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Chair

Mr. Bryan May

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

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● (0845)

[*English*]

The Chair (Mr. Bryan May (Cambridge, Lib.)): I call the meeting to order.

Good morning, everybody. Pursuant to Standing Order 108(2) and the motion adopted by the committee on Monday, June 13, 2016, the committee is resuming its study of poverty reduction strategies. I'm going to forgo my preamble this morning to wish one of our colleagues a fantastic...it's your 30th birthday, right?

Mr. Dan Ruimy (Pitt Meadows—Maple Ridge, Lib.): Yeah. How did you know?

The Chair: Fil, do you want to start us off?

M. Dan Ruimy: Oh God, no.

Some hon. members:

Happy birthday to you,
Happy birthday to you,
Happy birthday, dear Mr. Ruimy,
Happy birthday day to you.

The Chair: Thank you very much for indulging me on that. It's a pleasure to have you join us. We're not usually this silly this early in the morning.

From the Mental Health Commission of Canada, we welcome Ed Mantler, who joins us here in Ottawa.

Cedars Society via videoconference in Vancouver, British Columbia, is not here quite yet, so I'll skip Marshall.

Also via video conference from the Centre for Addiction and Mental Health in Toronto, Ontario, we have Dr. Vicky Stergiopoulos.

Did I get that right, or close enough?

Dr. Vicky Stergiopoulos (Physician-in-Chief, Centre for Addiction and Mental Health): Perfect.

The Chair: Also from the City of Toronto via video conference, we have two groups, and I like the fact that you're sharing your time today.

We have Ricardo Tranjan, manager of the poverty reduction strategy office, and Kelly Murphy, a policy development officer, both from the City of Toronto.

Then, from Working for Change, we have Michael Creek, director of strategic initiatives, and Lubna Khalid, coordinator.

Welcome to all of you.

We are going to get started right away because we have a full slate of witnesses today. I would ask that the witnesses keep their comments as close to seven minutes as possible. We're going to start off with Ed Mantler from the Mental Health Commission of Canada.

The next seven minutes are yours, sir.

Mr. Ed Mantler (Vice President, Programs and Priorities, Mental Health Commission of Canada): Thank you, Mr. May, and my thanks to the committee for inviting the Mental Health Commission of Canada to speak here today.

This week in Canada 500,000 Canadians have called in sick to work because of a mental illness. This week isn't special. The same thing happened last week; the same thing will happen next week. While it's not the same 500,000 people every week, some are. Some will be experiencing a protracted illness, and some will not be able to return to their work. Not being able to sustain employment leads, of course, to financial difficulties, which can spiral into poverty and homelessness.

The timing of my being here today is excellent, because it comes on the heels of the release of the final sustainability study on At Home/Chez Soi, released in November. As many of you may know, At Home/Chez Soi was the largest research project of its kind in the world and has since been replicated internationally. It involved more than 2,000 participants in five cities across the country over five years, and proved beyond a doubt that a Housing First approach can rapidly end homelessness for those experiencing mental illness, who account for approximately 64% of homeless people.

The study proved beyond doubt that Housing First works and has had an impact on improving housing policy, especially as it relates to reducing poverty. I can't stress strongly enough how gratified we are that our voice has been heard. In fact, earlier this year the mayor of Medicine Hat announced that a Housing First approach has been used to eradicate homelessness in that community in Alberta.

Access to safe, affordable, secure housing has been proven to be cost-effective. In fact, we know that it costs less to provide stable, permanent housing augmented by social supports. It's not housing only; it's Housing First, and even with supported housing and subsidized housing and the augmentation of intensive case management or assertive community treatment, it's still cheaper than having people cycle through shelters, temporary accommodation, emergency departments, and even incarceration.

Just yesterday, our president and CEO, Louise Bradley, released a statement congratulating the federal government for engaging Canadians in the development of a national housing strategy. When we are crafting a national plan, the urgent challenges faced by people living with mental health problems and illnesses must be top of mind, since the need for affordable housing among this vulnerable population is nearly double that of the general population. We know that safe and secure housing has a profound and life-changing impact on a person's health and well-being, which is why it's enshrined in the mental health strategy for Canada, Changing Directions, Changing Lives.

At the commission we often say that everyone needs a home, a job, and a friend. That's of course an oversimplification of the broader social determinants of health, but I mention it here because housing is only one component of the puzzle. Recovery from mental illness is not only possible, it's expected. When I say “recovery”, that always raises some eyebrows, because people sometimes hear “cure”. I don't mean cure; I mean recovery—leading a full, healthy, fulfilling life despite some limitations in much the same way that people with chronic physical illnesses do.

I myself have a heart condition. I had a heart attack in 2006, yet when you look at me, I hope you don't see a heart patient. I hope you see a fully functional Canadian. I'm healthy and I'm recovered, but I'm not cured. I will always take medications every morning. I will always have a regular exercise regimen. I will always see a cardiologist. I will always lie to my cardiologist about my diet.

Voices: Oh, oh!

Mr. Ed Mantler: I'm recovered, not cured. I lead a full, productive life. I have a good job, with responsibility. I have friends and family who care about me. I have hopes and aspirations that I work towards. Recovery from mental illness is exactly the same—it's expected.

We know that poverty compromises the ability of Canadians to be well and to recover. Poverty exacerbates the symptoms of mental illness and can bring them out. At the same time, mental illness can sometimes make it difficult to sustain employment and therefore leads to poverty. It's a vicious cycle.

● (0850)

When we think about recovery from mental illness, that means taking a long-term view and making meaningful investments in programs that extend well beyond the health care sector, such as programs that support people living with serious mental illness to get and keep meaningful employment.

So what happens to those 500,000 people I talked about earlier?

We know that some of them will recover quickly and return to work, but we know that a large percentage of those with serious mental illness will not. Someone off work on illness leave for six months only has a 50/50 chance of returning to employment. After a year away, the chance of returning drops to 10%, and for that reason 90% of the Canadians who are experiencing a severe or serious mental illness are unemployed. That accounts for about 3% of the Canadian population.

People with mental illness are capable of contributing tremendously to society, yet a troublingly high proportion of those who are homeless suffer from mental illness. We need to improve policy that rewards and supports people who return to work, rather than penalizing or failing to incentivize earned income.

At the commission, we call that population “the aspiring workforce”. They are those who have left work because of mental health problems or those who have never entered the workforce because their mental health problems struck early in life.

It's interesting that there are many organizations that work with those individuals to help them—help them build resumés, help them gain skills, help them get training—but it's very hard to find organizations working with employers to make the workplace culture, policies, and practices more accommodating and more accessible to people experiencing mental illness and mental health problems.

The commission has done a pre-budget submission this year for a demonstration project as an example to support employers—hopefully to support 200 employers across the country—to learn what works and what doesn't, to determine the best practices for changing the culture of workplaces, changing the policies and practices in order to keep those with mental illness in the workplace, have them return to work as early as possible, and help those who have never entered the workforce be able to find meaningful work and jobs.

Taking it one step further, we should make a concerted effort to advance the research that informs our knowledge and understanding of the social determinants of health and the links between mental health and overall health. Collectively, we must work harder to provide services that address the social determinants of health. If the mental health system does not take into account social inequity and poverty, then the time and energy that we're spending will be wasted and the results diminished.

Efforts to address the social determinants of health must be collaborative and involve different systems, including all levels of government, ministries, and sectors, and must involve those with lived experience of mental illness. These efforts must apply a health equity lens, be evidence-informed, and focus on upstream initiatives as well as downstream services and supports for people living with mental illness.

I'd like to thank the committee for giving me the opportunity to be here today. Thank you.

● (0855)

The Chair: It's our pleasure. Thank you very much for being here.

We're going to quickly move over to the Centre for Addiction and Mental Health and Dr. Vicky Stergiopoulos, physician-in-chief, coming to us via videoconference from Toronto, Ontario.

Welcome. The next seven minutes are yours.

Dr. Vicky Stergiopoulos: Thank you, Bryan and members of the committee, for your work on poverty reduction strategies and for giving me the opportunity to appear before you today.

As you mentioned, I'm the physician-in-chief for the Centre for Addiction and Mental Health in Toronto.

CAMH is Canada's largest academic mental health and addictions science centre. We combine clinical care, education, and research to transform the lives of those affected by mental illness or addiction. We have over 500 beds, more than 3,000 staff, over 300 physicians, and 100 scientists. We work together to support over 30,000 patients each year.

For our patients and for Canadians with mental illness, poverty is a major concern. People with mental illness have lower incomes, are less likely to participate in the labour force, and are less likely to have adequate housing when compared to people with other disabilities and to people with no disabilities. Poverty can further exacerbate their physical and mental health conditions.

While evidence-based clinical care is essential for mental health recovery, CAMH also recognizes the importance of the social determinants of health and their impact on improving the conditions of living for people with mental illness across their lifespan. Therefore, we offer the following three recommendations to reduce poverty among people with mental illness.

First, we need federal investments in affordable, supported, and supportive housing. In Canada there are over 520,000 people with mental illness who are inadequately housed. Among them, almost 120,000 are absolutely homeless. Many of these individuals are able to live independently in the community, and improved access to affordable housing would assist them to move out of poverty.

Other Canadians with mental illness require support to find and keep housing. For them, access to affordable housing and evidence-based clinical support will provide the opportunity to maintain housing stability and to exit poverty.

There are some patients we see at CAMH and elsewhere in Canada who have more severe psychiatric disabilities. For them, access to high-support housing, housing with around-the-clock supports, is what is needed to maintain successful community tenure. Research has shown that access to housing can improve personal health and social outcomes for people with serious mental illness. Unfortunately, there is a shortage of these types of housing in Canada.

