I want to start off by saying that I will be sharing my time with my colleague Mr. Kelloway.

Dr. Lalonde, thank you for joining us and thank you for the important work you do. My understanding is that you're providing support and health care support for many of our health care workers. Based on what we heard in the previous setting, there's a critical need.

We've already seen everybody spending a lot of time projecting what our COVID virus cases will be. We're all talking about how serious mental health is. Frankly, I believe the next wave is going to be much greater, and a big role for this committee is going to be to identify the gaps going forward so the government can respond.

Is there any way we can project the trajectory of mental health needs and mental health cases going forward so we can start preparing now to have the resources we're going to need?

Dr. Carlos Lalonde: I think there are ways, and I think some people are working on those specific projections. Again, as this pandemic has continued, we know the rates of depression have increased further, and the rates of anxiety have increased further. It's one thing to be able to deal with a stressful situation for a short amount of time, but we know the cumulative effective of this type of scenario tends to continue to raise various rates of all sorts of different conditions.

Again, we know that those who are most under-serviced will probably be most impacted. Folks who already have medical and psychiatric conditions, folks who are already on the cusp of poverty, people who don't have access to those resources, people who are losing their jobs and don't have the financial resources otherwise—those populations will continue to get worse, as is the case for all of us. However, again, proportionally we know certain populations are likely to be more affected. Women seem to be at slightly increased risk over men at this point. As well, there are families with young children under the age of 18, those in marginalized communities, racialized people and members of our LGBTQ community, and people who are the most financially impacted.

We know which populations are at greatest risk. We know the rates are rising and we know that given the difficulty of predicting what's going to happen moving forward with this pandemic, rates of various mental health and addiction conditions will continue to rise.

Mr. Tony Van Bynen: Many points were raised about a pan-Canadian data system. If we could do that with respect to mental health as well, it would help us identify the gaps and the areas where the gaps are the greatest.

Dr. Carlos Lalonde: Yes, absolutely.

Mr. Tony Van Bynen: There's another wave I'm concerned about. Every year, Canadians show symptoms of seasonal affective disorder, or SAD. With winter just starting and as the post-holiday depression kicks in, we now have a pandemic on top of that. I know it's still early in the year, but is there any data so far that shows how this pandemic has impacted people who are experiencing SAD?

Dr. Carlos Lalonde: That's a good question, but it's very difficult to tease out. In truth, I haven't looked at the data on rates that could distinguish between those two conditions. We know that for many people, particularly in certain parts of the country where there is far less sunlight, the winter months are much more difficult. We know that for these winter months in particular the rates are far higher than before, but it is difficult to distinguish how much of that is related to SAD and how much of that is related to the pandemic. Realistically, compared with last year, given other conditions being the same, the rates are much higher in relation to the pandemic.

It's of less importance to tease out what the causation is than it is to recognize that the rates are higher, identify those most in need of treatment of severe depression, whether it's SAD or otherwise, and connect them with the appropriate resources—and not only counselling. Again, we need to go beyond counselling. When you get to the point of meeting criteria for certain conditions, you need more specific evidence-based therapies, including, potentially, a SAD light for some people, evidence-based psychotherapies, measurement-based care and, again, sometimes medications. That requires that human resources be available for those people to access.

● (1445)

Mr. Tony Van Bynen: Thank you.

I'll turn things over to my colleague now.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thank you, MP Van Bynen. I appreciate it.

My question is for Dr. Lalonde. Homewood Health is a partner in the mental health portal Wellness Together Canada. My question for you—or one of them, anyway—is, has this portal been useful? Has it been a useful resource for you and the people you work with?

On my second question, thank you so much for the four pragmatic areas to look at. I will need to call you or do a Zoom to unpack all of it, because I'm very interested in that.

Dr. Carlos Lalonde: Absolutely.

Mr. Mike Kelloway: If there is one area to start with in those four, where would it be and why?

Thank you so much.

Dr. Carlos Lalonde: In terms of the first part of your question on whether it has been helpful to people within certain organizations or nationally, I do think that it has been helpful. I think it has been very helpful, just by simply looking at the number of people who have accessed this service. I can't give you the specific number. I think Ms. Bradley mentioned earlier that it was over 500,000. I believe it's actually closer to 800,000 or so at this point, but I could be mistaken on that. We know that quite a number of Canadians have accessed that resource.

Again, in trying to provide the most appropriate level of care based on that individual's needs, whether it's connecting with certain online resources for education, iCBT, peer support or up to four sessions of one-to-one counselling virtually, we know that many Canadians have benefited from this service, but we know that it can only go so far. Again, if certain people have more severe conditions, that's when this service starts to be insufficient.

