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Chair

Mr. Dean Allison

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● (1120)

[*English*]

The Chair (Mr. Dean Allison (Niagara West—Glanbrook, CPC)): Order. Pursuant to Standing Order 108(2), our study on the federal contribution to reducing poverty in Canada will continue.

I want to thank the guests for their patience. Our last committee ran over a little bit, so we want to get to you right away. We're going to ask that you try to keep your comments to under 10 minutes. That way we can provide some time for each of the members, or at least some of them, to ask some questions.

Starting from my left, I will introduce each witness to make their presentation on behalf of their organization. I believe that would make Carmela Hutchison, from the National Network for Mental Health, the first presenter.

Carmela, you have 10 minutes.

Ms. Carmela Hutchison (Past President and Member, National Network for Mental Health): Thank you.

I thank the committee for inviting us here today.

I wish to acknowledge the Haudenosaunee people for welcoming us to gather here today on the traditional lands we share. I hope we have a time of learning from one another about the ways in which we may work together to bring an end to the poverty faced by all Canadians, though my particular focus today will be the 6,642,540 Canadians living with mental illness. I hope true action and substantive change will be the result of our collective work.

National Network for Mental Health extends profound thanks to the federal government for the establishment of the Mental Health Commission of Canada, and asks that you continue to support its vital work. One of the strategic goals they are developing includes the importance of the social determinants of health as related to positive mental health. Therefore, this is the one potential area where they'll be able to act as a bridge between the sectors.

Our organization further urges the creation of a Canada mental health act as a means to address the need for a national mental health strategy.

We are very pleased to see that work to reduce poverty is also ongoing during the global economic crisis. We feel it is a proactive step in helping citizens of this country as the country copes with the challenges that the economic changes will bring. It means everything to know that we will be remembered and also assisted.

In past economic crises, people living with mental illness have been blamed, ignored, or, worse, had the few resources we did have taken in the name of cost reduction. I thank the government for realizing that such punitive measures of the early 1990s actually cost more in loss of recovery, productivity, dignity, and hope. Full-cost accounting principles—of financial, environmental, and human costs—should be a guiding principle.

People living with mental illness die as a result of suicide at a rate 40 times greater than people with HIV/AIDS. This does not include the deaths that result from other health problems associated with mental illness, such as heart disease, addiction, and diabetes, all of which have poor prognosis for people living with mental illness. This number does not address the effects of poverty and homelessness on the under-serviced mentally ill who are consigned to a life on the street.

Immediate and swift action must be taken in order to address the pandemic of mental illness in this country. We do know from the HIV/AIDS experience that a concerted effort at disease reduction by all levels of the community results in reduced illness and death. We need to have mental health included, for all our citizens, as an issue as important as heart health, diabetes prevention, or HIV/AIDS prevention.

As pointed out in many of the documents on population health, access to the social determinants of health, as stated in Health Canada, are essential to positive mental health. Cooperation between ministries, at all levels of government, and the support of the wider citizenry will be the only way we can achieve full access to the determinants of health.

Where this cooperation cannot be achieved, we believe governments at all levels must take back their power. Legislate the actions needed to resolve problems. Rely on best evidence and consultation with stakeholder groups. Ensure there's access to justice in the pursuit of human rights for all citizens that do not pose onerous administrative burdens on the person.

Reference has been made to system navigators. We also need legal help programs for the many situations in which people find themselves. Reinstatement of the court challenges program would be a start, but we must go deeper. Legal aid programs do not help people with social assistance problems, Workmen's Compensation Board issues or labour issues, and such things as landlord-tenant issues.

Many mental health consumers who have incomes over the tax ceiling are unable to access the volunteer programs for filling out their income tax forms due to either the complexity of the returns or their levels of income. While they legitimately need assistance because of their disabilities, they're left to cope by themselves. Disabled people are not allowed to e-file.

Some of these preventative measures will help reduce poverty. There are some excellent funding initiatives across Canada for affordable housing. It's important to remember that people with mental illness can also be physically disabled and may be parents. Many of the housing options are not for disabled parents, and this can place families at risk of having children come into care.

Mentally ill people who own their homes also struggle with poverty, distress, and anxiety about maintaining these homes. So programs that help people who own their homes with repairs and that sort of thing are vitally important.

Canada needs a reliable poverty measure. Research suggests that the measure that supports quality of life with dignity is the pre-tax LICO, or low-income cutoff. Public opinion also supports that research. Use of the pre-tax LICO is our organization's official recommendation to our government as a poverty measure. Statistics Canada could easily monitor and report on an established income measure. Other population economic indicators are the homelessness count, mental health care wait-list report cards, depth of poverty, and income gaps.

In an ideal world, the perception of an individual's quality of life may also be useful. One wonders if there's a way to account for the time lag between available data and when an increase is issued for the cost of living. Government should report quarterly on the economy with other financial indicators, such as rates of unemployment and the gross national product.

We believe federal-provincial-territorial cooperation is becoming enhanced by the need to take action on serious issues faced by people living with mental illness, poverty, and other disabilities. Quick wins include agreement that one level of government benefit will not be used to deduct from another, tax incentives to employers with benefits plans for workers, national pharmacare programs, national home care, and home support acts.

There should be recognition that people living with mental illness also need to be entitled to some of the same disability supports as people with other disabilities. Dollars for disability support should follow the person. CPP disability should not be allowed to be deducted from people's long-term disability benefits when people have benefits through group or private benefits for long-term disability. Unless a person's income is at the level of LICO, they need to be exempt from any deductions regardless of income source. The disability tax credit should be refundable.

All income support programs should be indexed to inflation. The federal government could dovetail with existing provincial programs to fill in gaps. For example, the national pharmacare strategy would fill in gaps where provincial benefits do not exist. If money is provided from the federal government to the provinces, ensure it is designated funding so it is not absorbed for other purposes.

The federal government should reinstate a federal minimum wage and set it at $10 an hour, indexed to inflation. Provincial and territorial governments should freeze their minimum wages to where someone working full time could escape poverty.

Universities and other employers hiring contract workers should also adopt living-wage policies that would require procurement-of-service contractors to pay at least $10 an hour. It's poignant to note a particular study on child poverty on the CCSD website. It's by David Ross and it's called *Child Poverty in Canada: Recasting the Issue*. There is a series of effects of child poverty, and seven of the listed indicators—although there are 35—are mental health issues in children and youth that impact all of their successes in later life.

Many severe and persistent mental illnesses commonly have their onset in adolescence. Using access to employment insurance for youth, providing supported employment opportunities, and ensuring some form of episodic disability income that people with mental illness can access quickly in an episode would be very important steps in easing their poverty.

Capping and reducing post-secondary education tuition is also necessary for educational access. When illness calls for change in the educational path, that should be facilitated.

● (1125)

The mentally ill also need to be considered as economic drivers. One hundred per cent of the income of poor people is turned back to the economy. Most of this goes to the local economy, as they do not have the ability to travel far. Hiring workers and providing supports will create jobs and stimulate the economy in and of itself, while increasing the tax base. The government must be proactive and cautious about tax reduction for the sake of tax reduction and plan responsibly for the needs of all its citizens. Ideals are nice, but at the end of the day even the most strenuous cost reduction measures cannot escape the reality: things will cost what they cost. Revenue must keep pace with the needs of service.

Finally, I would like to share that the mental health consumer movement in this country has given a great deal of leadership with respect to activities and programs that help the mentally ill and reduce poverty. Through the Opportunities Fund, National Network for Mental Health has developed supported entrepreneurship programs, three of which still exist today in Calgary, St. Catharines, and Nova Scotia. People in this program are assisted in developing small businesses that range from supplementing income support programs to achieving full-fledged financial independence.

The newest program, BUILT Network, is a supported employment program that was started by Dave Gallson and National Network for Mental Health. Its objective is to provide customer service skills and computer skills to enable persons in the community to gain employment in customer service, administration, order desks, or call centres. The primary mandate is to empower the mental health consumer through skill development and employment. This entails identifying and removing perceived and real barriers to the workplace. This is achieved by bringing in local employers and having them participate through guest presentations in the classroom, submissions in course content, and the hiring of graduates of the program.

National Network for Mental Health is proud to announce that the BUILT Network project has been recognized nationally for excellence in learning by the Canadian Council of Learning, June 12, 2007. To date, BUILT has served about a thousand people. Of these, 750 have returned to work, and a further hundred have gone back to school.

