HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

COMMUNITY SERVICES

Tuesday, January 5, 2021

Via Video Conference

Impacts of COVID-19 on the Mental Health of Vulnerable Nova Scotians Who Utilize Community Services Supports

Printed and Published by Nova Scotia Hansard Reporting Services

COMMUNITY SERVICES COMMITTEE

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[Hon. Margaret Miller was replaced by Hon. Tony Ince.]

In Attendance:

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Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Canadian Mental Health Association, Nova Scotia Division

Pamela Magee
Executive Director

Susan Henderson
Executive Director, Colchester-East Hants Branch

Beverley Cadham
Co-Director, Halifax-Dartmouth Branch

Margaret Murray
Co-Director, Halifax-Dartmouth Branch

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Senior Lead Housing Support

Sally Tucker
Employment Support Services Lead

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, JANUARY 5, 2021

STANDING COMMITTEE ON COMMUNITY SERVICES

10:19 A.M.

CHAIR
Keith Irving

VICE-CHAIR
Rafah DiCostanzo

THE CHAIR: I'd like to call the meeting of the Standing Committee on Community Services to order. My name is Keith Irving. I am the MLA for Kings South and Chair of the committee.

A reminder to all members of the committee to keep your video on at all times. That helps us ensure quorum. You can, of course, step away if need be for a moment, but then we know you're gone, and we know where we stand with respect to quorum. Keep your videos on and keep your phones off and on vibrate.

For those wishing to speak, please raise your hand. I'll be recognizing people, so you stay on mute until I recognize you. We'll proceed along that route.

I'd like to begin by asking committee members to introduce themselves. We'll begin with Ms. DiCostanzo.

[The committee members introduced themselves.]

THE CHAIR: We apologize for the delays. We dealt with some technical issues to get us online here this morning.

On today's agenda, we have officials from the Nova Scotia Division of the Canadian Mental Health Association, and they're here to discuss with us the impacts of COVID-19 on the mental health of vulnerable Nova Scotians who utilize the Department of Community Services supports. I'd like to ask the witnesses to introduce themselves.

[The witnesses introduced themselves.]

THE CHAIR: Welcome everyone, and to all our witnesses, thank you for taking time out of what I'm sure are busy schedules to join us here today. I'll now turn it over to Ms. Magee to make her presentation. Your presentation has been circulated, the PowerPoint, to all members. The floor is yours.

PAMELA MAGEE: Once again, my name is Pamela Magee and I'm the Executive Director of the Canadian Mental Health Association, Nova Scotia Division.

Isolation, social distancing, fear of uncertainty, and economic insecurity are all contributing issues to mental ill health. Dramatic societal changes have led to high degrees of intense stress, anxiety, depression, and suicidal thoughts. COVID-19 does not discriminate. It has taken a mental health toll on people around the world from all walks of life. The pandemic is widening its resistance on mental health inequities.

Many have lost access to mental health supports and services due to social and economic inequalities. As such, it's overburdening the health care system. Mental health is, and should be, a basic human right.

Over the course of those past two waves of data, CMHA has found that 38 per cent of Canadians recorded that their mental health had deteriorated since the onset of the pandemic. The data projects that the numbers will continue to rise, and it already has. Amidst the stress and duress of the pandemic, there are encouraging signs of resilience, and CMHA is here to help. We offer a wide range of programs and services that are based on resilience. Our mandate is to provide people with the tools and the supports to cope with life's challenges, whatever they may be.

Without policy-led, universal, resilience-based primary prevention and interventions to improve social conditions and safeguard mental health for all, the pandemic will have - and has had - a series of long-lasting impacts on social, emotional, mental, and physical health, and the economic well-being of the most vulnerable.

The most vulnerable are at risk of developing persistent and severe long-term mental illnesses. The time to act is now. There is a need to provide universal mental health care that stands in the continuum of care with a focus on primary prevention to ensure the

mental health and well-being of all. CMHA is well-positioned to play a key role in mental health promotion in the primary injury/disease prevention with adequate resourcing to support our work. The economic burden of mental illness in Canada is estimated pre-COVID to be $15 million per year, and the pandemic projects (inaudible).

As noted, the time to act is now. As the presentation that was circulated demonstrates - the data from the first and second wave of surveys conducted across Canada in collaboration with CMHA and the University of British Columbia - we found that 40 per cent of Canadians are saying that their mental health had deteriorated. This has gone up slightly since the first wave of data, where 38 per cent of Canadians had indicated the same. This remains true in Nova Scotia - that the percentage of individuals indicating that their mental health has been impacted is upwards of 40 per cent.

[10:30 a.m.]

Forty-eight per cent of Canadians and Nova Scotians reported that they had high levels of anxiety and worry on a daily basis as a result of COVID-19. Seventy-one per cent are worried about the impact of the virus throughout the second wave and possibly into a third as the slide demonstrates - breaks it down by degree of concern. Worry about their family members becoming ill or dying is the No. 1 reason for worry and stress, fear of contracting the virus is No. 2 - right straight down through to worry about loss of jobs and not having enough financial means to secure basic life needs such as food security.

Substance use is also on the rise as the presentation slide shows: 17 per cent of Canadians have reported an increase in their substance use as a way to cope with the virus and the sense of isolation and disconnect that it's creating to all.

Cannabis use in a Canadian perspective is up by nine per cent. In Nova Scotia, according to Nova Scotia statistics, it's up a little higher than that. We seem to be leading the country in substance use - alcohol and cannabis - right now so that is concerning given the long-term impact of substance use on mental health and well-being.

As well, we're seeing that suicide, self-harm, and family violence rates are up across the country. This remains true in Nova Scotia as well. In Wave 1, those who had thought about suicide and contemplated the thoughts thereof was around 2.5 per cent. It's up by four per cent in Wave 2. We're seeing and hearing on the ground on a daily basis, through the calls that we're receiving from those looking for supports or just wanting an ear to listen to their concerns and their challenges that they're facing daily, that they're finding it difficult to cope with.

The vulnerable and marginalized populations in our province have disproportionately been affected by COVID-19. During the first and second wave, we're seeing marked increases in some of our marginalized and vulnerable populations in the province. They're feeling very disconnected.

A lot of it has to do with their social and economic status and their inability to secure the means to stay connected either through the lack of internet or devices to reach out and stay connected during times of social isolation and/or they've lost access to primary care through the pandemic and feel very vulnerable and alone.

Parents of children under the age of 18 - and this remains true in Nova Scotia, as well - have expressed concerns about the safety of their children and themselves. They're also concerned about job loss, job security, income security, and the basic needs. It's something that most families are concerned about.

We've seen a rise in domestic violence rates across the country and this remains true also in Nova Scotia. Many Canadians are also struggling to meet their health care needs. Prior to the pandemic, there were gaps in mental health service delivery and support in a timely manner. This trend has continued throughout the pandemic.

We're hearing on a daily basis from people who are experiencing mild to moderate to severe impacts on mental health and their inability to secure treatment in a timely manner without fault or blame to the health care system. The health care system - prior to the pandemic - was ill-prepared to support the growing needs in the mental health realm and it continues to follow trend.

Many people who have the ability to access online supports feel that from the service support realm that the online support isn't giving them the care that they need. There's stress and ill health concerns expressed as a result of that.

We're hearing this trend also within those who are contemplating suicide and have lost hope. They feel that there isn't a door that they can walk through to receive timely and adequate care. They're concerned about their future well-being as a result.

Issues throughout the pandemic have been amplified for our vulnerable and marginalized populations to the degree that their health is even further marginalized because they can't have access to means of support through online and virtual supports due to economic limitations.

