House of Commons
CANADA

Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities

HUMA • NUMBER 017 • 2nd SESSION • 40th PARLIAMENT

EVIDENCE

Thursday, April 30, 2009

Chair

Mr. Dean Allison

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● (1110)

[*English*]

The Chair (Mr. Dean Allison (Niagara West—Glanbrook, CPC)): Pursuant to Standing Order 108(2), our study on the federal contribution to reducing poverty in Canada, I would like to offer a warm welcome to Mr. Kirby. We thank you very much for taking time out of your busy schedule to be here. The committee believes that mental health is not only a serious issue, but it's an issue that people don't know enough about. We appreciate your coming here in the context of our study on poverty to talk about it.

Mr. Kirby, I'm going to ask you to introduce the guests you brought with you, and then I understand you have a 10- to 15-minute presentation. You understand the way things work around here. We'll have some time for some questions, and we'll go around the room in that way.

Welcome, sir. The floor is yours. Do you want to introduce your colleagues, and then we'll get started?

Hon. Michael Kirby (Chair, Mental Health Commission of Canada): I will do that, Mr. Chairman. Thank you very much.

May I also say it is kind of neat that you asked someone who spent so many years in the other place to come and talk on this side of the building. So thank you very much.

I have with me today the three people who are directing the institute's main programs. Dr. Howard Chodos is responsible for the study on mental health strategy for Canada. Dr. Jayne Barker is the director of policy and research for the commission. Micheal Pietrus is both the director of communications and the director of the anti-stigma program.

I believe my opening statement has been circulated in both languages to people. I won't read it precisely; I will more or less talk to it.

I really am delighted that a committee of the House of Commons asked the commission to come and talk to it about the issue of mental illness in Canada, because not only is this an important issue, but it is very much a personal cause of mine. So I'm delighted to be able to take you through, in my opening statement, a very brief outline of the work of the commission, and then to turn it over and prepare to answer your questions on any mental-health-related issue you might have.

I think it's important to put the issue of mental illness in perspective. This year seven million Canadians will experience an episode of mental illness. That is one person in five, although I will tell you there are those in mental health, professional researchers, who actually think the number is moving fairly rapidly toward one in four as opposed to one in five. In other words, the percentage is increasing. We know that during the recession the incidence of mental illness among Canadians will increase significantly.

Many of these people, unfortunately, will not get any help. That's for two reasons. One is that nowhere in the country is there an adequate supply of mental health services. The second reason is that they're afraid to come forward because of the stigma associated with mental illness. Indeed one of the biggest barriers to people getting adequate treatment is stigma. Stigma and discrimination exact a huge toll on people with mental health problems. In fact, many of the people you talk to will tell you that the stigma and discrimination they face from family, friends, and co-workers is actually greater in terms of its impact on them than the symptoms of their illness itself. I want to emphasize that the stigma they face is not the stigma from the general public, which exists but they basically don't see; it's the stigma they face from people who are closest to them—from their family, friends, and co-workers.

In economic terms, mental illness costs the Canadian economy an estimated $33 billion a year. To put it in perspective, by the way, that's roughly half the Ontario budget. More strikingly, I think you'll be surprised to know that more hospital days are spent by people in hospital with a mental illness than by people with cancer or heart disease combined.

That number sounds almost unbelievable, so let me explain it to you. If someone has a mental illness that is severe enough that they have to be hospitalized, the impact of that is that they are usually in there for a considerable period of time, frequently months. Typically, someone in the hospital for heart disease or cancer is in for a much shorter time. But it helps to explain, when you look at mental illness increasing and the length of time someone with a mental illness is required to stay in hospital, why we're finding a shortage of hospital beds in the country.

If you talk to employers, you find that the most rapidly increasing part of health care costs to employers—that's short-term disability and drug costs—is due to mental illness. In fact, somewhere between 4% and 12% of payroll costs are now being spent on mental illness. The exact number varies, obviously, from employer to employer.

More interestingly, pharmaceuticals for depression and anxiety and other mood disorders have overtaken cardiovascular drugs. I think, for example, of Lipitor and other drugs like that, which have overtaken cardiovascular drugs as the principal or main drug being paid for by drug plans.

The Mental Health Commission begins with a very simple view, which is that someone with a mental illness deserves the same level of service as anybody being served anywhere else in the health care system. We're not saying that every person with a mental illness has to have the problem treated instantly, any more than anyone with a physical illness has to have it treated instantly. We know that's impossible. But what is happening is that the service accorded to people with a mental illness is very, very significantly worse than is accorded to people who have a physical illness.

As I think you know, the commission was created out of a report from the Standing Senate Committee on Social Affairs, Science and Technology, which I chaired. The report was entitled, *Out of the Shadows at Last*. We used the words "at last" very deliberately because of stigma. This issue has been in the shadows for far too long. Indeed, if you ask me in a sentence what is the real goal of the commission, it's to keep the issue of mental health out of the shadows forever; that is to say, to not let it slip back into the shadows.

We are structured legally as a not-for-profit corporation. We're not a service provider. We are a catalyst. We have a board that consists of 18 members. Twelve, including myself, are non-governmental members, which is to say representatives or individuals in the private sector across the country. Many of them are service providers. Three of them actually are people living with a mental illness, to ensure that we get the consumer perspective. The other third of our members are governmental members, one from the federal government and five from the provinces and territories.

We have the active support of all the provinces and territories except the Province of Quebec. With the Province of Quebec, in fact at their request, we've now set up a bilateral relationship. The issue there is that they view us as a federal institution, which we are not. I repeat, only one out of 18 board members is appointed by the federal government. They clumped themselves, if I could put it that way, in the intergovernmental constitutional context.

On the other hand, on the ground in the province of Quebec, in Montreal—and Jayne Barker can comment on this, if you want—we have the enthusiastic support of service providers to people needing mental health services and so on. Indeed, there are representatives of the government on the steering committee for our Montreal homeless project. So the reality is that while at the sort of very high level of constitutional niceties there is an argument from the Government of Quebec, on the ground, where it really counts, because our objective is to try to help people, we have very good support, even in Quebec.

We have eight advisory committees that are really designed to ensure that we have the best possible advice on a whole series of issues. To give you a couple of examples, we have children and youth, we have seniors, we have a family advisory committee, and a family caregivers advisory committee.

Let me say parenthetically, by the way, about the family issue, that the vast majority of mental health services in this country are actually provided free by family caregivers. What I mean by that is that the amount of work they have to do looking after someone at home with a mental illness is enormous, and it's all volunteered, because they are people doing it at home for their loved ones.

The need for respite care, for example, for people in those very stressful positions is an issue that no government has yet touched. We have one on the law and mental illness, because there are some very quirky things in the law, and we will be proposing some changes with respect to that. They largely affect the way in which police and others handle 911 calls related to a mental episode.

● (1115)

As an interesting aside, if you talk to the chief of police in any major city, you will find that on the order of 50% of their 911 calls are actually mental health calls. In that sense, in many ways our police officers are the ultimate front-line mental health workers in a time of crisis.

What is our objective? Our objective is really to offer people a sense of hope that the system can be changed and will be changed for their benefit, which really leads to the first issue, the one Dr. Chodos is working on, the mental health strategy for Canada.

We've done two things. We're doing it as a two-stage process. The first is to figure out where we really want to go. That is to say, if you could revise the system, what would it look like at the end point? To that end we've produced a document, and we have copies in English and French if people want them. It's a framework document. It's been widely consulted on. Howard and his team visited 13 cities across the country, and more than 1,300 Canadians responded to our online consultation, including many organizations, so the number is actually a lot bigger than that.

We are basically at the point of having a final version of the framework, which will have very strong support across the country from all interested parties—from governments, from individuals with a mental illness, from caregivers, from service providers, and so on.

The second step will be the more difficult one: if this is where we want to go and this is where we are today, how do we get from one place to the other? The reason that's the most difficult, by the way, is that we've been able to get people to agree on where we want to go, but to get from here to there, a lot of those people are going to have to change what they're doing and change the way they do it, so the difficulty will be in persuading people to change. It's very much symptomatic of the Mark Twain comment that "Everybody is in favour of progress; it's just change they don't like."

We've agreed on what constitutes progress; the change issue will be more difficult. We will work on that over the next couple of years.

I won't read the brief outline of the framework, which is there for you in eight bulleted points. Instead let me turn to the second of the four big pillars we have, which is the one dealing with homeless mentally ill people.

In the budget 15 months ago or so, the federal government asked the commission to undertake five pilot projects to try to understand how we could provide service to the homeless mentally ill. It is an issue that has bedevilled governments in all industrialized countries. Jane can talk in some detail about the exact studies. They're now just under way, which is remarkable, since it took us only 12 months to go from a dead stop to actually having researchers out in the field. The results are going to be helpful in not just Canada; the international organizations responsible for providing homeless services are very much involved.

To put it in perspective, by the way, although nobody knows the exact number, somewhere around 50% of the people who are on the streets have a mental illness of some kind. A lot of them also have a substance abuse problem. The incidence of mental illness and homelessness is very high.