One barrier to this program is the difficulty posed when we have to reject an applicant who has EI eligibility, even though this program would enhance employability and might even shorten recovery time.

In addition to these achievements, National Network for Mental Health provides leadership to national mental health consumer movement organizations through a board of directors acting on behalf of the Canadian Alliance on Mental Illness and Mental Health. One of its programs is the Canadian Coalition of Alternative Mental Health Resources, a body made up of 24 leaders of the mental health consumer movement from across Canada. They advise NNMH on policy issues and explore best practices within the mental health movement.

In spite of these achievements, funding levels for these programs have not kept pace with the cost of living, service demand, or expansion requirements. This poses a significant risk as we struggle to meet operational demands brought about by economic fluctuations. NGOs have to provide a great deal of leadership in these challenging times, and must therefore be assisted in every possible way to do their vital work. It is our hope to work with the committee in an ongoing way to achieve positive mental health for all Canadians.

I thank you for your interest and look forward to your questions.

● (1130)

The Chair: Thank you.

Dr. Taylor Alexander, welcome. Thank you for being here today, along with Ruth-Anne Craig.

[*Translation*]

Dr. Taylor Alexander (Chief Executive Officer, National Office, Canadian Mental Health Association): Good morning, Mr. Chair.

It is a pleasure to be with you today in order to provide you with our thoughts on the links between mental health and poverty.

[*English*]

I'm accompanied today by Ruth-Anne Craig, executive director of the Canadian Mental Health Association, Manitoba division, and the principal author of our brief. Ruth-Anne will be dealing with most of the presentation and the questions following my presentation. We look forward to discussing the issues in our brief with you today.

By way of background, the Canadian Mental Health Association is Canada's only voluntary charitable organization that exists to promote the mental health of all people and to support the resilience and recovery of persons experiencing mental illness. CMHA accomplishes this mission through advocacy, research, education, and service. Our vision—mentally healthy people in a healthy society—promotes individual and collective health and public accountability, while providing a framework for the work we do.

In addition to our national office in Ottawa, we have 11 provincial and territorial divisions and some 135 branches and regions in communities across Canada. Since 1918, CMHA has worked to advocate for policy change related to mental illness and mental health for all Canadians. CMHA serves over 100,000 Canadians annually, with programs and services in education, advocacy, research, direct service, mental health promotion, mental health literacy, information, and public policy development. Because poverty affects so many persons living with mental illness and is one of the causal factors that produces mental illness, income equity has been a major advocacy issue for CMHA for many years.

Ms. Ruth-Anne Graig (Executive Director, Central (Manitoba) Region, Canadian Mental Health Association): As Ms. Hutchison has already stated in her presentation today, people living with mental illness are severely affected by social and economic inequality. Through no fault of their own, they face extended and often lifetime unemployment, social exclusion, isolation, relationship distress, poor physical health, and lack of hope for the future.

In Canada, persons who suffer from mental illness constitute a disproportionate percentage of persons living below the poverty line, thus exacerbating problems associated with mental illness and contributing to stressors that cause poor mental health. A high proportion of those with mental illness are also underemployed. The correlation between a high incidence of poverty and poor mental health profoundly affects families, especially children, and creates barriers to education and other economic opportunities.

With over 20% of our population living with mental illness and a much higher number impacted by increasing stressors associated with daily life, the effect on Canadians and on the national health budget is profound and staggering. We now spend over $14 billion per year on mental health care.

According to the Canadian Council on Social Development, individuals with disabilities are vulnerable to poverty. In Canada, according to the 2006 census, there are an estimated four and a half million individuals with disabilities. According to the PALS survey in 2006, 15% of those individuals had a psychological disability. Of that 15%, over 70% were unemployed—over half a million people. The median income for a person with a disability is almost 30% less than for someone without a disability, and that's for persons who are fortunate enough to be working.

Lack of opportunity is still the biggest barrier for persons with mental health problems. Stigma and discrimination have largely directed the treatment of services for recipients of mental health services. Policies have also been driven by deficit perspectives and incorrect assumptions of the real lived experience of those affected by mental illness, inevitably preventing the adoption of recovery-oriented legislation. Yet we know that recovery from mental illness is possible and that persons living with mental illness can be and are mentally healthy.

Like anyone else, persons with mental illness require a safe, affordable home, a job, education, and opportunity for advancement for themselves and their family. A structural change is necessary if we are to realize the potential of a mentally healthy society, including the full participation of persons experiencing mental illness.

This is completely possible within an integrated mental health strategy supported by policies founded on principles of comprehensiveness and accessibility. We wish to stress the need for leadership and collaborative action on the part of the federal, provincial, and territorial governments in a shared mental health strategy.

The climate for achieving this is now opportune because of two of factors—namely, the federal government's commitment to an integrated mental health strategy and the groundwork already done by the Mental Health Commission of Canada and organizations like ours, the CMHA, on linking the number of practical and policy issues involved in mental illness and wellness.

In this brief, we argue that income support and other measures to prevent and reduce poverty can play several roles with regard to mental illness and mental health. They can help those with labour attachment to maintain it. They can help those with the potential for employment to attain it, or support those without significant labour attachment and with limited employment potential. They can prevent the original occurrence of mental illness and relapse, because income, as already demonstrated today, is a determinant of mental health. They can promote mental health and wellness by optimizing psychological, social, civic, and economic functioning.

First, we would like to address the vital issue of helping those who have entered the labour market to maintain their attachment when periods of unemployment occur. Such periods may occur because mental health symptoms have become more problematic or because of employment in a vulnerable economic sector. This would involve strengthening the present employment insurance program. That can be accomplished by increasing EI's salary replacement ratio from the current 55% to 75% of average weekly earnings, thus lessening the sudden burden of decreased earnings for families, especially for those with low income. It can be accomplished by returning EI to its pre-1996 status by readopting a 360-hour qualifying period for benefit eligibility. This will assist many persons with mental illness whose disabilities are cyclical in nature, as well as those for whom part-time work is the only alternative because of mental health symptoms and the effects of many medications used to treat it.

● (1135)

It can be accomplished by extending the duration of EI sickness benefits from 15 weeks to 30 weeks, providing persons with mental illness adequate time and opportunity for rehabilitation. It can be accomplished by broadening access to and funding for EI training programs to assist re-entry into the labour market for persons who are experiencing work stoppages due to mental illness or mental health stressors.

Second, many more persons with mental illness could be employed if the appropriate workplace accommodations were in place. The federal government has acknowledged its responsibility for a national mental health strategy through creating the Mental Health Commission of Canada and charging it with developing a national mental health strategy. This strategy should include a substantial fund to work with provinces and territories to expand supported education and training programs, employment programs, and training and resources for employers to implement workplace accommodations.

Persons with mental illness face several barriers that prevent opportunities for economic advancement. They often encounter difficulty securing adequate education and employment and face undue discrimination and stigma in these domains due to their mental health status as well as society's misconception of mental illness. Due to these factors, persons with mental illness often cannot earn adequate income in the labour market and must rely on income support programs. Only those who have had significant labour market attachment are eligible for Canada Pension Plan disability benefits or employment insurance sickness benefits. The others must rely on provincial social assistance programs.

Approximately 70% of unemployed individuals with psychiatric disability are subsisting on social assistance payments and living in poverty. According to the National Council of Welfare, in all ten provinces the yearly income of an individual with a disability can be as low as $7,851. All welfare income in the provinces was below two-thirds of the low-income cut-off line. The poverty gap for individuals with a disability was larger than the amount of income they received in each of the provinces. That is in every single province.

These provincial programs are partially funded through the Canada Social Transfer. To ensure that recipients with mental illness receive sufficient income to support their recovery and a life of dignity, we recommend that the Canada Social Transfer be restored to the value of 1992-93 transfers, and that the federal government develop standards of adequacy and humane program delivery in consultation with the provinces and territories.

In the medium and longer term, CMHA agrees with the Caledon Institute of Social Policy that the federal government should initiate and operate a basic income program for persons with disabilities, including persons diagnosed with mental illness. This initiative would remove persons with disabilities from provincial social assistance programs. It would provide a fairer, more uniform basic income, similar to the OAS benefit and the guaranteed income supplement for seniors, with benefits sufficient to decrease the prevalence and depth of poverty for persons with disabilities.

Benefits for persons unable to participate in the labour force due to disability could also be increased by changing the disability tax credit to a refundable credit at the current federal plus provincial level. This must be accompanied by further changes to the eligibility test to increase its sensitivity to the restrictions that flow from interest.