In 2012 it was estimated that 100,000 new units of housing would be needed across the country over the next 10 years just to begin to address the housing needs of people with mental illness. In Ontario, people with mental illness can wait up to six years for housing.

In our submission to the national housing strategy, CAMH recommended that a portion of all federal funding for affordable housing be reserved for the development of new supportive housing units. We also recommended an increase in funding for Housing First, which is an evidence-based supported housing model for people with mental illness who are homeless. We believe that these investments in supported and supportive housing will help reduce poverty among Canadians with mental illness.

Our second recommendation is that the federal government support initiatives that assist people with mental illness to find and keep employment. Most people with mental illness can and want to work, but up to 90% of those with a serious mental illness are unemployed due to stigma and discrimination, inadequate job supports, and problematic income security policies. People with mental illness who work are heathier and have higher self-esteem and a better standard of living. They're also less likely to use high-cost health and social services.

With federal government support for evidence-based employment supports and alternative employment options, in addition to the work the Mental Health Commission of Canada is doing to address stigma and discrimination in the workplace, poverty among people with mental illness can be reduced.

● (0900)

Finally, we recommend that the federal government work with other levels of government to implement a basic income guarantee to support Canadians with mental illness who cannot work and those who cycle in and out of work because of the nature of their illness. Current income support systems are inadequate and create disincentives to work. A basic income guarantee, along with housing and employment supports, could dramatically improve the health and standards of living for people with mental illness.

Poverty is a challenging and multi-faceted problem, and CAMH commends the government for making it a priority. We are also glad to see that you are recognizing the unique needs of people with mental illness and addictions as you shape the strategy.

We hope that our recommendations can be helpful to you.

Thank you. I'd be happy to answer any questions.

The Chair: Thank you very much.

Now from the City of Toronto, coming to us via videoconference from Toronto, we have Ricardo Tranjan, manager, poverty reduction strategy, and Kelly Murphy, policy development officer.

The next seven minutes are yours. Go ahead.

[*Translation*]

Mr. Ricardo Tranjan (Manager, Poverty Reduction Strategy, Social Development, Finance and Administration, City of Toronto): Good morning, Mr. Chair and members of the committee.

First I want to thank you for having invited us today and for giving us the opportunity to discuss the developments, achievements and challenges of the Toronto Poverty Reduction Strategy.

We also want to take this opportunity to thank the Government of Canada for investing in social and affordable housing in phase 1 of the infrastructure plan.

We are happy to contribute to the work of this committee and to the development of a federal poverty reduction strategy which will be informed and supported by provincial and municipal strategies.

[*English*]

In 2015 Toronto City Council unanimously approved TO Prosperity, the Toronto poverty reduction strategy. This strategy is based on thorough research and a year-long community engagement process co-led with community organizations and people with experience in poverty, and it involved more than 2,000 city residents.

In adopting this strategy, the City of Toronto has acknowledged the importance of municipal leadership in poverty reduction and the need to commit resources to ensure the economic, social, and environmental prosperity of Canada's largest city. TO Prosperity is a system strategy that focuses on five key issues: housing stability, transit equity, service access, food access, and quality jobs and liveable wages.

We have three overarching objectives.

The first is to address immediate needs. We want to ensure that vital services are well funded and coordinated and meet the needs of those living in poverty.

Second is to create pathways to prosperity. We want to ensure that the city programs and services are integrated, client-centred, and focused on early intervention.

Third is to drive systemic change. We want to leverage the economic power of the city to stimulate job growth, support local businesses, drive inclusive economic growth, and tackle deep-rooted social inequality.

At the City of Toronto we firmly believe that tackling poverty must be a collective effort. In some areas, the City of Toronto has the tools, resources, and authority to lead the way, and it is doing so. In other areas, the city must collaborate with other orders of government, the private sector, labour, and community organizations to reduce poverty and promote inclusive economic growth. Siloed policy development, uncoordinated services, piecemeal programs, and intermittent investments often exacerbate poverty and vulnerability.

In year one of the poverty reduction strategy, the city invested in student nutrition programs, employment programs, social housing, shelters, child care fee subsidies, recreation centres where programs are free, and public transit, which is now free for children 12 years of age and under.

In 2016 the city council also approved the new social procurement policy and program that will increase access to city contracts for businesses that are owned by, employ, or provide employment training to equity-seeking communities and low-income residents. Last week, the executive committee approved the creation of the low-income transit pass, which will be brought to council next week.

Finally, city divisions introduced innovative approaches to program development and delivery, including pilots that will use intensive case management strategies to improve services and outcomes for social assistance recipients facing barriers to employment, such as mental health challenges.

We're proud of these achievements, but there is much more that needs to be done, and the Government of Canada can play a crucial role in helping us move forward. Significantly reducing poverty in urban centres requires major investment in social and affordable housing, child care, and both the building and operations of public transit. Our efforts to prioritize limited municipal resources and to find innovative and effective ways to support low-income residents will not yield the desired outcomes without adequate funding for housing, child care, and transit. These are the key pillars of socio-economic stability and inclusion. Without them, residents cannot fully participate in economic and civic life.

The city applauds the recent investments in these areas through phase one of this infrastructure plan and hopes that phase two investments in the national housing strategy and, of course, the Canada poverty reduction strategy will further advance that.

I would also like to briefly talk about monitoring and evaluation.

It is widely known that the currently used low-income and poverty measurements—LIM, LICO, and MBM—have major methodological limitations. In this regard, we would like to echo previous witnesses who appeared in front of this committee and recommended that the federal government task Statistics Canada with the collection and dissemination of non-monetary poverty data, including material deprivation data. Our ability to monitor and evaluate our poverty reduction efforts would increase significantly if we could combine monetary low-income measures with a material deprivation index.

● (0905)

[*Translation*]

Once again, I thank you for this opportunity to address you this morning.

My colleague Kelly Murphy and I will be pleased to answer your questions, to the extent of our knowledge, of course, and to put any material that can be of use to the work of the committee at your disposal.

It is a pleasure for us to work with our federal government colleagues on the development of a poverty reduction strategy for Canada.

Thank you very much.

[*English*]

The Chair: Thank you very much.

Now, from Working for Change, we have Michael Creek, director of strategic initiatives, and Lubna Khalid, coordinator of Women Speak Out, both via videoconference from Toronto.

Welcome, both of you. The next seven minutes are yours.

● (0910)

Mr. Michael Creek (Director, Strategic Initiatives, Working for Change): Good morning.

On behalf of Lubna and myself, I want to say that we are happy to be here with you today. Having heard other people speak, I'd like to mention right off the top that 99% of the people who work in our organization are people with mental illness or addictions, or people who have experienced poverty or been marginalized in some way in society, which makes us a rather unique organization.

Thank you for the invitation to appear before the committee today and to share the work that we do at Working for Change and the systemic work we undertake around mental health and addictions in regard to employment opportunities, poverty reduction issues, housing, etc. We believe that people with lived experience are experts and need to be consulted in areas of policy development by the federal government.

There is still a serious stigma attached to the words “mental illness” and “addictions”, although society's views around other disabilities have changed somewhat. People from my community are still facing huge barriers to employment, housing, and social inclusion. The unemployment rate for people with disabilities remains extremely high—some believe as high as 70%—and for people with serious mental illness it is as high as 90%. We know that 45% of people entering the Ontario disability support program have mental illness or addiction disabilities. The cost of this program could become unsustainable in the future.

Why is it that we continue to see this increase? Everyone on ODSP lives in poverty, some in very deep poverty that often compounds their inability to recover their health. Many whom we speak with are looking for a way out of poverty, but we have not developed the pathways to help them out.

Ms. Lubna Khalid (Coordinator, Women Speak Out, Working for Change): The work that the Mental Health Commission has undertaken over the last 10 years has made some inroads into making our communities feel stronger—that there is a place for us and that Canada and Canadians are willing to make the investments in housing, social supports, employment opportunities, and choice. We still have a tremendous amount of distance to cover; we believe that we can get there together.

Here are a few of the areas where we have found success for our community in the work we have undertaken over the last 10 years.

Over the past several years, we have developed different leadership and pre-employment programs that have assisted people in gaining access to employment and moving out of poverty. In 2005, we developed a program called Voices from the Street, which was designed to have people with lived experience of poverty, mental health issues, and addictions provide education on these issues to members of the public and sit at the table where policy-makers were making decisions. Over the past decade, members of Voices from the Street have spoken to thousands to people, including students, nurses, resident physicians, social service workers, psychiatrists, and policy-makers. Women Speak Out, our women speakers bureau, adds a gender lens to issues and includes the voices of women who have experienced domestic violence, poverty, and newcomer or refugee challenges.

As our speakers bureau grew, we also found that many of our graduates desperately wanted to find employment, particularly in the social services area. We now offer two pre-employment programs. One trains people on social assistance to work in the food services or horticultural fields. The second program offers relief worker training to people with lived experience of poverty so that they can find employment in drop-ins, shelters, and social housing settings. Our intensive 12-week programs combine sessions that recognize the struggles that people living on social assistance face with sessions that build their confidence. Participants then learn very practical skills for employment in food services, horticulture, or social services, as well as job search techniques. To date, approximately two-thirds of our graduates have found full- or part-time employment.

Mr. Michael Creek: People can find pathways out of poverty. We need the federal government to take on this important role with the provinces and municipalities in poverty reduction. The cost of doing nothing or saying we can't afford to make investments in these key areas of employment and housing for people with disabilities must end.