For those of you who have not read the book, go see the movie *The Soloist*, and you will understand. It just came out last week. It is a story about a homeless person with schizophrenia on the streets of Los Angeles. It's worth seeing because it will put the problem in perspective.

Our third initiative is our 10-year anti-stigma or anti-discrimination program, which Mike Pietrus is running. This will be the first systematic attempt in Canada to change public attitudes.

● (1120)

It's obviously very difficult to do, but we know from the experience in Australia, where they've been running an anti-stigma program for nearly 15 years now, and New Zealand, where they've been running it for 10, and England and Scotland, where it's been under way for some time, that a properly targeted program—and by that I don't mean your classic public service announcement ads on television, but a program targeted at very specific groups of people—can in fact be very effective.

So we've decided to target two groups, initially, for very specific reasons. One is children and youth because the attitudes of children are, frankly, a lot easier to change than the attitudes of adults. We also know that 70% of adults who have a mental illness had their first episode of that mental illness when they were under the age of 18. So if we can begin to embed in the next generation of Canadians positive attitudes towards people with a mental illness, that will be critically important. The results in other countries have shown that in fact you're likely to get a fair bit of success in doing that.

The second group we're going to target will be health care providers, and particularly mental health providers. Now, many of you may say—because this is certainly what I myself said at the beginning—why would you do that? Surely someone who's a doctor or a nurse will think that if you have a mental illness they should treat you the same way they would treat someone with cancer or heart disease or whatever. The fact of the matter is that isn't what happens. The fact is that the health care professions and people in the health care business have the same negative attitudes towards someone with a mental illness that every other profession has and that every other Canadian has. So in an attempt to at least deal with the issue of someone feeling stigmatized by going to seek help from a health care provider, we hope to change those attitudes.

Finally, let me make a comment on the issue of poverty, since that is an important part of your work, and let me make it in two contexts. The first is that while mental illness affects people of all ages, the reality is there's lots of data that shows the lower your income, the greater the incidence of mental illness. There's a bit of a chicken-and-egg issue there: your income may be down because you had the mental illness, but the reality is that there is a very clear linkage between income and mental illness. The Canadian community health survey, the one done by StatsCan, shows very clearly that socio-economic status and mental illness have a very strong linkage.

There's a second issue that's coming down the road. The incidence of mental illness among Canadians is going to increase significantly during the recession. It always does, because when people are suddenly out of work, they have a problem, there's a huge stress in families, and the impact on the family and children is very staggering.

Just to give you a couple of instances, in the first three months of this year, in Oshawa—and I'm saying Oshawa just because I happen to know the numbers—the number of people seeking help for mental health problems increased by 20% over last year. We know that in a place like Windsor, the numbers are substantially higher than that. We know it's also, unfortunately, having a very significant impact on children, because the impact of increased stress in the house as a result of layoffs—in some cases of both breadwinners—is such that it adds huge stress on the family and huge pressure on children.

So there is a clear linkage on the income side, and we have started to ask ourselves if there is anything that could be done to begin to look at trying to help reduce the impact of mental health problems on individuals during the recession.

By the way, this is not a uniquely Canadian problem. There's data from New Zealand that shows the suicide rate jumps dramatically, for example, during a recession. People just give up and they just can't take it.

Let me go back to the beginning, in winding up. All the commission can do is be a catalyst for reform. We don't actually provide services. We can cajole people, we can talk to them, we can raise the issue, we can spur people on, and we can give them ideas of what to do. But in the end, the ultimate success of the commission is going to depend entirely on the response of individual Canadians, and I say to you and all your colleagues in Parliament that we really need the support of you people, because you are leaders in your communities.

● (1125)

To have you doing events with us, speaking out on the issue, and simply indicating that it's now okay to talk about mental health, that it's not stigmatized...there are a lot of surprising little things you can do that don't cost money and that would be very helpful to us in our work.

I was delighted that you asked us to come here today, Mr. Chairman, and I very much look forward to working with you and your colleagues down the road.

Thank you very much.

The Chair: Thank you, Dr. Kirby. As we embark on this study on poverty, I think one of the things is trying to find out some of the things we can do, and you can obviously educate us on some of these issues.

We're going to start with our first round, which will be seven minutes for questions and answers. I'm going to start with my colleague, Mr. Savage.

You have seven minutes, sir.

Mr. Michael Savage (Dartmouth—Cole Harbour, Lib.): Thank you, Chair.

I certainly want to thank all of the witnesses for coming here today and talking to us about the work that's being done.

I would be remiss if I didn't single you out, Dr. Kirby, for the work you have done in health and health care in this country and the work you did in the Senate. If anybody doubted that the Senate served a useful function in Canada, you are a shining example of what kind of work can be done. The work you've done both in public life and in private life has been very important. As a Nova Scotian, I would expect nothing less of you, as somebody who has spent most of his public life in Nova Scotia.

I can honestly say that in the work I do in poverty and with mental health groups in my area there are people who I think have your picture on the wall now. You wouldn't overstate the impact of the work you've done, but to people who have been in the shadows for so many years, it's very significant. Congratulations for that.

I'd like to talk a little about something you touched on, which is what I refer to as the social infrastructure of Canada. It seems to me that a lot of the social infrastructure that we have to protect, and also the enhanced opportunities for people, whether it's employment insurance or other programs, are not very well designed for people who have mental illness.

If you break your arm, you know what to do. You get it fixed and you know when it's fixed that you go back to work. I wonder if you, or any of you, have any thoughts on that specifically, and also on what we could do. Should there be a special social infrastructure that takes people with mental illness and deals with them entirely separately, for example? Or should we modify some of the programs we have to deal with people who are either in poverty or headed towards poverty and who don't have the kind of support they need?

● (1130)

Hon. Michael Kirby: Thank you for that question, and thank you for your opening comments.

I remember when I was chief of staff to the Premier of Nova Scotia a very long time ago, if anybody had had my picture on the wall, they would have been throwing darts at it. So this is maybe a step forward.

I will make a couple of comments, and then I am going to ask Jayne to add on.

If you step back and look at the package of federal programs, particularly the HRSDC programs, whether it is EI sickness benefits or CPP disability, etc., they were all designed for people who had a physical illness. That is what people had in mind when they were designing the programs.

Frankly, they don't work very well for mental illness. Let me just give you an illustration, and you will know this better than I do. I think it's 15 weeks. When you get to the end of 15 weeks, you lose the EI sickness benefits. Fifty per cent of the people who are still sick at the end of that fifteenth week are sick with a mental illness. In other words, half of the people who get to the end and still need help but don't have help because they have run out of sickness benefits are there with a mental illness.

The second thing is a lot of mental illness is chronic or episodic in nature. You will have a bout of depression. You will get better, you will be fine, you go back to work, and then you'll have another bout. Frequently the time between those two episodes is not long enough for you to be able to again get back into the EI program. Again, that is simply because on the EI sickness benefits, the thought that people had, logically, when they were developing it was, what to do with someone who has an illness? They are going to get better, as Mr. Savage said, and go back to work. So that's one problem that needs to be looked at.

CPP disability benefits are another thing. While technically, legally, they apply to mental illness, all of the tests you have to pass in order to get CPP disability benefits are clearly geared toward a physical ailment. You will be incapacitated for some period of time, but the incapacitation is a physical limitation, not a mental one.

In general, if you look at the programs, it would make a lot more sense to me to say, let's not keep trying to twist and tinker with a program that is designed for a physical illness; let's take mental illness out of those programs and design a single program to deal with the unique characteristics that mental illness has, which is, typically, longer to get better, sometimes episodic, and the nature of treatment is also different.

So I think the answer to your question is that I would actually favour looking at a new way, in some sense, a set of programs designed for people with a mental illness.

Now that CPP is allowed to run pilot projects, which they weren't until the last couple of years, I think you have a vehicle that would make experimentation possible. You'd have to be very careful that any changes to the programs are not street-smart. What I mean by street-smart is, I really want to know what's going to happen on the ground. I say this as a policy wonk myself. Sometimes I completely fail to anticipate how people are going to react, given a program. But with CPP you can now do experiments.

Do you want to add anything?

● (1135)

Ms. Jayne Barker (Director of Policy and Research, Mental Health Commission of Canada): No, I don't really want to add anything. I think Mike has covered the topic very well. I would just say it is a real interest of the commission to look at the programs that are currently available and to help define what a new program, what a different approach, could look like.

Mr. Michael Savage: So what would be your intent, then? And I know I do not have much time, Chair.

You would make some recommendations to HRSDC as to how they—

Hon. Michael Kirby: The officials in HRSDC are in fact being very positive on this, so I don't have any problems at all with the department, but what we need to do is work with them to develop a program, to then run a pilot project on this.

I would hope, frankly, that we could get that started sometime in the next six months. I place a very high priority on that, simply because it would get rid of a lot of the really stressful problems that people with a mental illness have trying to work their way through a maze of programs that aren't designed for them in the first place.