Improving the adequacy and operation of federal income support programs and employment and labour initiatives are key preventative measures that can limit the economic and human distress of mental illness. This is because income has been identified as a key determinant of health. Therefore it is fundamental for the federal government to improve delivery and sustainability of income support programs, and it is essential for the federal government to initiate national policies that promote wellness and positive mental health.

There are many ways of accomplishing this, but since I notice that I'm running out of time, I'll just indicate a couple. We must use intersectoral government initiatives that jointly involve departments such as labour, housing, health, and justice. An example of how preventive social policy can be improved for families in Canada, including families affected by mental illness, is to enhance the Canada child tax benefit and the national child benefit supplement, creating more spending power for low-income Canadians.

The maximum amount payable to low-income families should be raised to $5,100 per child in 2007 dollars. In this we support the Campaign 2000 to end child poverty because of the psychological damage to children living in poverty, which often has lifelong effects. The Canadian child tax benefit and the national child benefit supplement have been important measures in decreasing the depth of poverty for many children. The recommended increase would render the benefit even more effective in preventing sometimes lifelong mental health problems.

Housing is another initiative that the national government must address. Right now we're having a housing crisis in Canada, and the mentally ill are the largest proponent of homelessness and often live in substandard housing.

● (1140)

A comprehensive plan for housing must involve both capital and personal financing. Therefore, housing must be a primary federal consideration.

The Government of Canada has demonstrated a commitment to the mental health of Canadians through establishing the Mental Health Commission of Canada and charging it with developing a national mental health strategy. The analysis presented today shows that improvements to federal income support programs are important components of a pan-Canadian mental health strategy and that adequate funds to support these improvements are integral to its success.

Improving income support programs is relevant for the national mental health strategy for three reasons.

First, socio-economic status, and especially income, is an important determinant in the ideology of mental health problems for both children and adults. Therefore, improving the adequacy and operation of income support programs is a key preventative measure that can limit the economic and human burden of mental illness or mental health problems. This is an economically efficient measure that can avoid costly treatment for sometimes chronic problems.

Second, a disproportionate number of persons with disabilities live in poverty or near poverty, partially because of the costs of their disability, disability-related limitations to employability, and the lack of adequate accommodations in many workplaces. For persons with mental health problems, the stress and marginalization related to poverty and low income comprise their treatment and exacerbate their symptomology.

Finally, many persons with mental health problems live in or near poverty through no fault of their own. Mental illnesses such as schizophrenia or mood disorders are very often expressed in late adolescence or early adulthood, and interrupt educational attainment. This generally has lifelong effects on occupational success. Symptomology and the side effects of medication typically interrupt labour market attachment. Many persons with mental health problems are also victimized by stigmatization and discrimination in the workplace.

We must all work together, all levels of government and all citizens of Canada, to eradicate social injustice caused by stigma and discrimination and to support those living in disadvantage to achieve quality of life.

In Canada, this has been identified as a long-standing obligation. The federal government has an opportunity to demonstrate leadership by ensuring that income policy measures that improve equity begin without delay; that is, not wait for a national mental health strategy but develop simultaneously the components necessary to achieve this.

Therefore, we also suggest that the chairperson of the board of the Mental Health Commission of Canada be invited to discuss poverty reduction as a component of the emergent national mental health strategy.

● (1145)

Dr. Taylor Alexander: Mr. Chairperson, I fear that we are running over our time limit, and we have several recommendations that follow. We could do one of two things at this point, either refer the committee to these recommendations in our brief or briefly address them now.

The Chair: We'll get those translated and provide the members with copies. We need to move on to the next witness. Thank you very much.

Next is Mr. Palmer from Causeway Work Centre.

Thank you for being here. You have 10 minutes, please.

Mr. Don Palmer (Executive Director, Causeway Work Centre): Good morning.

I intend to focus my comments on the need to provide employment services and supports as mechanisms to promote recovery from mental illness and other disabilities and to help reduce poverty among persons with a disability. I also want to focus your attention on social enterprise as an innovative and cost-effective vehicle to create employment and wealth in the charitable non-profit sector.

All of us sitting in this room derive some, if not most, of our identity from what we do for a living. How many social situations do we find ourselves in when the first question we are asked is, "And what do you do?" Imagine the implications of answering, "Nothing", or "I don't work, I depend on social assistance". These are hardly answers that boost self-esteem or self-confidence. Unless we win the lottery, it is difficult to raise oneself above the poverty line without some form of paid employment.

Historically, accessing supported employment has been viewed unrealistically for many severely disabled persons. Many employers do not view the disabled as a valuable labour pool. Many mental health providers and service providers for persons with severe cognitive impairments view community-based competitive employment as unrealistic for many of the individuals they support.

As someone who has designed and provided support in employment services to severely disabled persons for over 20 years, I know this to be a myth. The Causeway Work Centre has placed and supported hundreds of persons with severe mental illness over its 30-year history. The technology exists and has existed for over 20 years. If that is the case, why aren't more severely disabled persons working?

The following, in my view, are at least some of the reasons.

There is a lack of incentives to do so. Most social assistance programs do little to provide the needed incentive to individuals contemplating a return or an initial entry to work. Either there is minimal financial incentive, onerous earning reporting requirements, or there is the constant fear of being cut off health benefits. Although there have been improvements made in the structure of social assistance over the past few years, the financial rewards reaped from going to work are often insufficient to lift a more severely disabled person out of poverty.

Employers are offered little incentive to hire persons with severe disabilities. The Ontario government enacted the Accessibility for Ontarians with Disabilities Act in 2005, and it is currently developing employment accessibility standards for all Ontario employers. As a member of the standards development committee, I'm concerned that we're more focused on sticks than we are on carrots. I would prefer a balanced approach similar to the Americans with Disabilities Act, adopted in the U.S. in the nineties, that builds in a strong tax incentive for employers who hire disabled workers.

There is a hodgepodge of government-funded programs to assist persons with severe disabilities to return to work. Whether municipal, federal, or provincial, each has its own set of admission criteria, permissible services to be offered, and most include time-limited supports, which, particularly for persons with a mental illness, do not meet the challenges imposed by what is often a cyclical illness.

Programs within sister ministries are not coordinated and rarely support each other to maximize results for the disabled worker. Many government-funded employment programs do not view the disabled worker holistically. Supports to employment are restricted to employment only, on-the-job training, or workplace-specific issues, while other negative events in an individual's life that will likely lead to a job loss are outside the scope of permissible service provision. An individual may be in jeopardy of losing his or her housing and under some employment-funded programs will be required to wait for a referral to a housing support worker or a case manager. The employment support worker will be restricted from intervening and must stand by and watch, hoping things work out before the disabled worker loses his or her job.

This is not solely the fault of government and government programs. Service providers do not always cooperate in a manner that is most beneficial to the disabled worker. Turf protection, restricted caseloads, and misplaced priorities also influence the way service providers behave.

The solutions are not tremendously complicated. Social assistance programs can be structured to encourage returning to work. Levels of government can cooperate and structure programs to work collaboratively, and, by doing so, eliminate duplication and save taxpayers money. Best practice models can be adopted and funded so that the disabled persons receive the support they need to find employment and, most importantly, to keep employment. Employers can be provided financial incentives to hire disabled workers.

● (1150)

In addition to the above, we need to explore innovative solutions to creating employment and eliminating poverty. One of the most promising, yet underdeveloped, approaches in this country is social enterprise. The definition of social enterprise varies from country to country, and within cultures, but in a Canadian context we can define a social enterprise as an organization of business that uses the market-oriented production and sale of goods and/or services to pursue a public benefit mission. Social enterprises may take many forms, located on a spectrum from traditional grant-funded charitable or non-profits at one end and pure-for-business at the other end.

I want to focus on the social-purpose business, established to pursue, in equal measure, a defined public benefit and economic benefit. These are often referred to as double or triple bottom-line businesses because they measure their performance in terms of positive social and/or environmental impacts as well as economic profits.

Causeway Work Centre operates three social enterprises: Krackers Katering, Good Nature Groundskeeping, and Cycle Salvation. These three enterprises were developed to create competitive employment for severely mentally ill persons and to show by example how it is possible for disabled workers to contribute to the community's economic growth and well-being. All three businesses embrace a double bottom line. They earn financial revenues and support business expenses and the wages of the workers while social revenues are produced in the form of healthy, productive workers who are able to maintain competitive employment. In 2007, Causeway's three social enterprises provided competitive wages to 107 severely mentally ill workers, and they earned in excess of $150,000 of earned revenues. All three businesses continue to work towards self-sufficiency.

