

# focusON

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## Aging in place in social housing



**ONPHA**

Ontario  
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The **Ontario Non-Profit Housing Association (ONPHA)** represents 740 non-profit housing providers in 220 communities across Ontario. ONPHA members operate more than 160,000 non-profit housing units and provide housing for approximately 400,000 people including seniors, low-income families with children, Aboriginal people, the working poor, victims of violence and abuse, people living with developmental disabilities, mental illness, HIV/AIDS or addictions, and the formerly homeless/hard-to-house.

ONPHA's **focus ON** series examines key issues facing Ontario's affordable housing sector, presenting a variety of perspectives to encourage thoughtful and reflective discussion on the development of sound housing policy and the future of the community-based housing sector in Ontario.

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# Executive summary

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Across Ontario, our population is aging at a rapid pace. The number of seniors is projected to more than double over the next few decades, peaking in 2041 when over 25 per cent of Ontarians will be 65 years of age or over.

As seniors get older, the costs associated with an aging population increase. In an attempt to curb health care spending, governments have responded by embracing “aging in place” approaches. Aging in place has seniors stay in their homes as they age, instead of living in hospitals or long-term care facilities. While aging in place approaches are popular with seniors who want to remain in their homes and maintain their independence, they can have unintended consequences for low-income seniors.

Many aging in place approaches, like the Ontario Government’s *Aging at Home Strategy*, fail to acknowledge the unique challenges that low-income seniors experience as they grow older. Because low-income seniors have poorer health outcomes and more support needs than other seniors, they need more assistance in order to age in place. As the number of low-income seniors continues to rise in coming years, it will be critical to recognize that aging in place is not a one-size-fits-all solution to seniors’ challenges.

This report examines the limitations of aging in place approaches for low-income seniors through the lens of Ontarians living in social housing. Because of the challenges of aging, older adults as a group already experience increased risks and vulnerabilities. Due to the environmental, social, and economic barriers that many tenants in social housing face, having seniors age in place can be especially difficult – though not impossible. Like other seniors, many tenants in social housing would like to remain in their homes for as long as possible. But when these seniors don’t have access to the supports they need, the consequences affect not only the tenants themselves, but also their landlords, their communities, and provincial health care costs.

In this report, we explore a number of policy responses that would go a long way towards helping seniors in social housing stay healthy and secure as they age. These responses include provincial funding for supports in social housing communities; an expansion of the supportive housing system; financial assistance for age-related building modifications and renovations; and improved access and options for long-term care.

All of the above options require a dedicated commitment from the Ontario Government to supporting seniors in social housing as they age. As tenants living in social housing grow older and the number of seniors on housing wait lists increases, it is clear that the Province can no longer afford to ignore the urgent needs of this population.

# Background: Seniors and poverty

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As the population ages, health needs increase and costs rise. The Ontario Government already spends close to half of its health care budget on seniors<sup>1</sup>, a number that will increase by 50 per cent in the next 15 years unless significant changes are made<sup>2</sup>. Currently, older adults with the most complex health issues – roughly 10 per cent of the senior population – account for 60 per cent of provincial spending on seniors' health care<sup>3</sup>.

At the same time, the number of Canadian seniors living beneath the low-income measure has risen slowly but steadily since the mid-1990s<sup>4</sup>. As the number of seniors increases, so will the number of seniors living in poverty. Low-income seniors are more likely to have complex health and care needs, and thus require special attention when considering approaches for aging and seniors' wellbeing.

Over the past half-century, Canada has made significant progress on reducing the number of low-income seniors in the country. In the mid-1970s, almost 37 per cent of Canadian seniors were living in poverty<sup>5</sup>. The creation of the Canada Pension Plan decreased that number to less than five per cent by the mid-1990s. But while the Canada Pension Plan, Old Age Security, and the Guaranteed Income Supplement have gone a long way towards helping seniors, many elderly adults are still struggling. The poverty rate for single seniors, for example, remains high at 29 per cent<sup>6</sup>.

Even seniors that were financially solvent in their work years may face challenges as they age. Because income levels drop across the board at retirement and adults reach their lowest income level after they turn 75<sup>7</sup>, seniors who were getting by may find themselves in a precarious position if their costs increase. Seniors that rely on government transfer payments as their primary source of retirement income have lower incomes than those who do not, placing this group at a heightened risk<sup>8</sup>.

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1 Unless specified otherwise, in this report the term "senior" refers to adults age 65 and over.