Mr. Michael Savage: Thank you very much, and thank you, Mr. Chair.

The Chair: Thank you.

We're now going to move to Mr. Lessard.

Seven minutes, please.

[*Translation*]

Mr. Yves Lessard (Chambly—Borduas, BQ): Thank you, Mr. Chairman.

I also want to thank the guests who are here this morning. We greatly appreciate your contribution to the area of mental health. We are getting to share your experience this morning.

I am very pleased by several aspects of your work, especially your focus on health care providers. They play a crucial role in supporting the mentally ill and raising awareness of their contribution to society.

You also say that we must be able to give hope. Before me, somebody said that being poor is not only to lack money but also to lack hope. But I believe that you are able in some measure to give new hope to some people. I am not only talking about the research you are doing, but also the initiatives you have launched, for example these eight advisory committees that you set up in order to reflect on these issues and come up with ideas regarding certain groups in our society.

Do you already detect among the Canadian public a consensus as to the direction in which you want to go?

[*English*]

Hon. Michael Kirby: Because Howard has just finished national hearings on exactly that issue, I'm going to ask him to answer the question.

[*Translation*]

Mr. Howard Chodos (Director, Mental Health Strategy, Mental Health Commission of Canada): Thank you.

I think it may be a little too early to say there is a consensus throughout the country, but nevertheless we have now met with hundreds of Canadians in 13 cities during the 15 meetings we have held. We have also launched an on-line consultation through which we gathered over 1,700 detailed answers to our framework document aimed at developing a mental health strategy for Canada.

Insofar as a consensus is possible on a such a complex issue as mental health, we believe we have received significant support from the stakeholders in this area. We have gathered in a room representatives of the various provincial and territorial governments, of health care providers and people with mental health problems. We have had detailed discussions on the eight objectives we are putting forward in our framework document and asked the participants to vote on each objective using a grading scale from 1 to 5. For all objectives, the resulting score was between 4 and 5. There seems to be significant support for all these objectives. Participants also made suggestions for improving our document or some aspects of our work that they found weak. There were also suggestions about ways to improve our approach to those issues.

Generally, we feel that people want to cooperate with the commission and that they support the work we have done up to now. We recognize this is only a beginning. We are looking to a better future in the area of mental health, but we know that we still have lots of work to do before we can determine the best way to reach these objectives. Based on the consultations we have held and which were completed last week, we conclude that our general direction enjoys a great degree of support.

● (1140)

Mr. Yves Lessard: In order to understand how things might change, it may be necessary to target specific groups. We did a study on employability which showed that there are segments in our population that have less access to employment and are less able to hold down a job. This has a direct impact, just like unemployment, on mental health. I am thinking specifically about First nations' people.

I want to return to a comment of Mr. Kirby, when he talked about the sometimes unequal contribution between provinces. I would like you to elaborate on the role of the federal government in mental health. In your view, what main measure should the Committee recommend in order to make a difference in the results achieved by the federal government's actions vis-à-vis First nations people for example? This would give us an insight as to what should be done.

[*English*]

Hon. Michael Kirby: Thank you.

I will comment directly on the aboriginal one, before you go back to Howard.

When you look at the data on mental health for first nations, Métis, and Inuit, all Canadians ought to be embarrassed. When you look at the suicide rate among children under 24, for first nations and Inuit in particular, it's appalling.

If you look at the suicide rate among Canadian youth, it is the second biggest killer of our children between the ages of 15 and 24, second only to cars. If you look at the data for first nations and Inuit, for which the federal government has responsibility, it is somewhere between five and seven times higher than the national average.

As a Canadian, I'm embarrassed by that. I think a considerable effort needs to be made to improve mental health services for first nations, Inuit, and Métis, on reserves, which is a direct federal responsibility, but frankly, also in the cities. There are more first nations children living in Canadian cities—that is, off reserve—than there are living on reserve. All of the problems of mental illness and of substance abuse are colossal. The fact is that we have a unique opportunity in the world to do something.

We know it can be done. We know, for example, the work that Australia has done with its aborigines and the work that New Zealand has done with the Maoris has had a very significant impact over the last decade in terms of improving their mental health. I think, frankly, it's not only time; the time is long gone when we as Canadians should be making that same effort.

So, Mr. Lessard, I'm completely in agreement with you on that.

Howard, do you want to comment on the other pieces?

● (1145)

Mr. Howard Chodos: Thank you. I think with respect to the role of the different levels of government, and in particular the role of the federal government, the commission was set up to be able to work with all levels of government and to address some of the complex jurisdictional issues that arise, especially in areas with respect to indigenous populations in this country. Mike was referring to on reserve and off reserve, where needs for services cross jurisdictional boundaries and people have a great deal of difficulty finding the appropriate places for them to have service.

It's premature for us to be able to say specifically the one central measure we would recommend, but we have tried to begin a process of engaging with people from the different indigenous communities and listening very carefully to what they have to say. The commission has a first nations, Inuit, and Métis advisory committee. In particular, they have encouraged us to adopt what they call a perspective that would allow people to be treated in an environment of cultural safety, where we take into account not only the linguistic or cultural requirements but that we acknowledge with them the whole environment—the socio-economic and political environment—to be able to establish partnerships that will enable people to get the kind of care they need to enable them to heal and get better at confronting mental health challenges that are particular to their situations.

Our first step has been to try to listen as carefully as possible to understand the reality. Part of our cross-country visits with respect to our document took us to the north. We were in Iqaluit and Yellowknife, and I can tell you this was my first opportunity to visit those parts of the country. The challenges there are enormous. When we talk about the inadequacies of the system in the south and in the more populated regions of the country, I'm sure you know as well as we do that the challenges in the north are starting from next to zero, where services are simply not available.

We have to have realistic expectations about what can be accomplished. At the same time, the challenge is absolutely immense, and we are committed to working with the indigenous populations to work through how to move forward on this front.

The Chair: Thank you very much. That's all the time we have for this round.

We're now going to move to Mr. Thibeault. Welcome to the committee, sir. We're glad to have you here. You have seven minutes.

Mr. Glenn Thibeault (Sudbury, NDP): Thank you very much.

Thank you for coming today. As a former front-line worker for 10 years on the streets, I've been scribbling notes because I have so many questions I'd like to ask.

One of the things we've been able to witness time and again in different communities is what I call the cycle: the cycle of poverty and the cycle of mental illness that people get stuck in. It starts with mental illness. If they have a mental illness, they lose their job and become homeless. Through unfortunate circumstances and because of the mental illness, they get caught with addiction to some type of substance, which then continues to spiral.

There are so many fantastic organizations out there. In my community of Sudbury, I can think of the Canadian Mental Health Association, Centre de santé communautaire de Sudbury—there are so many of them. However, we're trying to come into this cycle from so many different points. We're trying to come in from the homeless avenue, from the mental health avenue. We get four or five different case files opening up, all trying to find this person one support system.

In your opinion, have you been able to find any way we can stop this cycle, and is there something the federal government can do to unite all these great organizations with that one access point and stop that spinning cycle so we can provide the support at that point?

● (1150)

Hon. Michael Kirby: Mr. Chair, I'm going to ask Jayne to comment on that and then I'll come back and make an additional comment.

Ms. Jayne Barker: I agree with you. It's interesting that you've spent years on the front line. That resonates very closely to my heart. It's where I've spent most of my career, too.

One of the opportunities that is part of the mental health and homelessness research demonstration projects, from the money the federal government provided to the commission, is a real opportunity to work with the homeless mentally ill population in five cities across Canada and take a careful look at what approaches work best.

We know, not from research done in Canada but from research done in other countries, that what's called a “housing first” approach has some very promising aspects to it, but it has never been tested in the Canadian context. That's an approach where client choice is what drives the services a person gets, where they are provided with not only adequate housing but also with a variety of health supports and mental health supports and services, so they can become functioning citizens.

The early indications are that people who participate in that kind of program can become contributing citizens again and have housing stability and health stability. We're hoping that out of the research demonstration projects that we're doing we'll get some solid policy evidence we can bring to the government that will have recommendations to address exactly what you're talking about.

Mr. Glenn Thibeault: Fortunately, if you're looking for an example, again, my community of Sudbury has implemented something similar, and we've been looking at ways to get federal government funding. We've been looking at a "housing first" initiative. We've been creating an alliance of community stakeholders, even talking to the hospital. You mentioned before about how much time and services, ambulance services, police services, that are going into this.

I also had the opportunity of living in Vancouver for a while. They had a great pilot program. I'm not sure if it's still around. I believe it was called "Car 87", where they had a police officer going around with a mental health nurse. Those are great ideas that we could be bringing forward into other communities. I know at the time it was the Vancouver police, but the RCMP were saying it would be great if they could have some of those resources to provide those types of services.

Ms. Jayne Barker: Yes, absolutely.

Hon. Michael Kirby: Let me make one other comment about the on-the-ground problem. If you have a physical illness, what do you do? Let's assume for a minute it's not an emergency. You go to your GP and your GP then steers you through the system, if you need a test or if you need to see a specialist. In effect, your family doctor becomes your system navigator, your case manager. No such thing exists in mental health.

