

Submission to the Ontario Human Rights Commission

Consultation on poverty and systemic discrimination in the areas of accessible, adequate and affordable housing, and mental health and addiction disabilities

September 30, 2022

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health teaching hospital and one of the world's leading research centres in its field. Every day our clinicians work with patients on their mental health recovery. And every day, a significant number of those patients struggle with that recovery due to poor social determinants of health. They are part of the 20% of Ontarians with disabilities who live in poverty¹- a group that is over-represented by people living with mental health and addiction disabilities. People with mental health and addiction disabilities 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

In the supporting documents for this consultation, the Ontario Human Rights Commission notes that 'freedom from poverty' is one of several human rights that Canada and its provinces/territories are obligated to uphold under international treaty obligations. Despite this responsibility, people with mental health and addiction disabilities living in Ontario experience systemic and direct discrimination in housing and health care that contributes to chronic poverty. Discrimination and its ramifications are felt even more acutely by the growing number of people with mental health and addiction disabilities who also have a history of involvement in the criminal justice system.³ For that reason, where relevant, this submission highlights the intersection of mental health and addiction disabilities and criminal justice involvement.

The relationship between poverty and systemic discrimination at the intersection of housing and mental health and addiction disabilities, compounded by criminal justice system involvement, is complex and multilayered. Just as systemic discrimination in housing and health care contributes to the poverty experienced by people with mental health and addiction disabilities involved in the criminal justice system, systemic discrimination and poverty create and sustain the conditions for mental health and addiction disabilities and criminal justice involvement.⁴ Racism, colonialism, trauma and substance use are also closely intertwined. While a myriad of responses are needed to address this complex web of social and health concerns, efforts to address systemic discrimination in housing and health care are a crucial step - not only for alleviating poverty, but also for mental health promotion and illness prevention.

A word on social assistance

It is impossible to look at poverty and systemic discrimination experienced by people with mental health and addiction disabilities without also addressing social assistance, and specifically the Ontario Disability Support Program (ODSP). Because of the complexity and episodic nature of mental health and addiction disabilities, many people who experience more serious forms of mental illness have difficulty finding and maintaining employment and therefore rely on ODSP for income and benefits. Mental health and addiction disabilities are the most prevalent primary disability amongst ODSP recipients and account for 39% of ODSP cases.⁵ While the Ontario government is legally obliged to provide social assistance to those on low incomes, subject to certain limitations of the legislation,⁶ the amount provided through ODSP does not protect people from sinking into deep poverty. ODSP rates have been insufficient for decades, with recipients with mental health and addiction disabilities and other disabilities forced to live at 43% below the poverty line.⁷ This is compounded by a

punitive 50% claw-back of earned income above \$200 that discourages people from seeking employment.⁸ The government's recent announcement that it will raise ODSP rates by 5% and adjust future rates to inflation⁹ is insufficient. ODSP recipients will remain in deep poverty, unable to afford food, housing and other necessities of life and may need to pan handle or participate in other such activities just to get by. This poverty has further, negative impacts on their mental health.¹⁰

Therefore, to truly ensure that people with mental health and addiction disabilities have freedom from poverty, the government must rectify social assistance policies and practices that do not provide people with mental health and addiction disabilities and other disabilities an adequate income to obtain the necessities of life. Anti-poverty groups have called for an immediate increase in ODSP rates to \$2000 per month, indexed to inflation, as the rate for single adults without children, as well as amendments to reduce punitive income claw-backs and increased exemptions on earned income.¹¹ Implementing a universal basic income would also lift people out of poverty and improve mental health.¹²

Housing

Central to freedom from poverty is accessible, adequate and affordable housing. Housing is recognized as a fundamental human right under the Universal Declaration of Human Rights¹³ and Canada's National Housing Strategy (NHS) commits to progressive implementation of the right of every Canadian to access adequate housing. Housing is also a key social determinant of health. Safe, affordable and good quality housing is imperative for good physical and mental health¹⁴ and is a significant component of recovery and wellbeing for people with mental health and addiction disabilities.¹⁵ Affordable and supportive housing benefits communities and contributes to long-term cost savings for governments.¹⁶ Despite Canada's obligation to uphold the right to housing under international treaties, and the obvious personal and societal benefits of adequate housing, there is a critical lack of affordable and supportive housing in Ontario.