According to a recent report on the cost of poverty in Toronto, the health and social costs of poverty, combined with lost revenues, are between $4.4 billion and $5.5 billion. Repeat these amounts across all of our cities, towns, and villages, and those costs rise dramatically.

A poverty reduction strategy must address a modern employment strategy that will target particular populations, of course including people with mental health and addictions issues, youth, and indigenous people. It should be integrated into provincial and municipal poverty reduction strategies, addressing economic, housing, health, and wellness issues. Most of all, it must recognize that far too many people with mental health and addictions issues are denied employment opportunities and choice.

We think we have shown that by having high expectations of people, we can and do succeed. At Working for Change we champion that every person deserves a home, a job, a friend, and social change.

Thank you.

● (0915)

Ms. Lubna Khalid: Thank you.

The Chair: Thank you very much, all of you.

Unfortunately, Mr. Smith from the Cedars Society has informed us he's not able to attend this morning, so we will move on to questions.

Before we do that, I want to thank everybody, both those who are present here and those who are present via video conference, for being able to present today with such short notice. I know some of you have had to, in some ways, move heaven and earth to be here today to contribute to this study. I really do appreciate that.

We'll move to questions. First up is MP Zimmer.

Mr. Bob Zimmer (Prince George—Peace River—Northern Rockies, CPC): Thanks again, everybody, for appearing at committee this morning. I know that for some of you it's early. I guess it's not too bad for us. It's about 9:20 a.m. now.

I want to start off by speaking specifically to Ricardo. You mentioned a few curious things that I would say are definitely paths that I see as important to take in terms of poverty reduction. It's the prevention side of things. Instead of dealing with a condition that already exists, we'd like to prevent that incident from happening. The example that I would use is a car accident. It needs an ER to address the immediate concerns, but there's also a reduction component with education, being in schools, and showing that this is what's going to happen if you drink and drive, etc.

You mentioned you have a section called Pathways to Prosperity. I want you to expand on what you mean by pathways to prosperity. Again, keeping in mind that this is a poverty reduction strategy, can you speak to that?

Mr. Ricardo Tranjan: Sure. Thank you very much for the question.

Yes, we are in full agreement that there needs to be a focus on both. We have to address immediate needs of residents who do not have enough to eat or don't have a shelter or don't have any way of addressing their basic needs tonight. They need that tonight and not tomorrow, not next week. There's a focus on improvement, and every time doing more for residents in that particular situation. Then there's also a focus on creating pathways to prosperity.

There is an understanding that there are things governments can do to improve and better support those who are taking their first steps toward being a little more stable in their economic and social lives. At that crucial crossroads point, governments need to be in and need to be helping. We need to be providing whatever is necessary.

Mr. Bob Zimmer: Ricardo, I'm going to ask for a bit more substance when you're answering that question. You talk about things, but what do those look like? We've heard a lot of the same kinds of conversations about governments needing to do *x*, *y*, *z*. What, specifically, are you suggesting to do? We're looking at real and tangible....

You talked about pathways to prosperity. What do those pathways look like?

Mr. Ricardo Tranjan: Here are a few examples of the things the City of Toronto is investing in right now and working on.

We have ever more programs focused on youth employment to make sure that kids who are getting out of high school or vocational training or even university can be easily integrated into the job market. We work with our workforce development strategy, which was approved a few years ago. The focus is working on both sides, supply and demand, to make sure that they knit and that everyone benefits from those economic opportunities.

We have a social procurement program, which I just mentioned recently. The idea of a social procurement program is to channel a portion of the city's economic power—or more directly, the money the city spends every year procuring all sorts of services and goods—to organizations that employ mostly, or that provide opportunities for, low-income residents and vulnerable populations.

The transit fare equity pass that the executive committee just approved last week also comes within that package of programs. It will offer to low-income residents looking for jobs, trying to access services, or trying to access programs that can have long-term positive impacts on their lives the opportunity to do so without being impeded by the cost of transit.

Finally, one thing we're working hard on as well is human service integration. It's the idea that our housing services, our child care services, and our social assistance and employment services ought to be integrated. Residents need to be able to walk into one city office and receive all those supports at once and not be sent to different doors or be asked to call different phone lines or fill out different forms. We're trying to integrate these.

● (0920)

Mr. Bob Zimmer: Thank you.

I want to ask another question, this time to Ed.

Credit goes to you. This is the mental health section of the poverty reduction strategy meetings that we're having, and you spoke to that. We've asked and you've seen me ask what you see as one of the biggest obstructions on the pathways to prosperity, in terms of mental health. You talked a bit about various aspects, but what would you say are the top two obstacles related to mental health to getting people out of poverty?

Mr. Ed Mantler: As I indicated in my opening remarks, being able to sustain employment is absolutely key. There are a couple of factors that I think we've seen clearly impact one's ability to sustain employment.

Mr. Bob Zimmer: Let me ask you more clearly. You mentioned those, and maybe my question wasn't as clear as I should have made it, but how do we get to that? We talk about this as the barricade, but how do we pull it down?

Mr. Ed Mantler: There are two very significant factors that we see as impacting the ability to earn a living. Number one, first and foremost, is the stigma that clings to mental illness. When I say stigma, what I really mean is discrimination. Tackling stigma, changing attitudes and beliefs about mental illness, and fostering a belief in recovery as an expectation are absolutely key to the second part of the equation, which is the workplace.

We know that most Canadians who work spend more time at work than they do at home with their families and that the workplace is highly impactful upon one's mental health in a positive or a negative way. The national standard of Canada for psychological health and safety in the workplace is a tool that's gaining traction with employers across the country—large, medium, and small, both public and private—to change the culture of workplaces and change the psychological factors within workplaces that impact people. Having workplaces that are inclusive, workplaces that accommodate mental illness, whether it's on a short-term or a longer-term basis, is absolutely essential to allowing people to make the most of their abilities and sustain themselves.

The Chair: Thank you very much, sir.

We'll go over to the birthday boy for six minutes.

Mr. Dan Ruimy: Thank you, everybody, for coming today. It's a very interesting topic, very tough.

I'm going to ask Mr. Mantler my question. I'm glad that Mr. Zimmer brought up the question of stigma, because that's my biggest challenge right now. The passion that I have is for the youth. If we can figure out how to help them move forward, that's going to help us in the long run. With the programs we have, such as Bell Let's Talk, there's an awareness going out there, but I'm not sure how well it's working, because we come back to this challenge: are we getting anywhere?

My youth council, which met last week, specifically for two hours talked about youth mental health. I was surprised to hear that given all the programs the schools offer, they didn't feel that they did anything for them. They didn't think they were effective.

Trying to wrap this up, how do you envision the federal government embedding mental health and addiction into the national poverty reduction strategy, which remains in the federal jurisdiction? We all have different jurisdictions. How does this fit into the federal jurisdiction?

● (0925)

Mr. Ed Mantler: Thank you for the question.

I'm happy that you've targeted stigma in your question, because it is absolutely key. As a commission, we've had the opportunity to work with researchers across the country, particularly researchers out of the University of Calgary and Queen's. Through that extensive research, we know the key ingredients to programs that reduce stigma, so we know how to tackle the problem. There are some target populations that will be strategically most impactful, one of those being youth. Also, there will be media, health care providers, and particularly workplaces that involve first responders.

We've worked with a number of school boards and communities across the country on a program called Headstrong, which is specifically designed for high school age students. It's a process of going into the school, hosting summits that are educational and raise awareness of mental health and mental illness, and sending those students out to take a whole-school approach. It's been determined to be quite effective. This year, we focused on partnering with first nations communities to make Headstrong more available in those communities.

Mr. Dan Ruimy: I want to bring you back to the federal level. Is Headstrong provincial or federal?

Mr. Ed Mantler: Headstrong is a community-based program. It's one that requires some level of support through both policy and financial support. Embedding stigma reduction and mental health promotion in education policy is one step towards making them more of a reality across the country.

Mr. Dan Ruimy: Thank you.

You also mentioned different types of programs that are out there. Do you have a list of programs that are successful and some that are not successful?

Mr. Ed Mantler: We do, in fact.

Mr. Dan Ruimy: Because I'm short on time, can you send that to the clerk so we have that in our arsenal over here?

Mr. Ed Mantler: Yes, we can send you some information.

What we can provide that's perhaps even more relevant is that we've taken the best aspects of those successful ones and put them together in one package.

Mr. Dan Ruimy: Perfect. Thank you.

The other thing, and it's been mentioned over again, is if I have a problem with my heart, I go to the hospital. They don't even think twice; they try to fix me up. With mental health, we have a stigma, and when people do go to the hospital, they're just shooed away.

Can you elaborate a little bit more on the economic benefits of addressing mental health for low-income Canadians? There's a notion that we don't want to deal with this because it's going to cost us too much money. If we do deal with this, what are the economic benefits?

Mr. Ed Mantler: Your question is quite astute. In fact, people with lived experience of mental illness tell us that the time they feel most stigmatized or most discriminated is when they seek help, when they see their family physician, or when they go to the emergency department. Often, they do wait. Often, they are given cursory service and sent home without a longer-term plan.

Part of the reason for that is we hear from physicians that they feel ill-equipped to deal with the mental health problems that they face in their office or in the emergency department.

We have a document called “Making the Case for Investing in Mental Health in Canada” that I think will give you some significant detail on the economic impact. Rather than going into detail, I would be happy to provide that document to the committee.

Mr. Dan Ruimy: That would be great.

You talk about the “aspiring workforce”. Again, what specific steps do you think the federal government can take? Is it a policy thing that we put in? Give us some help here in trying to understand the role of the federal government.