Food security is another issue that is impacting the marginalized population. Safe and affordable housing - although that's being worked on in the province currently, right now there's a lack of safe and affordable housing, so a strategy to support current needs is something that is needed immediately in our province, as well as outside of our province. This isn't unique to Nova Scotia; it is a universal issue that was in play prior to the pandemic, and it's just further reinforced throughout the pandemic.

Lastly, how does CMHA support communities? As noted in my introductory remarks, we support through resilience-based, strength-based community programs,

services, and supports such as food security, housing support and eviction prevention, employment support for those who are living with mental health and struggling to secure employment, to psycho-social wellness, resilience-based programs, social programs, support groups, community peer support groups, life development skills, suicide prevention support at a community level, non-clinical and community navigation, and linkage to other partners throughout our community.

Looking at the determinants of health that support mental health and well-being is the primary focus through which we deliver all our programs. We use a client-centric, person-centric, community-centric approach to meet the needs of individuals living in communities, and to engage community partners and stakeholders (inaudible) communities to support the mental health and well-being of all Nova Scotians.

At that point, I'll say thank you very much and open to questions, and sorry, this feels uncomfortable because I'm talking to a screen and can't see anybody. If I'm sounding a little off, I apologize. It's just something that right now, it's just feeling very uncomfortable talking to a screen without seeing a face.

THE CHAIR: Thank you very much, Ms. Magee. You're doing a great job, so no need to feel uncomfortable. We'll get through this like the rest of the COVID pandemic, bit by bit and support each other.

As we move to questions, perhaps, Ms. Magee, I will assume they're going to you, since I can't see you putting your hand up, and if you wish to delegate that to one of your fellow colleagues, you can do that and I will notify you if I see any of them waving their hand, wanting to take the stage away from you.

Before we get into questions, we did start late, at 10:19 a.m., so I just want to get out of the way a motion to extend to 12:19 p.m. Could I have a motion so that we get our full two hours? Ms. Coombes, thank you.

Is there any discussion? Would all those in favour of the motion please raise your hands, I guess.

The motion is carried.

We'll be going to 12:15 p.m.

We'll have a series of questions until around 12:05 p.m., and then any final wrap-up comments by Ms. Magee at that point. We'll start with at least an initial round of a question with one supplementary, depending on the timing and the list that I am keeping of people with questions. We may go to a single question without supplementaries as I try to get everyone in. I do have one committee member who has contacted me who has three questions, so hopefully we can give as much time to everyone as needed and get to

everybody's questions as best we can. The more concise the questions, the more questions we can get to.

We will begin with Ms. Coombes, then I've got Mr. Comer, Mr. Craig, Ms. DiCostanzo and Ms. Roberts on the list so far.

KENDRA COOMBES: Good morning. I'm glad to be here today to discuss the topic of the impact of COVID-19 on the mental health of vulnerable Nova Scotians who utilize the Department of Community Services.

Nova Scotia has the lowest welfare incomes in Canada for single-parent families with one child, and the second lowest for couple families with two children. Yet the Nova Scotia Government did not allow IA clients to receive both income assistance and CERB, despite the federal government urging the provinces to exempt CERB payments.

My question is: would you agree with the federal government's advice, and can you talk about the challenges that people will have in managing income clawback after receiving IA and CERB?

PAMELA MAGEE: That's a great question. I'm going to turn that question over to Susan Henderson, Laurel, Bev and Marg to respond.

SUSAN HENDERSON: You have brought up a fantastic question; we all expressed concern about that. The messages were very confusing for many of our folks at the beginning of the pandemic. It seemed like when that funding came out, yes, absolutely, do apply for it. But then we received - again, no fault or blame - conflicting messaging from the Department of Community Services regarding repayment and double payment.

We as an organization here in our area and the folks whom we support recommended immediately to all of them that they not apply for it. However, some did slip through. Of course, for people who often don't even have enough money to have a regular Tim Hortons coffee, it was very attractive - a short-term attraction - and who could blame them? I guess that's my point. We're talking about trying to meet basics of food security and basic living needs. When that money was offered, it was a very difficult decision for many of our folks, particularly with Christmas looming.

We do anticipate a number of people - and the calls are actually increasing. I know Laurel will be able to speak about this regarding the impacts on housing. Many of the folks whom we are working with are very afraid about not being able to meet their - and these are folks who are not connected to income assistance particularly, maybe they've lost their job, they're in between other issues and other pressures – who will absolutely be facing eviction if they're not able to secure money.

The other issue, too, is that when people did get cut off from income assistance, basically the approach was that you have to use up the amount of money that has been given to you. If I receive $1,000 - I know that's not the case, just for my own - I'm not very good at math these days - if I receive $1,000 a month in assistance, I would need to use up that amount when it came to the CERB before I can reapply to go on. The problem is the reapplication process can be very onerous and it often requires a doctor's note, other professional opinions in the community that they may not have access to at this point. It's extremely cumbersome and we are very concerned about that.

THE CHAIR: I believe you handed off to Ms. Taylor. Do you wish to weigh in here?

LAUREL TAYLOR: Yes, we are definitely seeing an impact amongst the individuals I'm working with every day between CERB and income assistance rates, which were historically quite low, as was pointed out by Ms. Coombes.

[10:45 a.m.]

CERB has added another wrinkle to that: the confusion around when it starts, when it ends, how much money people are going to receive. That has impact where you live and what you can afford, and the uncertainty around that. We are definitely seeing an impact around single parents that way. They're very concerned about where their next cheque may be coming from.

THE CHAIR: Is there anyone else from our witnesses who want to weigh in on this question before we go to a supplementary? We'll go to a supplementary. Ms. Coombes.

KENDRA COOMBES: I agree with you that this is causing quite a problem. What the Department of Community Services did was provide a one-time $50 payment to clients. Do you feel that this one-time $50 payment was adequate to address the people's needs?

PAMELA MAGEE: I'm going to hand this one off to Marg and Bev, please.

MARGARET MURRAY: No, I don't think that was adequate. Also just regarding the previous question - just to make a comment - this was something we were very concerned about right from the beginning. Bev can say a bit more. We do a variety of things in our branch, but our social programs are for adults aged 19 to 70, although we have many over 70.

The majority - about 75 to 80 per cent - do receive income assistance. The others, perhaps, are on CPP disability or a combination and sick leave. In many cases, people have moderate to severe mental illness, mental health problems, a past with addictions and mental illness, and are isolated. When this happened and we all had to close our doors, but

we were all still working behind the scenes - Bev and I belong to a group called the Society to End Poverty and Bev can speak to that - we advocated that people on income assistance, particularly with disabilities, should not have to face a cut-off when their CERB ended. These were individuals who perhaps worked part-time as crossing guards - a lot of people connected to us who have part-time jobs earning a certain amount of money. We had thought that we were assured that - and Bev can speak to this - that that would not happen. What we soon found out was if you're on the Disability Support Program, that was totally different.

We ended up encouraging people who were perhaps crossing guards and other types of jobs who were on the Disability Support Program not to take CERB. It was our understanding that if the person were on regular income assistance with disability, they wouldn't be cut off. I think a few people we know weren't at the end. That was just such a major concern.

Like Susan and others, we soon became aware that there were some people who thought they qualified, and they didn't. Although now there's a cap on evictions, people are worried about evictions. This relates to other issues that we deal with and it goes to your question, Ms. Coombes: was $50 adequate? It's not, and also people are facing being cut off assistance.