In terms of what I would do first, again, in terms of what can be done right away, I think the co-operation of various colleges across Canada can happen very quickly, and it would very suddenly increase access for a whole lot of Canadians to psychiatrists, other physicians, psychologists and other mental health professionals if we were able to break down those interprovincial boundaries.

Mr. Mike Kelloway: Thank you so much. I will be reaching out to you.

Thanks to the witnesses. It has been very illuminating.

The Chair: Thank you, Mr. Kelloway.

[*Translation*]

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

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

Ms. Bradley, the Mental Health Commission of Canada prepared a very good brief on e-mental health in Canada. That said, I'd like to make a general comment. We often say that happiness is in our head, meaning in the way that we see things when we get up in the morning. At the same time, the pandemic is showing us that, throughout history, mental illness has never had the same status as all other illnesses. It has always been overlooked in our health care systems. This is coming back to hit us square in the face now that we're in a crisis.

I gathered from your presentation earlier that we must continue to invest in the determining factors of mental health, to intervene proactively and to improve our ability to reverse poor mental health situations that lead to suicidal conditions. Obviously, there were suicidal conditions before the pandemic, but these conditions may have been exacerbated by the crisis. As decision-makers and as a society, we don't have the right to repeat the mistakes of the past. We have the opportunity to right the wrongs. This pandemic may give us the chance to review our priorities. A society can't tolerate an individual in perfect physical health wanting to take their own life as a result of profound suffering related to how they see reality.

I now want to talk about your brief entitled "COVID-19 and Suicide: Potential Implications and Opportunities to Influence Trends in Canada". You stated the following:

> While history demonstrates the *potential* for COVID-19?and the resulting anticipated economic recession?to impact suicide rates, an increase is *not* inevitable.

How could we avoid the worst-case scenario? What would be the priority actions? What most urgently needs to be done, here and now, to prevent this avoidable increase from taking place?

● (1450)

[*English*]

Ms. Louise Bradley: Thank you very much for your question. I will try to answer the various parts of it.

Certainly your initial comment about this being important to address upstream is critical.

With regard to historical events impacting mental health and mental illness, you're absolutely right on that one as well. That stigma, while we have certainly gone a long way to reducing it, is still alive and well. I think that is impacting, in particular, structural stigma. It's impacting why we aren't making the important decisions that are needing to be made, particularly during a pandemic.

If I could reference the previous question in answering yours as well, with regard to the Wellness Together portal, it's based on a stepped care 2.0 model. I want to point out that was piloted in one province first, and it's now available in three others, including Nova Scotia. In that first province it was shown to decrease wait times by 68%. That's a very significant number, particularly when you're looking at wait times in Canada of about 18 months for youth and adults.

I agree that with serious mental illnesses, it does need to be dealt with differently. There is a big concern that the pandemic is probably impacting a lot of vulnerable populations, but in particular people with serious mental illnesses. There was a study that came out this morning that showed that people with schizophrenia are dying more from COVID-19 than are other populations.

I do believe that suicide rates are avoidable. The difficulty with suicide rates is that we don't have very good data. We know that approximately 4,000 people every year in Canada die by suicide, and those rates supposedly have not increased, but they haven't decreased either. In order to address suicide, we need to know exactly what the rates are to begin with. There is a community program to speak to avoidable suicides, which is now being rolled out and piloted in eight communities across the country through the Mental Health Commission of Canada. A number of others are now joining that provincially.

It's a very complex question that you've asked, but I do believe that there are definite ways to ensure that suicide rates do not increase, but we do have to look at the plight of people with serious mental illnesses and chronic illnesses.

[*Translation*]

The Chair: Thank you, Mr. Thériault.

[*English*]

We go now to Mr. Davies.

Mr. Davies, please go ahead for six minutes.

Mr. Don Davies: Thank you.

Mr. Adams, back in May of 2020, you wrote, “We are social beings who crave social contact, human contact. These are being blocked during the pandemic and there will be fallout.”

Can you describe for us what that fallout is, in your view?

● (1455)

Mr. Paul Adams: We know from the research that complex grief, by which we mean people who are not allowed to grieve in the normal way, the natural way for those who are privileged to have family, friends, space and time to recover their normal lives, can tip people into more serious mental health issues. That can be suicidal ideation, anxiety, depression or enduring features of mental health that make it difficult for people to recover their balance and to rejoin their community and their lives, their work and their family in the way that healthy grieving allows us to do.

