Submission to

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

On the Poverty Reduction Strategy

January 17, 2017

The Centre for Addiction and Mental Health (CAMH) is pleased to offer this submission to the House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities on the Poverty Reduction Strategy. This submission compliments the presentation that Dr. Vicky Stergiopoulos made of behalf of CAMH to the Committee on December 8, 2016.

CAMH is Canada's largest mental health and addictions academic health sciences centres. We combine clinical care, research, and education to transform the lives of people affected by mental illness or addiction. We have over 500 inpatient beds, 3000 staff, over 300 physicians and over 100 scientists. We treat over 30,000 patients each year. Poverty is major concern for many of our patients and is a recently established public policy priority area for CAMH.

Poverty and mental illness

More than 3 million Canadians live in poverty[1]. People with disabilities, and particularly those with mental illness, are over-represented within this group. People with mental illness have lower incomes, are less likely to participate in the labour force and are less likely to have adequate housing than people with other types of disabilities and people without disabilities[2]. Poverty further impacts their mental as well as physical health[3].

While a Poverty Reduction Strategy should address the needs of all Canadians who live in poverty, it must also recognize the unique challenges experienced by people with mental illness and include targeted, evidence informed interventions for this population. Therefore, CAMH makes the following four recommendations for consideration when developing Canada's Poverty Reduction Strategy:

- Improve access to mental healthcare

[1] As cited by Government of Canada, 2016
[2] As cited by Ontario Human Rights Commission, 2015
[3] Government of Canada, 2016

- Invest in affordable, supported and supportive housing
- Implement initiatives that assist people with mental illness to find and keep employment
- Explore a basic income guarantee

Recommendation 1: Improve access to mental healthcare

Globally, mental health disorders account for 13% of the world's burden of disease[4]. In Canada, that is higher than the burden of cancer or infectious disease. Despite these figures, Canada spends only 7% of our healthcare dollars on mental illness compared to other OECD countries that spend 10% or more[5]. This means that many Canadians with mental illness have difficulty accessing evidence informed mental healthcare and supports. In Ontario, we know that wait times to receive vital services at CAMH and other specialty psychiatric hospitals have increased significantly over the past 5 years[6]. We also know that wait times for community-based mental health services are lengthy. Children and youth who need counselling or therapy can wait over a year and half for service[7].

Accessing mental healthcare can be even more difficult for those living in poverty. Many individuals have limited resources and supports to help them navigate the complexities of the mental health system. Structured psychotherapies - which are an effective treatment for anxiety and depression – are not covered by most provincial health insurance plans if they are delivered outside of hospital. Even good third party insurers only cover about 1 ½ sessions per year. Therefore, those that can pay for private psychotherapy do. Those that cannot, go without.

Given the interconnections between poverty and mental health, improving access to mental healthcare must be a commitment of the Poverty Reduction Strategy. Through the Health Accord the federal government must work with the provinces and territories to earmark funding for evidence informed mental healthcare. Priorities should include ensuring structured psychotherapies are publically funded, as well as investing in a wait-times strategy for mental healthcare and a sustainable mental health research plan.

Recommendation 2: Invest in affordable, supported and supportive housing

In Canada, there are over 520,000 people with mental illness who are inadequately housed and among those almost 120,000 are homeless[8]. Many of these individuals would be able to live independently in the community if they had access to affordable housing. Unfortunately, there is a shortage of affordable housing across the country. In Ontario, there are 171,360 households waiting an average of four years for affordable housing[9]. Deteriorating social housing stock is contributing to the affordable housing shortage as we are losing existing units. Without investments of $864 million from all 3 levels of government over the next 10 years, 90% of Toronto Community Housing Buildings will fail to meet basic

[4] WHO, 2011
[5] Ibid
[6] AGO, 2016
[7] CHEO, 2016
[8] MHCC, 2012
[9] ONPHA, 2016

living standards by 2023[10]. This will leave even more Torontonians, many with mental illness, inadequately housed and deeper in poverty.

In addition to a shortage of affordable housing, there is also a lack of mental health supported and supportive housing in Canada. Supported housing provides people with mental illness with flexible, off-site support services in addition to affordable housing. Supportive housing provides people who have more severe mental health disabilities with affordable housing and onsite supports – sometimes for up to 24 hours a day. Research shows that these integrated models of housing and support improve personal, health and social outcomes for people with mental illness[11]. They are also cost effective[12]. Despite these benefits, there continue to be shortages. It is estimated that 100,000 new units of supported and supportive housing are needed across the country over the next 10 years to just begin to address the housing needs of people with mental illness[13]. In Ontario, over 30,000 new units of mental health supported and supportive housing are needed over the next 10 years[14]. Currently in Toronto, there are over 10,000 people waiting an average of 5 years for one of the city's 4400 units of mental health supportive housing[15]

Canada's Poverty Reduction Strategy must commit to addressing the affordable, supported and supportive housing crisis. Through the National Housing Strategy there should be increased federal funding for affordable housing development with a portion explicitly reserved for the development of new supportive housing units and rent supplements for people with mental illness. Housing First - an evidence-based supported housing model for people with mental illness who are homeless – must also be expanded. Investing in affordable, supported and supportive housing will be a significant first step in reducing poverty among Canadians with mental illness.