Canada's not-for-profit sector is economically significant. It currently represents $120 billion in annual expenditures, more than Canada's retail, mining, or oil and gas sectors. With government and philanthropy reaching their expenditure limits, engaging private capital represents our best strategy for growing the sector to meet new and expanding public needs and be more innovative in how we respond to our worsening economic climate.

The non-profit sector currently has very limited access to the financial tools available to the private sector. Many non-profits do not seek alternative forms of capital because they lack business expertise, they are wary of associated risks of borrowing, or they do not have a business model to support debt financing. Regulatory barriers also prevent charities and non-profits from structuring and financing social enterprises.

Private sector investors face additional challenges. Lack of tax incentives or other government-sponsored approaches to mitigating risk also discourage institutional investors from participating in this market. Despite these challenges, sectors like affordable housing have begun to connect to the private capital market and create badly needed housing stock.

In order to grow the employment opportunities available to the vehicle of social enterprise and to lessen dependency on government granting, we need to build an effective social capital marketplace in Canada. We need to move from our current stage of sporadic, uncoordinated innovation and put policies, regulatory frameworks, incentives, and infrastructure in place to harness the value social enterprise offers and enable the private capital flows that will drive it.

For the past decade in particular, federal and provincial governments have been beating the self-sufficiency drum. They have been encouraging charities and non-profits to work more collaboratively, to utilize evidence-based approaches, to aspire to self-sufficiency, and to tap into the private sector rather than government for financing.

Certainly as it relates to employment for the disabled and the disadvantaged, social enterprise is a perfect storm of many of these ideals. But we, the non-profit sector, cannot do it alone. We need government to create and encourage the regulatory-friendly environment necessary to promote social enterprise innovation.

Thank you.

● (1155)

The Chair: Thank you, Mr. Palmer, and thank you for fitting that into the time constraints as well.

We're going to move to our last group. We have the Ottawa Salus Corporation. I believe we have Carolyn Buchan as well as Margaret Singleton.

Welcome. You have 10 minutes.

Ms. Carolyn Buchan (President, Board of Directors, Ottawa Salus Corporation): Thank you.

First of all, I'd like to thank you for inviting us to address the committee today. My colleague Margaret Singleton and I are here because we too are deeply concerned about poverty, and in particular, the poverty experienced by people with mental illness.

Salus, the organization we represent, is a non-profit organization that has worked in the community of Ottawa for over 30 years with people with serious mental illness.

As our colleagues here today have said, serious mental illness leads to stigma, social isolation, and poverty. Often it leads to homelessness.

I'm the president of Salus—Salus, by the way, is the Latin word for well-being—and I'm the chair of our 18-member volunteer board of directors. Our board includes clients, former clients, friends and family of people living with mental illness, and others who simply want to make a difference for our client group.

[*Translation*]

We provide our services in French as well as English. Last year, Ottawa Salus received a partial designation from the provincial government under Ontario's French Language Services Act. This designation ensures that francophones have access to community mental health services in French. About 25% of our 375 clients identify themselves as francophone.

[*English*]

Salus's roots are in supportive housing, and supportive housing is one of the critical elements in the range of services needed by our clients.

Through our 72-person staff, we work with clients towards their recovery, which means, to paraphrase the framework report of the Mental Health Commission of Canada, working towards maximizing their potential and participation in the community and helping them to live fulfilling lives, despite illness that is usually chronic and that always is, or has been, debilitating.

Virtually all of our clients live in poverty, with most dependent on the Ontario disability support program. This means that after paying their rent, they have to live on $554 per month, barely enough for survival let alone full participation in the community, dealing with the extra costs associated with serious illness, or dealing with emergencies or extraordinary events.

I'd now like to ask Margaret Singleton, Salus's executive director, to speak to the needs of our clients and how our services help to meet those needs.

● (1200)

Ms. Margaret Singleton (Executive Director, Ottawa Salus Corporation): Thank you.

Others would be better able than Salus to define at a general statistical level the needs of people living in poverty. CMHA has done that very well this morning. But what we can speak to are the needs of people receiving and waiting for Salus services.

Our services help to alleviate some of the problems associated with poverty, and in particular, the extreme forms of social exclusion associated with mental illness.

[*Translation*]

We provide a range of bilingual services. In addition, we have a specific team that provides community accompaniment services for our francophone clients. This service is attuned to the specific nature of the francophone culture and community in our region.

[*English*]

In terms of access, there are really three main programs and routes into Salus service in both official languages.

Need far exceeds supply in all programs. Here is some basic information about access, as well as three examples, modified to protect the privacy of three clients who made it into our programs and whose lives have been transformed as a result.

For permanent supportive housing, for which we have 186 small, self-contained apartments, the waiting list is 797. There are 186 apartments, 797 people waiting. Turnover is negligible, and the few vacancies are often taken by people graduating from our transitional rehabilitation programs.

“Karen”, our newest tenant, is a deaf women with severe anxiety and depression, and co-occurring substance abuse. Because she is lucky enough to be deaf and we had a vacancy in a specially adapted apartment, she only had to wait five years instead of the more usual eight. She's lived in shelters and multiple rooming houses since 1996. She grew up in eight different foster homes and a residential school. She also has a Salus case manager. Two case managers have learned sign language to serve this client group. For Karen, this promises to be the start of her recovery process.

We don't keep a waiting list for our intensive rehabilitation programs, which serve 25 clients at any one time, including ten specifically from the forensic units of the Royal Ottawa Health Care Group. Referral has to be from the hospital, and demand is insatiable. We have to turn down many suitable potential clients.

“Dave” is now in his fifties. He came to the Fisher transitional program after 20 years in Brockville Psychiatric Hospital. Before that, starting in adolescence, he had multiple hospitalizations and minor brushes with the law. Like many Salus clients, he has addictions as well as mental health issues. When he joined the program, he had to be taught the basics: basic grooming, eating in an acceptable manner, as well as how to make adult choices—you don't get to make many of those in a psychiatric ward. After 12 months at Fisher, he moved to a Salus apartment. With the help of a case manager, he's now coping with independence, he's made a few friends, he's avoiding hospital, and he's happy.

For our intensive case management program, we share a waiting list through a partnership with all the local agencies offering this service. Clients joining the Salus program have generally waited around two years.

“Theresa”, now in her thirties, has a personality disorder and an eating disorder, as well as a history of abuse. She joined the Salus case management program in 2001 and left it recently, after about eight years of hard work in a variety of areas. When she left us, she had a community college diploma. She's now moved out of Salus housing as well as our case management program, and is married, with a child, and is no longer living in poverty.

People with mental illness should have options around the way in which they receive services, but for many, the Salus model works best. For them, appropriate service includes living in a building where on-site support is available to help tenants create a mutually supportive community. This reinforces the benefits of the one-on-one work of case management. It provides a solid base from which to build broader community connections.

Without access to Salus services or the services of agencies similar to Salus, poverty and social exclusion will remain a reality for people with serious mental illness. Access to our services does not in itself resolve poverty issues, but it does reduce some of the negative and more extreme aspects of poverty. For some, recovery can happen to the point where they're able to move fully out of poverty and into the mainstream community.

● (1205)

Ms. Carolyn Buchan: You asked us about the role of the federal government in dealing with poverty. We recognize the constitutional requirement for the federal government and provincial levels of government to play appropriate roles in all program areas. However, from our point of view, and more importantly, for our clients, what matters is that the appropriate services are funded and available in sufficient quantity, regardless of where the funding comes from.

Right now, Canada lacks both a national housing strategy and a national mental health strategy. In our view, these are key components of a serious attempt to reduce poverty. The Mental Health Commission is working on a mental health strategy for Canada, but no one seems to be working on a national housing strategy, although we note that a private member's bill calling for this, Bill C-304, was introduced in the House in February.

We believe the federal government should absolutely take a leadership role in the development of both strategies and in ensuring action to deal with the issues. Surely the elimination of poverty can be a shared objective with the provinces and surely there can be collaboration over such an important goal. Without strategies, there is no political direction, in our view, and no momentum to move in an appropriate direction, but if federal leadership at the level of strategy is to be respected, the federal government also needs to lead by example through funding.

Salus and its clients have benefited in the past from federal-provincial collaboration. We built 40 apartments using the Canada-Ontario affordable housing program and Supporting Communities Partnership funding. What was not available was funding for a support worker to be based in the building. By stretching existing staff resources, we have put that in place, but we can't responsibly continue to develop much-needed housing if we cannot put appropriate staffing in place to work with tenants. For our client group, funding for housing and funding for related support services need to go hand in hand.