I can say that one of the places that helped me and our two teenage children when my wife died was a local cancer organization that had a bereavement group. That organization, like many charitable organizations, has lost funding and donations, and it's been laying people off at a time when the need for these kinds of supports for people is greater than ever. There are all kinds of things that can happen. Remember, too, that just because you lost someone close to you doesn't mean that you haven't also lost a business or a job, or that you don't have other strains of the pandemic, of trying to work with children at home or going into a stressful or even a dangerous environment. It's the complexity of pressures that is particularly difficult.

Mr. Don Davies: Thanks.

Ms. Rattner, in December you co-authored an op-ed in iPolitics that said the following: “Three seasons into this pandemic, there’s been no comprehensive government response to the growing 'crisis within a crisis' of grief.”

Have you received any reason or explanation from the government for why it has been so slow to respond to this, I guess, foreseeable grief crisis that was warned about last May?

Ms. Maxxine Rattner: We haven't received a concrete response. I think there is percolating interest, but obviously there are lots of things to focus on for the government. The fallout of significant numbers of deaths maybe wasn't front and centre back in the first couple of seasons.

We do know that Wellness Together was a major response from the government around supporting people across Canada with mental health. We've met with the leadership of Wellness Together, who acknowledge the significant limitations of their portal around grief. We are kind of making inroads for different departments within government to understand this issue. The distinction between how to treat and respond to such mental health issues as depression and anxiety versus grief isn't something that's necessarily well understood.

I'm happy to elaborate on that, if that would be helpful, but I don't know if that—

Mr. Don Davies: Thank you. I have limited time. Maybe we can follow up on that.

Ms. Maxxine Rattner: Sure.

Mr. Don Davies: Ms. Bradley, the Royal Society of Canada recently issued a report entitled "Easing the Disruption of COVID-19: Supporting the Mental Health of the People of Canada". It recommended that Canada "increase funding for mental health services to at least 12% of the health services budget to respond to the longstanding unmet need that has been exacerbated by the COVID-19 pandemic".

Can you please tell us what percentage Canada spends currently on mental health, and whether you agree with that recommendation?

Ms. Louise Bradley: I do agree with that recommendation. Currently, Canada spends around 7% of its health dollars on mental health. With the recent investments, over the next 10 years, if memory serves me, which it sometimes doesn't, that will bring us up to approximately 7.2%. What we are advocating for, if we are going to aim for parity between mental and physical health, is that it needs to go to at least 9%. That will require quite a significant influx of dollars.

I would hasten to add that it's important to say that it's not just the amount. It needs to be done with innovation involved in that, and with different ways of providing services, some of which we've talked about.

● (1500)

Mr. Don Davies: Thank you.

Mr. Lalonde, I often hear that the answer to addiction isn't sobriety—it's connection. We know that in recovery, so much is delivered via peer support groups, 12-step programs and other such very important recovery models. I'm wondering what impacts you have seen or can tell us about in terms of the recovery of people suffering from addiction and how that may have been affected by the COVID-19 restrictions.

Dr. Carlos Lalonde: That is a very good point. Many of our folks with significant substance use disorders rely very heavily on community support, on their sponsors, on 12-step meetings and other peer support meetings. There is something to be said about physical presence in the environment. That, of course, isn't able to happen currently, but I am glad to share that many of these peer support groups are still meeting through online platforms. Many of our patients here at home are still accessing these online platforms. I have heard from various patients and people seeking out treatment for addictions that it's beneficial but not quite the same.

My hope is that as the stay-at-home order in Ontario eventually is removed and we're able to get back into at least socially distanced groupings, we are able to reimplement some of these important strategies in terms of those social connections of peer support groups but, in the meantime, are able to take full advantage of the online platforms that are available to all of us.

Mr. Don Davies: Thank you.

The Chair: Thank you, Mr. Davies.

That brings our round of questions to a close.

Witnesses, thank you for your expertise and for sharing your time with us as well as your care and concern.

That being said, I see that Mr. Van Bynen has his hand up to speak.

Mr. Van Bynen, please go ahead.

Mr. Tony Van Bynen: Thank you, Mr. Chair.

First of all, I want to thank the committee for pursuing the issue that we have just concluded. I think we've had a very extensive understanding of a very important study, and what I refer to, of course, as the looming silent pandemic. I think what we've heard today reinforces that.

What I think is important, though, is that we now take some time to consolidate what we've learned. I request, and in fact, I move:

> That the committee instruct the analysts to prepare an interim report on the topic of the impact of COVID-19 on the mental health of Canadians based on the four meetings held on this topic as part of the study on the Emergency Situation Facing Canadians in Light of the Second Wave of COVID-19.