The most recent review of affordable housing wait list data in Ontario found that there were 186,000 households, representing 481,000 people, waiting for affordable housing in the province. Wait times ranged from almost 2 years to over 9 years depending on the region of the province, and only about 5% of people were housed each year.¹⁷ In Toronto, over a two-year period, 4,000 new people with mental health and addiction disabilities applied for supportive housing, but only 600 were housed during that time.¹⁸ Almost 60% of people waited 2 or more years for housing and 10% waited 4.5 years or more.¹⁹ More recent data indicate that people with serious mental health and addiction disabilities and complex needs who need 24-hour high support housing can wait up to 5 years,²⁰ while those requiring an independent self-contained apartment can wait up to 7 years.²¹

Poor access to affordable housing negatively impacts mental health²² and can trap people in a cycle of poverty and criminal justice involvement. The critical shortage of affordable and supportive housing is felt most acutely by people with mental health and addiction disabilities as they are more susceptible to housing instability and homelessness.²³ People with mental health and addiction disabilities who are homeless are then more likely to become involved in the criminal justice system due to higher rates of police interaction, arrest and custody.²⁴ And once involved in the criminal justice system, people with mental health and addiction disabilities are at greater risk of homelessness upon discharge.²⁵

There are many explanations for the critical gap between need and availability of affordable and supportive housing. At the core, however, is mental health-related stigma and discrimination whereby affordable and supportive housing for people with mental health and addiction disabilities is not a priority for governments and

is feared by communities. Intersectional discrimination makes affordable and supportive housing even more inaccessible to those with multiple marginalized identities.²⁶

Policy and practice

While governments at all levels have committed to resourcing affordable and supportive housing to some degree, funding specifically for people with mental health and addiction disabilities to access affordable housing that meets their needs has been minimal. The NHS identifies vulnerable populations as a priority,²⁷ but does not earmark funding for mental health supportive housing,²⁸ meaning that appropriate housing for many people with mental health and addiction disabilities is not available through NHS initiatives. The federal Rapid Housing Initiative showed promise by pledging to quickly develop 4,500 units of affordable housing in response to the homelessness crisis perpetuated by the COVID-19 pandemic.²⁹ However, there were insufficient resources to provide those with mental health and addiction disabilities the supports they needed to successfully transition from homelessness to housing.³⁰ At the provincial level, the Community Housing Renewal Strategy,³¹ the Social Services Relief Fund³² and the Roadmap to Wellness³³ commit on paper to investing in affordable and supportive housing, but funding is far from sufficient to create the 30,000 units of mental health supportive housing that are needed across the province.³⁴

Even when affordable and supportive housing projects have sufficient funding to move forward, pervasive mental health stigma and discrimination can lead to neighbourhood opposition,³⁵ and government-cancelled projects.³⁶ While ‘NIMBY-ism’ towards people with mental health and addiction disabilities is discriminatory under the Ontario Human Rights Code (OHRC), ‘NIMBY-ism’ towards those experiencing poverty and homelessness is not. Therefore, neighbourhood opposition to affordable and supportive housing for people who are experiencing homelessness – many of whom experience mental health and addiction disabilities – is not technically in violation of the OHRC. However, in practice, it indirectly violates people with mental health and addictions’ right to be free from discrimination in housing³⁷ and their right to adequate housing more broadly.

In addition to discrimination perpetuated by government housing policy and community opposition, individuals with mental health and addiction disabilities, who are over-represented in the criminal justice system, can experience direct discrimination when trying to access the limited affordable and supportive housing that is available. Police record checks are used in the private rental market, as well as the affordable housing and supportive housing sectors, to screen out applicants who have been involved in the criminal justice system.³⁸ While ‘record of offences’ is not currently a prohibited ground of discrimination in housing,³⁹ the link between mental health and addiction disabilities and criminal justice involvement means that police record checks indirectly violate people with mental health and addiction disabilities’ rights to housing.

Similar, but more targeted ‘checks’ are often completed on outpatients in the forensic mental health system. While these individuals have been deemed Not Criminally Responsible (NCR) and do not have a criminal record per se, the behavior that initially led to their involvement in the criminal justice system is made public through Ontario Review Board hearings. CAMH clinicians have experienced affordable and supportive housing landlords using this information to refuse forensic patients the housing that they need to transition from hospital back into the community.

