British Columbia's
Office of the Human Rights
Commissioner

Inquiry into hate in the pandemic: Hearing transcript

Transcription prepared by National Captioning Canada

Presentation date:	Feb. 28, 2022
Presenting organizations:	Office of the Seniors Advocate
Roundtable attendees:	Isobel Mackenzie, Linda Carey
BCOHRC[1] attendees:	Human Rights Commissioner Kasari Govender, Sarah Khan, Sarah Hamid-Balma

Please note that third-party personal information has been removed from this transcript.

[Introductory comments by Human Rights Commissioner Kasari Govender not included in transcript.]

Isobel Mackenzie: Okay, thank you very much, Commissioner Govender, and I thank you actually for inviting me to present and to hear the voice of seniors in this review that you're doing. So, I'm just gonna do a share screen. I need the permission to share screen, so…
[Laughs]
Can someone give me a share screen permission? All right. I'll try it again. Nope. I'll just give it a second here. Oh, and I should—sorry, I was remiss. I am speaking to you from the ancestral lands of the Lekwungen speaking people of the Esquimalt and Songhees First Nations, also known as Victoria. Or I think there's about 13 other names that's used, but. Okay, there we go, okay. I think—hang on. I always get this screen is hiding, just a second here.

Sarah Khan: We can see it.

Isobel Mackenzie: You can see it, but what I'm trying to do is get it into-- and there's a scroll bar at the top that is obscuring what I need to click on in the… ..I'm just not sure how I get rid of-

[1] BC's Office of the Human Rights Commissioner

- okay, there we go, there we go, there we go. Slideshow. Okay, there we go. All right. So, I'm gonna look for a thumbs up, "Hate in the Pandemic"? That's great, thanks.

So just-- and I'm sure you are aware of the work of my office. But just for the record, this is the Office of the Seniors Advocate of British Columbia. We are a statutory office of government, with duties, obligation rights, and authorities. And in a broad sense, we engage with seniors and their family members across BC and hear from them about their challenges, their issues. We monitor the services there are for seniors, and report on progress, on gaps, and services, on trends over time. We analyze some specific issues or areas of concern for seniors when we produce systemic reviews based on that analysis. We provide reports, some are the reports from the systemic reviews, some are reports we produce annually. We do produce a monitoring report that measures key services each year, and reports on how we're doing, and we also provide an annual report on all of our publicly funded long-term care facilities in British Columbia, with key performance indicators and other metrics to measure over time. And of course, we do produce an annual report as well. And we refer seniors and family members to those supports and services that they need.

So, in a given year, I think we have about 10,000 people that contact our office, about 60,000 that use our website, and those are all parts of the connections that we're facilitating for seniors.

So, seniors and hate crimes and discrimination and when you sort of look at this pandemic and its impact, I guess the biggest hate crime out there against seniors was perpetrated by the virus itself. That it was particularly hunting out arguably older adults and those who had underlying health conditions or were immunocompromised. And we certainly saw at the beginning of this pandemic as, you know, depending on where you were, governments were slow to react, governments were quick to react.

What was the initial reaction of the public? There was this mixture of people who-- there was this groundswell and outpouring of support for seniors, which I do believe optimistically represents the vast majority of Canadians. There was a subtext of people who began to resent seniors because from their perspective, all of the upheavals to their life were being caused by trying to protect seniors, so this goes back to, you know, the real hate crime was the virus. It was perpetrated by the virus itself. It clearly very dramatically disproportionately affected seniors. And so you did-- there was a simmering subtext there that you would hear from some people about their resentment of seniors, because in order to save them, their life was being restricted and upset, and then you would hear the usual kinds of marginalizing language that you hear around the value of that life and they're going to, you know, they're at the end of the line, all of those kinds of things. I do believe that that was a very small minority of British Columbians and Canadians, and I do believe that their voices were drowned out to a large extent by the more prevalent sentiment which is that we need to protect our seniors.

So, one of the things I want to set the stage for as I talk about seniors and discrimination is the context of seniors in British Columbia, as it compares and contrasts to what people's stereotypical opinions of seniors are, because as you know, the root of discrimination is taking a single group of people who share one defining characteristic, and then ascribing to that group of people a whole set of commonalities that really are irrelevant. The only defining commonality they have is that single characteristic whether it's their religion or their age, or their race, or their language or their sexual orientation. And we do it with seniors. We have images of seniors. But when we look at the

reality of people aged 65 and over, the only thing really that they all share in common is whatever that age number is.