That's the end of the motion.

I think it's important for us to sit down and take a look at what we've heard before it gets lost in all of the others, and there's an opportunity, if the committee so wishes, to do the same thing for other topics. I really think it's important now that we consolidate and take a look at what we've learned and put together a report so that it can be a chapter in the overall study that we're undertaking as a committee.

The Chair: Thank you, Mr. Van Bynen.

I will ask the analysts if they want to jump in here and give us some advice on doing such a report and on what they require and so forth.

Mr. John Barlow (Foothills, CPC): Mr. Chair, if I can just pipe in on a point of order really quickly, you may want to let the witnesses go. I see that they're still on here, and there's really no reason for them to be sticking around.

The Chair: Yes, absolutely. Thank you, Mr. Barlow.

Witnesses, thank you so much for your time. We certainly welcome what you've told us, but we will be going into a bit of committee business right now, so feel free to leave if you wish. Thank you.

Dr. Carlos Lalonde: Thank you very much.

The Chair: We'll go ahead.

Once again, I'm asking the analysts if they wish to step in and give us some advice on how to proceed here.

Ms. Sonya Norris (Committee Researcher): I think writing an interim report would be very helpful. It would help to focus the committee on what they heard during those first four meetings, and it takes the study into some easier-to-consume bites. We're fine to go ahead and to start to draft an interim report. If the committee wishes, they could also go the way of each of the members submitting what they hope will be in the report. That could be submitted through the clerk.

● (1505)

The Chair: Thank you, Sonya, for the information.

Mr. Van Bynen, I see that your hand is still up. Do you wish to speak again? Okay.

Next we have Ms. Rempel Garner.

Hon. Michelle Rempel Garner (Calgary Nose Hill, CPC): The testimony we heard from witnesses today was deeply impactful for me, to the point where I was—as, I'm sure, some of my colleagues on the meeting today were—almost brought to tears. The impact of the pandemic is felt across all political stripes and demographics in this country.

I'm sitting here trying to manage news that the Moderna shipment of vaccines has been deeply cut today. We have more restrictions on Canadian civil liberties, with no end in sight. The EU is looking at trade restrictions on vaccines. I'm trying to manage all this news, and what I don't want to have happen with an interim report is for the government to use that as a way to stall witnesses on vaccine delivery or the ministers in front of committee next week on vaccines.

I don't mind if the analysts want to start writing an interim report, but if this is what this committee is going to do, then they can expect us to be providing recommendations as a committee on vaccine delivery.

We're in a national crisis. On a Friday afternoon, with no makeup on, I'm trying to absorb the fact that our country is not in a position to be receiving vaccines any time soon. In the middle of what is essentially a wartime effort, when we don't have vaccines, I don't want our health committee—the federal Standing Committee on Health—to be wasting meetings deliberating things like punctuation on a report that's not material to getting the tools to end this pandemic.

If that's the intention of the Liberals on this committee, it is a no go for me and it's a no go for the Conservative party. I don't mind if the analysts want to start writing stuff up, because I think reporting on the mental health impact of the pandemic is fine.

I'm going to look to colleagues, particularly from the NDP and from the Bloc, for agreement that if we are going to support an interim report on mental health, the deliberations on the report happen outside of the meetings that are scheduled on vaccines for the next couple of weeks, or over the break. If we want to deliberate an interim report on mental health, I would suggest that this committee do that over the parliamentary recess and not during the regularly scheduled meetings that are coming up on vaccines.

This committee needs to work across political stripes to encourage the government and come up with bold moon-shot positions to get our country vaccines.

As I'm sitting here, my phone has just been blowing up today with people asking, “When are we getting vaccines?” and me going, “I don't know. The government won't say. They say September, but it's not looking great.”

Put bluntly, that's my concern. I don't think we should be passive-aggressive on this. If the Liberals want us to be taking meetings away from a vaccine study, I do not support that. There will be no improvement in the mental health of Canadians unless we get vaccines, rapid tests, therapeutics and variant-testing capacity to every Canadian.

I'm not sure if any of the rest of my colleagues are of this opinion; I would like to hear it. However, I do not want to take committee business or meetings away to be looking at punctuation on a report, when we need to be getting vaccines to Canadians.

The Chair: Thank you, Ms. Rempel Garner.

We go now to Mr. Barlow. Please go ahead.

Mr. John Barlow: Thank you very much, Mr. Chair.

Ms. Rempel Garner has said much of what I was going say. I understand Mr. Van Bynen's motion and what he's trying to achieve, but I don't think this report should.... If the analysts have the time, they're able to manage that and they want to work on that in their own time, I can understand that, but that report should not in any way interfere with the ongoing study of this committee into what is now going into vaccines.