A lot of the people we know live with invisible disabilities or chronic illness. Some may have become disconnected from the mental health system. If anyone took the time to look at their history, they perhaps have never worked full-time - perhaps have never even contributed to CPP disability.

I think I wish - this is related to a future question, perhaps - that there was more time given to even looking at the history of the person. As Pam mentioned, people don't always receive. We know that there aren't enough resources. Not everyone receives timely care. Some people do - we know people with excellent care. Everyone's doing the best job they can, but some people have fallen through the cracks with their mental health care.

If someone looked and saw, say, that a woman had been involved with the mental health system for debilitating anxiety or something since they were pre-teen and then became disconnected from the system, and then because they're living with someone, they get disconnected off income assistance or perhaps CERB - where do people go?

Think for yourself if you've ever been in that situation where you had no income since you were an adult: have you ever been in that situation? That's a very, very scary place to be. That relates to your $50 and also people getting cut off because of CERB. We just have to be much more careful. I know people are really trying.

I think they have to have the support from people like yourselves - from the politicians - to say be very careful before you cut someone off income assistance. Don't

just look at their current situation. Look at their history. Just because they don't have a psychiatrist or someone backing up at the moment - perhaps they've tried to get that help and they couldn't.

THE CHAIR: Thank you. Just before we move on, we've been instructed by Legislative TV to not use the Raise Hand function in Zoom but to actually physically raise your hand for me. Some of you are obviously more professional at using Zoom more than others, but we're using the old-fashioned way.

I believe you were throwing it over to - now I've lost her on the screen. I'm sorry. It was to Bev. Where are you, Bev? I'm not seeing her. I'm on two screens at the moment here and I can't seem to find her. Is there anyone else who wishes to speak to the question?

PAMELA MAGEE: Susan, or Laurel or Sally, do you have anything to say in relation to the clients in the communities that you support on a daily basis in relation to the $50 surplus funds provided to all the recipients?

THE CHAIR: We'll move on then. Mr. Comer is next.

BRIAN COMER: My first question is discussing access. I guess this would be for Pamela, but any of your colleagues, feel free to jump in. Just curious as to your thoughts on the lack of access for vulnerable citizens across the province for preventive evidence-based therapy, and maybe discuss how you think stigma would play a role in this lack of access to treatment. And maybe discuss the thoughts around mental health parity in the province and how that would potentially play a role.

THE CHAIR: Ms. Magee.

PAMELA MAGEE: I think that's an excellent question, and in relation to parity, I think it really has to do with the underfunding and valuing of mental health. Mental health is a part of the Canada Health Act and has been since its inception, and it sits in parity with physical health, but has never been funded on par or treated similarly to how we support any other chronic disease known to mankind.

The access is in direct parallel and in relation to the amount of funding that's put into the system to support, and that's historical around the country. It isn't unique, once again, to Nova Scotia, but it's something that needs to be revisited.

We all have mental health - similar to the fact that we all have a state of physical health, we all have a state of mental health, and at any given time we can become ill and tip over. COVID is the catalyst that has created that tipping point where we're seeing upwards of 50 per cent of people in communities experiencing signs of stress and duress, and those who are marginalized are the most impacted by mental illness and mental ill health, because they, for the most part, live with the daily stresses and challenges, which have

impacted their mental health and well-being on a long-term basis. Not all innate disease burden, but they have never received adequate care and treatment due to the lack of funding and support programs available. In essence, that creates a polarity of disconnect across the mental health continuum, where we have haves and have-nots. But this is really a "we" issue; it isn't an "us and them" issue. As I noted, we all have mental health, and everybody deserves the right to proper care and support across their life course to ensure that they can flourish and sustain a positive state of mental health and well-being, similar to what we do in all areas of physical health.

The universalization of mental health across the continuum of care with a primary focus on preventive services, because most of the issues are preventive, but then the person is victimized and blamed for their diagnosis.

We haven't done that in the current state of health since the AIDS epidemic, where we created stigma and blamed people initially who were diagnosed with the disease, but then later when they discovered that it was an issue that would impact everybody, that stigma was removed and the doors opened up to greater funding and humane support and care to ensure that at a global level, the impact was not as broad-reaching as the data and the projections predicted.

That was a success story, so somewhere in mental health, as they noted, the time to act is now. We have the ability to prevent a lot of chronic and persistent issues, but we also have the ability to rise to the challenge to elevate the care that we're giving to those who are living with chronic and persistent mental health concerns by addressing the basic social, economic needs of individuals in Nova Scotia and beyond.

On that note, I'll stop and hand it over to Sally, Susan, Mark, Bev and Laurel. Does anybody else want to comment on this question? I realize it was multifaceted in its question, so hopefully I touched on most of the points that we were asked to address.

THE CHAIR: I'm getting nods from your colleagues, so we'll move back to Mr. Comer for his supplementary.

BRIAN COMER: Thank you, Pamela. That was an excellent answer. My second question is relatively straightforward, I guess you could say. As we sit here today, where does Nova Scotia sit in terms of the number of mental health care professionals required in the funding that they're receiving, to be where it needs to be for Nova Scotians to receive timely access to mental health care and addiction services?

PAMELA MAGEE: In relation to the numbers, I think that as many as it takes is the most appropriate answer. It shouldn't be a numbers game - it should be how are we defining timely access to care and services. Given that ill mental health is highly preventable, if we're looking at a full continuum of care and keeping people healthy, then

we need to infuse money upstream in mental health promotion and injury and disease prevention.

Right now, CMHA is taking the primary role within the province in that area. Sadly, we're underfunded and undersupported, so we need numbers of staff and we need core dedicated funding to elevate the work that we're doing to keep people healthy, because from an innate disease burden perspective in Nova Scotia, the data is showing 15 per cent of Nova Scotians are born with a discrete disease predisposition. Actually, that's three to eight per cent, and then you look at those living with issues right now. We're looking at numbers that are upwards of 15 per cent.

If we want to keep Nova Scotians healthy, we really need to work further upstream in preventing the issues before they even occur and alleviating the stress, creating the well-being and the balance in individuals, communities and provincially. On that note, I'll hand it over to Bev.

[11:00 a.m.]

THE CHAIR: Ms. Cadham, you're on mute, if you'd like to speak to the question.

BEVERLEY CADHAM: I think getting the services we need in a timely manner is critically important. There are many people in our community who fall through the cracks. They don't reach out, or they have tried to access the services that are in place in the formal system, and have not had any luck in doing so. They're put on a waiting list and as a result of that, critical issues arise. As a result of not getting the help they need in a timely manner, the chances of them reaching out again in another situation diminishes, because they are frustrated and they don't feel worthy.

If they've been denied that access the first time, that is just exacerbating the issue that they are living with poor self-esteem, angst, anxiety, depression, and addiction issues on top of all that. They feel very discouraged. They don't feel valued as humans. It doesn't matter what kind of supports we offer as parents, as community resources - we can offer those, but many of us who work in the community at the grassroots, our focus is not to provide psychological and psychiatric care. We're here to provide grassroots social support to people who potentially are falling through the cracks, and we are the place that they seek out in order to help them move through or cope with those situations.

It's not a numbers game. We have to be aware that we're underfunded not just in Nova Scotia - we're underfunded across Canada, we are probably underfunded across the world. If mental health is growing in nature, then we have to act accordingly to meet the needs of the demands of the individuals in our communities - in the provinces, at a local level, nationally, internationally - to make sure that people are getting the help when they need it and not waiting until there's a crisis.