2 Ontario Seniors' Secretariat, *Independence Activity and Good Health: Ontario's Action Plan for Seniors*, 2013 Queen's Printer for Ontario, p. 6

3 Ibid.

4 In 2010, the number of seniors living below Statistics Canada's Low Income Measure line was 8.1%, compared to 1.9% in 1995. Ontario Seniors' Secretariat, p. 6

5 The Conference Board of Canada, "International Rank: Elderly Poverty," January 2013. Accessed from: <http://www.conferenceboard.ca/hcp/details/society/elderly-poverty.aspx>

6 Statistics Canada, CANSIM table 206-0003, Date Modified: 2014-12-10

7 Margie Carlson, *A Slice of Affordable Housing for Seniors in Ontario may be Diminishing*, Housing Services Corporation, May 2014, p.12

8 Ibid, p. 24



Unfortunately, the number of seniors unable to financially support themselves will only grow in the coming years. Because the number of workers with workplace pension plans has declined and people are living longer than ever before, they need more personal savings to carry them through retirement. Household saving rates, however, continue to be lower than in previous decades<sup>9</sup>. Based on current projections, the Ministry of Finance has indicated that over 35 per cent of households are unlikely to have an adequate retirement income to maintain their current standard of living<sup>10</sup>. Moreover, seniors across the country are increasing their consumer debt at a faster pace than the rest of the population<sup>11</sup>.

The rising costs of housing in many Ontario communities has created difficulties for seniors. In the last long-form census, 17 per cent of all senior households in Ontario were unable to access affordable, adequate, and suitable shelter<sup>12</sup>. Seniors renters are at a significant disadvantage, as they are twice as likely to spend more than they can afford on shelter costs than senior homeowners<sup>13</sup>. As a result, more and more seniors have joined the queue for social housing. In 2003, seniors accounted for 21 per cent of all households waiting for a rent-geared-to-income unit in Ontario; by 2014, they represented almost a third of all waiting households<sup>14</sup>.

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- 9 Government of Ontario, "Ontario Pensions and Retirement Savings," Updated 18 September 2015, Accessed from: <http://www.ontario.ca/page/ontario-pensions-and-retirement-savings>
  - 10 Ontario Ministry of Finance, "Ontario's Long-Term Report on the Economy," Queen's Printer for Ontario, 2010, Accessed from: <http://www.fin.gov.on.ca/en/economy/ltr/2014/ch6.html>
  - 11 CBC News, "Canadian Debt Loads Increasing, Especially for Seniors Equifax Says," CBC.ca, 15 September 2015.
  - 12 Ontario Seniors' Secretariat, 2013, p. 6
  - 13 Carlson, May 2014, p. 30
  - 14 ONPHA, *2015 Waiting Lists Survey*, May 2015, p. 9

# Key assumptions in aging in place theory

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The drop in poverty rates for Canadian seniors from the 1970s to the mid-1990s coincided with the rise of “aging in place” approaches to seniors’ health and wellbeing. The number of academic articles mentioning aging in place doubled from the 1980s to the 1990s, and became even more common after 2001<sup>15</sup>. Aging in place is now a well-documented international policy response to growing seniors populations, with reports of initiatives across North America and in Europe, Asia, and Australia<sup>16</sup>.

Aging in place allows seniors to “live in their current home and familiar community for as long as possible, even if their health changes”<sup>17</sup>. Policymakers looking to control health costs have endorsed aging in place initiatives, as they are often more cost-effective than alternative options<sup>18</sup>. From 1980 to 2005, the Ontario Government reduced the number of acute-care hospital beds by 44 per cent, as care was transitioned out of hospitals and into the home<sup>19</sup>. At the same time, aging in place appears to be what seniors themselves want for their future. In one study, 85 per cent of Canadian seniors surveyed reported wanting to remain in their homes for as long as possible<sup>20</sup>.

The Government of Ontario officially adopted an aging in place approach in 2007, with the launch of the Aging at Home Strategy. According to then Minister of Health and Long-Term Care George Smitherman, “As our population ages, we need to look for innovative solutions that are more responsive to their needs and allow seniors to continue to live in comfort and with respect in their own homes,

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15 Sarinnapha Vasunilashorn, et al. “Aging in Place: Evolution of Research Topic Whose Time Has Come,” *Journal of Aging Research*, 2012, p.3

16 Ibid., p. 4

17 CMHC, *Impacts of the Aging of the Canadian Population on Housing and Communities*, CMHC Research Highlight, February 2008, p. 2

18 Community and home care services for seniors are significantly less costly than hospitals and long-term care homes, while hospital stays cost approximately \$450 per person per day, and long-term care costs \$135 per person per day, care services provided in a senior’s own home total only \$45 per person per day. Office of the Auditor General of Ontario, *Community Care Access Centres – Financial Operations and Service Delivery*, Queen’s Printer for Ontario, 2015, p. 10

19 Kelly Grant and Elizabeth Church, “No Place Like Home? Investigating Ontario’s Home Care Shortcomings,” *Globe and Mail*, 10 July 2015.