You have asked for suggestions around innovative solutions. We believe useful innovation is built on sound experience and organizational capacity. Much is already being done that is effective in meeting the needs of our client group. What is now needed is to expand existing services and to improve them incrementally.

What is needed are programs that are adequately resourced, not just to do the work but also to evaluate that work on an ongoing basis, building what we learn into program development. For that to happen, community-based organizations need a program and a funding environment that is stable, predictable, and collaborative, promoting the expansion of models like Salus that have been shown to work.

That's the direction in which we believe the federal government needs to take positive steps and provide leadership.

The Chair: Thank you, Ms. Buchan.

Thank you very much to all the presenters.

Now we're going to have a couple of rounds of questions and answers. The first round will be seven minutes, the second will be five minutes, and we're going to start off with Madame Folco.

[*Translation*]

Ms. Raymonde Folco (Laval—Les Îles, Lib.): Thank you, Mr. Chair.

[*English*]

I don't know what to say. We've heard so many groups who've come to bear witness, and the stories about poverty are each worse than the other one. Sometimes you wonder how low you can go; then you hear somebody else like the witnesses who are here today, and we go even lower. By lower, I don't mean anything prejudicial; I mean even worse conditions and even worse situations of people who have to suffer multiple conditions, if you understand what I mean. There is always something worse.

I would like to ask you a question that I have asked other groups. Rather than start from the bare bones, because we can never start from bare bones, and together we represent here the concerted efforts of government.... A number of actions have already been done. Certain things have been done that worked well for the people you represent. Others worked less well.

I'd like to hear from you what you'd like to see continuing or made better in what already exists from the federal government, and also the other actions that do not exist and that you'd like to see forthcoming. I'd like you to be as concrete as you possibly can, please. I'll leave it open to anyone who wishes to answer.

● (1210)

Ms. Ruth-Anne Graig: One thing that is happening now in several provinces and is an initiative of the Mental Health Commission of Canada is the shelter allowance benefits that some people are accessing. They're portable benefits, but that plan could certainly be universal, as it only affects a small population of the mental health community.

Mr. Don Palmer: I'll address the issue of federally funded employment programs. I'll give you a concrete example.

We have an employment program designed to place and support people with severe mental illness who are homeless. The initial process we submitted and the initial funding we received was based on a best practices model that has been well researched in North America. Unfortunately, through bureaucratic tampering, a program that was designed to provide supports to people for 24 months after they were placed was cut down to three months. So it became a program that produced great statistics in terms of people getting to work, but whether they kept their job for five minutes or five months was all that the funder was interested in. We were interested in people getting and keeping jobs.

Certainly keeping the bureaucracy out of best practices models is going to make a big difference in terms of the effectiveness of the dollars that are spent.

Ms. Margaret Singleton: Perhaps I can just comment that in the context of affordable housing programs, which the federal government has historically sponsored, it's really important for our client group that the depth of subsidy be sufficient. A program that's really designed to bring rents down to a level that's affordable to middle-income people is not sufficient for people on the low levels of income that our clients experience. Programs that are intended to help people such as our clients should be programs that target or provide subsidies that go deep.

Yes, that's expensive, but if it's going to work and if it's going to be available to the people who need it most, that's what is necessary.

Ms. Carmela Hutchison: In terms of very concrete things, if the government looks towards the assured income support program for the severely handicapped in Alberta, there are many recommendations from their low-income review that I think could be applied across the country, specifically with respect to changing the provincial social assistance allowances so that you can catch people before they fall. Have those asset allowables be the same across the country, and have a consistent program like AISH across the country.

Right now, DB2 in British Columbia and ODSP here in Ontario are the other two programs that are similar, but that needs to go all the way across the country. If the asset allowables were kept the same, we'd catch a lot more people before they fell.

The other thing is that the enhancement of federally funded non-government organizations is very important. I believe also it is vital that Canada ratify the UN Convention on the Rights of Persons with Disabilities and that mental health certainly be covered under those rights.

I think it's very important that we walk our talk. Those are some of the very concrete recommendations that we can make.

Drilling down into EI, the Caledon Institute was quoted here by our colleague. With respect to the employment insurance process, there's another paper that Michael Prince wrote, called *Canadians Need a Medium-Term Sickness/Disability Income Benefit*. Option two in that paper, with recommendations to the EI program, is another very concrete recommendation that could be a quick win put forward quite quickly.

When I presented under Status of Women Canada with respect to the effects of EI, they asked whether we should have the extended number of weeks or eliminate the waiting period. I said that ideally we need to do both. I really want to encourage government to do both if it's looking at modifying that regulation, because that can be something that happens right away.

One of the talking points that had been put forward is that the waiting period was like an insurance deductible. I had a devastating house fire in 2004, and the deductible in my insurance policy was waived because the damage was over $10,000. In looking at illness as being a very catastrophic thing that could happen in a person's life, we should perhaps eliminate the waiting period for people who are ill.

● (1215)

Ms. Raymonde Folco: Thank you.

Do I have any time left?

The Chair: Sorry, no.

Ms. Raymonde Folco: Thank you very much for those concrete suggestions.

The Chair: Monsieur Ménard, welcome again. You have seven minutes.

[*Translation*]

Mr. Réal Ménard (Hochelaga, BQ): Thank you, Mr. Chair. It is a pleasure to come to this committee because it is an important part of the work of the House.

Your presentations were extremely eloquent. They were both forceful and clear, but they were also distressing. They reminded me of a poem by Réjean Ducharme, but I will resist the temptation to read it to you and will concentrate on specific questions instead. Please know that I much appreciated the message you brought to us this morning.

I would like to ask three brief questions. I am not convinced that the federal government is in the best position to fight poverty. In the parts of Canada where the battle has been won most clearly, the initiative was provincial: in Quebec, in Newfoundland, and, to an increasing extent, in Ontario. But that does not mean that the federal government has no role to play.

The common thread in all of your testimony is the mental health problems. Researchers tell us that, in the coming years, one person in five will experience a mental health problem to some degree, and will suffer discrimination as a result. The Canadian Human Rights Act provides a number of guarantees designed to end discrimination, particularly in relations between governments. But the federal government has not included social status as one of the prohibited grounds of discrimination, whereas nine provinces have.

Should not the first thing that the government should do, simply out of respect for its area of jurisdiction, be to provide a tool that people with mental health problems could use to challenge any refusal to provide them with banking services or access to housing? Could the government not come together with all the legislatures and begin by amending the Canadian Human Rights Act to include social status? Have your organizations looked at that issue?

Does someone want to start that discussion off? Then I want to get back to housing.

[*English*]

Ms. Carmela Hutchison: I would definitely like to see the citizens have the ability to approach a human rights commission and for that commission to have actual power. There are provincial ombudsmen in most of the provinces, but I can only speak for Alberta in this case. I know the ombudsman there does not have the power to compel a solution, which then means that people have to go to the human rights act and Court of Queen's Bench. It costs $200 to file in the Court of Queen's Bench. There is no way we can provide that or have people to do it.

In terms of access to legal pursuit of one's rights, whether that be for private insurance, landlord and tenant issues, or marital issues, there are terrible problems accessing help.

I am simply a disabled woman. I have a complex mental illness, a brain injury, and as you know, I am physically disabled. I am certainly not a lawyer. I am a nurse by background, before I was injured.

One gentleman was a disabled pharmacist. He had access to a private plan that allowed him an income of $5,000 a month. Without that he would be homeless and destitute. The only way we could help him was to actually act as his attorney and go to court and file the documents ourselves. He had a lawyer at one point. He spent $30,000 on this lawyer, who did not, in eight and a half years, file a single motion on his behalf. I had to argue his case and file his documents.

It was a tremendous stress. I was telling them they had to get help, that I didn't know what to do and it was possible that I could lose them everything. They told me they had already paid a lawyer $30,000 over those eight years and they still could have lost and ended up with nothing. Happily in that situation they were finally able to achieve a settlement.

This is a tremendous problem, and that's the watershed of what goes on. People direct us to student resources such as Pro Bono Students Canada, for example, or local legal guidance clinics, who tell us that they can direct us this way or that way, but they can't represent us in court and can't do our documents. I looked at them and told them that they couldn't help me, because I could already write my own affidavits. But I had to learn that by the rules of court, and it was very strenuous and very stressful.