I'm going to be very open here - I don't share this with everybody, but I think it's very important. My son was a victim of that, and I say victim because he was vulnerable. I lost him in 2017 to suicide as a result of his mental health and addictions issues. He sought out help. He thought he was put on a waiting list. When he phoned back, he hadn't even been put on the waiting list. He waited three months to hear from them. The crisis got worse and worse and worse. I supported him to the best of my ability, but he needed help beyond what I could provide.

I'm talking as a parent, as a person who works in the mental health field. I'm not a psychiatrist, I'm not a psychologist, but I work at a grassroots level helping people just get through not just each day even, but sometimes each moment - meeting them where they're at.

I really think that that is a critical component of what we should be addressing - the intervention and prevention. We have the expertise and knowledge to do that. We have the compassion and the understanding. We just have a lot of talk and less action. I think we can continue to see the numbers increase, especially during this COVID period. People are getting more ill, people who have never experienced anxiety or mental health issues are experiencing them for the first time, and we don't have the capacity to deal with those overwhelming numbers.

I agree with Pam - it's not a numbers game. It's just focusing on what are our values in life. If we value people, then we need to put in place the services that are going to help them or prevent them getting to that crisis stage.

THE CHAIR: Thank you, Ms. Cadham. On behalf of all of us on the committee, we want to express our sadness for your loss. Thank you for sharing that. It's important for us to hear these stories because it makes it very real. Thank you for taking your energies and putting them towards this important issue.

I have two colleagues who want to add to the response to the question. Ms. Murray and then I'll go to Ms. Tucker.

Ms. Murray.

MARGARET MURRAY: Thank you, Bev. It still feels just like yesterday even though it's been three years. I know how tirelessly you're working, not only your own work here with our organization but throughout the community, to create change in memory of Shaymus. We all honour that.

What Bev and Pam have said is just so true. You may already be aware of this, but if you think about prior to the pandemic, we all knew that the mental health and addictions care across this country was chronically underfunded. As Bev says, we have the knowledge and many wonderful people involved in these services.

I know locally in Nova Scotia they've tried to have the central intake line to improve things. The reality is that these services do remain chronically underfunded. It's my understanding, and you probably know this, that across the country including in Nova Scotia it's less than seven per cent of our health budget that is devoted to mental health and addictions care.

I find sometimes when we give presentations, we try to get people to guess the amount and they're absolutely shocked. You can imagine, as Pam says, if we could have more investment in prevention, as well, in the whole mental health care continuum, what a difference that would make.

I believe CMHA national, and the Canadian Alliance on Mental Illness and Mental Health, have some excellent documents - some you have - on advocating for an increase for mental health and addictions care as a percentage of the health budget of at least nine per cent. I think the World Health Organization suggests, and someone can correct me, perhaps it's 13 per cent. I think the Association of Social Workers in Nova Scotia thinks it should be 10 per cent.

You're right in that it's hard to quantify this, but when you think about that - that percentage and how that could really be transformative. Also, I know that our national organization which we support suggests that for community services, there be at least a two per cent increase in budget.

I don't like to just talk numbers, but sometimes we do have to have something that we can hold on to to make as a goal. It's always kind of difficult to find out exactly what the percentage is that's invested in this province in mental health and addictions care. I just wanted to note those numbers.

I think this pandemic has really reinforced to people how complicated that caring for people is. I have expressed this to people in NSHA and others, if someone makes that call - and I know they're trying, but sometimes that will be the only call a person makes.

We also have created a system that almost has to be triage. That's not really the fault of the people working in it. We have to have people more in the community and we have to give more resources if we really care about people. We will always be bringing that up.

PAMELA MAGEE: I just want to add to Marg's remark that the latest research is showing that if we look at a continuum of care model, the best practice from an economic return-on-investment perspective is if you're working from a preventive stance to keep people healthy and to mitigate the impact of mental health issues and concerns at an early stage and phase in the transition of the disease, that it's a positive return on investment but it takes a greater infusion of money and support at that end of the spectrum. That's hard

when we're caught in a traditional health care model that helps people after they've fallen through the cracks and after they've become ill.

We're really working in an illness model. If we shift our focus and truly look at the stepped-care model that Nova Scotia has and focus money, resources and supports at the front end, it will alleviate the need and the cost on the back end so that those who need the clinical care can get clinical care in a timely fashion, and they can receive dedicated support and care.

The countries that have transitioned to that type of model have shown that it has actually increased quality of life, enhanced mental health and well-being, and cut the cost of overall health care delivery because mental health impacts physical health and well-being as well.

THE CHAIR: I think Ms. Tucker wants to weigh in as well.

SALLY TUCKER: I just want to comment. The program I run is the At Work program, so basically I'm working with people with mental health concerns and issues on this who are trying to find employment. The question has made me think about numbers. It's hard to say because it will be results-based: is it working, are people healthier? In my program, people come to it and sometimes it's very hard to help match people with employment and help them work because their mental illness might prevent normal employment and being able to follow through on what employment entails.

If we want people to be healthy financially, mentally - right across the board - we have to have them ready for certain things like employment. All these preventive programs that can help people be more mentally well will allow them to come to my program and be able to secure employment so they don't have to be on assistance, they don't have to have the financial burden, which obviously magnifies their mental health concerns.

I think it's an interesting question to look at what would be needed in numbers. Like Pam said, if we can have people's mental concerns being addressed earlier on the front end, then they can come through the system and get jobs, which will decrease their need for supportive housing.

I find it's interesting especially right now dealing with employers, because I think the one good thing that COVID-19 has brought is more understanding. A lot of the employers I work with are more accommodating to people's mental health. They understand that everybody is stressed right now. The problem was there before. It wasn't until it was a bigger issue that affects more of us - they didn't really understand how difficult it is for people to get up and go to work every day when they have a mental illness.

I think COVID-19 has done some okay things that way because now when I deal with employers, they're more willing to accommodate people - to accommodate having

children at home so that you can't necessarily go to work. When we're all locked down, we have our kids at home, so it really affects people's ability to follow through on employment commitments. I think the prevention piece has been highlighted during COVID-19. It was always needed, but more people experienced not having employment, losing jobs. Their mental health deteriorated to the point that they felt unsafe to go to work.

I have clients who want to work, but they feel concerned - especially single parents - if my kid is sick, they can't go to school, they have to be home. If they're tested, they have to wait for the results. Employers have to understand and be accommodating to that. I think the prevention piece is crucial at all times, but right now - I have a lot of clients who, with their mental health conditions currently, really probably can't sustain employment effectively. They can't follow through.

I think the prevention piece is the most important. Until you do that, people can't follow through. You want to look on the money side. If they can be healthy enough to work, then there's less assistance required. The economics being put in the front end will pay off for everybody on a financial side and a mental health side. That's what I want to add.

THE CHAIR: We're through two questions in 40 minutes - important topic. Again, I don't want to cut people off, but we're going to have to do the best we can.

I have Mr. Craig, Ms. DiCostanzo, Ms. Roberts, Mr. Ince, Mr. Horne, Mr. Jessome, and then back to Ms. Coombes. I'll continue for a little while with question and supplementary, but if we continue to get squeezed with time, I may have to move to just a single question without a supplementary.

Mr. Craig, you're up.

STEVE CRAIG: Thank you to all of you from CMHA this morning. I'm certain that everybody on this call would be able to talk for a couple of days on this topic, and each of us in our own constituency offices and on the streets will see people who are in need and have different mental health fitness and wellness on that spectrum, as Pamela indicated earlier, and how they may be suffering.