So, let's start with sort of this notion that all seniors are living in nursing homes, or, you know, it's inevitable that you're going to end up in the nursing home. The fact is over nine out of ten people over the age of 65 live completely independently in their own home. Only 6% live in either long-term care, which is about 4%, or assisted living, a retirement home kind of thing, which is about 2%. Even at the age of 85 and older, only 15% of people live in a nursing home.
So, the vast, vast majority of British Columbians are never going to see the inside of a nursing home, and most seniors are not going to see the inside of a nursing home. 25% of seniors live alone, which means 75% don't.

So, the other image we have out there is this lonely senior, you know, in there. That is not actually true, even at the age of 85. It goes up, but it's still not the majority. It's 40% of people 85 and older live alone. Now many more live alone proportionately than under 65., that's true. But three out of four people over 65 live with somebody else, mostly their spouse, sometimes their adult child, but most of them spouse.

One of the big ones is dementia. Only 6% of people over the age of 65 had a diagnosis of dementia. 94% of the people age 65 and over that you meet, although they may take a little bit longer to find something in their purse, they may frustrate you when you're standing behind them in the checkout line, and they're trying to get their pin number, and you're, you know, the young people are automatically, because they have gray hair and they look older or they have a cane and they're taking a little longer to do something, they automatically think, "Oh, they have Alzheimer's." Overwhelmingly, they don't. And this perhaps reflects back in my work at home in community care of my career before I came to this job. This is perhaps one that I find the most debilitating and the most, I don't know if egregious is the right word, but the most prolific form of discrimination that we practice in older adults is the assumption that, based on the way they look, i.e., older or the age we see on a chart, is that they have a diagnosis of dementia.

And in health care, you know, there has been a lot of discussion, and rightly so about racism in healthcare, and having practiced in health care, I absolutely agree, in terms of its prolific spread. But we also have ageism in healthcare and one of the classic demonstrations of that is just giving two sets of presenting symptoms and a differential diagnosis, and how that alters when you're describing somebody where they're 35 and you're describing somebody where they're 85.

Further to that, almost half the people over 65 are healthy or have low complexity chronic conditions. So over 42% of people aged 65 and over either are completely healthy, or they don't have any chronic condition that needs to be managed. Now even at the age of 85, arguably it shifts and there's more people with medium and high complexity conditions, but again, this idea, and, you know, there is this institutional ageism or discrimination, because it works for us to emphasize.

We all intuitively think, "Oh, if we could just get the seniors to stop going to the emergency department, it would solve all our problems." The only problem is when you look at who goes to the emergency department in British Columbia, about 26% are seniors, which is about the same percentage of the population that's seniors. Not quite, it's a little higher, but 75% of the people going to the emergency department are actually under the age of 65, right? But it suits our

purposes to sort of cap, you know, blame this inevitable aging of the population, and I do get concerned because the pressure on the healthcare system has not yet begun in terms of pressures from the older population. The youngest baby boomer is 75 and the healthcare system really begins to feel the stress when you turn it on balance at 85+.

And so, when you think about, you know, where we are today, and ten years from now where we're gonna be. 80% of seniors still drive. Now this drops, and our latest monitoring report actually, the percentage over 80 retaining their driver's license is increasing a bit because people are living healthy, but most seniors, you know, they're living in their own home, they're driving their car, they know their own mind. But they don't have high incomes.

So, the median income-- so half of BC seniors live on less than a minimum wage job would pay. But that's thinking of-- half have an income less than a minimum wage job. Now it is true, 80% own their own home, but when you talk about ageism, there's benevolent ageism and then there's malevolent ageism. And so, part of what I am concerned about is this division that is being potentially created, particularly around this issue of home ownership, and deflecting to the wealth of seniors. And it is true, the majority of seniors are homeowners, and a majority of those homeowners own their home mortgage free, but they have low incomes, and many of them will be accessing what they need from that home to pay for their healthcare needs.

Almost a third of seniors 65 to 69 are still employed, and overall, 14% of people 65+ are employed. So that's sort of some sort of myth-busting. First of all, all seniors are not rich. Most are not, actually. Most seniors are not frail. Most seniors do not live in long-term care or assisted living, they live in their own home. Most seniors are driving their car, and most seniors overwhelmingly don't have dementia, and most seniors actually are pretty healthy. So, what's their shared characteristic? Simply their age.