20 Carlson, May 2014, p. 39 – citing a figure reported in Canada Mortgage and Housing Corporation, *Seniors Housing Report*, 2011.



ideally for the rest of their days”<sup>21</sup>. The Strategy focused on establishing a continuum of community-based support services for seniors, making it possible for them to remain at home longer.

In 2010, the Province announced an expansion of the Strategy, with the goal of decreasing the amount of time seniors spent in alternative level of care (ALC) beds in hospitals<sup>22</sup>. Ontario now has the lowest number of hospital beds per capita of any province in Canada. In 2013, the Province released *Ontario’s Action Plan for Seniors*, which cited the *Aging at Home Strategy* as a foundational element of the Province’s approach to seniors and aging<sup>23</sup>. *Patients First*, the Province’s 2015 action plan for health care, continued the intentions of the Strategy by promising additional investments in home and community care for seniors<sup>24</sup>.

Gerontologists have noted that as seniors age, they become increasingly influenced by the places where they live<sup>25</sup>. In order for aging in place strategies to be successful, seniors’ homes must meet certain preconditions. A reduction in the “environmental barriers” within buildings is key, with a focus on accessibility modifications and retrofits<sup>26</sup>. Successful aging in place also assumes a positive connection between seniors and their physical community. Studies have shown that seniors view aging in place as a way to facilitate continued access to good local services and feelings of community security<sup>27</sup>. Communities that help seniors age in place are age-friendly and safe, with easy access to public transit, health and community services, and other amenities<sup>28</sup>.

Finally, successful aging in place approaches assume that seniors have a solid support system to rely upon. For many seniors, family members play a key role in assisting with their medical needs and daily tasks such as housekeeping. Aging in place approaches often reference the role of family and friends as informal caregivers as an important component in the process<sup>29</sup>. A system of local, community-based support services is also recognized as necessary for seniors to age in place. These services must be affordable and accessible, and mechanisms must be in place for coordinating care for seniors with complex health needs<sup>30</sup>.

Not all seniors, however, have equal access to such environments, resources, and supports. Because of this, their experiences of aging in place can be quite different. By examining how income and health intersect, we can begin to see why some seniors experience additional challenges as they age.

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21 Ministry of Health and Long-Term Care, “McGuinty Government Transforming Community Living to Help Seniors Live Independently at Home,” Newsroom Release (archived), 28 August 2007.

22 An ALC bed refers to a bed in a hospital occupied by a patient who no longer “requires the intensity of resources/services provided in this care setting” but cannot yet be discharged. Ministry of Health and Long-Term Care, “Ontario Wait Times,” Accessed from: [http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/alc\\_definition.aspx](http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/alc_definition.aspx)

23 Ontario Seniors Secretariat, *Independence, Activity and Good Health: Ontario’s Action Plan for Seniors*, p. 8

24 Ministry of Health and Long-Term Care, *Patients First: Action Plan for Health Care*, Queen’s Printer for Ontario, February 2015, p. 11

25 “Environmental gerontologists assert that as people age they increasingly become attached to the place where they live, but concurrently become more sensitive and vulnerable to their social and physical environment (Lawton 1977; Lawton & Nahemow 1973).” Esther Iecovich, “Aging in Place: From Theory to Practice” *Anthropological Notebooks* 20 (1), 2014, p. 24

26 *Ibid*, p. 25

27 *Ibid*, p. 23

28 Public Health Agency of Canada, *The Chief Public Health Officer’s Report on the State of Public Health in Canada 2010*, Date Modified: 2012-06-20.