You get into the system somewhere. It is complex, to say the least. Once, a few years ago, I actually tried to trace out, to draw a diagram of all the places you would have to go to get all the services. I gave up. It was too complex to understand.

Clearly, some of the changes that are needed...and this will come into how we get to our end point. There has to be some element of a case manager, system navigator, or something. There has to be someone who does for the person with mental illness what the family doctor and the family doctor's office does for the physically ill, no question.

Mr. Glenn Thibeault: I have a minute and a half. I like coming to this committee. This is great.

One of the things that we also need to look at when we're setting up federal services—and I look forward to your comments on this—for an individual who has been homeless, or who has an addiction, who's in poverty, who needs to access services in a building that they may not seem so comfortable in accessing.... It comes down to the pride of the person and the stigma that's associated with mental illness, or being a homeless person; all of a sudden they get this epiphany that they want to stop the drugs or they want to get off the streets, and they walk into a door and they're not allowed into the building because they haven't been able to shower in two weeks. How do we ensure that our services are accessible to people with mental illness?

● (1155)

Ms. Jayne Barker: Again, that's something that does happen fairly well in lots of communities. Lots of communities have street outreach workers and people who actually go on the street and meet people where they're at. Car 87 is a really good example of a pilot in Vancouver that works quite well. But those programs are few and far between. It takes a lot of creativity in terms of fundraising and putting together bits of funding from different places to have that kind of a program in a community.

You're right, it can be a real barrier to accessing service, to go into an office that's intimidating and often won't let you in. That's one of the things we're learning more about through our study on homelessness, and looking at the kinds of approaches that are needed to support the unique needs of people with different ethnocultural backgrounds, where language and customs can add increased barriers. People from an aboriginal background who are coming to services that are predominantly for white people can be very intimidated and it can create real barriers.

That's part of what we're hoping to learn.

The Chair: Thank you, Jayne. And Glenn, thanks again for being here today.

We're going to move to the last questioner of this round.

Mr. Komarnicki, you have seven minutes.

Mr. Ed Komarnicki (Souris—Moose Mountain, CPC): Thank you, Chair.

Thank you, Dr. Kirby and presenters. Certainly you exhibit a lot of passion and an abundance of knowledge and understanding. I do appreciate that you're doing further research on the ground to see how things are going, and that's good. I certainly see you as helpers, encouragers, and facilitators. It's certainly good for us to shift from a crisis-driven approach to something that's more comprehensive, as you've mentioned.

There are a couple of areas on which I have some questions. You mentioned one, which I read about in the spring 2009 issue of *MHCC News*. You started your anti-stigma, anti-discrimination campaign at a journalism and community services student group. I wonder if that was strategic or not.

Secondly, how did that go, and what are the underpinnings of your campaign as you go forward?

Hon. Michael Kirby: I'm going to ask Mike Pietrus, who is responsible for that campaign, to answer.

Mr. Micheal Pietrus (Director, Anti-stigma/Anti-discrimination Campaign, Mental Health Commission of Canada): Thank you.

It's very interesting, because initially we were hoping just to reach journalism students. The media play such an important role in shaping people's public opinion and views about mental illness, in the language they use, for example. It's the language that becomes so hurtful to people when they're dealing with stigma.

We know from work that has been done in Australia, for example, that you begin right at the source where you can have the most impact in influencing young journalism students. So we approached Mount Royal College as a pilot test site, and lo and behold, we were very, very pleased to find out that in fact a number of other faculties —for instance, the faculty of health and community studies, which includes nursing, social work, and the justice program—were also very interested and asked if we could put on a second session for their students as well.

We brought in four experts to talk about it from different perspectives. We also invited two consumers, people who had personal experiences, who could tell their stories. Again it's that direct contact with people who have experience with a mental illness that is so successful at breaking down those stereotypes and many of the myths surrounding mental illness.

I'm pleased to say that it was very successful. It's one of the initiatives we're looking at moving forward, trying to do this in other universities across the country, and perhaps even taking it down to the high school level where we're introducing it at an even earlier age.

Our senior consultant, Dr. Heather Stuart, at Queen's University, prepared a pre- and post-survey so we could begin to see what people's opinions were going into the conference or symposium, and how they may have been affected coming out.

Just to give you an idea of how successful the program was, Mount Royal College then came back to us and asked if we would do this on an ongoing basis and use its students, to a degree, as test subjects to see how in the course of the three-year journalism program, for example, and the three-year community services program they would change their opinions and how their views might change over the course of being introduced to stigma-reducing education programs in the curriculum and things of that nature. By getting in early, they're hoping many of their teachers and professors will be able to actually introduce that into the curriculum.

We think it's a great area to intervene.

● (1200)

Mr. Ed Komarnicki: Thank you.

There are many barriers, but the stigma is probably one that pervades all the other areas. So it's good to see that initiative and other initiatives that you may have going forward.

The other area that is of interest, of course, is your “housing first” model. I've always been of the view that if you have a roof over your head, a bed to sleep on, and food on your table, you can start tackling some of the other problems that are facing you. It's not a problem particular to one group; it's common to everyone. Your “housing first” model obviously focuses on providing a place to live. Having a job is another important aspect to give you the support or the structure you need to move forward.

I'd like to know, first, where you are in terms of your research and how far you have gone on the ground on this issue.

Secondly, and maybe you don't know yet until you've done your research, but how is the availability of housing stock? Is it more than just physical availability? Do we need to be looking at assisting by way of income supplements, in addition to housing stock, to provide a basis from which a person can start to work?

Maybe one of you can comment on that. I understand Vancouver is perhaps one of the places you're going to start.

Ms. Jayne Barker: Thanks for the question.

You're right. The “housing first” model is really exciting, and it's just common sense that having a decent, safe place to live is a really significant step in creating stability in someone's life, whether they're mentally ill or not.

The challenge of finding suitable apartments in the various cities —and it is a challenge—is one that we're just starting to tackle. As Mike said, we received the funding about a year ago and really started from nothing. It's taken the last year to develop relationships with the service providers and researchers in each of the five cities. We've worked hard to work collaboratively with the organizations in each city. We didn't want to come in and say, this is how you have to do it, but we wanted to develop coalitions of researchers and service providers to work with us, and we have achieved that in every city.

An RFP was posted at the end of September, and we have now gone through a process where, in each city, we have identified service providers and researchers. The funding has started to flow.

We haven't actually started collecting data. We expect to do that at the end of the summer. The actual research will take place over the next four years; it's early yet. We don't yet have results or anything like that, but we're very excited to be where we are and have started to deal with the challenge of finding suitable housing.

You mentioned Vancouver, and because of the Olympics, of course, Vancouver has some unique challenges. To find an apartment right now, no matter your income, is difficult in Vancouver. But the whole area of providing rent supplements is an important one to focus on, because the kind of housing you can afford when you don't have that kind of supplement is often substandard, and it doesn't provide the kind of safety and stability that people with a mental illness need to get on with getting better. So that's part of what we're looking at.

Mr. Ed Komarnicki: I guess we're running out of time. There are other questions I'd like to ask. Obviously, having had some of the funding to establish the commission and then the funding to operationalize it, it would be very interesting to see, in a few years from now, the fruits of that labour. It will probably have some specific direction then.

I notice that you've mentioned various advisory committees, and I would say there are some issues that pervade all aspects of this. But I gather from what you've done in your set-up that there are specific issues for specific groups that need to be addressed particularly. I'll leave that with you to comment on somewhere along the way, but not necessarily now.

The Chair: You can catch that the next time.

Hon. Michael Kirby: Could I just make one comment on that?

The Chair: Sure.

Hon. Michael Kirby: You're right, a lot of the issues we work on actually cross among the different advisory committees, and we actually have a mechanism for getting more than one advisory committee together collectively to do that.

Let me just make one other comment about the role of the federal government, because one of our approaches to the homelessness issue was to take the federal government's money and lever it, that is to say, to use it to get other people to come to the table with cash. We've actually managed to do that. We're running some 25% ahead of the amount of federal money we received, through a variety of ways. We have the provincial governments, we have the regional health authorities, and we have the private sector coming to the table.

You mentioned the Vancouver example. Just as an interesting illustration, the private sector in Vancouver—just as the private sector is doing in Montreal, Toronto, Calgary, and other places—is paying for supportive housing for a group of people for whom we will then pay their mental health services. Since we don't have to pay for their housing, we're able to treat a lot more people.

This is an interesting area, and the nature of the questions around the table absolutely prove that it's a non-partisan issue. It's a non-partisan issue in the bigger sense that everybody out there seems to be willing to put aside the traditional jurisdictional lines and say, we have a problem and let's all pitch in and help.

That's one of the very encouraging things about this. There are people from the private sector, governments, and a variety of services who all seem willing to say, "We won't do the usual business of operating only in our own square box; we're willing to look more broadly."

● (1205)

The Chair: Great. Thank you very much.

We're now going to move to the second round of five minutes for questions and answers. We'll start with Madame Folco.