So, what are the real challenges around age-based discrimination? Autonomy and agency are not age limited. Now, one of the things your definition of a hate crime is it needed to have the intention of hurting someone. When it comes to seniors and discrimination and things that happen during the pandemic, some of them were love crimes, not hate crimes. But we took a group of people based on their age and our perception of everything that that meant, including they didn't have the right of agency or autonomy that you and I have, we set out to quote unquote "protect them", and we robbed them of some very, very fundamental human rights. Based on our assumption that your right of autonomy and agency expires at some point, and that we get to step in and because it's with the best of intentions. It's not a hate crime, it's a love crime. We separated you from your family members with the visit restrictions in long-term care. We have a lot to answer for that. We did it for the right reason. Nobody was malevolent, ill-intended, in fact, the opposite. But at the end of the day, the underlying principle upon which we made these profound decisions was age discrimination and our belief that we should make decisions for you. We didn't do that for other people, we have restrictions. But that fundamental right of agency and the right of risk, we didn't take away from other people. We're going to have to wrestle with our tolerance of benevolent discrimination and the unintended consequences that stemmed from it.

Visit restrictions of the pandemic are but one illustration. And this is very challenging because when you say you get this entitlement because you are 65, and that is the only reason that you get that entitlement, that's age discrimination. It's the same premise as saying, "You don't get this

because of your age," right? So, the benevolent discrimination, the malevolent discrimination. But the underlying principle is the same. Now we rationalize it.

In healthcare, we rationalize it all the time, and to be fair, healthcare has always had a prin—well, not always, but certainly in modern times, has always had a principle of triage. There's always, you know, a balance of probability when you've got, you know, one ventilator and two people. Are you going to give it to the 40-year-old or the 90-year-old? There are certain elements we can't escape, but I think we have to examine the degree to which we've allowed this to seep into the population. Seniors are a minority. They are currently one out of five British Columbians, or put it another way, four out of five British Columbians are not seniors. And when we follow the growth of the senior's population, you've heard about the bulge. When it's at its apex, it will still be one out of four are 65 and older, but it will still be three out of five are under 65.

So, people over 65, they're 20% of the population now, they will become 25% of the population. That's a minority. But they're not homogeneous. They're not all rich, they're not all poor. They're not all sick, they're not all healthy. Some speak English, some don't speak English. They have different religions. They have different values. They have different wants, needs, hopes, and aspirations. Some will embrace medical assistance in dying, some will run from it. Some will want every intervention, some will not, some will. But we consistently treat it. You know, when people say-- they ask me all the time, "What do seniors want?" And I say what it is that they want. There's no single answer, except they want what they want. But what that is different for everybody, and we forget that.

And we illustrated that in some ways during the pandemic a little bit more acutely, but because it was done with the best intentions, it obscured this underlying discrimination that was happening. And these issues are going to become more apparent as the boomer generation enters into their eighties. Here are some examples. We now say that when you're 75, we stop screening you for colonoscopies—or we stop colonoscopy screening. Why do we do that? Not because you're more likely or less likely to develop colorectum cancer. We've decided that you don't want to go through the treatment. Shouldn't that be up to you to decide? It's all women on this call. You're gonna find that they're gonna stop cervical cancer screening, they're gonna stop mammograms, they're gonna stop all these things. Now, I think you're all younger than me, so they're gonna stop them for me before, not because I'm unlikely to develop breast cancer or cervical cancer, but because they've decided that I'm not gonna want to go through the treatment or it's slow growing enough, or all kinds of things.

And you know, a lot of medical decisions are based on balance of probability and averages, right? And the average can be nobody's story, right? You, you know, you know the mathematical example where you're, you know, $100,000 a year income and $25,000 a year income and the average income is, you know, like 60-some thousand, which tells nobody's story, right? So, you know, usually is not always. But, you know, we've taken away, you know, bullet number one. We've decided that we'll decide for you at that point.