29 “The gerontological literature has extensively addressed the strategic role played by family caregivers in order to enable their older family members to age-in-place.” Iecovich, 2014, p. 25

30 A. Paul Williams, et al., “Aging at Home: Integrating Community-Based Care for Older Persons,” *Healthcare Papers* Vol. 10 No. 1, 2009, p. 13



# Health challenges for low-income seniors

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While aging in place approaches emphasize independence and “putting clients at the centre”<sup>31</sup>, such goals may be more challenging for a senior population living in poverty. Research on the social determinants of health has demonstrated the direct connection between poverty and poor health outcomes. In Ontario, adults in the lowest income quintile consistently report worse health outcomes than their higher-earning peers, with higher rates of mental illness, diabetes, and heart disease<sup>32</sup>. The health discrepancies between low and high-income households are evident in life expectancy rates: the difference between the highest and lowest income quintiles is 7.4 years for men and 4.5 years for women<sup>33</sup>. Health outcomes are particularly poor for individuals on social assistance, many of whom live in social housing<sup>34</sup>.

While health discrepancies based on income level are relevant for all adults, they can be especially extreme for seniors, who face additional health challenges<sup>35</sup>. Research has shown that low-income seniors are less likely to be physically active, less likely to access preventative health measures like cancer screenings, and more likely to engage in unhealthy behaviours such as smoking<sup>36</sup>. The challenges that seniors face when living in poverty can also exacerbate health issues. Being forced to subsist on a low income can have negative effects on seniors’ mental health, for example, increasing the severity of challenges such as depression and Alzheimer’s disease<sup>37</sup>.

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31 Ibid, p. 14

32 Bob Gardner et al., *Towards a Social Assistance System that Enables Health and Health Equity*, Wellesley Institute, October 2011, p. 4

33 Ibid.

34 Ibid, p. 6

35 As stated by Canada’s Chief Public Health Officer: “Seniors living in low-income may be unable to access nutritious foods, have difficulties paying their mortgage, rent or utilities, be unable to complete necessary repairs on their homes, and experience limitations in terms of access to and affordability of transportation and non-insured health services, all of which can impact negatively on their health.” Public Health Agency of Canada, *The Chief Public Health Officer’s Report on the State of Public Health in Canada 2010*, Date Modified: 2012-06-20

36 Canadian Institute for Health Information, *Health Care in Canada 2011*, December 2011, p. 16

37 Public Health Agency of Canada, *The Chief Public Health Officer’s Report on the State of Public Health in Canada 2010*, Date Modified: 2012-06-20

# Barriers to aging in social housing

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Aging in place in social housing

Because the home is the central foundation of aging in place approaches, seniors who have difficulty obtaining suitable and affordable housing or who live in housing that poses barriers to aging are at a disadvantage<sup>38</sup>. With this in mind, it is valuable to explore how seniors living in social housing experience the aging in place process.

Social housing sites are increasingly home to an older population. In Ontario, almost as many seniors live in social housing buildings as in the entire long-term care system<sup>39</sup>. These 75,000 tenants face aging challenges and obstacles that are different from other seniors<sup>40</sup>. The majority have incomes low enough to qualify for rent-geared-to-income housing, and many face chronic physical and mental health challenges.

It is important to differentiate social housing from supportive housing. In supportive housing, providers receive funding from the Ministry of Health and Long-Term Care to directly provide support services to their tenants. Social housing, however, was designed for households that are capable of living independently, or can coordinate their own support services<sup>41</sup>. Despite being home to a growing number of vulnerable people, including aging seniors, social housing providers do not receive any core funding to assist these tenants.

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38 "There is also a built in and perhaps naive assumption on the part of aging at home strategies that the housing available for low-income seniors is currently safe, affordable, and stable into the future." Carlson, May 2014, p.53

39 Approximately 75,000 seniors live in social housing. 50,295 senior households are currently on Ontario waiting lists. Combined, this is roughly equivalent to the number of seniors in Ontario's long-term care facilities (77,100 people), and on waiting lists for long-term care (23,436 households). ONPHA, *Strengthening Social Housing Communities: Helping Vulnerable Residents Maintain Successful Tenancies*, November 2015, p. 11

40 Ibid.

41 ONPHA, November 2015, p.13

Policy initiatives that promote aging in place often fail to adequately address the unique circumstances of low-income seniors in social housing. The specific challenges that frequently arise for these seniors are addressed below.

### Built form challenges

Many aging in place approaches specify that homes be modified to accommodate seniors' increased accessibility needs. Environmental barriers that inhibit mobility, or that make it difficult to perform daily activities, must be removed, and corresponding enhancements should be made<sup>42</sup>. Such modifications and accommodations often require significant resources and investment.