I want to focus my question on youth in care - our child welfare system. We have people who are in temporary care, permanent care, we have adoptive families, we have foster care, we have places of safety, we have institutions, we have the Reigh Allen Centre, we have the Wood Street Centre, you have courts that are involved in a lot of these cases now. All the stakeholders, whether they be the youth or whether they be social workers, whatever, they are really struggling, I feel, under the burden of this pandemic, and the systems are being stressed. They were stressed before, and now more so.

I'd be interested in hearing from you about what your observations have been and what your take-aways are relative to children and youth in care. They would be - when you look at your stats, you can perhaps tease out some of how you might apply that to youth in care, but there's nothing specifically in your surveys that look at youth in care, and I'm very interested in knowing what your thoughts are on that.

[11:15 a.m.]

THE CHAIR: Ms. Magee.

PAMELA MAGEE: That's a great question. I'm going to turn that question over to Susan and Sally to respond to.

THE CHAIR: We'll go to Ms. Henderson.

SUSAN HENDERSON: It is a great question, and it's interesting that you bring that forward, because it often is an unseen and unobserved area. We run a youth outreach program, which is funded by the Department of Community Services, and we support between - last year it was 80 and this year it was 100 unique youth. What we've found is just exactly what you're suggesting, that it's the turmoil in families. If the foundation of a strong, supportive family is not there, if the family is not able to - I don't know, it's almost like thinking about it like a sponge - the youth has absorbed a certain amount of safety from their family of origin or the family that they reside with.

If over time the world has been kind and they've been able to kind of try things and challenge things and find out that they have confidence and that they'll be successful, reasonably so, it's a better outcome. But what we're finding is that those children who are in care and are in crisis already whose situations are in turmoil, they don't know where they may be next year, they don't know how the world is going to impact on them - we have seen greatly increased anxiety levels with these youth. More acting-out behaviours, and more of a concern around the world being sort of a place of doom and gloom and not having an optimism for the future.

Of course, this is where our concern then gets translated into suicidal thinking, attempts of suicide, which we are seeing increase in our youth that we support, in the Colchester-East Hants area at least. It's a very valid concern and one that I think we need to pay special attention to in terms of helping support those youth who may not have the foundation that many of us take for granted with a strong, supportive family.

Sally, I'll let you comment now.

SALLY TUCKER: Before coming to CMHA, I worked in child protection for almost a decade. I can't directly comment on any stats in Nova Scotia at this point of what it would be like, but from my experience working in the system, I would assume that the

pandemic has increased problems substantially. Even, for example, working in child welfare at Christmastime and summertime, those were always times when we got more calls from families. Schools are a big protective factor for children. It's a big, consistent thing for kids in care, kids still in their home that are close to potentially coming into care. When you shut down a lot of supports, as Susan had mentioned, it can only amplify their problems already there.

I know that court dates have been delayed, so there are a lot of children who are waiting longer to find out where their home is going to be, if they're going back home, if they're staying with foster families. It also prolongs any potential adoptions when you have court cases delayed because of the pandemic.

Just from my experience in the field - again, I'm not working directly in that now, so I don't directly know - I can assume that even how it was in summers and Christmases in child welfare when things are shut down, problems were always amplified at that time. I would guess that the mental health of the youth and their comfort would be in a very bad state at this time.

PAMELA MAGEE: I was just going to say there is some initial data coming out of the new Centre of Excellence on Post-Traumatic Stress Disorder (PTSD) and Related Mental Health Conditions that's demonstrating that the marginalized population, children in particular, are being impacted to a negative degree. In some ways, the stress and duress that the parents are living with on a daily basis is funnelling and filtering down and impacting children.

Also, at a systems level, the restrictions are in place. Isolation is having an impact on the family's connectivity and ability to bond and create that socially and emotionally well environment for the children that may have been in place prior to COVID-19. It's something that, at a systems level, the justice system has struggled with without fault or blame. It's part of an institutionalized structure.

It's looking at different ways of providing care that can meet the emotional needs of the communities at large - the children are at the centre of those communities.

STEVE CRAIG: My view is there's going to be a lag in what we're seeing today in youth and children who are not in care and increasing the demand to take youth and children into care in the next couple of years because of our current situation.

I just want to ask this one question to Ms. Magee. How is CMHA functioning and operating through this COVID-19 pandemic and what are your challenges that you see? You are not isolated from this, nor anybody on this call - the impact of this pandemic on all of us.

PAMELA MAGEE: Absolutely. It's something that we're all challenged with daily. The demands on our workload have quadrupled, the money coming in hasn't increased, but people are leading with heart and supporting people who they have built a bond and connection with and understand at a different level.

When you're in the field, so to speak, and working with people on a daily basis struggling to keep their head above water and just to get through a day, as Bev had indicated, you don't turn your back on them regardless of how much demand there is on you. It's similar to front-line health care workers dealing with COVID-19 right now. You don't walk away from people who are in need of care.

CMHA has very much embraced that. We've tried to be as innovative as possible to stretch our reach and create other avenues for support that are virtual. We're looking for funding wherever we can find funding - most of it seed grant funds. There is a need for greater resourcing. There's a need for greater staffing to support the growing needs. It is daily.

From a leadership perspective, most of us on this call have very, very long days. They are most times seven days a week. As I noted, if someone's in need, we try to connect, link, navigate, and support to the best of our ability. That doesn't end at 4:30 in the afternoon. That can be a 24/7 type of role.

There has been generosity in donors, but at some point you can't rely solely on donor and sponsor funding to keep your doors open and continue with demands that we're receiving at an increased level daily. It takes core dedicated funding and that goes back to - if we truly want to support - and we know we need to support the mental health needs of all, in particular our most vulnerable right now because they're at highest risk. There are many that if we can keep in a positive state of recovery and maintenance of support for their well-being, it can alleviate the demand on the health care system, but also supporting the growing demands and needs of what was formerly our healthy population, that it's now tipping over into ill health. We're seeing that increasing in women in particular and our aging men and our youth.

On a day-to-day basis, the degrees of outreach and need for support continue to grow. Every day there are new issues that are coming up that didn't exist before that need navigation, need support to get them to the right door - and even sometimes figuring out what door is the right door. It's complex. It isn't a simple issue.

It does impact all our mental health and well-being. It's something that I'm concerned about as a provincial leader, how long my team can continue to take on the demands and the roles that have been placed upon them that we won't turn away from, because there is the need, without additional support for increased staffing and dedicated support. Part of recovery, maintenance support, is continuity. And that (inaudible) perspective.

[11:30 a.m.]

We know that the data show that there is a high percentage that could start presenting the signs of PTSD because of COVID-19. That needs dedicated support, dedicated programs and services that won't be here today and gone tomorrow because we're reliant on seed funding. I think that's one of the greatest stresses that we have at CMHA: the source of funding and whether we can provide a continuity of service support to people who are in need of that support. They should receive it, just like we do for any other type of support. We shouldn't have to say to them I'm sorry, we don't have money for that program, we have to stop delivering that service or program because of inadequate funding. That's something that we're challenged with on a daily basis.

The other challenge that we're confronted with from a funding perspective is the fact that in mental health at a community level, there's an expectation that for any type of annualized funding, we have to create a new program - you have to be innovative. The term "innovation" has become a noose around the neck of the community because we have to let go sometimes of what we know works and supports people and creates that continuity of support for wellness and well-being and maintenance of some type of quality of life to try to think of something new and innovative that will only end after years' worth of funding or three months' worth of funding, depending on the criteria of the funders.