The recent changes to the Community Care Assisted Living appeal when we developed the regulations for admission to a care facility, it's very interesting. I still have a few scars from that, and I'm not convinced I fought hard enough. But if we want to commit you to a mental institution, we commit you under the Mental Health Act, and we can talk about its shortcomings, but at the end of the day, it's two physicians and there's a very prescribed appeal process. When

we want to admit you to a care facility, only one person, doesn't have to be a doctor, we have a sort of an appeal processing there, right? So, it's a much lower bar. And when you talk to people about, you know, why should the bar be as high, and they say, "Well, it's, you know, when we admit somebody under the Mental Health Act, it's, you know, we take everything away from them." They have no—and I said, "Well, when you admit somebody to a care facility, by virtue of admitting them under-- they're unable to grant consent, you've got them in a locked unit. You're telling them when to eat. You're telling them what they can eat. You're telling them what medications to take. I'm at a loss to see the difference." But apparently there is.

So, when you, you know, there's a lot, I think, that is going to bubble up certainly over the next ten years. Because what is going to happen-- right now, the people most impacted by this are people really well into their eighties. That's when you really start to see the frailty. And that's not traditionally the establishment questioning culture. Again, there's some in there, because it's not all genius, but as a mass of people come up, and that mass of people come up with a greater sense of questioning authority and a lack of acceptance of status quo. These issues are going to get pushed to the forefront.

One of the first cases I'm looking forward to being litigated is that we cut employees off of long-term disability at age 65. I see the Commissioner's head nodding. But it's a workplace benefit. So, if I turn 65, my employer no longer has to pay premiums to cover my long-term disability, and I no longer get coverage for long-term disability. So, do I get that back and increased in my pay? It's part of my pay package. I'm looking very much forward to the first-- there'll be a case. Somebody's gonna figure it out, and it's either gonna be under a collective agreement and arbitrated, or it's gonna be under the courts. But that's just one example of many, many things.

You know, we say in British Columbia we eliminated the ability to have mandatory retirement, which is different. We didn't have mandatory retirement before then. Many organizations allowed people to work well past 65. It's just that now, you are by law prohibited from requiring that. Although there are some caveats, as you know, some occupations where it is still allowed, so it will be interesting to see the envelope pushed on that a bit. I hear most from seniors who feel their discrimination in the workplace more than I hear from seniors who are having to work past 65, and not wanting to, through some of that. Some people are working past 65 out of economic need, and they would rather not work. And I do hear from those people. But I hear more from people who feel they're not as valued in the workplace, and I remember doing-- this was 28 years ago.

I did a study on sick leave utilization in the home support industry, and I had 300 observations which meant 300 people and looked at a number of variables. There was one person in there who, over the course of one year, had not accessed a single sick day, and she was 70 years old. Again, this sort of notion when you start to look at the facts, "Well, you know older workers, they're sick." Actually, that's not true. Younger workers take more, and not only do they take more sick leave, they take more, um, what's the word I'm looking for, disruptive sick leave, unplanned sick leave, which from an employer's perspective, is more disruptive.

But, you know, it is so, you know, under-- can I say that I saw hate crimes against seniors during the pandemic? No. I saw love crimes. I can see this during the pandemic, and I saw a tremendous love for seniors during the pandemic in terms of—some of you may have heard me speak of this before when the pandemic first started and seniors had to stay at home, and we all put up the

phone lines for people to volunteer if they wanted to help seniors and for seniors to phone in if they needed help. And the phone lines crashed, not because seniors were phoning in for help, but because people were phoning in to help. And it was, you know, it brought out the best as well. And so that's why this may be the most challenging form of discrimination, because I think it will be challenging to define what does it really look like, and how are we going to tackle it, and also be true to the realities of aging and the realities of our public policies and our finite health resources?

So, I look forward to, if not as part of this review, Commissioner Govender, perhaps a wider reaching review of age-based discrimination. And I can appreciate, as someone who also has an office with finite resources and infinite…
[Laughs] ...number of people who want you to study this and study that.

[Laughs]

I can understand that everybody wants to be top of the list. And by definition only one person can be. But I will leave that with you, and I will turn it over for questions.

Commissioner Kasari Govender: Thank you so much for that. That was really, really helpful. I have a few questions, and then Sarah, I'll pass it over to you. I wanted to return to something that you said early on, when you talked about some of the ways in which, I don't know if you use the word disposable, but the ways in which seniors were seen as sort of the root-- potentially the root of the restrictions. And, you know, that resentment that folks felt, you called it a simmering resentment. I know you identified it as a small minority of BC'ers, but I'm wondering if you could tell us a little bit more, either whether you have any data on what your office heard, or just anecdotally what you heard from seniors during that time. Or if that was more your observations.