Unlike the majority of seniors that own their homes, individuals in social housing cannot introduce modifications like stair lifts, grab bars, or lowered light fixtures as they deem appropriate. Instead, they are dependent on their landlords to initiate these upgrades. Landlords must then have the resources required to finance these modifications. Current funding programs, like the Ontario Government's Healthy Homes Renovation Tax Credit<sup>43</sup> and the Ontario Renovates program, are geared towards increasing accessibility and supporting building modifications for seniors. Social housing providers, however, are not eligible to receive funding under either program. The most recent funding program for age-related modifications in social housing ended in 2011<sup>44</sup>.

At the same time, the age of social housing buildings means that many retrofits are not cost-effective. The majority of public housing stock in the province is roughly 40 years old<sup>45</sup>. Many of these buildings were constructed as housing for families; three-quarters of the units built before 1970 were designed for this purpose<sup>46</sup>. These buildings cannot easily accommodate modifications that support aging in place. The design of some buildings makes elevators and stair lifts impossible, and many hallways cannot be widened to accommodate mobility devices.

Under the Human Rights Code, social housing providers have a "duty to accommodate" the needs of tenants, up to the point of undue hardship. One of the three considerations for undue hardship of an accommodation is cost. Though the onus is on the housing provider to demonstrate undue hardship, many social housing providers are already struggling to afford basic maintenance and upkeep costs; an estimated 70 per cent of social housing units have capital reserve shortfalls<sup>47</sup>. These financial pressures, coupled with the growing number of senior tenants, will make it increasingly difficult for social housing buildings to accommodate aging seniors.

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42 Iecovich, 2014, p. 25

43 Recent evidence has shown that seniors' usage of the health Homes Renovation Tax Credit, however, has been limited – only 17 per cent of the program's budget was used in 2015. Critics have suggested that this is because the credit only covers 15 per cent of renovation costs, which are still prohibitively expensive for many seniors, and due to delays in assessments of seniors' homes for modifications and renovation needs. Rob Ferguson, "Ontario's 'Healthy Homes' Tax Credits Go Largely Unused," *Toronto Star*, 2 January 2016

44 In 2009, the Canada-Ontario Social Housing Renovation and Retrofit Program (SHRRP) was launched, which provided funding for repairs and modifications in social housing projects. One of the intentions of SHRRP was to "Provide enhanced accessibility for seniors and persons with disabilities." The program's funding was allocated over a two-year period, and has not been renewed since. See: Ministry of Municipal Affairs and Housing, *Social Housing Renovation and Retrofit Program: Program Guidelines*, Queen's Printer for Ontario, July 2009.

45 Office of the Auditor General of Ontario, *Annual Report 2009*, Queen's Printer for Ontario, p. 284

46 Smith, 1995, p. 907

47 Andre Cote and Howard Tam, "Affordable Housing In Ontario: Mobilizing Private Capital in an Era of Public Constraint," *Institute on Municipal Finance and Governance Perspectives* No. 3, 2013, p. 3

## Community environment

Liveable communities – neighbourhoods that are pedestrian-friendly and have accessible transit options and mixed-use development – are key to aging in place, as they are designed to meet the social needs of residents of all ages<sup>48</sup>. It is only in the past few decades, however, that the notion of liveable communities has emerged<sup>49</sup>.

Social housing sites, like most communities, were not designed with seniors in mind. Urban planning traditions have long been based on assumptions around mobility, with communities designed for healthy adults who are able to traverse long distances in cars<sup>50</sup>. The majority of Ontario's social housing was created in the car-dominant era of the 1960s and 1970s. Much of the public housing stock that was formerly under the Ontario Housing Corporation consists of high-rise buildings that were constructed by developers to meet minimum National Building Code requirements<sup>51</sup>. In urban areas, tenants in these buildings have difficulty accessing walkable spaces and limited access to amenities like places to buy fresh food<sup>52</sup>.

Meanwhile, in rural and suburban areas where public transit is limited, seniors in social housing that can no longer drive may be isolated from important services. In both urban and rural areas, social housing buildings often lack the accessible indoor and outdoor space necessary to promote healthy aging activities<sup>53</sup>.

Over time, the composition of tenants in social housing has also changed. In a number of locations, seniors live in buildings that were formerly seniors-only, but now house tenants of all ages<sup>54</sup>. While exact distributions vary, Ontario's largest providers report that generally around half of their senior tenants live in units in mixed-age buildings<sup>55</sup>.

These buildings are also home to a growing number of tenants who have been housed through provincial priority programs, such as programs for people experiencing homelessness and mental health and addictions challenges<sup>56</sup>. Some of these households are candidates for supportive housing, but due to limited availability are placed in social housing buildings instead. As social housing providers do not receive core funding for support services, many of these tenants do not have access to the supports they need, which can have a negative effect on their tenancies<sup>57</sup>.