● (0930)

Mr. Ed Mantler: To be quite—

The Chair: Give a very brief answer, please.

Mr. Ed Mantler: To be quite frank, it's money.

We have a project that will demonstrate what works and what doesn't and help us put some science behind understanding the best practices in terms of what workplaces should be doing. We need to enact that demonstration project and put the research in place that's necessary.

Mr. Dan Ruimy: Thank you.

Can you forward the demonstration project to us as well, please?

Mr. Ed Mantler: Absolutely.

Mr. Dan Ruimy: That would be great.

Thank you.

The Chair: For six minutes, Ms. Ashton, please go ahead.

Ms. Niki Ashton (Churchill—Keewatinook Aski, NDP): Great.

Thank you very much to all of our witnesses for being here today, either in person or by videoconference.

My first question today I will perhaps direct to you, Mr. Mantler, as well as to the team in Toronto who are working with the city.

Obviously the study is on poverty, but recent information, in terms of both our labour market and more broadly in the direction that our economy is taking in our country, is indicating that there is a rise in precarious work. One of the things I've been involved with is a national tour on the rise of precarious work in the millennial generation.

We've done consultations across the country, and while I'm an older millennial myself and know from my peers, from my friends, and from my family what this phenomenon looks like, I've been truly taken aback by how often the issue of mental health is brought up in the context of either living in conditions of unemployment or underemployment, and of course we're talking about a chronic, long-term situation here. Young people are making that very clear connection. Obviously we've heard some very heartbreaking stories, and they're calling for help.

One of the things I've heard extensively throughout these consultations is the need for a mental health strategy at the federal level, as well as pharmacare, recognizing that many young people are now in work where having access to benefits is but a dream.

I'm wondering if you've heard about some of these discussions that are emerging. Also, do you see an important role for the federal government in looking at a strategy in this area, obviously with resources backing it up, as well as a pharmacare strategy?

We'll begin with you, Mr. Mantler.

Mr. Ed Mantler: Yes. Thank you for a very relevant question.

About three-quarters of adults who experience mental illness tell us that their symptoms actually started in their teenage years, started as a youth, so clearly it's having an impact on those entering the workforce for the very first time.

We do, in fact, have a mental health strategy for Canada, called “Changing Directions, Changing Lives”. In that strategy, within its 109 recommendations, it does address poverty, it does address workplaces, and it does address stigma. We will ensure that you get copies of that sent over.

The pharmacare question is an interesting one, and I think the point you make is well made. I would stress, though, that although medication is a good intervention and often a necessary intervention, it is not the only intervention. Actually, access to psychological services—specifically, cognitive behavioural therapy—has been proven to be very effective, yet most individuals accessing psychological services have to do so through their work insurance plan because it's not publicly funded, and often those insurance plans don't allow for the level of psychological intervention over the period of time that would be required.

Ms. Niki Ashton: Okay, thank you, and thank you for being willing to share that information.

I'll turn to Mr. Tranjan and Ms. Murphy. Would you like to comment? We also recognize that in Toronto, in the GTA, the rates of precarious work, not just among young workers but all workers, are higher than in other parts of the country as well.

Mr. Ricardo Tranjan: Thank you for the question.

On top of the programs that I already mentioned—the social procurement program, our youth employment programs—the Toronto poverty reduction strategy has directed its staff to develop a job quality assessment tool. Next spring we'll be bringing to council a framework on how to better assess the quality of jobs in the city, and also some recommendations on how to move forward on improving those jobs.

The strategy also endorsed the concept of a living wage, and staff have been working on, studying, and examining the feasibility of further promoting a living wage in the city of Toronto.

● (0935)

Ms. Niki Ashton: Thank you.

Ms. Murphy, do you have anything? Others around the table may respond as well.

Ms. Kelly Murphy (Policy Development Officer, Social Development, Finance and Administration, City of Toronto): Thank you.

I will add to Ricardo's observations about the job quality tool that when we look at the literature internationally, we recognize that the dimensions of a job that make for well-being for the employee include wages and the benefits associated with the job. With the increase in the precariousness of work, we're seeing fewer and fewer opportunities, particularly for young people, to access benefits that would include a medicare program.

The level of a living wage is an algorithm that links wages and the benefits that are attached to that job. If there were opportunities for the federal government to provide a basic safety net associated with pharmacare, that would give more flexibility to employers to have a range of wage levels that would make it.... In an economy like Toronto's, there is anxiety in the employer community about raising wages too much. If the federal government were providing a pharmacare program, that would balance the benefits package to some extent.

The Chair: Thank you very much.

Mr. Michael Creek: Could I add quickly to that?

The Chair: Sure. I'll give you a couple of seconds. Go ahead.

Mr. Michael Creek: I think pharmacare is a wonderful idea, but I think other priorities should happen first, given the tremendous number of homeless people that we find now with mental health problems and addictions. A pharmacare program wouldn't help them at all. I think you have to look at what you're going to ask for first. I think there are a whole series of things you would have to go through at the federal level that should have priority over a pharmacare program at this point.

I'm only speaking from my experiences of living in poverty and being homeless. The pharmacare program is important, but nobody at this table has mentioned anything about recovery and non-medical practices, which are extremely underfunded but have shown extremely good practices within mental health and addiction. I think those programs also need to be funded. They would fall into a pharmacare program.

The Chair: Thank you for adding that.

Now we have MP Robillard for six minutes.

Mr. Yves Robillard (Marc-Aurèle-Fortin, Lib.): Thank you, Chair.

I would like to thank all our witnesses for joining us this morning.

My question will be in French, and I will share my time with Mr. Sangha.

[*Translation*]

My question is addressed to Mr. Mantler and concerns aboriginal communities.

Every aboriginal community has its own particular issues. In an effort to innovate, the government encourages the common use of exemplary practices, but we can do much better.

My question is simple. Recognizing the need to promote better mental health, how can the federal government encourage innovative approaches to fight poverty among aboriginal people? Moreover, how can the federal government help to provide better mental health services and programs to those same communities?

[*English*]

Mr. Ed Mantler: The At Home/Chez Soi project that I spoke about earlier took place in five pilot sites across the country. The pilot site in Winnipeg was one that had a particular focus on indigenous communities, due to the demographics of that population. It was successful because it was done in partnership and with the leadership of the indigenous community walking alongside, rather than by imposing interventions.

Through that process, we learned a lot about cultural humility, about how to work in partnership, and about the spirit of good partnership with the indigenous community. We've taken that learning and have worked on other specific initiatives alongside indigenous communities. Headstrong I spoke about, mental health first aid, the development of specific programs for first nations and Inuit communities.

Seeking innovative solutions means going to those communities and looking at what can be found within the community and within indigenous knowledge, whether it's remote rural communities or urban communities, and it must be pursued in partnership as the Mental Health Commission seeks a process of reconciliation within indigenous communities. We stand ready to work alongside the national, provincial, and local indigenous organizations, if and when invited.

Those are the two keys. The learning that I think the federal government can also take some knowledge from is that it's not an imposition: it's walking alongside, and it's done by invitation.

● (0940)

Mr. Yves Robillard: Thank you very much.

Mr. Ramesh Sangha (Brampton Centre, Lib.): Thank you, Mr. Chair.

My question is to Vicky, from the Centre for Addiction and Mental Health.

Immigrants and refugees coming to Canada are going through rough challenges. They're coming here after persecution in their countries due to war and other experiences. After coming here, they are under trauma. According to St. Michael's Hospital in Toronto, 20% to 50% of refugee children and youth suffer from post-traumatic stress disorder.

My question is, what program do you suggest we can implement to combat PTSD in this early stage? Could you talk about low-income families? You talked about how it is more common in low-income families. What do you suggest to the committee?

Dr. Vicky Stergiopoulos: Thank you for your questions.

Immigrants and refugees to Canada are at a higher risk of experiencing poverty as well as at a higher risk of experiencing homelessness and mental health sequelae, both from the experiences that brought them to Canada as well as from the difficulties in adjusting to Canada.

Easy access to mental health supports is instrumental for these communities, as are the other strategies that we talked about for combatting poverty and enabling social inclusion. Better access to treatment for post-traumatic stress disorder and better access to structured psychotherapies that are culturally informed and that are working are key. It is also key that we prepare our workforce, our mental health workers, to give them the cultural competency they need. We also need to use a variety of approaches, including approaches that are informed by anti-racism and anti-oppression frameworks of practice, so that we see people we work with as equal partners in recovery.

Mr. Ramesh Sangha: You talked about how the federal government should work with the provincial and municipal governments in order to achieve better outcomes in poverty reduction. What do you suggest for how the federal government should align a reduction in poverty with the other provinces, municipalities, and territories? How do you think the federal government should align with them?

The Chair: Give a very brief answer, please.

Dr. Vicky Stergiopoulos: I think that the opportunities for the federal government to align are through two initiatives. The first is the national housing strategy, which gives us an opportunity to invest in affordable, supported, and supportive housing. The other opportunity is through the health accord. Mental health services have been underfunded for years in Canada. I think it is about time that we corrected this inequity.

The Chair: Thank you very much.

We'll go to Filomena Tassi for six minutes, please.

Ms. Filomena Tassi (Hamilton West—Ancaster—Dundas, Lib.): Thank you to all the witnesses.

My first question is to Dr. Stergiopoulos. The Canadian Mental Health Association states that 10% to 20% of Canadian youth are affected by some form of mental disorder or illness. As a youth counsellor, I think that's conservative.

My question to you is, what do you think the federal government can do for vulnerable transitional youth with mental health issues who are at risk of falling into poverty and homelessness? Please give specific recommendations and suggestions. I know you've talked about investing, but what does that look like?