● (1220)

[*Translation*]

Mr. Réal Ménard: Now let me turn the discussion to the issue of housing. You are absolutely right to remind us here that, for the fight against poverty to be effective, we must accept that far too many people are spending a significant part of their income on housing.

I am sure that you know that the federal government got out of any form of social housing as long ago as 1993. There was an affordable housing program, but there is no low-cost housing program anywhere to which the federal government contributes, though it plays a role in housing co-ops. There are co-operative housing agreements that are coming to an end.

Is not the best way to ensure that that there is a viable and reasonable supply of social housing in our communities to establish transfer policies in the provinces? Could the provinces not play a far more useful role? Does the initiative have to come from the federal government only?

[*English*]

The Chair: Ms. Singleton.

Ms. Margaret Singleton: Clearly the provinces have a role to play. There was a point when Canada was recognized as a leader in the provision of affordable and social housing. At that time, there was collaboration between the federal and provincial levels, and the federal government was heavily involved in the provision of housing. The federal government withdrawal, effective in 1993, has had a significant impact on the options, if you like, across the country for the development of housing. I think the federal government is key to making this work at a practical level, although that's not to eliminate provincial participation and responsibility.

Ultimately, though, it really doesn't matter to our clients where the money is coming from.

Ms. Ruth-Anne Graig: Social housing isn't always the answer. Sometimes being in social housing leads to more discrimination. For people with mental illness, full citizenship means community integration, which is the healthiest measure for people.

So I think the portable housing benefit, not attached to programs, would be the ultimate solution.

The Chair: Ms. Chow, welcome back. You have seven minutes.

Ms. Olivia Chow (Trinity—Spadina, NDP): Thank you, Mr. Chair.

I've noticed that suicide attempts for people on welfare are ten times higher than they are for the average Canadian. For folks on welfare, one out of ten have considered suicide in the previous 12 months. So there's a definite link between poverty and mental health.

I also notice that the prevalence of depression among people with low income is about 60% higher than it is for ordinary Canadians, and they're more likely to land in hospital because of depression. That's 85% higher than it is for average Canadians.

You're right that the health costs alone, whether because of attempted suicide or hospitalization for depression, are huge. Of course, there's a huge human toll for people with mental illness. It seems to be a downward spiral. You get depressed, you get poor. Then when you get poor, you get more depressed. They just feed each other. Then you have drug dependency because of it and so on. And it just gets worse.

I have seen in the Toronto region a team called the Dream Team, which is a group of people who formerly had psychiatric challenges and mental health issues. They got back on their feet because they got housing, and because they got housing, they were able to take their medicine if they needed to. They have a group feeling. They are supporting each other. They are eating properly. There's stability in their lives that makes it a lot easier to recover from mental illness. This Dream Team then talks to people in Toronto about the need to invest in supportive housing and to invest to make sure that people don't fall into deep poverty and so on. They are educating to a great extent on this issue.

I want to ask Dr. Alexander, from the Canadian Mental Health Association, specifically about disability benefits, tax credits, tax incentives, and income. Right now, it's a hodgepodge approach. If one goes on the Internet to find some of the tax incentives—if I'm an employer who wants to employ someone with a disability, for example—it's chaotic.

Is there in fact one-stop shopping available for employers or people with disabilities? I think you ran out of time earlier, so perhaps you could tell us more about the tax credits, incentives, and benefits that would assist in making sure that people don't get trapped in this downward spiral or in this cycle of poverty.

● (1225)

Dr. Taylor Alexander: Thank you for your question.

There are different dimensions to it. In terms of any kind of standard across the board, one-stop shopping, to my knowledge, does not exist anywhere. Across Canada there may be individual communities or cities that provide those kinds of services, but it is very piecemeal and ad hoc. There is no national program at this point other than, perhaps, through the federal government's information centre that's available by telephone or online.

As an aside, one of the very worrying trends we are seeing in mental health, currently, is that people who are in poverty with mental health problems and are homeless because of a lack of facilities or services in local communities are actually ending up in jail. Jails are becoming the treatment facility of choice because of the lack of any other kind of facility. That's a trend that's not well known or understood across the country, but it's happening as we speak.

Also, the part that is very worrying is that people with mental health problems who may, for whatever reason, need to be dealt with by the police, perhaps because of behavioural issues or whatever, are at that point given a criminal record. So mental health becomes a label for criminal behaviour. We come back to the issue of stigma and the label people carry with them as they go and apply for jobs, for social housing, and so on. It's a terrible barrier to their participation in society.

In terms of some of the specific things we recommend, speaking to your point, increasing the EI salary replacement ratio from 55% to 75% of average weekly earnings would be a recommendation of ours, for example. These are all in our brief. I can refer you to them.

● (1230)

Ms. Olivia Chow: What about the tax benefits when you're on EI? Tax benefits, tax credits, disability benefits....

Dr. Taylor Alexander: The recommendation that we're making there, specifically around children, is to enhance the Canadian child tax benefit.

Ms. Olivia Chow: To $5,000?

Dr. Taylor Alexander: Yes, up to $5,100 in 2007 dollars.

Ms. Olivia Chow: What about the disability tax credit? I think you were looking at maybe—

Dr. Taylor Alexander: We recommended changing the disability tax credit to a refundable credit at the current federal plus provincial level, as well as changing eligibility tests.

Ms. Olivia Chow: Can you explain that a little bit? I don't understand it.

Dr. Taylor Alexander: I'll ask my colleague to speak to it.

Ms. Ruth-Anne Graig: Often it's very difficult to access the disability tax credit for mental illness. There are so many barriers surrounding that.

To get back to what you were originally asking, Ms. Chow, it's often very difficult accessing any kind of program because there's a lack of information. Also, a big problem is that when people fall into poverty, it's so overwhelming, and it takes up so much energy to—

Ms. Olivia Chow: They don't pay taxes anyway.

Ms. Ruth-Anne Graig: Well, that's not completely true.

Ms. Olivia Chow: Or some of them don't.

Ms. Ruth-Anne Graig: If you're looking at people with low income, they are still paying taxes.

Ms. Olivia Chow: Right.

Ms. Ruth-Anne Graig: We just believe the disability tax credit should be available to people with mental illness. And not all people with mental illness are living in such dire poverty that they can't access tax credits.

The Chair: Thank you very much.

We're going to now move over to Mr. Vellacott. You have seven minutes, sir.

Mr. Maurice Vellacott (Saskatoon—Wanuskewin, CPC): Thank you, Chair.

I'm really pleased and just delighted to hear our fine presenters here today with their different perspectives; I know Margaret and Carolyn here.

Those of us who have family members with mental health issues kind of get exercised about providing for them and for their futures when we're not going to be around anymore. We personally as a family have come to know a lot of wonderful people in the support groups. We have a son who has schizophrenia. We have a son who has Asperger's. So we know and deal with some of this stuff. These children are both a real blessing, but there are those special challenges, of course, as well.

I had a couple of questions, but I want to kind of make some comments first and maybe get some response to them as well.

As part of a caucus of a few of us around this place within the Conservative side of things who have family members affected directly by mental health issues, I was quite excited, obviously, when our government committed $130 million over ten years to create the Mental Health Commission of Canada. We thought that was a pretty good step, and we're pretty excited about that.

The other thing is in terms of the $110 million in budget 2008 committed over the five years to undertake research projects on mental health and homelessness in major urban centres across Canada. Maybe you could just hold a response for me on that; I would be concerned to hear what you would feel, as members of our panel, what those priority areas for research would be. You would have maybe some pretty good and helpful suggestions on the record in terms of what those areas of research should be to address this federally. It is primarily a provincial area, but as we collaborate and work together, what kind of good stuff could come of that research?

I did also want to ask—hopefully I'll get responses from you right away on this—about the new federal government registered disability savings program, effective January 1, 2009. Now, some of us went into the banks, and it was just kind of shaping together, trying to get the details and so on for that. A lot of people whom we talked to in our network of friends and associates within the support groups wanted to know more about that. I want it on the record here today that people should be getting on the website to check out the new registered disability savings program.

What's your response on that? It is where you can contribute. You can set up for your children. Even people of modest means can contribute into a fund for their children, securing their future in some manner so that they don't have that poverty later on. I read now—it just refreshed my memory—the fact that it's a match of 100%, 200%, or 300%, depending on the means testing that goes on there. So the government is matching heavily and very significantly whatever is put in by families.

Tell me if you have some early indications, questions that people are asking, and reactions in respect to the new, just-coming-into-effect registered disability savings program.