As part of the mental health study, we've heard from the witnesses that one of the root causes of people's stress, mental health and anxiety right now is not knowing when access to vaccines is going to be happening and not having home-based and rapid testing. If we really want to address people's mental health, we have to give them some answers. On those answers right now, the most critical thing is vaccines and where they are and what the distribution plan is going to be.

I have nothing against Mr. Van Bynen's motion, as long as that study in no way impedes what this committee is going to be doing next into vaccines. Mr. Davies may have a further point in regard to the fact that the NDP's priority is going to come up after the vaccine study. He may see that as equally important to how the Conservative members on this committee feel on the vaccine.

I agree that the impact on mental health as a result of COVID is immense and profound. We've all heard that from our witnesses. We've seen the statistics that have been released. We saw the suicide numbers from across Canada as a result of an Order Paper question released yesterday. Alberta, my province, was the second-highest in the country, behind Ontario. We understand the impact this is having, but the root cause and the number one priority with Canadians that I think all of us are hearing right now is vaccines—where are they?

Unfortunately, the news just keeps getting worse and worse every day. Our Alberta health minister earlier this week came out saying that we are getting zero deliveries this week. Our delivery access from the feds will be reduced by 80%, with 63,000 fewer vaccines provided to Albertans in this quarter. That is unacceptable. We need answers.

Mr. Van Bynen, I appreciate your push on the mental health aspect. I support that, but I cannot support this motion if it in any way impedes our study on vaccines.

Thank you very much, Mr. Chair.

● (1510)

The Chair: Thank you, Mr. Barlow.

Mr. Davies, please go ahead.

Mr. Don Davies: Thank you.

Yes, it's hard to debate this specific motion after hearing such impactful testimony, but what I want to do is broaden the discussion. We've been studying COVID since last February. We've heard a lot of evidence on a lot of subjects between February and now. Of course, with the prorogation, that ended that evidence. If my memory is correct, we adopted all that evidence when we struck the new committee, and we carried on with our study.

My concern is that, as impactful as the evidence we've heard over the last few weeks on mental health has been, we've heard a lot of impactful evidence on a lot of issues. I'm concerned that selecting one issue out of all of the different subjects and important areas that we've heard about, and then occupying the committee's attention on that one particular issue, doesn't do justice to many of the other issues we have. It kind of prioritizes one particular issue out of these things. I think a very strong case has just been made by Michelle and John that if an interim report were to be issued on anything right now, it probably should be on vaccines or the next thing. I don't think it does violence to anybody's position that all of these issues are important. It's just that the real question before us is that, in the middle of this study, do we really want to stop and isolate one aspect of it and then devote very precious and scarce committee time to that particular issue?

I think I can say at the same time that I think mental health is extremely important, but I don't know that it stands alone, among all of the issues we're facing in COVID, as being the issue that we should stop and focus on.

With respect to Michelle's case, I always admire her work ethic. I'm starting to understand why she was voted the hardest-working parliamentarian. I'm not as hard-working, I don't think. Actually, the truth is that we're really stretched. I mean, we have two committee meetings a week. I know that some of us are on more than one committee. I'm also on the National Security and Intelligence Committee of Parliamentarians, which meets four hours a week. We also have our caucus meetings and our question periods. We have our constituency work as well. Of course, maybe it's my unique situation, along with Luc, but we're just one on this committee. There are no substitutions allowed. There's just one of us. So I don't think the answer is to develop more meetings. That would be very difficult to schedule.

It's up to Mr. Van Bynen, but I'm wondering if you might consider withdrawing the motion or tabling it. We could reconsider this maybe after we've heard at least the first priority of each of the parties on this study. We've just completed the first theme. The Liberals chose mental health. Conservatives are choosing vaccines. The NDP's and the Bloc's issues are yet to come. I thought maybe at the end of that first priority, since we have four each, we could revisit this idea there. Maybe at that time we could review the major themes we've had and at that point consider doing an interim report, which I think is not a bad idea. Perhaps we can pick four or five or six or seven issues that we might want to select out of the many issues we've focused on over what's coming up to a year. We could issue an interim report, not just on one particular issue but on several. Perhaps that would be a logical break time for us to consider the wisdom of doing an interim report.

● (1515)

The Chair: Thank you, Mr. Davies.

Ms. Sidhu, go ahead, please.

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

I just want to remind the committee that we have scheduled the witnesses. There is no wish to.... It's one year of work. It will take time for the analysts to do the report. Ministers are coming. We are all willing to do the vaccine study. Witnesses are already scheduled for next week.