Isobel Mackenzie: It was observations based on what we were monitoring in social media, I would say. So, people were not phoning into this office with hate statements about seniors, no. But we do monitor social media, and we were picking up some elements of that. But it wasn't dominant. And I think it subsided, ironically, as the pandemic went on. Now part of it is, you might recall that most severe restrictions were right, and certainly for BC, were right at the beginning. I mean, we never experienced that level of restriction again. As you know, schools were-- well, technically, I think we say in-class learning was suspended. But, you know, the schools were closed. People were mandated to work from home, although we never actually required non-essential stores to close, most did because they didn't have any customers, and they weren't going to get any staff, right? So, there was—and at that point in time, the only people getting ill from it were seniors, right? It is as the pandemic evolved. The number of people getting COVID in the first wave, as you may recall, was very small. I mean, we were becoming hysterical when we went into three digits. [Laughs] Never mind four and five digits in terms of cases.

So, I think what was happening in the public's eye is that they were seeing this huge—to the, you know, the regular person, they were seeing their life totally abandoned. Nobody they knew was getting COVID except these old people in long-term care. And really, they were at the end of life anyhow, so why would we care? There was there was an element of that. But as the pandemic progressed, and a couple of things happened. First of all, more people got it. The focus moved on from long-term care in terms of the cases, right? But it's still when you looked-- and we tended not to dwell on the age, and I will credit health officials for, you know, in our reporting, we don't--

we will talk about the age in certain modeling. But we don't go out there on a daily basis, and get the age of the people who died, you know. And that has, I think, been helpful in dampening some of the age resentment that might have evolved if we had done it that way. You know, at the beginning, we did talk about the origins of this.

Commissioner Kasari Govender: Oh, that's interesting. So, did you see any increase in that again during these latest set of the protests that's swept across the country over the last month or so? Did you see any revitalization of that resentment or no?

Isobel Mackenzie: No, I don't think so. I think, in large part, because we shifted from, I don't know anybody who got COVID to everybody began to know somebody who had contracted it. And so, there was this sense it was about-- wasn't just about the old people in long term care. And frankly, I think maybe because of the recognition of the impact of the pandemic on seniors and certainly the impact of visit restrictions in long-term care, you know, maybe some people who might have otherwise been prepared to point fingers sort of cut them some slack because they've been through a lot, right?

Commissioner Kasari Govender: Mm-hmm. You also talked about some of, as you called them, the love crimes, the ways in which the paternalism potentially that was exercised in long-term care homes, the impact of that. Let me just back that up for a moment. Did you see the initial numbers, the initial impact in long-term care homes, as being a result of law and policy decisions? Or do you see that as the impact of COVID? And then we moved to the impact of law and policy through the isolation of seniors. Do you know what I'm asking?

Isobel Mackenzie: No, not quite, so.

Commissioner Kasari Govender: We initially saw, as you pointed out early on your comments, that the impact of COVID on seniors in terms of their actual—the impact of the virus itself on seniors, was significant and as we know, particularly significant in long-term care homes. And there were some that faced very significant outbreaks, high levels of death, and serious illness. Do you think that those high levels of death and serious illness in long-term care was the result of law and policy?

Isobel Mackenzie: Oh, okay, yeah, no.

Commissioner Kasari Govender: No, okay.

Isobel Mackenzie: No, no. I think that the reality is, you know, older people, on balance of probability, a person who is in long-term care is there because they have frailty and underlying health conditions, and their average age is 85. And even though the average age is 85, generally more than half of the people are over 85, right? And so, it simply was the reality that this virus, because yeah, it was a lower respiratory virus at that time, not an upper respiratory virus like currently. That is-- there are some biological realities that was gonna make that more serious for seniors. In fact, in British Columbia, I would say we reacted very quickly on long-term care, more quickly than a couple of the other provinces in the beginning, and I would say that our public policy in the first couple of months, two to three months, blunted the potential impact on long-term care. Certainly, that to say that the most-- I think the most significant decision wasn't the

visit restrictions, it was the single care work. The most significant decision that was made was that workers could only work in one care home, and that 25% of workers who would work in multiple care homes were not going to be able to carry because that's how the virus came in. That was, of all the decisions that were made, that was, in my professional opinion, the most significant that blunted the impact in wave one. When we got to wave two, I do believe there were public policy decisions we made that were not correct, and had we made different public policy decisions, we could have blunted wave two's serious illness and fatalities to some extent. We still would have had a significant second wave, but we could have reduced, to some extent, the severity had—and I did do a review of that. And basically, policy decisions around testing and policy decisions around sick pay, had that been different, I think there's strong evidence to suggest that the number of cases would have been reduced in the large networks.