● (0945)

Dr. Vicky Stergiopoulos: I think it's about investing in programs that are aimed specifically at this population.

You are correct that 70% of mental health conditions emerge in youth and young adults. I think targeted investments in this particular age group can go a long way.

First of all, we need to help them stay in school, finish school, secure employment training, have access to jobs, and have access to the mental health supports they need to succeed in these endeavours. CAMH has three innovation centres focusing on children and youth. Some of them have a national scope in trying to understand how we can serve transitional youth, address those social determinants and mental health conditions, and succeed. We're happy to share the work that we're doing across Canada in this area.

Ms. Filomena Tassi: Do you have any recommendations for youth? I know a number of youth who struggle with mental health issues but who don't come forward and voice those issues. How do we help those who, because of the stigma or because they're just embarrassed, come forward and share their issues so that we can offer the help they need?

Dr. Vicky Stergiopoulos: I think there are a number of avenues to do that. First of all, it's to have a no-wrong-door policy that mental health can be talked about at school and be supported at school, at work, or at the places where youth go, such as community spaces and social spaces.

The other opportunity that has emerged is through social media. The future of mental health care will be relying heavily on engaging affected people through web-based applications, so that they can anonymously find information about mental health and can get counselling around mental health. We can develop innovative ways of engaging individuals who may otherwise be reluctant to engage.

Ms. Filomena Tassi: Thank you.

My next question is for Ms. Khalid.

We know that more women than men live in poverty, so I'd like to hear from you what role you believe community-based mental health services play in ensuring housing stability and homelessness prevention for women.

Ms. Lubna Khalid: Thank you very much for the question.

I think it's about awareness in the community. The more we have awareness, the more people are engaged in listening to each other. I also think the peer-based approach is something we need to focus on more, because coming from a South Asian community, I know it's easier for us to relate to each other if we are seeing one person doing something or talking about something and being engaged. It motivates the other person. I think that needs to be focused on more.

Ms. Filomena Tassi: Thank you.

I know there are many great shelters for women. I represent Hamilton, and I know the YWCA there does some fabulous work for women. They have a variety of programs designed specifically for women.

I would like your comments with respect to whether the federal government needs to amplify these sorts of programs and how investing in shelters helps women's mental health. One of the frustrations is that the sustainability of funding seems to be a problem. Ms. Khalid and Dr. Stergiopoulos, could both of you comment on that?

Dr. Vicky Stergiopoulos: I can start.

When we look at the unique needs of women, it's important to recognize intimate partner violence and the need for women to be able to escape abusive relationships. What we see now is that women tend to stay in these relationships and put themselves at risk for fear of actually experiencing homelessness, so supports around that and supports for women who are living in an abusive situation are instrumental, as is raising awareness of intimate partner violence and supports available to women.

● (0950)

Ms. Lubna Khalid: I would add that the supports could be... Again, it's very culture-based when it comes to how women are seen in the community if they are leaving an abusive relationship, so I think that needs to be addressed as well. The supports should be culture-sensitive.

Ms. Filomena Tassi: How much time do I have?

The Chair: You have 30 seconds.

Ms. Filomena Tassi: Quickly, with respect to protecting families and the mental health issues that parents or children face, as well as parents who are caregivers, is there any advice you can offer us with respect to programs that would help this particular group, Dr. Stergiopoulos?

Dr. Vicky Stergiopoulos: I can start.

I think it's important to bring the services to where people are, and I think school-based programs and partnerships among mental health organizations and school programs and gyms in community centres are key. We need to bring our services to where people go. We need to make them accessible, available, and non-stigmatizing, and they need to happen in normative places. I think it will be key, and I think we're making progress in that area.

The Chair: Thank you very much.

We'll go over to MP Poilievre, please.

Hon. Pierre Poilievre (Carleton, CPC): I want to recount an experience I had when I was on the government side in working with an organization that helped young people who suffer from mental illness and addiction escape a life of crime and enter a workforce.

The organization basically created an apprenticeship. They employed the young people to learn. Those young people were actually paid a wage to show up every day and master basic mathematics that would allow them to work as a teller or at a checkout line, to master basic literacy skills that would allow them to read an instruction manual, and to master basic computer skills that would allow them to function in a modern society.

The program went on for about 40 weeks and had an extremely high success rate. The young people had to show up on time and do their tasks. They would not be paid or recognized unless they did those things.

They found that the biggest problem in dealing with people who had serious drug problems was that these young people had a very difficult time focusing on staying engaged and remaining motivated. The best treatment, they found, was physical exercise.

The organization went out and bought a bunch of rusty old dumbbells and used exercise equipment and made a half-hour exercise program every single day mandatory for these young people. The department said that this expense was not eligible for funding because this was supposed to be a job training program. It's supposed to be about employment. Building biceps does not create jobs.

This got me thinking about how we fund these kinds of organizations. Basically, the departments pay for eligible expenses. They receive invoices for rent and photocopiers and personnel and other costs that are eligible, and they send a cheque to the organization. In so doing, we prescribe what works and what doesn't work. This organization found something unconventional that did work. It seems to me that we should be funding them based on the results they achieve, not based on the costs that we as bureaucrats and politicians in Ottawa prescribe.

This organization said, “Frankly, give us no operating budget; just give us a share of the money that the government saves, because these people are going to be working, and we will financially be better off if you fund us that way.”

I wonder if your organizations can comment on the possibility of moving towards results-based funding for organizations that help people, particularly in the area of moving previously unemployable people into long-term, secure employment and specifically doing so without prescribing how these organizations achieve these goals, but rather recognizing and funding them when they do achieve those goals.

Anybody can answer that.

● (0955)

Mr. Michael Creek: Maybe I'll start with our organization, because a lot of the work that we do is working with people who often don't get an opportunity to try to improve themselves.

I'm a good example of that. I spent 13 years living in poverty on the Ontario disability support program. Today I'm a homeowner. I contribute in many ways to our country, both as an advocate but also as a person who is passionate about making sure that other people are lifted out of poverty.

We get to see that in our work every day. The problem with basing it entirely on their results in lifting people out of poverty and finding them employment is that you will get organizations that cherry-pick. We also see this happening now within organizations.

In our organization, we want to serve the most difficult people. We think that we have found a way of being able to do that with people with mental health, addiction, and poverty problems. We'd like to be able to expand those programs so that they'd be available to other organizations.

Hon. Pierre Poilievre: Mr. Mantler, would you comment?

Mr. Ed Mantler: Thank you.

I think that innovation poses a particular challenge for funders, in that they should be providing funding to things that are proven, that have evidence to show that they work, yet many innovations are based on common sense and what intuitively looks like it should work. We must invest in research to produce the evidence around those innovations. We must invest in advancing research to inform our understanding of what works—

Hon. Pierre Poilievre: I'm sorry to cut you off. My concern is that when an organization is involved with a group of kids with criminal records who have never worked in their entire lives and don't have high school diplomas and they're struggling to get them into jobs, they don't have time to fund a brand new study when they know that if they put these kids in a gym and have them exercise for 30 minutes a day, their performance vastly improves.

I worry about us in Ottawa, where people say, “Well, before you can do that, we demand that you file a study, and we want you to contract that out, and it has to be an open request for tender, and maybe you have to hire a consultant on how to do that contract.” That's not how real life works. Small businesses don't operate that way, and we're not going to solve problems in real time if we require new studies every time someone comes up with a solution that works on the ground.

Mr. Ed Mantler: Your point is well made. I don't think research is the only answer, but proving what works in an empirical way is a part of the equation that must be considered.

The Chair: Thank you.

Mr. Bob Zimmer: Mr. Chair, I have a point of order.

The Chair: Sure.

Mr. Bob Zimmer: Marshall Smith was supposed to present to us this morning. He couldn't make it because his facility had to deal with the fatality of an alumnus, a person who had gone through the system before, who had addictions for substance abuse and all the rest. Marshall is an advocate himself. He was dealing with that last night, so he would have had to get up about three o'clock this morning, and he just couldn't do it.

The Chair: Thank you for letting us know.

Mr. Bob Zimmer: I would pass along our condolences to the society, and thanks for the time.

The Chair: Thank you for sharing.

Mr. Bob Zimmer: It just proves why we're here doing what we're doing.

The Chair: Exactly. Thank you, Bob.

Go ahead, Mr. Long.

Mr. Wayne Long (Saint John—Rothesay, Lib.): Thank you, Chair, and my thanks to our witnesses this morning.

My team in Saint John–Rothesay serves breakfast at the men's shelter every Saturday morning. Depending on the day and the weather conditions, there are probably 30 men we serve hot breakfast to.

Out of the 30 men who are there, I would say that all 30 of them have mental health problems. The scary thing—or the challenge, if you will—is when you talk to the shelter operators at Outflow in Saint John, they're at their wit's end. They're there to provide shelter, but they're also there as counsellors, psychologists, and mental health workers, and they're overwhelmed, so one thing we're doing in Saint John is we're putting a group together with police, health care workers, levels of government, and we're going to go to the shelters and provide emergency mental health outreach as much as we can to help these people, because again, the concern is they're there, they get shelter, they have breakfast, and then they're back out on the streets, and it's just a vicious cycle.

I'm looking for your input. We're trying to put this project together. Can you give me some advice or recommendations as to how we could put that together, or how you see something like that working?

● (1000)

Mr. Ed Mantler: It's great that you've recognized the mental health issues and that you've realized an intervention is needed. Emergency mental health outreach in the shelters is one aspect of being able to do that.

