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Submission to the Federal Housing Advocate: Housing Rights, Severe Mental Illness, and the Need for High-Support Community Housing in Canada

Submitted to: Canadian Human Rights Commission Office of the Federal Housing Advocate

With perspectives advanced by families and caregivers from the Family Alliance on Severe Mental Illness ("FASMI")

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Introduction

This submission asks the Federal Housing Advocate to examine whether Canada's current housing rights framework, federal housing investments, and major publicly supported housing developments adequately address the needs of people living with **severe mental illness and co-occurring disorders who require sustained community supports.**

For many people with severe and persistent psychiatric disabilities, adequate housing cannot be understood solely as access to an affordable unit. Housing must be appropriate to disability-related needs and, where necessary, integrated with clinical follow-up, psychosocial supports, crisis response, medication support, intensive case management, supervised or intermediate housing resources, and long-term community-based care.

Without these supports, people living with severe mental illness remain at elevated risk of homelessness, eviction, repeated hospitalization, institutional cycling, criminalization, victimization, and family breakdown. A rights-based approach to housing must therefore assess not only how many units are created, but whether people with the greatest support needs can meaningfully access, maintain, and benefit from housing in the community.

In Canada, mental illness and addiction are widespread, but the greatest burden is concentrated among individuals living with severe mental illness (SMI)—including schizophrenia, bipolar disorder, and severe major depression—and co-occurring substance use disorders. The Canadian Institute for Health Information reports that approximately 1 in 5 Canadians experience a mental health or substance use issue each year, while 1 in 3 will experience a mental illness **during their lifetime**. Statistics Canada found that in 2022, more than **5 million Canadians met diagnostic criteria for a mood, anxiety, or substance use disorder**, including bipolar disorder, and one-third reported unmet or partially met mental health care needs. Individuals with severe mental illness are disproportionately affected by addiction; the Centre for Addiction and Mental Health (CAMH) reports that **at least 20% of people with a mental illness have a co-occurring substance use disorder**, while among people with **schizophrenia the prevalence may reach 50%**. Among people experiencing homelessness, the overlap is even more pronounced: federal homelessness data show that **60% report mental health issues and 61% report substance use issues**, with many experiencing both conditions simultaneously. Research examining homeless populations in Canada has found extremely high lifetime rates of

psychiatric disorders, with substance use disorder being the most common diagnosis, followed by major depression, schizophrenia, and bipolar disorder. These findings demonstrate that severe mental illness, addiction, and homelessness are deeply interconnected and should be addressed through integrated treatment, supportive housing, and long-term community-based care rather than as separate social and health issues.

While the **National Housing Strategy Act** recognizes housing as a fundamental human right and identifies vulnerable populations as priorities, there remains a substantial gap between the policy language of inclusion and the lived reality of many individuals living with severe psychotic disorders and chronic psychiatric disabilities. Across Canada, people living with psychosis-spectrum disorders and other severe mental illnesses continue to experience homelessness, repeated hospitalization, incarceration, victimization, untreated illness, family breakdown, and chronic instability due to insufficient access to adapted housing and coordinated services.

Families and caregivers represented through organizations such as FASMI have repeatedly raised concerns that public systems increasingly discharge highly vulnerable individuals into communities without ensuring adequate continuity of care, supportive housing capacity, or long-term clinical follow-up and services. In practice, many families become the default safety net for individuals who cannot realistically maintain independent tenancy without substantial support.

Human Rights and Substantive Equality

The housing crisis affecting people with severe mental illness is not simply an issue of affordability. It is fundamentally **a human rights and disability accommodation issue.**

The **National Housing Strategy Act** refers broadly to ***"vulnerable populations"*** and includes persons with disabilities, including those related to mental health and addiction. However, the framework does not adequately distinguish between individuals with moderate support needs and those living with severe and persistent psychiatric disabilities associated with profound

functional impairment, repeated psychosis, cognitive decline, anosognosia, or recurrent hospitalization.

A purely generalized or market-based housing approach risks excluding individuals with health needs and disabilities while technically satisfying affordability objectives. Equal treatment does not necessarily produce substantive equality. Individuals living with severe mental illness often require:

- supportive and supervised housing; •intermediate housing resources; • assertive community treatment; • intensive case management; • psychiatric follow-up; • medication support where clinically appropriate; • crisis stabilization; • peer and family support; •long-term wraparound services including employment programs integrated directly into housing environments.

Without these supports, many individuals experience eviction, deterioration, criminalization, repeated hospitalization, homelessness, or premature mortality.