Commissioner Kasari Govender: And then, taking that same question to our current state, sort of the loosening of restrictions, what do you think? What, in your view, is the impact on seniors of the loosening of restrictions?

Isobel Mackenzie: Well, it's positive, so if you think about-- so just from a very technical perspective, what you want to do is prevent the virus from come—first of all, you want to vaccinate everybody. You want to boost everybody. And the government policies have maximized the potential for a senior in long-term care to be triple vaccinated. To put it in perspective. the case fatality rate pre-vaccine was 30%. The case fatality rate now in long-term care is less than 5%. So, a senior in long-term care getting COVID has less than a 5% chance of dying from COVID. That is far less than pneumonia, and less than many, although not all, flu seasons, right? So, this vaccine is highly effective, we've done okay. But it's not innocuous, you can still get it. So, the next layer on, how do you prevent the-- so the government made the policy, not without criticism, every staff member has to be vaccinated. Now they haven't gone to say they have to be boosted. They've said they have to be vaccinated. That was highly protective. That was a policy that I think has saved lives. The government also said all the visitors have to be vaccinated. I think that has also saved lives. They have said all the visitors now have to be rapid tested. That is also, I think, potentially lifesaving. All staff are tested. They, when you look at how they distributed the rapid tests based on the science stop point, falling in line with where the risk is and where the rapid tests went. And certainly, the reluctance to embrace prophylactic testing in long-term care, I think that I haven't been, many of those people know, I didn't agree with that decision. Lots of decisions I agree with.

[Laughs]

Lots of things they did well. And, you know, none of-- what I find reassuring, of any of the decisions that I have disagreed with, none of them, and there aren't many, but none of them have been based on government wanting to save money or other kind—like, it's never been-- it's been, I think, a legitimate just disagreement amongst experts on the best way to do something. It wasn't based on a marginalization. The restricting of family visitors, I think you use probably the most correct word, paternalism. And I think that that ethos existed in our long-term care system before COVID, and we've got to come to grips with it. So, before COVID, I mean, one of the things that we really have to come to grips with is the medicating of seniors in long-term care. And what does consent look like. And because you don't surrender your rights to consent to medication when you go into long-term care. And if you're unable to consent, you have a substitute decision maker who should be consenting. And what is the use of these blanket riders

that care homes are getting families to sign that aren't-- I don't think they realize what rights they're signing away, and I'm interested in finding out whether they actually can sign away that right and what is happening there.

Commissioner Kasari Govender: I have one last question, I know we're running out of time, but my last question is around violence against seniors and by caregivers, and, you know, we've seen the numbers around gender-based violence going up, you know, whether that's violence against women seniors, or violence against seniors more generally. Have you seen any trends there?

Isobel Mackenzie: I expect we will. Now, one of the-- here's what we know happened. Number one, our adult day programs basically shut down for a year. So, there's 6,000 seniors, who are now at home, and the people there at home would get no break from them where they used to get at least a full day a week, if not more. We know that some families brought their mom or dad home from long term care, and we know that some people were resisting placement for longer because of all the, you know, part of it was the image of long-term care, but the other was separation from family and the buildup that that would have in the community. The way we measure it, it will take time for us to see the full impact of that. I do think we'll see it. I also think it will be underreported, perhaps to an even greater extent, although, you know, family violence is not my area of expertise, so I'll defer to the experts there. But that tends to be more about spousal abuse. The other phenomenon with older adults is abused by the adult child with whom the senior is either living, or the adult child is having to take. They may not live with them but take care of them. And abuse that isn't physical per se, but can be neglect, right? And the stripping away of autonomy. So, you know, it's a delicate issue. You know, women will have, of course, as we know, the economic dependence on their husband, or the fear that their children will be taken away from them. What older adults will have-- for some women, there will still be the economic dependence. But it will be that their partner or their adult child provides their care. They're not physically capable of leaving.

Commissioner Kasari Govender: Yeah. Yeah, absolutely. Those are my questions. I know we are out of time. But, Sarah, did you have anything urgent that you wanted to ask at this point?