I will go back, though, to my original comments and say that it may not be the long-term answer. Housing First we know is an approach that will end homelessness for those experiencing mental illness. Reducing the reliance on shelters for those people and providing mental health supports come with the Housing First approach.

Mr. Wayne Long: Do you have any comments, Ricardo? Kelly?

Ms. Kelly Murphy: Thank you.

I think what you're identifying is the need for an expanded and more integrated circle of care so that we're not recreating these narrow sector strategies for funding programs. We've seen in Toronto that the At Home/Chez Soi study provides a good example of what's effective, and we have others in Toronto where funding is available for agencies to work together and to identify strategies for sharing information about clients.

They are able to do this in a way that protects privacy but enables a wraparound set of supports for clients, rather than having one program that delivers one outcome and others that deliver separate outcomes. We need to be fostering a collective impact across different sectors and different organizations, and we need to support them in working together. Historically, government has encouraged groups to deliver only on the outcomes associated with their sector.

Mr. Wayne Long: Thanks for that. I am just going to....

Go ahead.

Mr. Ricardo Tranjan: Sorry; just to pick up on that and on the previous question on innovation and evaluation, I wanted to call attention to the Local Poverty Reduction Fund. The Ontario Poverty Reduction Strategy Office created, as part of the mandate of the office, a fund that provides grants for community organizations working on poverty to evaluate ongoing initiatives—on the ground, grassroots—and to then report back on whether or not those are feasible solutions moving forward and should be scaled up or not. I think that's a great example that should be looked at.

Mr. Wayne Long: Thank you.

I read a story last night about a business professional who had mental health issues and didn't get help. He really fell through the system, if you will, and he fell, and he fell, and he fell until he was on the street.

I jotted down some notes and I'll quickly read them: “Poverty creates barriers to accessing resources that people with mental illness need for recovery. For people predisposed to mental illness, losing stabilizing resources like home and income can increase risk factors for mental illness or relapse. It disrupts education and career path and diminishes opportunities for employment. No employment, no income, mental illness, chronic poverty.”

As a committee, we're looking for innovative ways or a new strategy to suggest to government, something innovative. We use innovation a lot.

I'm going to ask Mr. Mantler and maybe Kelly, Ricardo, Michael, Lubna, to tell me some innovative ways of thinking that you've seen over the last few years that we could use as a federal government to help in this crisis.

The Chair: Please be very brief.

Mr. Ed Mantler: Housing First started as an innovation and, of course, it's now been proven.

Mr. Wayne Long: But something—

Mr. Ed Mantler: There is work taking place in workplaces to make workplaces more accessible to those experiencing mental illness, either entering the work force or staying within the work force. We have a case study of 40 organizations implementing the national standard on psychological health and safety in the workplace that will highlight innovations. We would be happy to provide that report when it becomes available in the new year.

Mr. Wayne Long: Actually, what we'll do is.... I think I'll get some more time.

The Chair: Yes, we'll get another round in.

We'll go over to MP Warawa for five minutes, please.

Mr. Mark Warawa (Langley—Aldergrove, CPC): Thank you, Chair.

Thank you to the witnesses for being here. It's a very interesting discussion.

Poverty, as defined very broadly, is the state or condition of having little or no money, goods, or means of support. It's a very broad definition. The issue of poverty reduction is a very complex issue, as is mental illness. Mental illness comes in many forms. I appreciate your testimony, and we're looking for solutions.

I'm thinking of my colleague Pierre, who gave an example of some success that was seen, and there was resistance to funding because it was unconventional.

A question was asked at a meeting on this very issue. How do you create wealth? If poverty is a lack of wealth, then how does one create wealth? We heard from some of the witnesses that they were living in poverty, and then, through actions, they were able to get themselves out of that condition, whether it was caused by mental illness or other circumstances.

I think back to the 1980s when interest rates went up to 20%, and there were many people who found themselves homeless. They lost their homes. They lost their jobs. It was tough. There were huge stresses, and possible mental illness and stress caused depression.

I digress, I and reflect that this is a very complex issue we're discussing.

My focus is on seniors and how this impacts seniors. I had a meeting with the senior advocate of British Columbia. Probably the most vulnerable person to be stigmatized is a senior, a single female senior, who is struggling. Are we talking about job placement for that person? No.

Twenty per cent of seniors who are having difficulty are put in residential care. Twenty per cent of them should not be in residential care, and within seven days they begin to receive antipsychotic and antidepressant drugs as a way of managing them. They are being treated as if they have a mental illness, but it's a way of managing them.

When I heard this, I was very disturbed that we have that many people being put in care that don't need.... The proper way of caring for these vulnerable people is to provide home care, allowing them to age in place, but we're not looking for job placement; we're looking for dignity and care and help. They maybe would love to volunteer.

Could somebody make comments on how we take care of our aging population?

● (1005)

Mr. Michael Creek: I'll start.

I don't think we do a very good job of looking after seniors. Here in Ontario, which I can comment on, and particularly in Toronto, we're seeing more and more seniors falling into poverty and also into homelessness.

One of the things we also don't do very well is that we've created the medicalization of becoming older, and we need to get away from that. Hopefully, we can do that in Ontario with a new health care approach with patients first, where patients will have a little more control over their medicalization.

What you brought up around seniors being given medication is of great concern. It raises a lot of alarm bells for people in my community.

How does a 59-year-old person or a 60-year-old person return to work? We see them returning to work. They are the greeters at Walmart. They are the greeters at stores in low-paying jobs that are dead ends for people. We don't take advantage of the wealth and experience and knowledge that seniors often can bring to organizations.

I do think that within the component of developing a strong employment strategy that will help people out of poverty, the seniors will need to play a very vital role.

Mr. Ricardo Tranjan: In my opening remarks, I mentioned that the poverty reduction strategy is an assistance strategy. By that we mean that the strategy builds on our place-based and population-based strategies.

Toronto has a workforce development strategy, a youth equity strategy, a strong neighbourhoods strategy, and a seniors strategy, and we build on all that. We learn from it, and we try to use this strategy to further support the actions and recommendations in those strategies.

We are just in the process of developing the second iteration of the seniors strategy, and I would be happy to forward you our work thus far on that front.

● (1010)

The Chair: Thank you very much, everybody.

Now we have Ms. Ashton for three minutes.

Ms. Niki Ashton: Great. Thank you very much.

I realize this is a recurring theme in our discussions here, but when we're talking about recommendations, while we get excited about the idea of coming up with something new, the reality is that we certainly haven't mastered the age-old recommendations of how to deal with poverty and mental health.

What's clear to me here is that everybody is talking about the need for housing. There's a direct federal responsibility when it comes to housing, so I certainly hope that coming out of your presentations we have some strong recommendations on the need for the federal government to step it up when it comes to housing.

I also want to revisit one area that you, Mr. Mantler, have talked about, which is the particular experience of indigenous communities.

I have the honour of representing a number of indigenous communities in Manitoba. There's a very clear link between the neglect of the social determinants of health—we know that first nations, for example, fall under federal jurisdiction—and poverty and mental health. A number of the communities I represent have had mental health crises and suicide crises.

When you ask young people what they need, you hear them talk of recreation, housing, and the need not to go hungry. I'm wondering if perhaps you, Mr. Mantler, and others would like to share in the short time that I have how important it is to make sure that very basic fundamentals are covered. Is there a role for the federal government to step it up on that front?

Mr. Ed Mantler: We know the impact of the determinants of health. The ongoing systemic lack of access to safe housing, clean water, and food security has a devastating impact on these communities. We also know that access to good quality education, health care services, and psychological services that are culturally sensitive and appropriate is lacking in these communities.

I believe the federal government has a role to play in ensuring easy access to quality, culturally appropriate services in that way.

Ms. Niki Ashton: Does anyone else have a quick comment?

Mr. Ricardo Tranjan: I think we mentioned in our opening remarks the importance of the infrastructure plan and the investments that have been made so far in social and affordable housing. We can't stress enough how essential housing is. We need to continue to invest in it. Otherwise, a lot of the work we've been doing here at the municipal and provincial levels will not yield the results we hoped for.

Ms. Niki Ashton: Thank you.

The Chair: Fantastic. Thank you.

Now we'll go back to Mark Warawa for six minutes, please.

Mr. Mark Warawa: Thank you.

Another major problem that average human beings deal with as we age is memory loss, but that's not mental illness. If there's some sort of dementia and loss of cognitive skill, that would be mental illness, but there are normal physiological problems with aging that need to be addressed.

There was in the news just recently a man who lost all of his wealth through a form of elder abuse by his children, and his cushion to be able to retire with dignity was taken. We've heard over the years about the growing problem of elder abuse.

I believe seniors are stigmatized. They are seen at the end, yet they are a huge resource of experience and talent that can be tapped into and used to benefit Canada, even in the form of volunteerism, if they do have resources. About 80% of seniors do, while about 20% rent and have very limited supplementary resources.

I'll ask you to talk about how we can engage our senior population, who are maybe experiencing poverty, so that we can make full use of those talents. Even if there are some cognitive difficulties, we need to show them dignity and keep them active. Poverty is not only dollars, or lack of, but poverty is being left in isolation or experiencing elder abuse. How do we properly take care of our senior population? If we do it properly, it may not cost anything. It may be a huge benefit to our country and our communities.

Do you have any comments?

● (1015)

Mr. Ed Mantler: I can make two points very quickly—

Mr. Michael Creek: I'll go ahead again. I'll go ahead first.