Human Rights, Disability Rights and Canada's Legal Obligations

The concerns raised in this submission engage not only housing policy considerations but also Canada's domestic and international **human rights obligations toward persons living with disabilities, including severe mental illness.**

The National Housing Strategy Act recognizes that the right to adequate housing is a fundamental human right and commits the Government of Canada to the progressive realization of that right. The Act further acknowledges that vulnerable populations face systemic barriers to housing and that housing policy must be developed through a human rights-based approach.

However, for individuals living with severe and persistent mental illness, the right to housing cannot be understood solely as access to a physical dwelling. Meaningful realization of housing rights requires access to housing that is appropriate to an individual's disability-related needs and accompanied by the

supports necessary to sustain tenancy, health, safety, and community inclusion.

Canada's obligations are further reinforced by the Canadian Charter of Rights and Freedoms, particularly:

Section 7, which guarantees the rights to life, liberty, and security of the person; **Section 15**, which guarantees equality before and under the law and protection against discrimination **on the basis of disability**.

For many individuals living with severe psychotic disorders, repeated homelessness, institutional cycling, incarceration, and the absence of appropriate housing supports raise important questions regarding substantive equality and equal access to fundamental rights. Formal equality alone is insufficient where disability-related barriers prevent individuals from benefiting from housing programs on an equal basis with others.

Canada is also a signatory to the **United Nations Convention on the Rights of Persons with Disabilities (CRPD),** which recognizes the rights of persons with disabilities to live independently and be included in the community. **Article 19** of the Convention requires States Parties to ensure that persons with disabilities have access to a range of community supports necessary to prevent isolation, segregation, institutionalization, and exclusion. Without accessible supportive housing, individuals with severe mental illness are unable to fully realize their rights under Articles 19 (Living Independently in the Community), Article 25 (Health), Article 26 (Habilitation and Rehabilitation) and Article 28 (Adequate Standard of Living and Social Protection) of the CRPD.

Canada's obligations under the CRPD require the development of accessible, affordable, and community-based housing that enables persons with disabilities to live independently and participate fully in society. The National Housing Strategy and the National Housing Strategy Act provide an important domestic framework for advancing these obligations by recognizing the right to adequate housing and requiring a human rights-based approach to housing policy. However, the effectiveness of the Strategy must be assessed against CRPD standards, including accessibility, independent living, non-discrimination, and meaningful participation of persons with disabilities in housing decisions.

The Convention does not **merely** establish a right to housing; it establishes a right to the **supports** necessary to make community living possible. For individuals living with severe mental illness, this includes access to supportive housing, intermediate resources, psychiatric services, crisis intervention, rehabilitation services, and long-term community supports.

Failure to provide these accommodations may undermine the substantive equality protections contemplated by both the Charter and international human rights law.

The Rise of Community Treatment Orders and Systemic Gaps

The growing reliance across provinces on community treatment orders and related legal mechanisms reflects broader systemic failures in supportive housing and continuity of care.

Treatment orders are increasingly used to monitor individuals considered at high risk of psychiatric decompensation in the community. Their growing prevalence demonstrates that many individuals are being discharged into environments lacking sufficient supportive housing, intermediate resources, and integrated psychiatric services capable of sustaining long-term stability.

Families frequently observe that legal supervision mechanisms are expanding while investments in deeply supportive housing remain insufficient. In many cases, individuals are expected to function independently in housing environments that are not adapted to the realities of severe psychotic illness, despite documented histories of repeated crises, hospitalizations, homelessness, or contact with the justice system.

This creates a revolving-door dynamic between hospitals, shelters, correctional systems, emergency departments, temporary housing, and family homes.

The increasing use of treatment orders should therefore not be viewed solely as a legal or medical phenomenon, but also as evidence of structural deficiencies in Canada's housing and mental health systems.