The importance in the landscape of mental health - similar to the clinical - we shouldn't have to change our practice on a monthly, daily, annual basis to receive any type of funding to support people who are in need now. We know what works. It has been proven over time. We've had 114 years of history and practice to prove what works. We don't have the dollars to collect the data sometimes that the formal system has, so then we're seen as lacking and not viable of sustained funding. But the proof is in the fact that people are continuing to come back to us and they remain healthy because they come back to our source of supports and programs as they need, when they need.

For those living with chronic and persistent issues, it's a safe and secure place where they know that they're going to receive care and support without judgment. It's a hand-up instead of a handout type of approach, where we build capacity so that a community can build capacity together to support one another so that we're healthier together. We aren't just a singular person trying to struggle within a system that is broken and isn't working right now.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: In your presentation, you said that community navigation and service support. Navigation to me has always been the biggest obstacle, especially when it comes to newcomers and finding out what's available and how they can connect. I worked as a medical interpreter for 20 years, and I thought of myself as a

navigator, but I really didn't have all the resources. I got to learn what is available through different cases.

I just want to understand, when you talk about navigation, how your system works. Who are your navigators? Are you in touch, for example, with the mental health navigators that I'm very fond of in the city? I believe they're only in the city right now as a pilot program. What does navigation mean to you, and how do you deal with newcomers?

PAMELA MAGEE: That's an excellent question. I think navigation has a broad definition, and it can fit many models and facets. From the CMHA perspective, we don't have people hired with the title of navigator; we all navigate. We learn the system through linking into communities with our partners and with our influencers across the spectrum, whether it be in workplaces, housing support, day-to-day basic needs and support. Whatever door is the right door, we try to figure out how to navigate, what types of services and supports they provide and how we can link our clients and people through their doors.

As you noted in navigating the formal system, the formal system struggles with that. I've heard at a growing level the number of clinical practitioners and care providers that say that when they need to navigate someone through - whether it be a patient through the formal system, or a family member or a friend - they find it extremely difficult, and they're part of the system. The system is so complex, there isn't a simple way to navigate.

One of the unique methodologies that CMHA uses is that community connectivity: really linking and understanding the people in your community and the types of supports and services that they offer, so that there can be a door that you link someone through. In certain areas of the province, we have worked within CMHA to network that out. I know the branch in HRM has a huge network, Colchester-East Hants does, we do in the Annapolis Valley region. It's just over time, you're building new connections and networks every day.

From a newcomer's perspective, I think there needs to be greater work and linkages within the refugee newcomer community. When we are reached from individuals within those communities, the first place we always go is to look back within the community to see what they would recommend and advise for tailored supports. Then how do we navigate to different doors based on the needs that are impacting their mental health and well-being?

I know that doesn't answer your question directly. Maybe Susan, Bev, or Marg can add something to that. It isn't a simple question. Again, it's very complex and multi-layered. There isn't a one-size approach that we would navigate. The person at the centre, and their issues, help guide and direct how we link and how we partner within our community.

THE CHAIR: I'm just seeing if anyone else wants to speak. I think Ms. Magee has covered it.

Ms. DiCostanzo, your supplementary.

RAFAH DICOSTANZO: I have a few but I'm just going to stay on the same subject. What I'm trying to say here is newcomers are not just refugees. In fact, that is a very small number compared to the number of immigrants that we're accepting now. Out of 5,000, maybe 200 or 300 are refugees but the rest are all skilled workers. They have no clue of what is available and how it's done.

Are you targeting some of your staff to become involved? Are you hiring people or recruiting people who will understand the newcomers and what they need so that at least they have access to these services that they have absolutely no clue of what is available here? The hard part is educating them and making sure when that need is there, they actually use the service.

Another one actually that I have started in my constituency is for the seniors. I have a constituency that is probably the most sought-after for seniors. I have the largest number of apartment buildings and different levels from the luxury to the lower end. I cannot believe, prior to the pandemic, when I knocked on doors, how many seniors have moved here either from rural areas or the rest of Canada.

I wanted to do something. What I noticed is how lonely our seniors are. Our seniors are so lonely and don't know the services and are trying to find them because they're new to Halifax or to the centre. I've started a committee within Clayton Park West connecting seniors. I've started trying to do it with Zoom. Unfortunately, I was hoping to have a town hall for it in May and it didn't happen.

We're doing it through Zoom and connecting people, so the community helps the community. I'm happy that I will be reaching out to you as presenters in one of those Zoom meetings that I have. I've already brought in the government's Department of Seniors to talk. We were stunned at how much is available that people don't know about.

For me, exposing what's available and how people can reach it is the hardest thing - to reach people so they know. Whether they've moved here from a different part of the province or a different part of the country, we need help to let people know what's available.

PAMELA MAGEE: I couldn't agree more with the honourable member. Both areas are areas that are needed. Do we have dedicated staffing? No. Once again, a lot of our work is tailored around the funders and what the funders are funding us to do. We try to fill the gaps.

There isn't dedicated staff who wear a hat that only supports one marginalized group over another or at-risk or at-need group, but we provide universal support.

As I indicated, one of the first steps that we take is if someone from the immigrant newcomers society or a group of immigrants reach out to us and ask for support, one of the first calls that we make would be to the Immigrant Services Assocation of Nova Scotia to understand how to work with ISANS to navigate. We try to network and work with our community partners that have an expertise in the area from a cultural perspective and understanding as well as their language, because language can be a huge barrier at times. We connect with the partner agencies and organizations that already support, and we provide the mental health guidance and support to help navigate.

There isn't a simple solution to this. This is very complex, as I had indicated, but it is a huge need and area of concern. We have two online in the province right now that are intended to be a navigation support and linkage within the province. They're doing the best that they can do with the funding that they have, but it doesn't get down into the true navigation where you're saying given the need that this person has, they should walk through this door, this door, this door and this door. The determinants of health and well-being are as complex as the issue that the person is connecting with, as well as the systems that need to be connected in. It's creating that network of support that CMHA does, so that we try to create communities of support around a person.

Right now, sadly, because of lack of funding and support, for the most part it's from people reaching to us that we're providing that support, rather than being preventive and upstream and meeting the person where they're at. A lot of that is we just don't have enough of us to meet the demand right now from a staffing perspective. We try. We'll never turn anybody away and that's why we really rely on community networking and linking. Where they're receiving their core support, we'll partner and work with them through that realm, so they have a core body of support around them.

THE CHAIR: We'll move on to Ms. Roberts.

LISA ROBERTS: I'll just briefly say that immediately before being elected, my work experience at that time was in the non-profit sector, where there was a lot of talk about navigation. There are a lot of people navigating, but often there aren't enough resources to navigate people to. There are so many conversations about what's out there, and in the end, there just isn't enough at the end of those pathways for people.

Certainly, that is especially the case when it comes to housing. I was glad to see that there is someone here - Ms. Taylor - who is focused on housing. I know that has a huge impact on people's mental health. Also, I know from conversations with both a social worker and with a psychiatrist at the Abbie J. Lane Memorial Building that for people with very acute mental health challenges, housing and lack of availability of housing is actually a huge barrier to recovery and to maintaining health.

I have some notes here from a conversation with Dr. Jason Morrison, who said that housing is the number one problem for their patients. He also told me that they hold on to people who are fine. People remain as an in-patient in an acute psychiatric health care facility because the team there knows that releasing them to homelessness is going to undo whatever progress they have made.

[11:45 a.m.]

I know that CMHA doesn't, generally speaking, work with that same population of people with acute mental health challenges that would be admitted into, for example, the Abbie Lane. Ms. Taylor, I wonder if you could share who you do work with and how you are able to support them given sometimes the lack of resources at the end of those navigation journeys.