I was thinking the other day about seniors because I'm getting close to that age. One of the things I thought that we could do as a society—and the federal government, of course, could have a role in this—is an integration of seniors housing within university and college campuses. I think that the wealth and knowledge that people have can open up some areas to address low-income housing for seniors. It would give the experience to students to be able to have a better understanding of social programs and the needs of seniors communities. We could be quite inventive around things like that in addressing some of the social issues, but at the same time we could build a better type of community for all of us.

Mr. Ed Mantler: I'll make two points very, very quickly.

The first point is that often those who work with seniors and who are supporting seniors—home care workers, workers in care homes, bankers, lawyers, and others who interact with seniors—don't have the skills and abilities to recognize when a mental health issue is emerging or know what to do about it. We've worked with the Trillium Foundation in Toronto to develop a version of mental health first aid specifically to help those who work with seniors to recognize early on when there are issues and to know how to address them.

The second point I'll make is around recovery and the understanding that everyone needs a home, a job, and a friend. Perhaps a friend is one of the components that's most important to seniors, because many do live in isolation. Peer support is an effective mechanism to support and foster interaction within the communities, and there actually are guidelines to help anyone be able to support their peers that can be applied to seniors, I think, in an effective way.

Mr. Mark Warawa: Is there any time left?

The Chair: You have one minute.

Mr. Mark Warawa: Maybe I'll suggest that community groups could form visitation programs. They could visit seniors who are living in isolation and give them value. There's no cost to that, but there are great rewards.

The other issue is elder abuse. I think that as a country we need to take a serious look at seniors who did have a cushion to take care of themselves in their aging years, and now it's gone through elder abuse, and they find themselves in poverty. For example, the senior in the news this week couldn't even go to a Christmas party for $25 because all his money had been taken. It's very sad.

The Chair: Thanks, Mark.

We'll go over to Dan for six minutes.

Mr. Dan Ruimy: Thank you very much. Again, thank you, everybody, for participating. It has been great.

With what we've been hearing today, I think it's undeniable: mental health is connected to poverty, and mental health is directly connected to housing. Along that line, in an earlier conversation we had, the last thing you said to me was about money. You need money.

Earlier this year, the federal government came out with three programs. One is the homelessness partnering initiatives program, which is $112 million over two years. Part of that is an innovation fund for trying to find solutions through micro-grants towards housing and homelessness. We have introduced another program for affordable housing, which speaks to seniors, social housing, rent, and co-ops, which is $2.3 billion over two years.

For my first question, I'd like to get a straw vote from everybody, or a poll: have you heard about these three programs?

● (1020)

Mr. Ed Mantler: Yes.

Mr. Dan Ruimy: Okay, you've heard.

Dr. Vicky Stergiopoulos: Yes.

Mr. Dan Ruimy: You've heard.

Then the folks from Toronto—

Voices: Yes.

Mr. Dan Ruimy: Okay, good.

I want to get some comments on how you feel those programs are working and are geared towards helping to solve these problems.

Mr. Ed Mantler: It's quite gratifying to know that targeted funding within that structure is aimed at Housing First approaches across the country. We've been working with our partner, the Canadian Alliance to End Homelessness, to provide technical training and support to over 60 communities that are now accessing that funding and using it for a Housing First approach.

Mr. Dan Ruimy: That's excellent.

Vicky, do you have any comments?

Dr. Vicky Stergiopoulos: Similarly, I was involved with the Toronto Alliance to End Homelessness. It worked very closely with the city and community mental health organizations to implement a Housing First approach in Toronto. We are thrilled that there are opportunities for innovation to discover improved ways of supporting homeless people with mental illness. I think we need to pay greater attention to those who require high-support housing, including seniors who may require assisted living approaches to maintain successful community tenure.

Mr. Dan Ruimy: Thank you.

Are there any comments from Toronto?

Mr. Michael Creek: Yes. I'd like to make a really quick comment. I think the investments that have been made are fantastic. I'd like us to be able to do more. Specifically, I find it very disturbing that I still find people who are living for 20 to 25 years in shelters in Toronto. That raises a lot of red flags for me. We're spending money on programs for people who aren't finding a home. We need to find out why these people aren't finding homes.

There are some special projects going on that are determining some of the things keeping people in shelters, but I'd like to see more investments in the area, especially around the chronic long-term homelessness that is happening not just in Toronto or Ontario, but right across our country. Within that national housing strategy, we really need to develop a strategy that addresses chronic homelessness.

Mr. Dan Ruimy: Thank you.

Mr. Ricardo Tranjan: I have not been directly involved in these programs, so I cannot comment on any of them. I would be happy to follow up with a written submission if you so wish.

Mr. Dan Ruimy: Okay.

Now I want to take this one step further and actually speak to one of the comments that was just made. It's great that we have all these programs coming along addressing housing as a first priority, but I want to get some comments on the wraparound services. Are they tied into this? That seems to be where some of the challenges are, the wraparound services. Have you heard anything about those, anything you'd care to comment?

Ed, I'd start with you.

Mr. Ed Mantler: As part of the At Home/Chez Soi project, Housing First is not housing only. It's housing augmented by extensive case management or by assertive community treatment based on the needs of the client. That's an essential component to ensure that those wraparound services come into play.

Mr. Dan Ruimy: I guess the question is, who is providing funding for wraparound services? Where are you guys getting funding for that? Is that coming through the province? Is that federal? Is there a connection?

I hear a lot that we're providing homes, but sometimes those wraparound services are not there. Where can the federal government play a role in the wraparound services?

Mr. Ed Mantler: I don't know I'm sufficiently informed in where those dollars are coming from in each community to give a meaningful response.

Mr. Dan Ruimy: Okay.

I have about 45 seconds.

Vicky, you look like you have something you want to say.

Dr. Vicky Stergiopoulos: That's right. These services are funded provincially, and through the health accord it would be nice to encourage provinces to combine those clinical supports with rent supplements that would support housing. It would be supports in combination.

Mr. Dan Ruimy: Excellent.

Mr. Michael Creek: I want to quickly add those supports around harm reduction are inadequate. The supports around alcohol management programs are really inadequate. We need to do more around those smaller things that we can do to work with people in our communities to provide those supports they may need.

Ms. Kelly Murphy: The municipality and the local health integration network that serves residents in Toronto are piloting opportunities to link, as Vicky was saying, new rent supplements with social supports, but having further direction from the federal government about how to overcome those silos between housing and health and see them as necessarily combined is a direction we would very much welcome from the federal government.

● (1025)

Mr. Dan Ruimy: It's a great suggestion. Thank you very much, everybody.

I think I'm out of time.

The Chair: You are. Thank you, sir.

Now we have Ms. Ashton for six minutes.

Ms. Niki Ashton: Thank you very much.

Perhaps going to the team in the City of Toronto as well as Working for Change, one of the areas that we broached more broadly —not necessarily our committee, but certainly as parliamentarians— is that adequate supports don't exist for those who are struggling with mental illness and with addictions as well. We know that harm reduction is an important way of empirically helping people who are living in these situations, but we know that there are immense challenges, certainly legal ones, when it comes to providing the kind of harm reduction services that are required, whether it's safe injection sites or whether the kind of medical work that needs to be done. Of course, as we know, when there isn't that help, the cycle of poverty, addiction, and mental illness continues for people in these situations.

I'm wondering if, perhaps, you see the need for the federal government to further support harm reduction and lift the legal barriers and the legislation that's in place that prevent safe injection sites from opening. Is this an important way of dealing with poverty and mental health?

Ms. Kelly Murphy: As you know, the Board of Health and the City of Toronto have endorsed a harm reduction approach across many domains and submitted an application, I think the second in Canada, to establish safe injection sites in Toronto. We've identified, through research, the cost-effectiveness and the safety and the health benefits of having safe injection sites in Toronto in three different locations. We welcome the lifting of the restrictions and welcome the opportunity for the federal government to provide further leadership in supporting this direction for urban and rural environments and communities that need the support that has come through harm reduction.

Mr. Ricardo Tranjan: As well, more broadly, we welcome the general approach of trying to work together to find practical solutions to issues that often fall through the cracks where there is no jurisdiction for them. I think the federal government has already indicated that the collaboration of the Canada poverty reduction strategy review involved a lot of community engagement and engagement with stakeholders such as the City of Toronto. Overall, their approach is a great one, and we are looking forward to participating more actively in answering very concrete questions like this, and others related to poverty reduction.

Mr. Michael Creek: I'll quickly add, because I'd like to hear what Dr. Vicky has to say, that one of the things I see still reoccurring is the stigma that is attached to addictions and approaches around harm reduction. I think we still need to do a lot of education with physicians and health care professionals, but also with society in general, about what addictions really are and how we view people.

Often we attach blame to individuals who find themselves addicted, and I think that if we're going to find success, if we don't address the addiction issue, we'll get a lot of resistance from the general public to funding these programs, and those programs are essential for the wellness of those people in those communities.

Dr. Vicky Stergiopoulos: I think there is definitely a great aim to include harm reduction strategies in greater and bigger addiction strategies. I think we have a lot to learn from B.C. and the progress they've made in their supervised injection site. In Toronto, we had the first managed alcohol program in a shelter. Since that, others have been developed in different cities in our country.

However, I agree with Mike. We have a lot more work to do to combat addiction stigma and discrimination for people who use drugs. If people with mental illness experience discrimination, it is much worse for those whose main issue is substance use.

● (1030)

Ms. Niki Ashton: Thank you, Doctor.

I'm not sure, Mr. Mantler, if you have any comments on the need for support on harm reduction from the federal government.

Mr. Ed Mantler: When it comes to the interplay between mental health and addictions or substance abuse issues, we work in partnership with our sister organization, the Canadian Centre on Substance Abuse. If the committee has not heard from that organization, I would advise that it may be something to consider.