[Indiscernible]

You're muted.

Sarah Khan: If you don't mind, thank you so much, Isobel. Following up on the last question about elder abuse and neglect, I was just wondering about whether there are places that you recommend that we look for statistics on the-- in any potential-- on statistics around financial abuse or other forms of abuse against seniors? Should we be checking with the police departments or other places for that kind of information?

Isobel Mackenzie: Well, you've touched-- so the short answer is, Sarah, if you go to our monitoring report, you will find the data such that exists. So, we report from RCMP E Division from the Vancouver Police Department, from the designated agencies from SEO and PGT. We have all those, it's all in one place and you can go there. And if you have some questions, link back with my staff. But we just issued a report on abuse and neglect, and the bottom line is it's an incredibly fragmented system. Nobody knows what a designated agency is. If you're

interested, you can just get a flavour of it by reading the highlights of the report, and one of the most telling things is there's more people over 65 than under 19. But in the child abuse system where there's a centralized number and a robust tracking system, it's something like 60,000 reports a year versus for seniors. I think it's less than 10,000, and we're not even sure it's 10,000, right? Because some of those could be reported here and reported there and we're adding up because we have there is, without a doubt, a need for, you know, if you see or suspect, call this number, and then when they call the number, there's an intake number assigned, and then the case then could go to whatever agency is best suited to investigate. But right now, you've left the poor member of the public with where do I call? And I would say that this applies not just to seniors, but to many marginalized communities, this over reluctance to police wellness checks now for what used to be the work of the designated agencies. We should all be little bit concerned about and I would think in your work particularly, because, though-- I don't think the health authorities are the best suited for the responding to abuse and neglect calls, and it's evidenced I think by the fact that they-- what is it they want, three coordinates to confirm who they're going to. So, if you're reporting something and you can't give an address, a name, and a date of birth, they're going to tell you to call the police for a wellness check because they don't want to send there. So, we've got to think about the whole—

[Chuckles]

I mean, first of all, a police officer shows up on a doorstep. And what does that look like if you're living with the person that is abusing you, whether you're the senior or the child or the spouse or whomever, and who's called and what's going to happen when, you know, after you say everything's okay, and the door closes, and neighbours saw. I mean, I don't think I need to go on, but I did talk to the-- there was a review, as you know, of the Police Act, and I did raise this issue around. You know, these wellness checks, they're being used a lot and a lot more than they have been. And we don't have good data, we don't know outcomes, we're not thinking through how we are using this tool called a Wellness Check.

Sarah Khan: Thank you.

Commissioner Kasari Govender: Thank you for that point. And thank you so much for being here with us. Sorry, Sarah, were you gonna add something?

Sarah Khan: Nope, sorry.

Commissioner Kasari Govender: No problem. Thank you so much for being here with us and providing these submissions, incredibly helpful. And I don't know if you're planning on sending us any written submissions. But if you don't mind sending us your PowerPoint, we'd really appreciate it as any further written information or any other data that you think may be relevant to some of the questions that we asked.

Isobel Mackenzie: What's your deadline for written submissions?

Commissioner Kasari Govender: End of March.

Isobel Mackenzie: Oh, yeah, okay. I think I might want to just put in a little written submission, sort of tie it up a bit and go around the side, so I think that's what I'll do.

Commissioner Kasari Govender: That would be wonderful. Thank you so much for doing that. So, thank you again, and with that, I'll just pass it to Sarah for a moment for some just final comments.

Sarah Khan: Well, you've already done the reminder about the written and/or video submissions for March 31st. And also, our public survey around hate or experiences related to hate is still open until March 6th, and of course, age is well within scope with how we're defining it, so if you can continue to help share, spread the word around the public survey, and we will be in touch around-- once the recording is ready to post, in case you want to review it.

Isobel Mackenzie: Appreciate that.

Sarah Khan: Okay.

Commissioner Kasari Govender: Thank you so much for taking the time.

Isobel Mackenzie: Well, thank you for your interest. I appreciate being invited to participate and thank you for thinking of seniors.

Commissioner Kasari Govender: Absolutely.

Isobel Mackenzie: We're all getting older.

[Laughter]

Commissioner Kasari Govender: Absolutely, we'll all get there.

Isobel Mackenzie: Thank you so much.

Commissioner Kasari Govender: Thank you.

Isobel Mackenzie: Bye-bye.