The Federal Housing Advocate should recognize that individuals living with severe mental illness, including those subject to Superior Court treatment orders or Review Board dispositions, are especially entitled to the full protection and equal benefit of the human rights recognized under the National Housing Strategy Act, the Canadian Charter of Rights and Freedoms, the Canadian Human Rights Act, and Canada's international human rights obligations, including the Convention on the Rights of Persons with Disabilities. Courts, Review Boards, governments, and housing providers are bound by these legal and constitutional obligations and cannot disregard the rights to adequate housing, equality, dignity, and non-discrimination on the basis of mental disability. Increasingly, however, courts and forensic mental health systems have become the de facto mechanism for managing individuals with severe mental illness due to the chronic absence of adequate housing, community supports, and mental health services. While treatment orders and Review Board oversight may regulate certain aspects of an individual's liberty, they do not relieve governments of their responsibility to ensure access to rights-based housing and support services. Courts and Review Boards are not service providers and cannot substitute for the housing, health, and social supports necessary for community integration and recovery. Reliance on judicial, forensic, policing, and emergency systems to address unmet housing and support needs risks perpetuating institutionalization, homelessness, and systemic discrimination. As recognized by the Office of the Federal Housing Advocate in its 2024 Review into Encampments, Unsheltered Homelessness and the Human Right to Housing, governments cannot rely on emergency, policing, or enforcement systems as substitutes for rights-based housing solutions. Any housing-related decision affecting individuals with severe mental illness must therefore be consistent with Canada's human rights commitments and the principle that adequate housing is a fundamental human right for all persons, regardless of mental health status or involvement with the forensic mental health system.

Concerns Regarding the National Housing Strategy

The National Housing Strategy repeatedly emphasizes affordability, inclusion, mixed communities, and Housing First approaches. While these

models have demonstrated positive outcomes for many populations, they do not adequately address the needs of all individuals living with severe mental illness.

Individuals with severe psychotic disorders, major functional impairments, concurrent disorders, or forensic psychiatric histories may require highly adapted and permanent supportive environments that cannot be replaced by standard affordable housing models alone.

Despite extensive public investment through the National Housing Strategy framework, there remains:

• no enforceable national standard for supportive psychiatric housing capacity; • no minimum targets for high-needs psychiatric populations; • no obligation to earmark federal funding for deeply supportive mental health housing; • no integrated national strategy linking housing infrastructure with psychiatric continuity of care. As a result, people with severe mental illness risk becoming statistically absorbed into broad "vulnerable population" categories while remaining largely excluded from practical implementation.

Montreal, Quebec: Namur–Hippodrome Redevelopment

The Namur–Hippodrome redevelopment project in Montréal Quebec illustrates these concerns.

The project has been promoted as a large-scale inclusive and affordable housing initiative aligned with broader federal and provincial housing objectives and significant funds directed towards this project. Public authorities envision approximately 20,000 housing units, with substantial portions described as affordable or off-market housing.

In Quebec, existing data further demonstrates the significant gap between current housing infrastructure and the needs of individuals requiring intermediate and supportive living environments. According to the October 2024 dashboard of the Association des ressources intermédiaires d'hébergement du Québec, nearly 4,937 people across Québec were waiting for placement in an intermediate resource ("ressource intermédiaire" or RI), reflecting substantial unmet demand for supervised and adapted housing linked to healthcare and psychosocial support needs. Particularly concerning

is the situation in Montréal's western sectors: the Sante QC de l'Ouest-de-l'Île-de-Montréal reported approximately 353 individuals on waiting lists for RI placement, while the Sante QC du Centre-Ouest-de-l'Île-de-Montréal reported approximately 154 individuals waiting, representing more than 500 people combined awaiting access to intermediate housing resources. Importantly, these figures do not include individuals captured through homelessness "dénombrement" counts or other vulnerable persons living in precarious, hidden, temporary, or unstable conditions across the territory. The actual level of unmet need is therefore likely substantially higher. These numbers strongly suggest that current supportive and intermediate housing capacity remains insufficient relative to the complexity and scale of psychiatric, cognitive, and functional support needs present within the community. Against this backdrop, the allocation of only approximately **70 units with "specific needs"** designation in the first 2,500-unit phase of the Namur–Hippodrome redevelopment raises important concerns regarding whether publicly funded housing initiatives are proportionately addressing the realities of individuals requiring intensive supports and wraparound services.

Broad affordability targets alone do not guarantee meaningful accessibility for people living with severe mental illness whose disabilities substantially impair independent functioning. Without sufficient supportive and intermediate housing units integrated into major publicly funded developments, many individuals remain excluded from housing stability despite being among the populations most vulnerable to homelessness and institutional cycling.

This concern is particularly significant given that people living with severe mental illness are disproportionately represented in chronic homelessness, emergency psychiatric admissions, shelter systems, police interventions, incarceration, victimization and involuntary hospitalization.

Supportive Housing for Individuals with Co-Occurring Disorders

Individuals living with severe mental illness frequently experience co-occurring substance use disorders. Research consistently demonstrates that the presence of both conditions is associated with increased rates of

homelessness, hospitalization, emergency service utilization, incarceration, victimization, and housing instability.

The existence of co-occurring disorders presents important challenges for housing policy. While some supportive housing programs are specifically designed to serve individuals with active substance use disorders, others focus primarily on supporting individuals whose severe psychiatric disabilities require stable, structured, and recovery-oriented environments. Both types of housing are necessary components of a comprehensive housing continuum.