Ms. Niki Ashton: Thank you.

The Chair: You have about 30 seconds.

Ms. Niki Ashton: Thank you for your thoughts on that front.

If you know of others who could send in a submission to support the message around the need for federal support for harm reduction and safe injection sites, please let them know to send us a written submission as well.

The Chair: Excellent. Thank you.

Ms. Tassi, you have six minutes, please.

Ms. Filomena Tassi: Thank you, Chair.

Mr. Creek, I loved your suggestion about incorporating seniors into university campuses and residences.

As a chaplain, I've connected youth with seniors through shopping trips. At Christmas we've connected the two together, and we've also gone to homes for seniors. I have to tell you that what happened there was absolutely magical.

However, Mr. Mantler, I recognize your point about the diagnosis. What often happens with seniors is that there's no indication that depression or loneliness is going to hit. They live healthy lives, and then all of a sudden their friends pass away and they're on their own, and this is what happens. The diagnosis part is so important, but the other frustration is that the waiting lists are too long with respect to psychiatric care for seniors.

Can you offer some suggestion with respect to that? How do we engage more people to take this up as an area of interest, to pursue education in this area, or to have people come to Canada who have expertise in this area to help our seniors?

Mr. Ed Mantler: I would say that more impactful than bringing in specialized seniors care providers would be to better equip family physicians, general practitioners, the broader range of health providers, and the broader range of people who work regularly with seniors, even outside of the health care realm, to recognize the signs of possible mental illness and know what to do with them.

Ms. Filomena Tassi: Okay. Thank you.

This question is for each of you to comment on.

We have connected mental health with poverty because we've heard from some witnesses that it's the single most significant contribution to poverty. Not everybody would agree with that statement, so in our recommendations we have to be assured that we can say mental health is an issue that needs to be addressed in a poverty reduction strategy. Can you provide evidence, through either numbers or experience, that makes that link very clear?

Mr. Mantler, would you like to go first?

Mr. Ed Mantler: Among homeless individuals, 67% are experiencing a mental health problem or illness.

Dr. Vicky Stergiopoulos: We know from research that people with mental illness have lower incomes, are less likely to work, and are less likely to have adequate housing compared to people with other disabilities or to people without disabilities. We can send you these studies.

Ms. Filomena Tassi: Thank you.

Mr. Michael Creek: As a person who has experienced poverty, it played a role in my mental health.

I can't imagine any person I've talked to who has lived in poverty who hasn't experienced some sort of mental health difficulty through that whole process. It's just impossible for it not to happen. You become so dehumanized in the process of poverty that all of these mental health issues or addiction issues rear their ugly head. I'm a survivor of cancer, and I can tell you that poverty caused me more damage than my cancer treatment or other illnesses I've faced. In itself, poverty could be described as an illness also.

● (1035)

Ms. Lubna Khalid: I just want to add violence against women as one of the factors causing poverty for women and children.

Again, there is a need for more shelters for women who are fleeing abuse. Every given day, there are more than 300 women and children in Toronto who cannot find a place to sleep.

Mr. Ricardo Tranjan: In Toronto, 18% of the adult population lives in households with an income below the low-income measure. That figure goes up to close to 30% for residents who have physical or mental disabilities, and there are good reasons to believe that this is an underestimation.

Ms. Kelly Murphy: We know that people with mental health issues are overrepresented among low-income Canadians. We can give you the statistics.

We can also give you the stories. The 2,000 community members who helped design the poverty reduction strategy in Toronto have shared their narratives about living with the stigma of mental illness and the stigma of poverty, and how those compound. We can share those narratives with you.

Ms. Filomena Tassi: That would be great. Thank you.

Mr. Tranjan, you spoke earlier about StatsCan and the importance of their also studying non-material poverty data. Can you expand on that point a bit for us?

Mr. Ricardo Tranjan: Yes. We now use the low-income measure or LICO as indicators of poverty in our cities. They capture part of the story, but they don't capture the entire story.

As has been mentioned before, there are other aspects of both material deprivation and social inclusion. There are key components of the fuller experience of poverty that right now are not adequately addressed or captured in the statistics that we are using.

I think previously you had witnesses who referred to the Caledon Institute who mentioned the same issue. They have been doing really good work that demonstrates the need to combine income-based indexes and material indexes to have that full picture that will help us work better and evaluate the work we are doing, especially.

Ms. Filomena Tassi: Thank you.

The Chair: Excellent. Thank you.

Mr. Long, go ahead, please.

Mr. Wayne Long: Thank you, Chair.

As a federal government, what can we do to help with enhanced, effective employment support programs for those with mental illness?

Mr. Mantler, go ahead.

Mr. Ed Mantler: That's a great question.

The federal government itself is a huge employer, and adopting the national standard for psychological health and safety in the workplace for the federal public service is an amazing step forward.

Public policy that supports individuals getting back into the workplace or removes the financial disincentives for getting back into the workplace and that can influence programs across the country as well would be helpful.

Mr. Wayne Long: Okay.

Ms. Kelly Murphy: I'd like to share the experience of the City of Toronto in implementing a social procurement policy. The federal government, like the City of Toronto, is a huge purchaser of goods and services, and we can use that power for social benefits.

What we have done—

Mr. Wayne Long: Give me an example.

Ms. Kelly Murphy: We have developed a social procurement policy, which we are also encouraging other anchor institutions in Toronto to adopt, such as universities, colleges, the TTC, and Metrolinx. Together we have a collective buy of about $30 billion a year.

If we reorganize the way we select bidders when we purchase goods and services to ensure that we are not only getting maximum economic value from our public dollars but also generating environmental value, or in this case social value, then we can make the dollars that we have to spend go much further, and we can increase employment opportunities for equity-seeking groups.

We have developed a policy that requires one out of every three bids to represent a diverse supplier. If the federal government thought it was very important to increase the employment of people affected by mental illness, you could build that into your procurement policies for the federal government.

● (1040)

Mr. Wayne Long: Thank you.

Mr. Michael Creek: Can I add quickly to that?

Mr. Wayne Long: Yes, of course you can.

Mr. Michael Creek: As the federal government, you have a real opportunity around infrastructure spending. We're using things in Toronto called community benefits agreements. If those were integrated into some of the infrastructure projects the government is going to roll out across the country, it could create employment for people with mental health issues and also could address youth and indigenous issues. There's some real opportunity around community benefits.

Ms. Kelly Murphy: We agree. The infrastructure projects are the greatest candidates for effective community benefits and social procurement initiatives.

Mr. Wayne Long: How much time do I have left, Chair?

The Chair: You have about two minutes.

Mr. Wayne Long: For the record, I suffer from anxiety. I had or have had an anxiety disorder for probably five or six years. About 20 to 25 years ago, I could tell you first-hand about the lack of understanding. I always made it to work, but there were days when I was going to go back home, but I was lucky enough, thank God, to have support around me to get the help I needed. The lack of support out there for people who suffer is unbelievable.

I wanted to follow up on innovation. I know, Mr. Mantler, we got cut short, but I also wanted to talk to you, Mr. Tranjan and Ms. Murphy, about innovation in mental health services support programs. Can you comment on what you've seen? One thing that frustrates me is that we seem to do the same things over and over again and send people out on the streets, and then they're back. Can you give us some new ideas on innovation?

Ms. Kelly Murphy: I'd like to talk to you about the risk-driven community safety program that the Province of Ontario is supporting. The model came from the city of Glasgow. There have also been experiments in Manitoba. The City of Toronto has really become engaged with this model, which encourages very regular, very intensive communication across multiple sectors, across service providers representing different sectors who are going to come in contact with the same vulnerable clients.

In the past, different sectors were working with the same clients but were not sharing information. They weren't talking about this vulnerable person and they weren't making the linkages this vulnerable person needed so that they wouldn't end up back in the hospital or in jail.

It looks expensive, because we have the teams come together on a weekly basis to talk about risk situations, but our data is showing that over the longer term these clients of integrated processes are worth the investment, not only because their individual situation is being reviewed from the multi-dimensional perspective but also because relationships are being forged across the various agencies that are working together so they know to get in touch in a proactive way when an individual is released from hospital into the community. The other sectors know about it. This is an innovation we strongly support.

Mr. Wayne Long: That's great. Thank you very much.

Mr. Ricardo Tranjan: There are three more examples the Toronto poverty reduction strategy supports.

One is intense case management. As Kelly mentioned, there's enough research, some of it coming from the U.K., that it is a much better way to integrate services, and there's more bang for your buck. Sometimes that comes in the form of intense, one-to-one case management. Toronto Employment and Social Services is piloting a number of initiatives that provide more intense case management for a particular group of the caseload that is further removed from the job market.

On the youth employment front, we also have a program that is focused on youth who have experience with the judicial system. When they come to an event—a job fair, for example—we follow up with them, and then we give them access to a support person who will then follow them through the next steps of getting that job.

In the third case, we have a program that brings together recreation, which is usually not seen, although it plays a major role in poverty reduction. Toronto Public Health and again Toronto Employment and Social Services provide one-to-one support to families so they can access the full range of services, from enrolling their kids in swimming classes to getting the social assistance benefits they qualify for, and then have access to dental care and other things that Toronto Public Health offers.

● (1045)

Mr. Wayne Long: Thank you.

The Chair: Thank you very much, everybody. I'm afraid that is our time. I want to thank everybody who joined us today, both here in Ottawa and via videoconference.

As always, thank you to all the committee members for their fantastic work and to everybody who supports this meeting—the interpreters and everybody else here with us. Thank you very much.

The meeting is adjourned.