LAUREL TAYLOR: Speaking to that, yes, we deal with many different individuals who are requiring housing. I will tell you, and I'm not saying anything shocking here, but housing was an issue before COVID-19 happened. It has been ramping up over the past at least five years that I've noticed. COVID-19 just brought it to a much bigger head.

Yes, we do deal with individuals who have a chronic and persistent mental health issue to try to find and locate housing. We have individuals with addiction issues who have a huge issue with housing. Housing most definitely is an issue and it's also an issue for everyone else, as well.

We're seeing people who may have never had a mental health issue before - some related to job loss - and they can't afford where they're living anymore, or something has happened where they're being evicted. The resources to help support them towards that does impact their mental wellness immensely.

I am concerned not just about the current situation we have right now, which is only going to get bigger as time goes on. If I have someone right now who's going to be homeless, my only option is really a shelter, which is an overnight shelter - so from 9:00 p.m. to 9:00 a.m. What do they do in the daytime? What happens with that individual in the daytime? If they're on income assistance, I can go to income assistance and say that they have a medical disability. They would be willing to put them in a motel. That's what we have.

So they're not even looking at the mental health issue, they're looking at the physical disability as an issue before someone can be placed in a motel. I am very concerned about that. People are moving across the province. I have clients who have moved outside huge areas - they've left the Valley, they've gone to Yarmouth, they've

gone to HRM, they've gone to the New Glasgow area - just to find a safe and affordable place to live.

To me, that's the rock bottom of so many mental health issues going forward. It's having a safe roof over your head and a meal you don't have to worry about finding. That is immense and it isn't just those who are chronically mentally ill that this is going to impact. It's all those other individuals who may not have thought that they might have a problem going forward, and then suddenly do.

It always amazes me, when I calculate the numbers, how many children are also impacted by homelessness in our province. The numbers almost match the adults when I add them up. This month they didn't, but they normally often do. This impacts youth who are living with families in single homes or single dads or families where there are both parents in the home.

Housing is definitely an issue. Transitional housing is an issue. Emergency housing is an issue. I deal with it every day.

MARGARET MURRAY: You may or may not know, because the branches are the grassroots of the CMHA and the majority of our programming is around social support, we support many people who live with severe and persistent mental illness, other mental health problems, and individuals who are admitted to hospital.

Certainly, we are seeing an increasing issue with housing and people who were facing eviction. What Dr. Morrison says is true. I know that they have kept people at times not just sometimes because of a lack of housing but also because of a lack of safe and secure housing. We're seeing - I hate to bring up that topic of bedbugs - that resurgence of bedbugs in a lot of places. That even, on top of a pandemic - so it's not always just getting the place to live. It's getting a safe and secure place to live, and I think there's been a lot of compassion shown by many care providers trying to help.

We often will just really work with trying to get people to make sure they're on the list for the housing authority, even though there's nothing available at that time, because if they are on income assistance, at least there's a better chance of a person getting a rent subsidy, because sometimes lately it's certainly not just being on assistance and having money. As you know, in HRM, the rents have gone up just unbelievably. There's very little that's available for less than $800 a month, and we know what people receive on income assistance.

We do work with a lot of people who are in real distress, certainly, and I just want to mention, too: we try to, as do other agencies, work with all our partners. Even with navigation, we do it off the side of our desk, because the only funding we do receive for programs is just that - some funding for programs. We raise over 40 per cent of our budget every year, and as Pam said, we could be doing so much more if we had core funding.

We're so grateful this year that we do have some grants that we've received: COVID grants, either from the United Way or through the Department of Health and Wellness, through Feed Nova Scotia even. But it's going to be sad - we've really been able to support our members - and the new United Way grants are short-term, but they even have some help in there that we have a very small fund now that we can help some of our members if they can't pay their power bill and that sort of thing. We've never had that. We'll never have it again.

We need some consistency to be able to offer what we should be able to do and to do prevention, because a lot of people walk through our doors thinking we're like CMHA Toronto branch that has 300 staff, and we have seven next year. We actually laid people off at the beginning of the pandemic and had to use a wage subsidy. Thankfully, because of some pandemic grants that are just for the short term, and donors, we were able to hire those people back and now have a few more people we're hiring.

We could be doing so much more with outreach. It's heartbreaking to see people losing their housing, or in housing where they feel so unsafe that they can't sleep at night, which exacerbates a pre-existing condition.

LISA ROBERTS: Thank you, both Ms. Taylor and Ms. Murray, for helping me get a broader sense of how you're serving people and who you're serving.

I'm going to take this opportunity to go back to something that Ms. Murray mentioned at the beginning, which was around the Employment Support & Income Assistance program and CERB. I'm wondering if this is having an impact on housing. We know that in Nova Scotia, there were a number of changes made to income assistance a couple of years ago that allowed people to hold onto more of their income when they did work part-time, even while receiving disability support, income assistance in general, and that would include - for example, you mentioned crossing guards. However, employment insurance is clawed back 100 per cent from income assistance, which I think is truly unfortunate and ought to be changed as other sorts of employment income, as well as child support, have been changed.

I'm wondering what impact that has had on your clients, and how that plays into also housing and security at this time.

PAMELA MAGEE: Laurel, I'll ask you to speak to that, and then Susan, Bev, Marg, if you have anything to add after that.

LAUREL TAYLOR: So to try to answer the question around income assistance and CERB, et cetera, it is sort of a minefield to navigate around for many individuals, let alone someone living at home with them while they're trying to navigate. We give people

very little to live on as it is. I know many of the clients that I have receive $850 a month from income assistance to live on. That includes what they have to pay for rent.

I don't necessarily see a wrinkle so far with CERB, EI, and IA in that sense, but I am concerned about the new targeted housing benefit that has come out that was changed over in October because those on income assistance are calculated at a different rate than those who receive EI or a pension, or work. I have individuals now who may have been able to access a rent supplement up to $400, who now only receive $91. I am concerned about that - the lack of that.

There very much is very tight accounting around individuals and money. If you're on income assistance, believe me, they're very aware of every dime that you receive and every dime that you're spending. It's very, very monitored that way. I am very concerned about that because not only in HRM, but the cost of rent is up everywhere in the province. It isn't just HRM - the cost and the availability of housing is also.

THE CHAIR: Does anyone else want to add? We'll move on to Mr. Ince.

HON. TONY INCE: Thank you all. This is very important. It's a great presentation. You've helped to educate me. Ms. Magee, the one question I do have - does the CMHA have the ability to collect data on African Canadian communities? In your list, you list many communities, but the African Canadian community is not on that list.

PAMELA MAGEE: When CMHA national receives some funding, the majority of the funding came from the Province of British Columbia and the government there that allowed for pan-Canadian data to be collected. There was random sampling done in Nova Scotia so that we would have an Atlantic region - a large enough population to move forward on what was happening (inaudible) uniquely to each province and share it universally that way because of confidentiality. There was a broad range and reach of diversity within the sample that was surveyed, so there were African Canadians that were part of this first wave and second wave.

At CMHA, we don't receive annualized core funding from government currently, so our ability to collect data at a meaningful level within any subset of the population right now is slim to none, but that doesn't mean that we couldn't if we had adequate funding and support and we wanted to measure the impact and the success of an approach or a comprehensive strategy. That's what it's going to take to create well individuals and communities going forward.

It's going to take a comprehensive, assertive approach that needs to be fast and monitored and tracked, and understand what's working, why it's working, how it's working, how it can be replicated, what's unique to the different subsets of the populations around our province. Mental health, similar to physical health care and support, isn't a band-aid where there's one band-aid that fits everybody. We have to treat people as

individuals, look at their individual issues that are intertwined with the determinants of health, mental health and well-being, and what's impacting a person's mental health and well-being, and what are the best supports - whether the doors and combinations of doors because it isn't a singular issue typically that a person is feeling within their life that's creating ill mental health.