[*Translation*]

Ms. Raymonde Folco (Laval—Les Îles, Lib.): Thank you, Mr. Chairman. I wish to thank the four of you for this extremely interesting presentation, especially for me, because I have a private member's bill aimed at episodic illness and at offering to people suffering from this problem the possibility of accessing various benefits. I focussed mainly on employment insurance, but you have mentioned other benefits that I will be wanting to look at.

I would like to begin by saying that this is the first time that I have heard talk of this. I would perhaps be interested in meeting with you, in exchanging documents, in order that I might incorporate into what I have in mind the element that you have targeted in this debate, at the very least, and perhaps even the categories of persons who would be affected by this bill, if ever it found its way to the House of Commons. This is obviously something that is very dear to my heart.

You talked about a project, Mr. Kirby. I am presuming that it is a pilot project. I would like to know more about it. In other words, I would like you to keep me abreast of what you are doing in this area so that I might, in due time, integrate it into my work and do something more serious with it given that it would apply to a much broader clientele. I believe this is important.

What you have also clearly done is try to remove other taboos in our society, and we are very greatful to you for that.

I would like to hear your thoughts regarding two aspects. I know that the clock is ticking. First of all, you mentioned in passing that the government of Quebec is not a partner in this project. I would like you to offer us not recommendations but rather suggestions in order for us to get the provincial government to come on board, despite the respect I have for provincial and federal jurisdictions.

Secondly, I would like to talk to you about women and recent immigrants. You discussed the homeless and those suffering from mental illness. I would have liked to hear you speak in general terms about the issue of women and recent immigrants, and I would like you to tell us how you view the cultural issue, especially with regard to recent immigrants, because in certain communities, this is very highly charged matter and people's reaction is to keep the person suffering from a mental illness completely hidden away.

I will stop there because I really want to hear your response.

[*English*]

Hon. Michael Kirby: That's right. Thank you for that.

Before turning to my colleagues, let me respond to your first point. I did not know you had the private member's bill. Afterward, let's make sure we know how to keep in touch, because that's really critical.

What I said about the pilot project, though, is that I'm hoping to have conversations in the relatively near future with HRSDC about running a pilot project on exactly the kind of thing you talked about. So keeping each other mutually informed would be helpful.

I'm going to turn to Howard and then to Jane on the multicultural issue.

● (1210)

[*Translation*]

Mr. Howard Chodos: Thank you for the question. With regard to our relations with the government of Quebec and the ministère de la Santé et des Services sociaux, Quebec's department of health and social services, as Mr. Kirby mentioned at the outset, we have with the government a bilateral relationship so as to be able to share information and keep up to date, on both sides, in the mental health area. That is the first thing.

Secondly, as we explained, one of the sites for the pilot projects on homelessness and mental illness is in Montreal, and we are working closely with advocates in this sector. In a way, we are trying to develop, to the extent possible, both our relationships with the representatives of the government of Quebec and our relations with service providers in the sector, so as to better understand the situation in Quebec and allow for information sharing throughout the country on what is being done in English-speaking Canada, supplying this information to stakeholders in Quebec and vice-versa.

It is our hope that, given the fact that we will be faced with similar questions throughout the country, this process based on information sharing will allow us to develop relations with the government but also to establish for the Commission a certain presence in Quebec in order that people be able to benefit from it.

Ms. Raymonde Folco: What about the cultural communities?

Mr. Howard Chodos: For now, we have no specific project targeting the cultural communities. However, in our document, we propose a framework for resolving these types of problems and providing a safe environment for people to deal with their mental health problems, while recognizing that there are tremendous differences from one community to the next.

Ms. Raymonde Folco: Before giving the floor to Ms. Barker, I would like to make a suggestion. I am deeply involved in this area, and if I could be of any help to you, I would be very pleased to do anything I can.

Ms. Barker, would you like to add anything?

[*English*]

Ms. Jayne Barker: Thank you for the opportunity to speak to this.

Through our advisory committees we have two projects that are specifically focused on the needs of multicultural communities. One of the projects is assessing the barriers to accessing mental health services once people come to Canada. The other project is looking at and is actually developing tools for mental health practitioners to use in a variety of languages, incorporating very culturally appropriate and specific approaches.

The experience of different cultures is very different, both how they experience mental illness and how they interpret it in a cultural sense. In the Chinese language, there isn't even a word for mental illness. So there are some really significant differences. It's one of the challenges as Canada increases the number of people from different ethnic backgrounds in our population. We really haven't shifted the mental health system to provide appropriate services to all of those groups. Through these two projects we're trying to develop materials and to understand what the exact barriers are in more depth.

Ms. Raymonde Folco: I repeat my offer, Madam Barker.

Ms. Jayne Barker: Thank you.

The Chair: Thank you very much.

We're now going to move over to Mr. Lobb.

You'll have five minutes, sir.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you.

And thank you very much for coming today. It's been a pleasure to hear what you're advocating for.

One puzzling piece for me as we've journeyed along in our study on poverty is that we've had a number of different groups come in—in fact just the other day we had groups come in—describing poverty reduction strategies. What's really mind-boggling to me is that in virtually every case there's no mention of mental health or addiction in these presentations. There's lots of discussion around employment insurance, guaranteed income supplements, and child tax benefits, but in the document we have here there's not one mention of mental health or addiction. I think it's a real shame that there are groups advocating to reduce poverty and homelessness without referencing this. I'm curious about why these groups don't mention it.

● (1215)

Hon. Michael Kirby: I can't speak for them, but I will tell you what my guess is, and it's probably pretty accurate. The stigma that is attached to mental illness and substance abuse is sufficiently strong that most of them don't even necessarily provide services to those people. In other words, there is a feeling that if you have a mental illness and a substance abuse problem, you're kind of "over there", and we will deal with the broader population of poor or low-income Canadians.

I don't know that this is the answer, but I will tell you that the way the system is structured, it's what happens.

In fact, it even happens between substance abuse and mental health. If you have both problems, which is not uncommon, and the first person you go to for help is a mental health worker, it's not uncommon to be told, "Go and fix your substance abuse problem and come back and see me", or the other way around, if your first stop is related to substance abuse. The reality is that the two problems are so intertwined you can't separate them.

So I would suspect that the real issue is that people are trying to pretend it's not out of the shadows for them.

Mr. Ben Lobb: I appreciate those comments. It's pretty obvious to me and others that you can increase the amount of funding to these people, but unless the other issue is dealt with, it's just going to manifest itself and spiral out of control.

I know our time is running short, but I'm really excited about your demonstration sites and your "home first" program. We will be doing some outreach in different cities further to our study on poverty, and it would be great if we could talk to the individuals in maybe not all but in some of the cities and hear what they're doing right at the ground level.

Hon. Michael Kirby: Just get hold of Jayne.

I go back to where I started. We have to get everybody in on this, and any help we can provide to any of you, either collectively as a committee or individually, we'd be more than happy to give.

Mr. Ben Lobb: Thank you.

If you were going to summarize, what is the single most important thing this committee should take away, from the mental health aspect, from your perspective, that we should make sure we don't omit in this report?

Hon. Michael Kirby: The single most important thing for dealing with individuals with a mental illness, frankly, is more supportive housing. If you look at the Senate committee report, we recommended a very significant increase over a decade in supportive housing units. That would be number one.

Number two would be, as I said in response to Mr. Savage's question, a redesign of all the federal programs that are designed to help people, so that they're designed effectively or uniquely to take into account the differences between a mental illness and a physical illness, and not doing it by simply tinkering with the individual programs but by producing a single program, so that you're not overlapping all the time and are not dealing with different people.

Those are, right off the top of my head, what I think are the two most important things.

The other thing we ought to think about is whether you ought to be offering some form of incentive to employers. We did this way back—I guess, looking around the table, none of you were here—when I first came to Ottawa. Back in the 1970s, we launched a couple of pilot projects to encourage employers to employ the physically disabled. Look where that is today: access to public buildings with ramps, bathrooms—we've come a long way in this country in 25 years with respect to physical disability. A lot of it began with incentives from the federal government originally to employers, and then the feds deciding that they would change access to public buildings, and so on. We have to do the same thing with respect to mental illness.

The fact is that 80%-plus of the people who have a mental illness are employable. You may have to make some adjustments. If you have someone who has an episode of depression and they are away from work for two or three days, that's okay; you're going to have to make some workplace accommodations. But you could go a long way to starting us down the road we've already come with respect to physical illness and physical disability by recommending some pilot projects that deal with that sort of issue, so that we could begin to find out what works and what doesn't work, which is exactly what we did with respect to physical handicaps.

The Chair: Thanks, Ben.

Thank you, Senator.

We're going to have to move over to the Bloc.

Madame Beaudin, you have five minutes, please.

● (1220)

[*Translation*]

Mrs. Josée Beaudin (Saint-Lambert, BQ): Thank you very much.

Thank you for being here today.