Intersectional discrimination

People with mental health and addiction disabilities who have multiple marginalized identities face additional discrimination that violates their right to housing and freedom from poverty under international treaty obligations. Indigenous, Black, racialized and 2SLGBTQ+ peoples are impacted by colonialism, racism and violence when seeking affordable and supportive housing.⁴⁰ While data is limited, there is evidence from

Toronto that indicates that Indigenous, Black and racialized people are significantly over-represented amongst those experiencing homelessness in Toronto, but under-represented in supportive housing in the city.⁴¹ Further, Indigenous and Black people with mental health and addiction disabilities are more likely to experience violence at the hands of police,⁴² making the consequences of housing discrimination (i.e. homelessness) even more perilous for these individuals. Widespread discrimination and violence also make it difficult for 2SLGBTQ+ individuals to access affordable and supportive housing as evidenced by their overrepresentation among those at risk of, or experiencing, homelessness.⁴³

Addressing discrimination in housing

To address systemic and intersectional discrimination in housing and begin to break down the cycle of poverty experienced by many people with mental health and addiction disabilities, several actions will be required. Most urgently, governments at all levels need to explicitly make affordable and supportive mental health housing a policy priority accompanied by sufficient, earmarked funding. Changes to laws, policies and practices to effectively combat NIMBY-ism and other housing-related discrimination that impacts people with mental health and addiction disabilities is also needed. Adding 'social condition' as a protected ground under the OHRC would offer a safeguard for people experiencing poverty and homelessness against discrimination in housing and ensure that neighbourhood and government opposition do not impact the development of affordable and supportive housing. Also required is an examination of if/how the protected ground related to criminal records adequately protects individuals with mental health and addictions disabilities, specifically in relation to police record checks and housing.

Further measures to address intersectional discrimination in housing should include a requirement that affordable and supportive housing providers explicitly commit to anti-racism and anti-oppression principles and ensure safe and welcoming environments for all tenants.

Health and Health Care

Freedom from poverty and the right to housing are also connected to the right to health. The International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the interdependence of all human rights,⁴⁴ and that is evidenced in the complex interplay between poverty, housing and mental health. The right to health and to timely, appropriate and affordable physical and mental health care is recognized as a fundamental human right that applies to all states.⁴⁵ While the right to health care is not explicitly contained in the Canadian Charter of Rights and Freedoms, the Canada Health Act commits to providing Canadians with reasonable access 'quality health care without financial or other barriers'.⁴⁶ Despite this commitment, many people across the country do not have meaningful access to mental health care, which contributes to poverty, homelessness and criminal justice involvement. Systemic discrimination in health care, whereby mental health care is under-resourced in the community and correctional system, plays a key role. As does allocation of resources within the mental health system itself.

Mental health funding

Mental health care has historically been the poor cousin of health care. Governments at all levels have not treated mental health as a priority or afforded it the same importance as physical health, and this reflected in the meagre proportion of health care dollars allocated to mental health care across the country. Canada spends less than 10% of its overall health care budgets on mental health, which is below that of peer nations.⁴⁷ In Ontario, mental illness accounts for about 10% of the burden of disease,⁴⁸ but receives only about 7% of health care dollars.⁴⁹ This means that relative to burden, mental health care in Ontario is underfunded by about \$1.5 billion. While recent investments have narrowed the funding gap⁵⁰ they have not been sufficient to meet the

need, and demand for mental health care continues to increase along with wait times for services.⁵¹ Moreover, life-saving mental health treatments such as structured psychotherapies – which are an effective treatment for anxiety and depression – are not universally covered by OHIP if delivered outside of hospital settings.

Inadequately publicly funded mental health care does not affect everyone’s right to health care equally. Those with financial means can pay out of pocket for mental health services and those with workplace insurance or other private health care coverage can access psychotherapies and medications. It is people who are living in poverty – people that are already susceptible to poor mental health – that are disproportionately impacted by underfunding in publicly funded mental health care and have more difficulty accessing services as a result.⁵² Without access to mental health care and supports, people experience deteriorating mental health, which for those already living in poverty, can lead to homelessness and/or involvement in the criminal justice system.⁵³ This is of particular concern for people with serious mental health and addiction disabilities who have other risk factors for criminal justice involvement. Without access to targeted mental health care interventions, these individuals may commit crimes or behave in ways that draw police attention to their unusual behaviours.⁵⁴