To the question about the African Canadian community, sadly, we don't have data at a comprehensive, meaningful, representative level that can be shared.

From within that community, we do have a small representative sub-sampling in Wave 1 and Wave 2, but how we know that the findings are valid is we're seeing other surveys that have been conducted by national agencies, organizations, local universities, that are mirroring the same finding that we found. It isn't unique to Nova Scotia. The findings are representative across Canada. Some results were higher than others in relation to mental health and the reasons for the impact, but sadly I can't funnel it down and target it in and give unique, meaningful data in relation to the African Nova Scotian population.

[12:00 p.m.]

HON. TONY INCE: Thank you, Ms. Magee, I'm aware of that, and I'm also aware that there is a challenge gathering this data from communities, not just African Nova Scotian but right across the country with African Canadians, from having conversations with my colleagues.

That being said, let me go back and ask you this then, and again, I'm asking because this is all relatively new to me: who are your funders?

PAMELA MAGEE: Our funders vary. We don't have core, dedicated funding. We have sectors within government that we receive funding from for unique purposes and needs. The Department of Community Services provides some funding, the Department of Municipal Affairs and Housing provides some funding. This is annualized funding - it isn't core, dedicated, permanent funding. We receive funding from the Department of Health and Wellness, health authorities at a local community level as Marg had indicated.

We have our branches and division supports communities - we don't call them branches because they aren't separate from our - we fund them through the division, because there's a lack of ability at the current time for branches to sustain themselves. It's been a struggle all along. Whenever there's a grant call, CMHAs are always talking about how we can apply for funding. Most of it is seed funding. A lot of the funding that we receive can't support the hiring of staff and definitely doesn't support the day-to-day operational costs that we have to incur to keep our offices going and our staff on salary and pay insurance and so on and so forth, overheads and the leadership roles.

None of our leadership roles are core-funded through any entity. The majority of funding in CHMAs does come from generous donors and sponsors, and that varies year after year after year. There are core grants that we apply for every year. Sometimes we're successful, sometimes we aren't. That's where it leaves that instability in our program delivery, because we hope to continue with programs, but we never have that confidence in the ability to continue with a program.

A lot of times we have to - we won't necessarily stop the programming altogether, but we have to roll it back and really limit the amount of people whom we support through our programming if we don't have any funding from it, so then we lose non-dedicated donation and sponsorship funds to pay for the services, and for the most part it's staff doing it as Marg and Susan had indicated - staff working off the sides of their desks a lot of times. We all wear multiple hats. Yes, we may have a title within our entities, but we do everything from sweeping the floor to front-line support to leadership support work. It's quite variable.

From a federated perspective, we aren't core-funded by the national entity and the divisions pay national a licence fee for the ability to operationalize CMHAs in the province or territory. The divisions who are accountable and responsible for the continuity and the universality of the service program supports at a provincial level will then grant branches if they have the ability to operationalize programs and bring in their own funding. They're accountable and responsible for their own funding.

Sadly, in Nova Scotia, at one point there were 17 branches in Nova Scotia, but because of the increase in demand for supports and services at a non-clinical level over the years, we're now down to two independent branches in Halifax, Dartmouth, Colchester-East Hants and all the other catchment communities. Division core funds provide the service supports through the staffing that I hire to deliver the community-based services and programs that would be similar to what Halifax, Dartmouth and Colchester-East Hants branches are providing.

THE CHAIR: Unfortunately, we've exceeded our time for questions. My apologies to Mr. Horne and Mr. Jessome for not being able to get to you this morning, but I think there was a lot of information shared by our five witnesses here and hopefully, they touched upon some of the subjects that you were hoping to inquire about. I'd like to turn it over to Ms. Magee for some closing comments for three or four minutes.

PAMELA MAGEE: I'd like to reiterate the fact that the time to act is now. We can't wait for Nova Scotians to become ill as a result of the trauma impact of the pandemic. The literature and the historical data shows that if we don't get out in front of the trauma and the impact that COVID-19 is creating on all areas of health and well-being, from a mental health perspective our system is struggling now to stay intact from a clinical support level - not to say that they aren't doing great front-line work and support. They are,

but there are only so many people that they can provide and so much money that can be put into a formal illness system.

We really need to revisit the way that we have medicalized mental health and created it as a medicalized - almost criminalized - issue to the point that we have polarized it and created great stigma around it. Really it isn't an us-and-them issue - it's a "we" issue. We need to get out in front of the issue now to make sure that Nova Scotians are healthy because we won't be able to afford to support the level of ill health that we will see coming down the road as a result of this pandemic.

There is historical data to prove that it isn't "if" it will happen - it will happen. Repeated long-term trauma does have an impact at a population level on the health and well-being of all citizens. Our marginalized populations are going to be impacted at a level that we won't be able to support, but we have an opportunity to get out in front of this now.

I really urge and encourage current government leaders to consider that, and CMHA is well placed to play a role from an upstream perspective. We just need core funding and to hire staff and provide that universal support across the province for all Nova Scotians. That role in turns helps with our marginalized individuals as well, because as Sally had indicated and others, people are understanding now that mental health is an issue that impacts everybody, and the stigma has lessened as a result of COVID.

We have the opportunity to keep people healthy who are living with chronic and persistent issues and to keep those who are healthy at a healthier end of the spectrum, and those who are struggling, bring them back into full health before the financial burden becomes too great and it collapses everything at a systems level, because financially we won't be able to support a province and people within the province if everybody is unwell.

BEVERLEY CADHAM: Can I just say one thing? I appreciate all that Pam said. I just want to end on a note that one life lost by mental health or an addiction or concurrent disorder is one life too many. So (inaudible) community and the people who live in it, let's show that. Each individual has something unique to offer in their lifetime. Let's hope that it's a long lifetime. I just wanted to end on that note.

THE CHAIR: Thank you very much, Ms. Cadham; I think that's an important note to finish off with. I'd like to thank Ms. Magee, Ms. Henderson, Ms. Cadham, Ms. Murray, Ms. Taylor, and Ms. Tucker for joining us here today. This has been a very important discussion, and I know on behalf of all my colleagues, we really appreciate your wisdom and insights from being there working so hard on the front lines. You clearly all have deep caring and compassion for the clients that you serve and for this issue, so again I want to thank you and appreciate your advice.

As MLAs we do see this in our offices many days of the year, and CMHA is a partner in us helping to provide folks with supports, and so you're key to that, and again thank you.

You may now leave the meeting. We've got a couple of quick little items of business to wrap up. Hopefully, 2021 will be a better year for us all, and again, thanks for all your work.

PAMELA MAGEE: Thank you very much for inviting us. We really appreciate the opportunity that you have provided to us today. I wish you all well and continued health and well-being.

THE CHAIR: In terms of committee business, folks, just want to note for the record that members were polled and agreed to continue with the committee's agenda business as previously set, so that is now in Hansard.

We've got our next meeting on February 2nd at 10:00 a.m., and the topic is phasing out adult residential centre and regional rehabilitation centre facilities with witnesses Tracey Taweel and Maria Medioli from the Department of Community Services, Joyce d'Entremont from the Mountains & Meadows Care Group in Harbourside Lodge, and Wendy Lill from the Community Homes Action Group.

If there's no other business, I will adjourn the meeting. Thank you all and enjoy the rest of your day.

[The committee adjourned at 12:14 p.m.]