Thank you, Mr. Chair.

The Chair: Thank you, Ms. Sidhu.

Mr. Van Bynen, go ahead.

Mr. Tony Van Bynen: Thank you, Mr. Chair.

Let me be clear that there was no intent to delay the study on vaccines. I think that's an important issue, which I think we all want to make sure we study. We're looking at options on how we might do this. I note that the analysts had indicated that this would be helpful for them. Going back over materials and things we heard a long time ago makes it difficult for us, I think, to capture what we heard in these last number of meetings.

I had in mind that, if need be, I'd be quite willing to participate in additional meetings, as was suggested by Ms. Rempel Garner, during the recess. That was a very welcome suggestion, on my part, so that we could go forward and capture the essence of what we heard. Frankly, I think it's a good idea to do the same thing for vaccines and any of the other programs. I think there's a real benefit for us to do it. If we can find a way to make that happen without delaying our progress on the overall plan, I think we should seriously consider that.

Thank you.

The Chair: Thank you, Mr. Van Bynen.

[*Translation*]

Mr. Thériault, the floor is yours.

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

I first want to point out that I didn't receive this motion, at least not in French.

That said, I want to talk about methodology. We did some work before the prorogation. However, I haven't seen a single written note of it. I would have liked a reference document, a bit like the notes that we receive before our meetings, simply to continue to give us food for thought. This isn't about embarking on a process of interim or final reports.

We've just completed the series of meetings on the first topic. We decided, after several meetings, that we would work by topic, based on the priorities established by the parties. As Mr. Davies said earlier, before we start working together on any part of an interim report, perhaps we should first go through the topics that the parties want to study. That's one thing.

In terms of mental health, it seems that the analysts could prepare a document, similar to the notes that they give us on a regular basis, which we could read and enhance on our own, depending on our schedules. Before we go any further, let's wait until we've finished addressing at least one of the topics chosen by each party, such as mental health or vaccines. The Bloc Québécois has tried to prioritize elements of the pandemic that haven't already been covered by other parties, to avoid overlap. For example, we shouldn't spend eight or twelve meetings on vaccines. For our part, we haven't thought about this issue yet. We're biased in favour of all the collateral damage, meaning the impact of the pandemic on patients who don't have COVID-19. That said, we aren't announcing anything yet today.

So let's do what Mr. Davies is suggesting. Since there may be an election coming up, we shouldn't lose sight of all this. In terms of methodology, it's important to create a reference document that summarizes what has been said on a given topic. We should have this type of summary at each stage of the study and we should be able to add to it. Once we've finished studying the first topic chosen by each of the four parties, perhaps we can then dedicate meetings to preparing an interim report. That way, we'll stop wasting an incredible amount of time on details. At one point, it took us seven meetings to come up with our methodology. That doesn't make sense.

I want us to have a summary of the work done before the prorogation and to know what was written, out of respect for the people who worked on this. We never discussed this. I understand that we're in an emergency situation. Nevertheless, we could receive this document, which would give us information for our work and enable us to ask even more relevant questions.

If Mr. Van Bynen and the Liberals are serious about scheduling additional meetings to work on an interim report starting now, and if that's the purpose of the meeting this afternoon, I certainly disagree. I hope that my proposal is clear. We should wait until we've studied the first topic chosen by each party before we focus on an interim report. At the end of the study on each topic, the analysts should prepare some type of reference document that would then help us work on an interim report. Right now, I think that we need to manage the crisis.

● (1520)

The Chair: Thank you, Mr. Thériault.

[*English*]

We go now to Dr. Powlowski. Please go ahead.

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

I don't think, in fact, we have disagreement over this issue. We want to get on with the vaccine study too. We're all in the same boat; everyone in Canada is. We all have.... My parents have been staying by themselves in their little house for the past four weeks or something, not able to see their grandchildren. There's an outbreak at my kids' school. None of them got their vaccines. My colleagues in the emergency room haven't gotten their vaccines. We're all in the same boat. We shouldn't all be rowing in different directions, and I don't think we are.

The Liberals do not want this to impede getting on with the vaccine study. In my reading, that wasn't the intent. I would have thought that perhaps the analysts could start putting together the material while we continue, as planned, with bringing the ministers here and bringing in the other people on the vaccine issue.

We're not being passive-aggressive. I want to be aggressive. Bring the vaccine people here. Let us ask them the questions. Let everybody.... Let Michelle ask them the hard questions, because we want answers. We're not trying to hide anything. I want to ask the questions, too.