We receive so much information all at once. I will begin by saying that I am very pleased to have heard you say that housing should be a priority. There are at present various federal housing programs targeting, among other things, homelessness. You even stated that housing is one thing, especially when dealing with homelessness and those people suffering from mental illness, butt that all of the support that goes hand in hand with housing is equally essential.

In my community, there are several organizations that work with the homeless. You can have the most wonderful federal housing program, but if the street workers, the psychologists, the resource persons who support those people were not there, these programs would not succeed. We would not be able to save those homeless people who, often, are not ready, from one day to the next, to go and live in an apartment. I consider this to be important.

In your document, I was impressed to see that 70% of adults develop a mental illness before or at the age of 18 years. You therefore are giving priority to children and adolescents. Congratulations! This is a matter of prevention and I would like to hear you speak more about this. In terms of prevention, how might we reach out to children and adolescents?

[*English*]

Ms. Jayne Barker: I agree with your comment that simply providing a place for people to live is very often not the answer. They can't maintain the housing, the landlord gets frustrated, and it becomes a vicious cycle. Providing adequate supports is exactly what needs to happen.

Mike mentioned that one of the things you may like to include in your report is more supportive housing. We're not just asking for regular housing, but for housing with supports attached to it, because that's what really helps people to stabilize. It's the combination of those two things. Supports on their own don't provide the safety and the stability that people need either; they need that combination.

[*Translation*]

Mr. Howard Chodos: With regard to prevention and mental health promotion, one of our objectives, in the context of the development of a strategy, is the promotion of mental health in the general population. We recognize that the measures aimed at promoting mental health within the general population can also contribute to the prevention of mental illness. Unfortunately, we do not quite know how to go about preventing mental illness, but there is conclusive evidence that targeted interventions in specific areas, be it in schools or elsewhere, are the best route to developing prevention programs. We hope to be able to integrate prevention and promotion in all of the initiatives undertaken in this area, in order that these activities not be stand-alone.

Mrs. Josée Beaudin: I do not know if you have looked at the situation of the elderly, our young people, the Inuit, the Metis and the First nations' peoples. Is there a segment of the population that is more affected by mental illness than the others?

[*English*]

Hon. Michael Kirby: Given your comment, I'm going to ask Mike Pietrus to comment on the anti-stigma program. Ideally, I suppose, if you told me that we could put money into only one segment of the population, I would put it into children, and I would put it into children for two reasons. One, you would stop the problem when they become old, you would get it early; and secondly—and this is an amazing comment—only one in six, only 17%, of Canadian children who need professional help get it. There's no other part of the health care system in which 84% could not be served without there being an outcry. Part of that...and this leads to the stigma thing that I want Mike Pietrus to comment on. This will amaze you: 40% of Canadian parents, that's two out of every five sets of parents, would not tell anybody if their child had a mental illness. They would be too embarrassed by it. So 40% are not going to get help because their parents aren't going to look for it. And then there are another 40% who don't get served because we don't have a way to serve them.

Do you want to comment?

● (1225)

Mr. Micheal Pietrus: Reaching children is so important, because they don't know a lot about mental illness and also because of the stigma around mental illness and coming forward to seek help. Early intervention, as Mike said, is so important and can make such a dramatic difference in terms of somebody's life later on.

One of the areas we're looking at with the anti-stigma initiative is to identify programs across the country that are working very well, particularly those aimed at children and youth, whether they're educational in nature, operating already within the school system, whether they're in the arts, whether they're on the Internet, for example—different ways of approaching young people so that they can learn more about mental illness and become more comfortable with it. But there's also engaging the people who influence young people: educators, people within the guidance community, and especially parents. So again, you're trying to engage all of these people. That's what we're doing.

When we identify some of these programs that are successful, we're going to evaluate them, see how we can also help improve them, if that's necessary, and then begin to try to replicate these programs elsewhere across the country so that communities aren't starting from square one, so we're not reinventing the wheel, for starters. As phase two goes along, what we're hoping to do is build on those programs that may require more work, more funding. And then ultimately, phase three would look at those things that people haven't thought of before, that really haven't had an opportunity to be developed, and then take some of those programs and move them forward.

Again, the whole idea behind this is not reinventing the wheel, but providing people with toolkits and programs that they can pick up on so that they're not starting from ground zero.

The Chair: Sorry, that's all the time we have.

Thank you very much, Mike.

We're now going to move to Mr. Vellacott for five minutes, please.

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

I appreciate very much our panel being here today. This is an issue that I know seizes all of us. Some around the table here, myself included, know this kind of more from a first-hand or family basis, too, so we understand the broader piece through support groups, that kind of thing, and on a fairly direct basis, too.

The one thing I was going to suggest, and maybe it's more of a comment, and you can respond.... I have four different questions along the lines of denial, stigma, that whole range of things; the paranoia around mental health issues, and why some are on the street that way; and then there's also this issue of employment and the stressor that sometimes is, and I think you've inferred that; and then lastly, because you made the statement about family care, which I think will always be a key kind of component of it, the nature of those who they trust around them more. My question is what can we do in terms of changes in the tax code. That's where I'm going with the four questions.

Around the issue of denial and stigma, I know there's the stigma issue, and I'm well aware of this piece of it, but there's also the denial thing. I don't know in terms of this study and so on that you folks have done, but in that aspect, as you would be well aware, sometimes the higher the IQ of the person, the greater the denial. Maybe it's stigma, but it's also as much that person.... For instance, who around this table wants to say, there's this part of my life that is not functioning as it maybe should? So there's that aspect. I don't know if you have any quick comment on that.

And I don't know how you'd change it, because until somebody comes to the point of accepting that they have this, that it can be worked with, that it's not a terrible dark secret in society, or whatever...and I guess that's where society comes in for the difference. But I don't know how you can change that. And believe me, I speak of this on a fairly knowledgeable basis. If people deny it, it's hard then to get the help.

Hon. Michael Kirby: Of course, and the only way you can really deal with that problem is indirectly, and it is by reducing the stigma to the point where people don't feel they have to deny it.

The problem now is that people are so afraid. If someone has a mental problem and they are so afraid that their friends, their family, will say to them, get over it, there's nothing wrong with you, etc., then they're afraid to raise it with even their closest friends. So you can't attack their problem directly; you've got to change the environment, which makes it safe for them to talk about it.

Mr. Maurice Vellacott: Yes. In other words, it's like when somebody has colitis or diverticulosis or some other issues, and this is one of a range of things. We all have our different....

Hon. Michael Kirby: By the way, just to give you an example, 30 years ago breast cancer was exactly where mental health is. Thirty years ago, a woman with breast cancer wouldn't tell anybody. Indeed, the newspapers wouldn't report it because they weren't allowed to use the word “breast” in news stories. It's kind of interesting, but we just have to change it.

● (1230)

Mr. Maurice Vellacott: Yes, exactly.

Let me jump to my third thing here. I'll come back if I have time at the end.

It's the issue of employment, which I know you stress as important in terms of mental health and the restoration of things and so on. I think you did allude to that fact as well, and you're well acquainted with it, no doubt, but for some people employment—and maybe it's a cyclical thing, episodic, as you say, it comes around—is a stress in itself and it sometimes requires an entirely different, more pastoral, calmer outdoor country setting, or whatever. Yes, we can restructure employment situations and so on, but maybe there just has to be some guarantee of support there, without it being, as you say—

Hon. Michael Kirby: Right. Look, a “normal” job isn't going to work for some people, there's no question. On the other hand, at the present moment, what happens is that if you have a mental illness, if you suffer from depression and so on, employers are inclined to simply not hire you, even though the fact is that 90% of the time you could do a very good job. So I'd like to get some incentive to get over that. There will obviously be some people for whom that doesn't work and for whom you've got to have a network of supports, absolutely.

Mr. Maurice Vellacott: I'll go to my last question very quickly.

There's the issue of family care, and as you well put, it's people they trust, and even then they have to come to the point...there's more trust in some family relationships than in others. But if you could recommend any change by way of the tax code to assist those other caregivers, those supporters...is that a line of thinking you've pursued?

Hon. Michael Kirby: Yes, we have, although we haven't looked at the exact numbers. When the Senate committee looked at that issue, we came to the conclusion that you needed to find a way—whether through a tax deduction or some income-tax-driven measure—that would recognize, frankly, that governments are getting an awful lot of free service, because if the family members didn't exist, a lot of these people would have to be institutionalized, which would cost the federal and provincial governments a lot of money.

To some extent, there ought to be a recognition of that, and in particular, you need an element of respite care. I'll give you an example, because I was on the phone with someone early this morning. An 84-year-old woman looking after her mentally ill 87-year-old husband desperately needs a break or she's going to crack. Yet, not only do the facilities not exist, but she couldn't afford them if she had to buy them because they're not covered under medicare.

That example, by the way, is not a random example. There are examples like that. The same thing is true for people with mentally ill children, when the wife drops out of the workforce in order to stay home to look after the child. The family income has gone down substantially, yet that's not recognized in the tax system, though it is saving the health care system a lot of money.

The Chair: Thank you very much, and thank you, Mr. Vellacott.