Mental health care in corrections

If people with mental health and addiction disabilities end up in jail they become reliant on mental health care provided in correctional facilities, which is even more inadequate than what is provided in the community.⁵⁵ The UN Standard Minimum Rules for the Treatment of Prisoners (the ‘Mandela Rules’) are a set of international rules for protecting the fundamental human rights of the incarcerated. The Mandela Rules state that prisoners should have access to the same standard of physical and mental health care that is available in the community.⁵⁶ In Canada, the *Corrections and Conditional Release Act, 1992* outlines the obligations of the federal corrections system to provide essential health care to offenders⁵⁷ and the *Ministry of Correctional Services Act, 1990* outlines the health care duties of the provincial corrections system.⁵⁸ Despite these obligations, many people with mental health and addiction disabilities in both the federal and provincial corrections systems do not have access to timely and effective mental health care.⁵⁹ Inadequate resources, supports and infrastructure allocated for mental health care in correctional facilities violates the Mandela Rules, contributes to worsening symptoms of mental illness and increases risk of homelessness upon discharge.⁶⁰ This is compounded by inadequate and inaccessible community mental health care as well as direct discrimination from some community mental health service providers who are known to have ‘unwritten’ policies which bar people from accessing mental health supports due to their criminal justice history.⁶¹ And without mental health supports, people with mental health and addiction disabilities with histories of homelessness and criminal justice involvement are more likely to be turned down from supportive housing.⁶²

High intensity mental health care

People with serious mental health and addiction disabilities, including those involved in the criminal justice system, often need high intensity supports to live successfully in the community, but these supports are not readily available to them. At CAMH, for example, we have a population of Alternate Level of Care (ALC) patients who, in addition to serious mental health and addiction disabilities, typically have cognitive disabilities, medical issues, and/or complex behavioral challenges. Many of them have been involved in the criminal justice system or forensic mental health system. These individuals, as well as others with serious mental health and addiction disabilities, can face wait times of up to 5 years for housing with high intensity supports in Toronto.⁶³ That is because there are only 375 units that offer high intensity supports⁶⁴ out of the approximately 5000 supportive housing units in the city.⁶⁵ Further, wait times for an Assertive Community Treatment Team (ACTT) are usually more than 1 year in Toronto⁶⁶ (across the province the average wait time for ACTT is 128 days, with 22% of teams reporting wait times over 6 months and 11% reporting wait times of over 1 year).⁶⁷ Without access to high intensity housing and supports, people with serious mental health and addiction disabilities become/remain homeless, involved in the corrections systems, or stuck in hospital.⁶⁸

High intensity housing and case management services are costly and within already tight mental health budgets priority is often given to lower support services that reach more individuals. Therefore, policy decisions made in both health care and mental health care violate Canada's obligation to uphold the right to health care, housing and freedom from poverty for people with mental health and addiction disabilities, particularly those with the most serious conditions.

Addressing discrimination in health care

While not a panacea, addressing systemic discrimination in health care can help breakdown the cycle of poverty, homelessness and criminal justice involvement experienced by people with mental health and addiction disabilities. To do so, the federal and provincial governments need to significantly increase the proportion of health care dollars allocated to mental health care, and within the mental health system, high intensity services must be adequately resourced to meet the need. An examination of if/how the protected ground related to criminal records adequately protects individuals with histories of criminal justice involvement from discrimination in mental health care is needed. In addition, health care practices within the corrections system must comply with the Mandela Rules and prisoners readily able to access effective mental health care.

In conclusion, many strategies are needed to ensure freedom from poverty for people with mental health and addiction disabilities, particularly for those with histories of criminal justice involvement. Central for achieving this goal is addressing systemic and intersectional discrimination in housing and health care policy and practice. Governments must prioritize and commit to sufficiently funding affordable and supportive housing. They must recognize the crucial importance of mental health care and ensure that it receives health care dollars proportional to the burden of mental illness. Prisons and jails must comply with the Mandela Rules on health care. In addition, the OHRC should be amended to add 'social condition' as a protected ground, and be reviewed as it relates to criminal record checks. Finally, while all of these actions are important, most crucial for ensuring freedom from poverty for people with mental health and addiction disabilities is access to a stable, adequate income.

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