It certainly wasn't the intent to put off the vaccine study, because we all agree that it is overwhelmingly the most important issue facing the country right now.

Thanks.

The Chair: Thank you, Dr. Powlowski.

We go now to Mr. Maguire. Please, go ahead.

Mr. Larry Maguire: Thank you, Mr. Chair.

The mental health issue has been on everybody's mind as well, but as we said earlier on, one of the best ways to help solve that is to learn more about vaccines and when we're going to have them available.

As Ms. Sidhu said, the meetings have already been set for Monday, Friday and going forward on vaccines, with the ministers coming in next week. As Ms. Rempel said, I wouldn't want to do anything to disrupt the process that's going for vaccines. I know that was a priority for Don's team as well, and I concur with the comments of Mr. Davies. He's absolutely accurate in regard to making sure we're not interrupting what's going on.

I wouldn't even mind having that.... It's a good idea to look at taking the first priority of each party and doing an interim report on those at the end as well. There is a need for each one of them to be done in a similar manner, but then we're breaking up what we said we would do in the agreement to start with. We said we would have two studies, one on the medical prices review board and the one on COVID, which included mental health, vaccines and other issues like PPE and such.

The only thing I'd be concerned about, if there is going to be discussion on an interim report on mental health, is that we look at it as taking some extra meetings. I believe our colleague from the Bloc, Luc—he can correct me if I'm wrong—just indicated that he wasn't on side with that.

I would look at proposing some wording for an amendment, Mr. Chair, that any meetings related to the drafting or review of this interim report be held over parliamentary constituency weeks. We have one of those coming up the week after next. We already know what we're doing next week. If the staff feel they have the time to put towards this interim review on mental health discussions that we've heard about in detail from all of our witnesses, and provided that any discussion we would have on that review would be done during those weeks, I would make that as an amendment.

● (1525)

The Chair: Thank you, Mr. Maguire. That is so moved, although it restricts our scope of action. It means we can't add time to existing meetings. Anyway, that's your amendment.

The discussion is on the amendment.

Ms. Rempel, go ahead.

Hon. Michelle Rempel Garner: Chair, I was just wondering if Mr. Maguire could clarify his wording for me. I was listening to it. I just wanted to clarify that what he was moving as an amendment to the motion was that the wording “interim report” be changed to “summary of evidence”, per Mr. Thériault's suggestion, dating back before prorogation, and that any meetings relating to the drafting review of this interim report be held over parliamentary constituency weeks.

The Chair: That was not Mr. Maguire's amendment, as I recall. He was just adding the request or the requirement that we deal with any meeting relating to review and approval of such a report during constituency weeks. His amendment did not change the nature of the report to be a summary of evidence.

Mr. Kelloway, please go ahead.

Mr. Mike Kelloway: Thanks, Chair.

There's some really good discussion happening here. To start off, MP Michelle Rempel Garner made some good points in terms of the heaviness of not just today but this whole pandemic and how it impacts mental health. It's personal for me on multiple levels. What I heard today reinforced a lot of things I've seen in my own community and in my own family.

I want to go back to where Dr. Lalonde talked about pragmatic and practical approaches to this. Again, being somewhat relatively new to this job—I'll be able to say that for only so long—when we look at interim reports.... Again, I guess this is on the elasticity of the analysts, but I personally would be happy to do an interim report on the things that happened and were discussed before mental health. We could look at ways to bookmark this, with one on mental health and one on vaccines. Is that practical? Is that doable and whatnot? I've been an author of many studies. The worst thing that can happen when you do a study is that it sits on a shelf and gathers moss. Those are a couple of the things I wanted to bring up.

The other aspect of this is how we started off the conversation. To paraphrase it, we don't want this to be a way for the Liberal members to slow down discussion on vaccine, or meetings on vaccine, or whatever the case may be. You know, that to me is such a.... I'm trying to find the words here and I can't really find them. There is no way, in any reality check, that we would do that. Would anybody do that? Would anybody on this panel do that? Would any party delay a discussion on vaccines that is already lined up?

My hope is that throughout these sessions, because it is wartime, we sit down and.... Again, we can critique the hell out of each other and our parties' stances on this, but I wonder if we can start with the practical first and then work at the political second.

● (1530)

The Chair: Thank you, Mr. Kelloway.

[*Translation*]

Mr. Thériault, you have the floor.

Mr. Luc Thériault: Mr. Maguire seems to have misunderstood my comments, and I seem to have misunderstood his comments. We both agree with Mr. Davies' suggestion that we should consider each party's priority before preparing an interim report. However, he's moving an amendment that contradicts this idea. I don't support this amendment.