We're going to move to Mr. Pacetti.

Welcome, sir. You have five minutes, though you said you were only going to need a couple.

Mr. Massimo Pacetti (Saint-Léonard—Saint-Michel, Lib.): Thank you, Mr. Chair.

Hopefully it will only be a couple. It's a very interesting topic. I'm used to being on the finance committee, and this is a change of pace. I think we're getting into a subject that normally we touch upon very briefly at the finance committee. Groups come before the committee asking for money, but we're not so sure that we understand the problems in-depth.

My question is the same question you have been asked, but I guess it's from a different perspective. In terms of services, are services ultimately getting to people who need them? We see a lot of groups coming before the finance committee representing different things and providing different services. I'm not so sure they provide services—because isn't the ultimate service provider the health side at the provincial level? Are the groups just there? They seem to be asking for programs, but there are a lot of administrative things involved. Is there money clogged up and not being used for the ultimate beneficiary?

Hon. Michael Kirby: Yes, and I have two comments.

Is the system inefficient? It's colossally inefficient. It's inefficient because there are so many service providers operating in any given municipality that the same number of services are provided by a large number of service providers.

Do I think you could ultimately redesign the system so it would be a lot more efficient, and with the administrative numbers more money would fall to the bottom line? Absolutely. That's what the mental health strategy will do.

Let me be clear. For an average person with a mental illness, less than one-third of the public money that is spent on them is spent by health departments. The rest is spent by housing, by training, by social services, and so on. If someone has a heart attack, it is all spent by the health department. You not only have the fragmentation at the service delivery level, you have the fragmentation at the provincial level and at the federal level.

There is no minister in the federal government responsible for people with a mental illness. The funds the feds spend come out of a lot of different pockets. The same thing is true provincially, and the same thing is true on the ground. Clearly, you're right. There's a huge element of duplication.

● (1235)

Mr. Massimo Pacetti: I don't mean to interrupt; it's just that our time is short.

We have constituency offices, and a lot of people who come to see us are going through hard times—and some have permanent hard times. It depends on what they're there for. We try to channel them in the right direction, but in fact it's not necessarily towards the traditional health institutions. The local Quebec MPs—we have CLSCs—will refer them to a CLSC, and sometimes there is a follow-up, but there just don't seem to be enough resources. Sometimes we'll get good success, but there doesn't seem to be the 100% hit rate. I'm not even sure what the hit rate is.

The other part of the question is about funding. I think you spoke about it in terms of proper programs from the government point of view. What I've been seeing is that businesses have been taking responsibility for certain items. When we were in Victoria last year with the finance committee, the chamber of commerce from Victoria got together with the homeless, and there seemed to be an initiative so that they were going to work on it together. When we got to Halifax, it was still the social workers versus the chamber of commerce. There wasn't that linkage. I'm wondering what your perspective is. Is there some collaborative work being done? Mental health is an issue in the workplace. And let's face it—a lot of times employers, rather than dealing with the issue, will try to find a way to get rid of this guy or this woman so that they don't have to deal with the person.

Hon. Michael Kirby: That certainly happens. The reality is that there's growing recognition now among at least the major employers in the country that there's a real need for them to begin to deal with it. We have a workforce advisory committee that is working with a number of companies now on pilot projects to figure out—I'm going to use the same word as we use for people with disabilities—what workplace accommodation is required for them to be able to employ people.

We're making progress on that, and it is hugely economically beneficial to the company. When someone goes off on short-term disability, they continue to pay the salary during the short-term disability. So to the extent that you don't have to send that person off, or they're off for a much shorter period of time, the money that would otherwise be spent is now going to fall directly into the profit line.

So there's a huge economic incentive. The more progressive employers in the country are starting to recognize that. I'm going to ask Jane to comment specifically.

We're hoping to really make some progress on that. I will tell you, interestingly enough, that governments and government agencies are not anywhere near among the best people to deal with this issue.

Ms. Jayne Barker: I was going to pick up on your comment about where the responsibility for the homeless population rests in communities. You talked about Victoria as an example, where the business community was seeing themselves as having some responsibility for the homeless community or for outcomes for homeless people.

There are several communities in Canada, and Calgary is a very good example, where business leaders and others in the community have come together. In my experience, and with the exposure I've had to this issue, I think until every Canadian takes some responsibility for the homeless and recognizes that they have a part in making it different, there isn't going to be the kind of lasting change and commitment to change that we need.

The business community is a very important player in sustaining long-term change.

The Chair: Thank you, Mr. Pacetti. It's good seeing you here today.

We're going to go to Mr. Cannan, who has five minutes. We're almost done. There's been some great discussion. It's not like we can get you every day.

I'm going to have Glenn ask one question and Candice as well, just to round it out.

You have five minutes, Mr. Cannan, and then we'll go over here for one minute.

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

Thank you, Dr. Kirby, for your outstanding work. In working closely with the Canadian Mental Association in my riding, as Glenn has alluded to, and the great work they're doing across the country and in the business community...the model after the Calgary strategy, which our own community is embarking on. It takes all levels of government, the community, the taxpayers—and the business community is a big component of that—to have a successful plan moving forward.

I just want to comment on an aspect of progress and change. In my own personal experience, my oldest daughter is going to be 24 this year and she has gone through a borderline personality disorder and had a breakdown after two years of university. I have had the opportunity to work with professionals. There are many out there in the community, and I appreciate their dedication.

My question to you is this. As far as your commission is concerned, what do you see as the definition for mental health illness, and what percentage of Canadians are affected by that?

● (1240)

Hon. Michael Kirby: Do you want to go ahead?

Ms. Jayne Barker: Well, there isn't one universal definition, but definitions of mental health usually encompass the idea that people can have successful relations with other people, that they can make contributions to society by holding down a job. How they think and how they feel allows them to function fully and engage in everyday life.

When you start talking about mental illness, then you're really talking about having how you think, how you feel, how you respond, and how you behave affected by your illness. So the symptoms are manifested through, as I say, how you think, how you feel, or how you behave.

Mr. Howard Chodos: Just to add to that, the working definition of mental health, at any rate, that we've used in the context of developing the mental health strategy comes from the World Health Organization. It says that mental health is:

> ...a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

That is a definition of mental health.

What we've tried to do is distinguish between mental health and mental illness, and to recognize that people who are living with the symptoms of mental illness can also experience a great deal of mental health, in the sense of having a positive outlook on life and having the resilience to cope with the symptoms of their illness.

So when we talk about mental health and mental illness, it is in fact two different things. Having positive mental health can contribute in ways, independently, of having the symptoms of mental illness. We would want to encourage the greatest degree of positive mental health for all Canadians, at the same time as we find ways to encourage people and to enable them to cope with the symptoms of mental illness when they experience them.

Mr. Ron Cannan: I think that's an excellent fact that we have to communicate to Canadians. You alluded to where we are with mental health in comparison to breast cancer 30 years ago. That is an excellent analogy. I believe individuals with mental illness deserve the services, support, and access to them.

The federal government is trying to provide those funds to the provinces and territories. I spent nine years in local government working at that level and getting the funds down, but the challenge we have jurisdictionally is ensuring that the provinces deliver the dollars where we'd like them to go. As you said, supportive housing is something we've heard from other witnesses who have come to the committee, and we'll continue to get that message to the provinces. Once again, each province and territory is unique.

I have a follow-up question about facilities for the individuals you mentioned. The police force has indicated that approximately 50% of 911 calls are due to mental health. How are you addressing networking with our judicial system and the Criminal Code? Are there recommendations coming forth from the task force?

Hon. Michael Kirby: Absolutely. The reality is that when we de-institutionalized in this country.... We closed the old asylums, as they were called when I was a kid, the mental hospitals. In theory, we were putting people out into community-based facilities, except that we didn't build the community-based facilities very fast. The result is that the streets and the prisons have really become the asylums of the 21st century, which is outrageous, frankly.

We are working not only with the Canadian correctional services —in fact, we're running a conference with them on this specific issue in about two months—but I think all of the people concerned with the justice system, beginning with the judiciary and the lawyers, recognize that we need to do two things. We have to start providing mental health services to people we incarcerate, which we don't do now. The result is that they're worse off when they get out than when they went in. More importantly, we have to start focusing on the broad question of how we stop them from going to jail in the first place. Having mental health courts is one way of doing it, but we think there may be other ways.

Our mental health and the law advisory committee is chaired by an Ontario judge, Ted Ormston, who created the first mental health court in the western world, in Ontario. He has some very creative ideas that we're talking to the provinces and the people who run the jail and penitentiary systems about.

● (1245)

The Chair: Thanks, Ron.

We're almost out of time, but I'm going to ask Glenn for one question, and then Candice; as you've been so gracious to be here, you'll get one question as well.

Glenn, go ahead.

Mr. Glenn Thibeault: Thank you, Mr. Chair. I appreciate the question and I will try to keep it brief.

You mentioned the repatriation. I'm sure we could talk for an hour and a half about the repatriation and the term they use when they've taken individuals from institutions with no preplanning and put them into the community. Many of the issues we're talking about now could have been resolved if there had been a lot of preplanning.