First off, Carolyn.

Ms. Carolyn Buchan: I'm going to leave to my more informed colleagues the specific answer to your question. I just want to say that one of the things that motivates those of us who are on the board of Salus is knowing that for every one of our clients who has safe, affordable housing, we have a multiplier effect beyond just that one person. It's their whole family who really, as they age and worry about their children—if it's a child involved—have been reassured to a certain extent. When they come to our housing, our clients generally stay, but not in all cases. They can recover and go back into the community at large, but for many, this is their home, so this multiplier effect is very important.

I also wanted to thank Ms. Chow for her suggestion about the Dream Team. One of the things we are always concerned about is that we don't have enough profile out there, all those of us in the business of trying to help people with mental illness. Perhaps we have to get some lessons from you a little bit later on how we can raise the profile of what we are already doing. In many ways, what we are doing is a wonderful success story.

I'll turn over the specifics to my colleagues.

● (1235)

Ms. Ruth-Anne Graig: We've known for a long time in mental health that having a home is one of the most integral components of a person's quality of life. Things like the “housing first” model have been very successful. When we look at the long-term effects of housing and the research that the Mental Health Commission of Canada is doing from the homelessness initiative at this point, we'll find that we can probably see effects in the other domains such as education and employment, social quality, and certainly relationships.

In terms of your other question, perhaps I can just go there for one moment.

Mr. Maurice Vellacott: Well, it's one of many, but anyhow, carry on.

Ms. Ruth-Anne Graig: My biggest problem with the new disability savings program is that it is great for people with resources. Unfortunately, it leaves a lot of people who are dealing with mental illness out of the picture—people who have become disenfranchised from their family and natural support networks. It is great for people who can access it.

Mr. Maurice Vellacott: There's not a great deal of knowledge out there on this right now, but a person doesn't even have to have...and I guess you're right in that, if they're connected or disconnected from family and so on. But they don't even have to....

In fact, when you get to age 18, if you have this plan or this fund open, without even contributing on your own, the government will contribute significantly; it's a means basis. That's as I understand it; we've gone through some of the fine print.

So you don't even have to have family with significant wealth or means or anything—

Ms. Ruth-Anne Graig: But *you* have to have some wealth to match it.

Mr. Maurice Vellacott: No, you don't, actually. No, that's not correct.

Ms. Ruth-Anne Graig: Okay.

Mr. Maurice Vellacott: That would be good for people to read up on pretty carefully, because we did check it out with the bank. When he's on his own without any resources at age 18-plus, he can still be a beneficiary of this. In terms of the amount, it will be entirely the government contribution kind of thing.

Anyhow, I've run out of time. I was going to ask you about Hansen trusts. I was going to ask you about the Ontario disability program and many other things. A competitive minimum wage was a question that I wanted to ask Don about.

If I can cheat from my colleagues here later, I might get those in. If not, we'll ask them of you personally.

Ms. Ruth-Anne Graig: Thank you for that information.

The Chair: We're going to move to a second round.

I want to welcome Ms. Coady to the committee.

You have five minutes.

Ms. Siobhan Coady (St. John's South—Mount Pearl, Lib.): Thank you very much.

First of all, let me thank you all very much for your very comprehensive presentations here this morning. You have obviously put a lot of time and consideration into your presentations. It certainly showed in the presentations and the number of suggestions that you have made, and we certainly appreciate that.

Secondly, I want to thank you as well for all that you do in the community for mental health. It is certainly a very serious issue for Canada, for Canadians, and for individuals. Anyone in this room at any given time could be utilizing your services, so I appreciate that very much. There but for the grace of God, right?

Those were just some opening remarks. I want to talk a little bit about the hierarchy of needs.

Many of you talked about housing. I have two questions to formulate, so I'm going to start with the first one on housing.

I'd like to get specifics on what we should be doing on housing. As you know, the Canadian government over the last number of years put a significant amount of money towards housing initiatives. I am going to be holding in the next week a round table in my community about housing issues and concerns. I've been to a lot of the places where those with mental illness live, and it's not pretty.

Will any of you make suggestions on what we should be doing specifically for housing at this point in time? It's a very serious issue.

I want to get to my second question, because we only have seven minutes. Are you seeing an increased demand for your services because of the downturn in the economy? For example, I think Mr. Palmer talked about the availability of jobs. Has that been decreasing? Are we having more serious impact? What I'm concerned about is prevention and early intervention and the spiralling effect, because it's a spiralling effect. We could all have mental illness today and find ourselves in poverty, it's that serious of an issue.

I have many questions, but I'll start with those two.

● (1240)

Ms. Carmela Hutchison: We must look at the hierarchy of needs in the first place, and I'm really glad you brought it up. Abraham Maslow's hierarchy of needs is a wonderful place to begin. Shelter is on the base level. It's with food, water, air, and the basic things we need to just survive as an organism.

Having said that, in terms of the issues around housing, I think the private landlord rent subsidy is one very concrete program that could be enhanced that would really help a lot of people. Many mental health consumers who have the ability to access it really express its benefits.

Also, in terms of preventing homelessness in emergency situations, when a person starts to not meet their payments, there could be some kind of assistance there. I think also that income protection as preventive medicine cannot be overstated. That has to be seen as one of the forms of preventive medicine.

We have a city of homeless people in Calgary and another city of homeless people in Edmonton, and that's just those two communities. So there are about 4,800 people homeless in Calgary right now, and 50% of them are actually employed. Then there are another 3,000 in Edmonton. This is something that has to been seen...and I know it's across the country. This is a national crisis.

For a flood or a disaster, we would be rolling out emergency measures. I am begging our governments—provincially, locally, federally—please, this is a crisis. This is an emergency. Respond accordingly. This is an epidemic.

There's already enough research out there to talk about what needs to be done. I suggest that one of the first priorities of the research department of the Mental Health Commission is to mine that research and only address gaps. I think this is one thing that's really important because the answers are already in those files and that's crucial.

On the increased demand for service, I live 45 miles in the country from Calgary. There are people who access me on a daily basis over the Internet, over the telephone, who drive out to my house, and it's never-ending. We eat it, live it, breathe it, sleep it. It never ends. I know that many organizations that have a mandate perhaps to do an educational program end up trying to solve the basic needs of the individuals.

So again, the fact of crisis cannot be overstated.

Thank you.

Ms. Margaret Singleton: Perhaps I could just comment.

You asked about specific things that could be done. I think the comments that are being made about how we already have a lot of knowledge are very appropriate, but I also think it's important that there is no one solution. It's not one size fits all. People are different. Whether they have mental illness or not, people are different. One solution can be good for one person and not for another.

The rent supplement model has been talked about. Certainly it's very positive, but for many of the clients we work with, it would not work well. They need the community base of a supportive housing community. An integration can happen in small supportive housing communities within the larger neighbourhood.

Those are just two things, but I think it's really important not just to focus on one solution.

● (1245)

The Chair: Thank you.

Mr. Cannan.

Mr. Ron Cannan (Kelowna—Lake Country, CPC): Thank you, and my thanks to our witnesses.

This has been a compassionate, compelling talk, and it is something close to my heart. I spent nine years on Kelowna city council, and worked on the committee for community housing and the board for social planning. As we've said in this committee, poverty is something that crosses all party lines, ages, and social, economic, and demographic sectors. Each of us has a story to tell about individuals we know in our communities. I have an adult daughter who has a borderline personality disorder, and it's been a real challenge. We who have worked with the Canadian Mental Health Association appreciate their efforts. With the street programs and with our homelessness partnering strategy, we've had quite a number of success stories in our home community.

And Carmella, like Calgary, they're working on a 10-year capital plan. Two of the problems are knowing where to start and how to know if you're making progress. That's what we're embarking on right now. There's no silver bullet. It's multifaceted, all levels of government, non-profit and private sector. Everybody has to work together. We respect the hard work of Senator Kirby's report and the commission on mental health. The 2007 budget put in over $130 million over 10 years; the 2008 budget called for $110 million over five years.

At the end of the month, this committee is going to be travelling to Vancouver, where we will see first-hand some of the work that's being done and needs to be done in the community. Coming from British Columbia, I've seen it many times, first-hand.

As to where we go with housing, I know we talked about a national housing strategy, but somebody from Ottawa telling us what to do in our community doesn't go over well out in British Columbia. In the 30-year plan that our government signed off on in 2006, we invested $2.2 billion. The plan works with BC Housing and CMHC, partnering in the community. So we're having some success.