Recommendation 3: Implement initiatives that assist people with mental illness to find and keep employment

Like many Canadians, people with mental illness are impacted by the growing problem of precarious employment where unpredictable work hours at low wages leave many individuals and families in poverty. In addition, people with mental illness experience high rates of unemployment. While most people with mental illness can and want to work, up to 90% of Canadians with serious mental illness are unemployed due to stigma and discrimination, inadequate job supports and problematic income security policies[16]. Since we know that people with mental illness who work are healthier, have higher self-esteem, better standards living and are less likely to use high-cost health services[17] it makes good sense to invest in initiatives that help these individuals to find and maintain employment.

[10] CCEA, 2015
[11] Nelson et al, 1997; Nelson et al, 2010; MHCC, 2014
[12] MHCC, 2012; MHCC, 2014
[13] MHCC, 2012
[14] Wellesley Institute, 2017
[15] TAP, 2016
[16] MHCC, 2013
[17] Ibid

Through the Poverty Reduction Strategy, the federal government should commit to funding evidence informed supported employment models and alternative employment options for people with mental illness. We know that rapid job placement models with long-term supports are best at helping people to stay employed compared to pre-vocational training models and that social enterprises are successful at giving people with mental illness the opportunity to own and operate their own businesses[18]. Such initiatives are best implemented in an environment where stigma and discrimination in the workplace is better understood and addressed – an area where the Mental Health Commission of Canada has already made important headway. Collaboration with business leaders to develop a labour market strategy that creates and sustains jobs for people with mental illness will also help to reduce poverty amongst this population.

Recommendation 4: Explore a basic income guarantee

For Canadians with mental illness who are unable to work, work limited hours or who cycle in and out of employment due to the episodic nature of their illness, income support programs are essential. Unfortunately, many of these programs, such as Ontario Works (OW) the Ontario Disability Support Program (ODSP), are inadequate and leave people living in poverty[19]. Income support systems are also complex and difficult to navigate. They can put limits on earnings and assets creating disincentives to work and hindering the ability of recipients to emerge from poverty[20].

The concept of replacing income support programs with a basic income guarantee (or guaranteed annual income) has recently regained traction at all levels of government. Evidence suggests that a basic income can improve health and social outcomes at less cost to taxpayers[21]. The Poverty Reduction Strategy should commit the federal government to working with provincial and territorial counterparts to explore the provision of a basic income to people with mental illness and all Canadians living in poverty. As many different models of basic income exist, it will be imperative to implement a model that ensures that no one is worse off under a new system. The recently proposed Basic Income Pilot Project for Ontario will be worth monitoring.

Final Thoughts

Poverty is a challenging and multi-faceted problem and CAMH commends the government for making it a priority. We recognize that any Poverty Reduction Strategy must be broad in scope and positively impact the lives of all Canadians who live in poverty. We also know that many people with mental illness - who are over-represented amongst those living in poverty - have additional and unique needs that must be addressed to help them move out of poverty. CAMH believes that the four recommendations that we make in this submission will help them to do so. In addition, we encourage the government to explore opportunities to scale up innovative models of service delivery for people with mental illness who are living in poverty. Toronto's Inner City Health Associates have been

[18] Ibid
[19] DBFB, 2014
[20] Segal, 2016
[21] Forget, 2011

successful at providing interdisciplinary health services in shelters, drop-ins and other social service settings[22]. Toronto is also home to Canada's first recovery education centre for people experiencing poverty and mental illness. The STAR Learning Centre uses adult education and employment opportunities to facilitate recovery and community integration for this marginalized population[23]. Finally, CAMH recommends that an inter-ministerial task force be set up to guide the implementation of the Poverty Reduction Strategy as it will be important to align policies and spending to achieve measurable rates of poverty reduction in Canada.