We've talked a lot about “housing first”, and one of the things that I think is very clear that I would like to hear you explain is.... It's great when you get a roof over your head. That's an important piece in reducing homelessness and addressing mental illness. But as soon as they get a roof over their head, you can't wash your hands of the individual. There are so many responsibilities in becoming a tenant, and with mental health, all of a sudden you have to worry about paying all of your bills. The “housing first” strategy can't just be putting a roof over their heads. There have to be so many other support services in place. Is that correct?

Ms. Jayne Barker: That's absolutely correct.

One of the supports that is part of the program we're testing is the interface with the landlord. So when landlords feel frustrated, or when something happens, they have somebody they can call who will go and address the issues.

It's also about teaching people who have lived on the streets, who maybe don't have the skills to deal with landlords and have never had that opportunity to learn how to talk to a landlord. It's teaching them the kinds of things that are expected in keeping an apartment or a place to live. You're absolutely right, supports that help in dealing with a landlord as well as supports for dealing with health and mental health problems are crucial.

The Chair: Thanks, Glenn.

Candice, thanks for being here today. You have one question.

Ms. Candice Hoeppner (Portage—Lisgar, CPC): Thank you very much for the opportunity. I'm going to try to make this brief as well.

My question has to do with treatment. I know there are a lot of drugs that have been prescribed. Many times that contributes to or doesn't help the problem. I'm wondering if you have looked at faith-based communities and programs to help the mentally ill, more of a holistic approach.

Hon. Michael Kirby: Your question was, have we? We are so early getting going. The answer is, we have not, but we will. The answer is yes.

Let me tell you where my bias is on this issue. I had a sister who suffered for many years from severe depression, including a suicide attempt. She subsequently died of cancer. She would say to me that she felt she got more help from her spiritual adviser than she did from her psychiatrist. While that is anecdotal, it gives a little bit of bias on the question.

The reality is that the aboriginal Canadians have understood for centuries that you have to treat the whole person, and the whole person is not just the head and not just the physical body. It is the combination, and it has a spiritual element to it. I use spiritual rather than faith-based, which connotes a somewhat purely religious point of view. Spiritual need not be religious in the normal sense of the word.

Yesterday at a meeting Jayne Barker and I were at with CIHR, we discussed the question of how we get some evidence to establish empirically what appears to be anecdotally very true, which is that the spiritual element of treatment is a very important element.

The Chair: Thank you, Dr. Kirby and your colleagues, for being here today.

We are going to suspend for a couple of minutes just to go off camera, off broadcast. Then we are going to come right back to deal with some committee business.

Hon. Michael Kirby: If I could just say one closing comment to all of you, thank you for having us. I don't say this to flatter you. It's really important that Canadian leaders like yourselves get involved in this issue. If it is okay with you, Mr. Chair, we will come back to the members of the committee and through them their other colleagues in the House over the next little while to talk about events you could participate in with us.

If community leaders like you are prepared to stand up and be seen on the mental health front, that's a huge step forward in reducing the stigma. So thank you very much for inviting us. We were delighted to come.

The Chair: By all means, anything you send to the clerk, as you know, we'll make sure members get, in addition to any other meetings you have. Thank you very much.

We will suspend just for a couple of minutes.

● (1245)

(Pause)

● (1250)

The Chair: Could I get the members back to the table, please?

[*Translation*]

Mr. Yves Lessard: Mr. Chairman, while we are waiting for colleagues to come back, we might be able to revert to public meeting mode, because staff has set this up to be in-camera.

Thank you.

[*English*]

Mr. Ed Komarnicki: I think we left the last meeting, as I recall it, with a read-in amendment by me that was in the process of debate. That's my recollection. I don't know what the feeling of the committee is or whether we can come to any kind of consensus.

I know Mr. Lessard would like to have at least one meeting, maybe two, and his view is not at the end of the poverty study but maybe something sooner. I'm not sure where his head is at. I don't think he's finished debate, setting out his thoughts on that, as I recall it.

The Chair: Just so everyone knows, the amendment by Mr. Komarnicki that we're working on is that the motion be amended by adding between the words “examine” and “the” the following, “at the conclusion of the poverty study and for one meeting”.

That's what we're discussing right now, to be clear.

I have a list of speakers. I have Mr. Savage and then Mr. Lessard.

Mr. Savage, the floor is yours.

Mr. Michael Savage: Chair, I'd be prepared to go after Mr. Lessard, in case he answers my question as we go forward. Is that possible?

The Chair: Fair enough.

Mr. Lessard, the floor is yours.

[*Translation*]

Mr. Yves Lessard: Mr. Chairman, let us remember that this is a motion asking that the Committee study the way the Enabling Accessibility Fund has been managed. The purpose of this fund is to help organizations supervise their work, in particular with regard to the persons with disabilities aspect. The purpose of Mr. Komarnicki's amendment is to limit debate on this matter to a single meeting, once our work on the study on poverty is finished.

Mr. Chairman, I do not know if Mr. Komarnicki still wishes to maintain his amendment, but my suggestion, with all deference and much respect, is that we deal first with the main motion. We will then be able to decide how much time we want to devote to it. It seems to me that this motion has two elements to it. It would be difficult to determine now how much time we would devote to this. Furthermore, the matter to be discussed is sufficiently urgent for it to not wait until the end of our work on poverty.

That being said, once we have disposed of my motion, if the Committee agrees to it, I would suggest that staff provide us with scheduling options, in order that we not encroach on the time set aside for our study on poverty. My intent is not at all to delay the study on poverty. To the contrary, you know how much this is important to us. We must ensure that both issues are harmonized and are not in conflict one with the other. I am not excluding the possibility that we only devote one meeting to this matter. However, we must not limit ourselves. This would handcuff us at the outset and deprive us of a tool that might allow us to do our work properly. This is not something we should be doing, in my view.

● (1255)

[*English*]

The Chair: Thank you, Mr. Lessard.

Mike, I have you on the list here.

One of the things I'd suggest is that we are discussing the amendment, so we're going to need to deal with that before we go back to the main motion anyway. As a compromise, maybe we could look at—once again, you guys are going to vote on this at some point, I'd suspect—trying to fit it in either through a subcommittee meeting to discuss when we could look at it, realizing that you're suggesting we'd like to look at it before the end of the poverty study, but also realizing we have the ministers coming before us. Next week we're away for travel, so a subcommittee may need to talk about when that could take place. I don't want us to jump ahead of ourselves, but that may be a compromise.

Mr. Savage, you have the floor. That's all I have here right now.

Mr. Michael Savage: Thank you.

I want to thank Mr. Lessard. He has answered some of the questions I had.

When this first came up, I would have supported an amendment that said we would do this after the poverty study. I would no longer support that amendment. This is part of the poverty study, in my view. The way that persons with disabilities are being affected is very important.

I raised this issue in the House yesterday, as members know. There are some serious issues about this program, which started out very nobly but seems to have gone astray. We need to deal with this.

Mr. Lessard's idea, if I understood him correctly, is that we support this motion today and then ask the clerk and staff to come back to us with a recommendation.

I think we need to talk to officials. We may need some other witnesses as well. For today, I would certainly support passing this motion without a time allocation or limit, and let them come back to us with a recommendation.

The Chair: Are you also suggesting that we could have a subcommittee meeting to try to figure out when we could work it into the schedule?

Mr. Michael Savage: That's fine, too.

Also, I have a question on travel. Not all of us are travelling starting the week of May 11, and there may be a possibility for some of the committee to get together to do that.

The Chair: The only problem is that we'll have no support staff at that point.

I have Massimo.

Mr. Massimo Pacetti: I know it's not my committee, but to offer advice, in our committee every time we put in time limits we never respect them, because things come up.

I would just as well vote for a motion like this, have the officials come forward, and then at that point have your steering committee meeting and decide where you want to go and how many meetings you want to have. The officials will provide you with more information at that point.

I'm in favour of the motion as is, and I would recommend that the committee go ahead with it.

The Chair: Okay. Is there any more discussion on the proposed amendment?

Go ahead, Ed.

Mr. Ed Komarnicki: Mr. Chair, in light of the discussion I'm hearing, I think it would be appropriate for me to withdraw the amendment and have the motion as it stands, with the understanding that the time would be set having regard to the staff and whatever else we're doing.

● (1300)

The Chair: Do we have unanimous consent to withdraw the amendment?

(Amendment withdrawn)

The Chair: Great. Then we'll go back to the main motion as it was read out earlier. Is there any more discussion on that?

Sorry, did you have a final comment, Mr. Lessard?

[*Translation*]

Mr. Yves Lessard: Mr. Chairman, I am asking for a recorded vote on the motion.

[*English*]

The Chair: Most definitely.

All right. We'll have a recorded vote.

(Motion agreed to: yeas 11; nays 0)

The Chair: We're at one o'clock, so I'm going to adjourn the meeting. We'll be meeting with the ministers when we meet next Tuesday.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

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