I'd like to get your comments about giving long-term funding to the provinces and working with local communities, versus having a national program with no capacity for making local decisions. What would you favour?

Ms. Carmela Hutchison: I think a blended approach is absolutely essential. To echo and support our colleagues from Salus, it is true that supported housing for many people living with mental illness is essential. I myself could use housing supports that aren't otherwise readily available to us. Home care is one of those unfunded issues, and home care and housing supports are often the first things to go. The first thing to go is the supported component— they might do the nursing care, but they're not going to help with the shopping, getting to appointments, or house-cleaning. Yet these things are profoundly needed, as is basic life planning. Housing has to have a supported component, along with other components.

It's important for the federal government and the local areas to work together, allowing communities to come together. A recent CMHC paper demonstrated that giving users a role in designing and planning their housing projects is fundamental to the projects' success. It is also important to assist beleaguered municipal and provincial governments through federal transfers.

Mr. Ron Cannan: I agree. I also agree with my colleague Mr. Ménard that the closer you get to the problems, the better the chance of finding a grassroots solution.

My brother works with mentally challenged adults, trying to find employment for them. In British Columbia, they experimented with taking individuals out of institutions and attempting to integrate them into society. Do you think that was a mistake?

● (1250)

Mr. Don Palmer: No, absolutely not. The technology has been there for 30 years. The number of people who have been taken out of institutions and integrated into the community, who have been provided jobs and have kept those jobs successfully, is significant. It does take some initiative and it does take some skills, but it certainly is a way we should be going.

On the issue of whether it's employment or housing, I think we need national standards. Your point is well taken. Local solutions are what we need. We need innovation. We need our hands freed to be innovative, but we do need national standards so we don't see the erosion from province to province or area to area.

The Chair: Thank you, Mr. Cannan.

Madame Beaudin, five minutes.

[*Translation*]

Mrs. Josée Beaudin (Saint-Lambert, BQ): Thank you, Mr. Chair.

Thank you so much to the witnesses for being here today. Thank you for the work you do. I imagine that you are as impatient as I am to see the results of your work.

You have identified so many factors this morning that I will probably seem a little disorganized as I deal with several of them.

Among other things, you talked about everything that is being done provincially. Of course, mental health is in provincial jurisdiction, but we cannot forget all the work that is done at local level by community organizations. I heard you all talk about local initiatives that provide help and support to people with disabilities. I assume that you have constant funding problems there. How can we help you with all the work done by local organizations on the ground in your areas?

You also talked about priorities. Housing is likely a major priority. I would like to know about the priorities that could come next. Given the economic situation, if we were in a position to do something quickly that would produce quick results, what would it be? I know that we have to understand the big picture, but what measure or measures would you like to see put in place?

[*English*]

Ms. Ruth-Anne Graig: I think one of the most profound ways that we could increase people's salaries would be to provide resources to people on low income, such as we're doing for the OAS and the guaranteed income supplement at this time. That would put money into people's pockets right away.

Another thing you were saying is that the government needs to work with the non-profit sector more. We were just talking about deinstitutionalization a couple of minutes ago, and one of the biggest problems is that those funds are not being transferred to the community, where everything is happening.

Dr. Taylor Alexander: I would just like to add that the community-based services are the least well funded of all the mental health services. For example, in Ottawa right now they are having great difficulty attracting home support workers into the home care system, because they don't pay them enough. Home support workers are the backbone of home care, so we have a catch-22. The human resource issue has to be addressed.

Just to come back to a comment of the other member, there's an urgent need for a national human resources strategy in mental health on both the supply and demand side. I think that's a really important area of research that we need to look at.

In terms of funding, we had on the books at one point a mental health transition fund. That seems to have gone by the boards. That kind of federal fund would go a long way to making funds accessible to community-based services across the country. I think at one point there was a half-billion dollars in the mental health transition fund. It would have to be revisited. But there's a good example of how the federal government could show leadership, yet the provinces could use those funds in appropriate ways.

Just to deal with the other issue of the federal-provincial dynamic, I think what the federal government can do very well is to set those national standards. But the provinces, obviously, have the responsibility to implement these programs. I think one of the downfalls with the health funding a few years ago was that it remains important to have accountability on the provinces' side of how those funds are spent.

In terms of a housing strategy or a mental health funding strategy, yes, make the funds available, give the provinces the freedom, but have some accountability mechanisms built in for their use so these funds don't go into general revenues, for example, as has happened in the health care system.

● (1255)

Ms. Carolyn Buchan: From a Salus point of view, I think we would agree completely with the last speaker. Earlier, when we were in the hall waiting to come into the committee meeting, Gillian Mulvale from the Mental Health Commission asked us where our funding came from, and we had to say to her, well, it has a mixed history. Over the 30 years, it has come from all levels of government at different times, depending on which level was more active in the field at the time.

At the end of the day, as Margaret said earlier, to our clients, it doesn't matter where it comes from. We are pretty adept at working with every level of government. But I think from an administrative point of view, what was said earlier would be the way we would like to see it go.

The Chair: Thank you.

That's all the time we have for this round.

We're going to finish up with Mr. Lobb, and you have about five minutes.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you very much. I'll try to ask these questions as quickly as I can.

My mother-in-law has worked in the mental health profession for over 30 years in southwestern Ontario, so I'm kept well apprised of the situation there.

We talked about gaps in rural Canada. Being from rural Ontario or rural Canada generally, I was happy to hear Carmela say she was from rural Alberta near Calgary. I'm curious to know from your perspective where you see some gaps in mental health care in rural Canada that you'd like to see improved.

Ms. Carmela Hutchison: Actually, when I was injured, I was working in a rural mental health clinic in Hanna. I was injured in a rollover car accident on my way to a team meeting. So I can certainly speak to this issue quite extensively.

The gaps for people living in rural areas are just tremendous. The human resources issue is profound. That is certainly one thing. Also, we can't attract clinicians in the same way you can't attract home support, because of the lack of wages necessary to sustain the employment of people.

As we're all NGOs here at this table, we're also employers, and it's very difficult to find quality staff when you're trying to hire people. In the mental health consumer movement, that's also a huge problem, because we're trying to get staff who have lived the experience of mental illness. If the wage isn't commensurate with meeting their basic needs, then it's really not something that, ethically, we can do. In the Alberta Network for Mental Health, in particular, we have operated without staff for the past two years, because we cannot pay somebody a wage that would allow them to even afford housing. Ethically, as a board, we feel we can't do that.

So that's where we're at. Right across the board, human resources is an absolutely profound issue.

Access to treatment has been helped by telehealth, but that really isn't the only thing that people need. In rural hospitals, there need to be at least one or two beds for some of the less severe, and perhaps shorter-term, mentally ill persons who don't necessarily need the big infrastructure of a city psychiatric ward, for example.

Sometimes transportation to treatment is an issue. If somebody has to go out of the community for treatment, there often isn't disability transportation. One example is that there is actually an allotment given in Alberta to rural municipalities for transportation. The problem is that this disability transportation money is not designated. Any dollar that goes to people with disabilities that is not designated often very quickly finds its way absorbed into general revenues. That practice must be stopped.

Mr. Ben Lobb: Thank you very much.

To Mr. Palmer, social enterprise is one area that I'm very interested in, and have been for awhile. I just wonder if you would like to expand on where you see social enterprise heading in the next five years.

● (1300)

Mr. Don Palmer: I think there's been an increased interest among the not-for-profit sector in developing social enterprise as a way of mitigating some of the social issues we're dealing with. We know that government has a limited amount of money, and I think there's a lot of entrepreneurial intent. There are restrictions, for instance, imposed by the CRA around social enterprise. Social enterprise has to be training-oriented. Hiring people with a disability and providing them with employment alone is not considered to be exempt, so there's a real and negative incentive for a lot of not-for-profits moving in that direction.

A question was asked earlier about the job market and how it's affecting the people who are coming through our doors. I think we're seeing less available jobs, particularly for a lot of the people we support, who often need jobs in the service industry or manufacturing. Social enterprise is a way of getting around that. We work with a lot of talented people who could be mobilized into operating businesses that can provide them with a decent wage.

The Chair: Thank you very much.

To our guests, I want to thank all of you for being here today, not only for your great testimony but also for the great work you do in the communities. As we move forward with the study, your input is very important. I think education among members of Parliament, among other things, is important as well.

Again, thank you for being here today to share your experiences and your recommendations with us.

The meeting is adjourned.

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