I agree with Mr. Davies' idea. It would be worthwhile for the analysts to provide a summary, which we could work on separately. We could then address the topic of vaccines, then the topic proposed by the Bloc Québécois, and then the topic chosen by the NDP. We could then table an interim report. Rather than having a big document to work on afterwards, it would be good to receive a document that we could enhance at each stage. That way, once we get to the meeting on the interim report, we would save a great deal of time. That's what I said.

Since I support Mr. Davies' proposal, I don't see the need to hold meetings next week in order to work on an interim report before we move on to another topic.

We don't want to stop anyone from working. I'm not questioning the motives of my Liberal friends. They want us to keep working. I assume that they're acting in good faith. I believe that we can prepare an interim report only after each party has determined its priority.

I want to remind you that the motion passed in the House involved a study on COVID-19 that included topics that we could propose. We decided to start with mental health, and that has now been done. We can move on to another topic. We'll also be effective when the time comes to prepare an interim report.

In short, I don't understand why Mr. Maguire is moving this amendment.

The Chair: Thank you, Mr. Thériault.

[*English*]

Mr. Maguire, go ahead, please.

Mr. Larry Maguire: Thank you, Mr. Chair.

I can certainly agree with Mr. Thériault more now. I am much more clear on what he was looking at.

Mr. Chair, would it be possible to add 15 minutes to the next meeting so that we could have a separate part to discuss this at that time?

The Chair: I think it would be possible, if it's the will of the committee to do so.

● (1535)

Mr. Larry Maguire: I would make that as a suggestion. We could discuss this further at that time.

The Chair: I think what we're looking for here is a motion to amend to a date certain, which I believe is in order. If it's not, I will ask the clerk to step up.

If that's your will, Mr. Maguire, I suggest you make a motion to adjourn the debate until Monday after our witness testimony.

Mr. Larry Maguire: I would make such a motion.

The Chair: Is everyone in agreement with that?

I will follow the guidance of the Speaker and just look for negatives. Does anybody oppose that suggestion?

Ms. Rempel Garner opposes.

Hon. Michelle Rempel Garner: Not “opposes”, but the motion is “after witness testimony”. I don't want this discussion to be taking over question rounds in the minister's time. My understanding would be that this would be, like, 15 minutes at the end of the next meeting.

The Chair: Absolutely. There was no suggestion, there is no suggestion, and there will be no suggestion of impacting witness testimony.

Mr. Van Bynen—

Hon. Michelle Rempel Garner: On a point of order, Chair, that's not what I asked. It was on the question rounds after the witness testimony.

Mr. Larry Maguire: Mr. Chair, I believe that's where we were going. Certainly what I wanted was to have the discussion here, the 15 minutes on Monday, after our regular meeting is all over.

The Chair: That is absolutely how the chair interpreted it as well.

Mr. Larry Maguire: That's what I thought.

The Chair: We have three people to speak, but we now have a motion on the floor, a motion to adjourn. I believe that's non-debatable.

Mr. Larry Maguire: It's non-debatable.

The Chair: We will have a vote on that. I will ask for dissent only.

If anyone opposes this motion, please indicate. Please wave at me.

Mr. Tony Van Bynen: Mr. Chair, could you please clarify the motion? Is this motion to adjourn now, or is this motion to move the debate to the 15 minutes after our questions?

The Chair: The motion is to adjourn the debate now until a date certain, which will be following the rounds of witness questioning on Monday.

Mr. Tony Van Bynen: Perfect. Thank you very much.

The Chair: Again I'll ask, does anyone dissent on this motion?

I am seeing no dissent....

Mr. Fisher, you waved at me. Is that dissent?

Mr. Darren Fisher: I was thinking that this is something we could just do today. I'm looking for Don to come up with some suggestion to make this....

I don't want to speak for Mr. Van Bynen on what he wanted, but maybe there is no terrible rush on this. The analysts could be working on something in parallel to all of our studies, with culminating information, and then maybe a report comes out after. I don't want to speak for Tony, and—

Mr. John Barlow: This isn't debatable, Mr. Chair. We're supposed to be voting.

The Chair: Maybe we'll just be a little more direct and ask the clerk to take a vote on this motion.

The motion is to adjourn this debate now until Monday, following the rounds of questions that are currently scheduled.

Mr. Clerk, would you please conduct the vote?

(Motion agreed to: yeas 6; nays 5)

The Chair: Thank you, Mr. Clerk.

The motion to adjourn has passed. This debate will be resumed following the two rounds of witness testimony on Monday.

With that, we will adjourn the meeting.

Thank you, everybody.