A recurring concern raised by families, service providers, and some tenants is that housing systems often lack sufficient specialization to address the diverse needs of these populations. Individuals living with severe mental illness may require housing environments that emphasize psychiatric rehabilitation, medication support, clinical follow-up, and structured community living. Conversely, individuals experiencing active substance dependence may require housing models that encourage abstinence, incorporate some harm reduction, addiction treatment services, relapse prevention supports, and intensive case management.

Housing policy should avoid treating all supportive housing models as interchangeable. While integrated approaches may be appropriate in some circumstances, evidence suggests that different populations often benefit from different levels and types of support. A continuum of housing options should therefore include:

• supportive housing specifically designed for individuals with severe mental illness;

• supportive housing for individuals with co-occurring mental health and substance use disorders;

• recovery-oriented housing environments with integrated addiction treatment services;

• intermediate and supervised housing resources for individuals requiring higher levels of support;

• specialized forensic and transitional housing where appropriate.

Importantly, recognizing the need for specialized housing options should not be viewed as exclusionary. Rather, it reflects the principle that disability accommodation requires services that are responsive to individual needs and circumstances. A rights-based housing framework must acknowledge that meaningful housing stability often depends upon access to supports tailored to the particular challenges individuals face.

Developing a diverse range of supportive housing models would improve outcomes for residents, reduce pressure on hospitals, shelters, and correctional systems, and enhance the long-term effectiveness of public housing investments.

High Supportive Housing, Dunn House, Portage, Entre-Toît and Chai Tikvah

The current shortage of high supportive housing across Canada has contributed to growing public concern regarding the development of new housing projects for vulnerable populations. In some communities, proposals for supportive housing have faced significant opposition, resulting in delays, increased costs, and challenges in expanding much-needed housing capacity.

A recurring concern raised by residents, family members, and some tenants relates to housing models that combine individuals with diverse and complex needs within the same building, including people experiencing active substance use disorders, individuals with criminal justice involvement, and persons living with severe and persistent mental illnesses. While integrated housing approaches may serve some populations effectively, they may not always provide the level of safety, stability, and therapeutic support required by individuals with the most serious psychiatric disabilities.

For individuals living with severe mental illnesses such as schizophrenia, schizoaffective disorder, or bipolar disorder with psychosis, housing is not merely a social service—it must include essential components that promote safety, stability, treatment adherence, rehabilitation, and community integration.

Promising examples exist across Ontario that demonstrate the benefits of housing models specifically designed for individuals with severe mental illness. Dunn House in Toronto, developed through the University Health Network's Gattuso Centre for Social Medicine, treats housing as an integral component of healthcare. Residents receive access to onsite primary care, mental health services, personal support workers, and a range of social supports. Early evaluations have demonstrated significant reductions in emergency department visits and hospital utilization, while improving housing stability and overall well-being. Dunn House is an example of **CRPD Article 19** particularly because it combines accessible housing, community living, and individualized supports while moving people away from institutional and emergency-based systems.

In Quebec, high supportive housing such as Portage and L'Entre-Toit St-Jacques demonstrate how integrated housing and support services can promote community inclusion, recovery, and autonomy for people with severe mental illness and co-occurring mental health and substance use disorders. Chai Tikvah in Toronto provides a structured, recovery-oriented residential environment for individuals living with severe mental illness. The program emphasizes rehabilitation, skill development, and community living while maintaining clear eligibility criteria designed to ensure a safe and supportive environment for residents. These criteria include psychiatric stability, engagement with treatment, absence of active substance misuse, and a demonstrated ability to participate in communal living.

Such models recognize that individuals with severe mental illness often benefit from specialized housing environments that combine affordable accommodation with clinical supports, psychosocial rehabilitation, and structured supervision. They also acknowledge that not all supportive housing models are interchangeable and that a "one-size-fits-all" approach may fail to meet the needs of distinct populations.

Future housing policy should encourage the development of a continuum of housing options that reflects the diversity of needs within the population. This includes dedicated housing models for people with severe mental illness, supportive housing for individuals with concurrent substance use disorders, and integrated healthcare-housing partnerships that provide appropriate levels of clinical and social support.

By investing in evidence-informed housing models tailored to specific populations, governments can improve resident outcomes, reduce pressure on hospitals and emergency services, and strengthen public confidence in supportive housing initiatives.