For more information on this submission, please contact:

Roslyn Shields
Senior Policy Analyst
CAMH
roslyn.shields@camh.ca

[22] Stergiopoulos, 2014
[23] Chung et al, 2016

References

Canadian Centre for Economic Analysis. (CCEA). (2015). *Socio-Economic Analysis: Value of Toronto Community Housing's 10-year Capital Investment Plan and Revitalization.* Retrieved from: http://www.toronto.ca/legdocs/mmis/2015/ah/bgrd/backgroundfile-79525.pdf

Children's Mental Health Ontario. (CHEO). (2016). Ontario's children waiting up to 1.5 years for urgently needed mental healthcare. Retrieved from: http://cmho.org/blog/article2/6519717-ontario-s-children-waiting-up-to-1-5-years-for-urgently-needed-mental-healthcare-3

Chung T.E., Curwood S.E., Thang H., Gruszeki S., Beder M., & V. Stergiopoulos. (2014) Introducing a recovery education centre for adults experiencing mental health challenges and housing instability in a large urban setting. *International Journal of Mental Health and Addiction,14(5),* 850-855.

Daily Bread Food Bank. (DBFB). (2014). Who's Hungry: 2014 Profile of hunger in the GTA. Retrieved from: http://www.dailybread.ca/wp-content/uploads/2014/09/2014-Whos-Hungry-Report.pdf

Forget, E. (2011). The Town With No Poverty: Using health administration data to revisit outcomes of a Canadian guaranteed annual income field experiment. Retrieved from: https://public.econ.duke.edu/~erw/197/forget-cea%20(2).pdf

Mental Health Commission of Canada. (MHCC). (2012). *Turning the key. Assessing housing and related supports for persons living with mental health problems and illnesses.* Retrieved from: http://www.mentalhealthcommission.ca/sites/default/files/PrimaryCare_Turning_the_Key_Full_ENG_0_1.pdf

Mental Health Commission of Canada. (MHCC). (2013). The Aspiring Workforce: Employment and income for people with serious mental illness. Retrieved from: http://www.mentalhealthcommission.ca/sites/default/files/2016-06/Workplace_MHCC_Aspiring_Workforce_Report_ENG_0.pdf

Mental Health Commission of Canada. (MHCC). (2014). *National Final Report: Cross-Site At Home/Chez Soi Project.* Retrieved from: http://www.mentalhealthcommission.ca/sites/default/files/mhcc_at_home_report_national_cross-site_eng_2_0.pdf

Nelson, G., Hall, G.B. & Walsh-Bowers, R. (1997). A comparative evaluation of supportive apartments, group homes, and board and care homes for psychiatric consumer/survivors. *Journal of Community Psychology, 25(2),* 167-188.

Nelson, G., Aubry, T. & Hutchison, J. (2010). Housing and mental health. International Encyclopedia of Rehabilitation. Buffalo, NY: Center for International Rehabilitation Research Information and Exchange.

Office of the Auditor General Ontario. (AGO). (2016). Annual Report, 2016. Retrieved from: http://www.auditor.on.ca/en/content/annualreports/arreports/en16/2016AR_v1_en_web.pdf

Ontario Human Rights Commission. (2015). By the numbers: A statistical profile of people with mental health and addictions disabilities in Ontario. Retrieved from: http://www.ohrc.on.ca/en/numbers-statistical-profile-people-mental-health-and-addiction-disabilities-ontario

Ontario Non-Profit Housing Association. (ONPHA). (2016). 2016 Waiting lists survey report. Retrieved from: https://www.onpha.on.ca/onpha/web/Policyandresearch/2016_Waiting_List_Survey/Content/PolicyAndResearch/Waiting_Lists_2016/2016_Waiting_Lists_Survey.aspx?hkey=08cff4ce-7f97-4af4-910c-c64954d28a4a

Segal, H.D. (2016). Finding a better way: A basic income pilot project for Ontario. Retrieved from: https://files.ontario.ca/discussionpaper_nov3_english_final.pdf

Stergiopoulos V. (2014). Collaborative approaches to community-based mental health care for homeless people: Toronto's Inner City Health Associates. In: M. Guirguis-Younger, S.W. Hwang and R. McNeil (Eds.), *Homelessness & Health in Canada* (pp. 275-291). Ottawa.

The Access Point. (TAP). (2016). *The Access Point: Our Data July 2013-March 2016.* Retrieved from: http://theaccesspoint.ca/wp-content/uploads/2016/06/TAP-data-2013-2016-updated.pdf

Wellesley Institute. (2017). Supportive housing in Ontario: Estimating the need. Retrieved from: http://www.wellesleyinstitute.com/wp-content/uploads/2017/01/Supoortive-Housing-Estimating-the-Need.pdf

World Health Organization. (WHO). (2011). Mental Health Atlas, 2011. Retrieved from: http://apps.who.int/iris/bitstream/10665/44697/1/9799241564359_eng.pdf