The Voice of Families and Caregivers, Essential but Unrecognized Partners

Many caregivers experience burnout while navigating fragmented systems that separate housing, healthcare, social services, and legal oversight into disconnected silos. Families are frequently told that individuals must first "choose" treatment or maintain stable tenancy independently before receiving sustained support, even where severe illness itself impairs insight into care needs. This creates situations where intervention often occurs only after significant deterioration, homelessness, incarceration, victimization, or medical crisis.

A human-rights based approach should not require families to compensate indefinitely for structural gaps in public housing and mental health systems.

Throughout Canada, families and caregivers have become the de facto providers of housing stability, crisis management, treatment engagement, and community integration for individuals living with severe mental illness.

Organizations such as the Family Alliance on Severe Mental Illness (FASMI) have repeatedly documented the significant burdens carried by families when public systems lack sufficient supportive housing and integrated services. Families routinely coordinate appointments, monitor treatment adherence, provide transportation, manage finances, intervene during psychiatric crises, and prevent homelessness among loved ones whose illnesses substantially impair judgment, insight, executive functioning, and independent living capacity.

Despite their critical role, families are often excluded from policy development, service planning, and housing discussions, even though they possess extensive knowledge regarding the practical realities of severe mental illness and the gaps within existing systems.

Many caregivers report experiencing significant emotional, physical, and financial strain while attempting to compensate for deficiencies in housing, healthcare, and social services. In some cases, aging parents continue to provide housing and support to adult children with severe mental illness well into later life, creating profound concerns regarding future care and housing stability once family supports are no longer available.

A rights-based housing framework should recognize that families cannot serve indefinitely as substitutes for publicly funded supportive housing and community-based services. Reliance on unpaid caregiving to compensate for structural shortcomings effectively transfers public responsibilities onto families without adequate support, recognition, or protection.

Meaningful implementation of housing rights for persons living with severe mental illness requires the inclusion of family and caregiver perspectives in housing policy, program design, oversight mechanisms, and accountability frameworks.

Recommendations

We respectfully recommend that the Federal Housing Advocate examine:

1. Whether current federal housing investments adequately address the needs of individuals living with severe mental illness requiring wrap-around services and supports;
2. Whether large publicly funded developments sufficiently earmark supportive and intermediate housing units for populations with SMIs and co-occuring disorders;
3. The relationship between insufficient supportive housing capacity and the increasing use of community treatment orders;
4. The absence of enforceable national standards for supportive psychiatric housing;

5. The need for dedicated federal funding streams for: • supportive psychiatric housing, • supervised housing, • intermediate resources, • forensic community housing, • integrated housing-healthcare models;

6. Mechanisms to better coordinate housing systems with healthcare and community mental health services;

7. Policies aimed at preventing eviction, homelessness, institutional cycling, and criminalization linked to psychiatric disability;

8. Greater inclusion of families, caregivers, and persons with lived experience in federal housing policy development and oversight. The Federal Housing Advocate should also examine the impact that inadequate supportive housing capacity has on families and caregivers who are compelled to assume long-term housing stabilization, crisis intervention, care coordination, and support responsibilities in the absence of appropriate public services, and should ensure that family and caregiver perspectives are incorporated into future housing rights reviews and policy development.

Conclusion

A human-rights based housing framework must recognize that housing stability for some individuals cannot be separated from access to sustained care and support.

People living with severe mental illness and co-occuring disorders represent one of the populations most vulnerable to homelessness, institutionalization, incarceration, victimization, and premature death. Yet current housing frameworks often minimize the complexity of their needs by subsuming them into generalized vulnerability categories without ensuring concrete supportive housing capacity.

The realization of housing rights for persons living with severe mental illness must be assessed not only through the availability of housing units, but through compliance with Canada's obligations under the **National Housing**

Strategy Act, the Canadian Charter of Rights and Freedoms, and the United Nations Convention on the Rights of Persons with Disabilities. A truly rights-based housing framework requires substantive equality, disability accommodation, and access to the supports necessary for community living. The experiences of families and caregivers, including those represented by FASMI, demonstrate that without adequate supportive and intermediate housing, the burden of addressing systemic gaps continues to fall on families, emergency services, hospitals, shelters, and correctional systems rather than on coordinated, rights-based community supports.

Canada's housing strategy should not measure success solely through the number of units created, but through whether the most vulnerable individuals are meaningfully able to access and sustain housing adapted to their realities.

Without substantial investment in supportive, intermediate, and integrated psychiatric housing models, governments risk continuing to rely on emergency systems, shelters, correctional institutions, and coercive legal mechanisms to compensate for systemic gaps in care and housing infrastructure.

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