Providers have acknowledged that seniors in these mixed-age buildings report the lowest levels of satisfaction of all tenants. Some senior tenants have said they feel uncomfortable leaving their unit, while others have concerns about the level of security in their buildings. If seniors feel insecure in their community or feel confined to their units, they will not be able to engage in the “independent living and social engagement” activities important for aging in place<sup>58</sup>. As the number of seniors living in social housing will rise in coming years, this presents a significant obstacle to aging in place.

48 Ann Bookman, “Innovative Models of Aging in Place: Transforming our Communities for an Aging Population,” *Community Work & Family* Vol. 11, No. 4, November 2008, p. 422

49 CMHC, “Community Indicators for an Aging Population,” CMHC Research Highlight, July 2008, p. 2

50 Bookman, November 2008, p. 422

51 Smith, 1995, p. 914

52 Toronto Public Health and the Centre for Urban Growth and Renewal, *Toward Healthier Apartment Neighbourhoods: A Healthy Toronto by Design Report*, City of Toronto, September 2012, p. 3

53 Carlson, May 2014, p. 49

54 In 1988, the Province ordered all Local Housing Authorities to their convert seniors-only buildings into housing for all ages.

55 In Toronto Community Housing, 45 per cent of seniors live in mixed-age buildings. In Ottawa Community Housing, 41 per cent of senior tenants live in mixed-age buildings. In Peel Living properties, approx. 63 per cent of senior tenants live in mixed-age buildings. It is important to note that different providers use different ages for their definition of “senior”: Peel Living considers seniors to be age 65 and over, while OCH defines seniors as age 60 and over and TCH uses age 59 and over. Figures supplied to ONPHA by Peel Living, OCH and TCH.

56 Figures from Ottawa Community Housing, for example, show that from 2005-2009, 52 per cent of tenants housed from the RGI waiting list had a priority designation, such as fleeing domestic violence or exiting homelessness. From 2010-2014, priority applicants rose to account for 65 per cent of all households housed from the waiting list. Ottawa Community Housing, *OCH Placements per Year by Category*, 2015 (as cited in ONPHA, November 2015, p. 12).

57 ONPHA, November 2015, p. 14

58 Iecovich, 2014, p. 27

Increased support needs

As discussed earlier, low-income seniors generally experience more negative health outcomes than other seniors. The increased likelihood of health challenges manifests in the more extensive support needs of seniors living in social housing. Research on public housing in the U.S., for example, shows that over 30 per cent of senior tenants require assistance with at least one activity of daily living (ADL)<sup>59</sup>. The number of seniors in these communities with a mental disability that limits their daily functioning is 12 per cent, while five per cent have a level of disability equivalent to patients in nursing homes<sup>60</sup>.

Low-income seniors can also have significant mental health needs. In Ontario, people experiencing emotional, psychological or psychiatric conditions are almost three times more likely to be low-income than individuals without disability challenges<sup>61</sup>. As a result, social housing sites are often home to a large number of individuals of all ages with mental health challenges<sup>62</sup>. At the same time, many individuals moved into social housing as adults but are now seniors, and have begun experiencing mental health challenges commonly associated with aging such as depression, dementia<sup>63</sup> and hoarding disorder<sup>64</sup>. Unfortunately, many of these tenants do not have a caseworker, often because they have refused services.

While seniors in social housing have poorer health outcomes than other seniors, they are often the most under-served when it comes to support services. Across the country, more Canadians use private home and care services than government-subsidized ones, such as the services provided through Community Care Access Centres (CCACs) in Ontario<sup>65</sup>. But the CCAC system remains over-stretched. The number of patients served by CCACs has doubled over the past decade, resulting in reductions in hours of care and stricter eligibility requirements<sup>66</sup>.

Because low-income seniors are unable to replace or supplement community-based services with private options, they are often unable to have all their needs adequately met. As one housing provider noted, “Our tenants are frail, and there’s not enough funding to give them the supports they need. The rich can pay for additional services to fill the gaps. But whatever our tenants get through the CCAC, it’s never enough.”

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59 Stephen M. Golant, “Political and Organizational Barriers to Satisfying Low-Income U.S. Seniors Need for Affordable rental Housing with Supportive Services,” *Journal of Aging & Social Policy*, Vol. 15(4), 2003, p. 23

60 Ibid.

61 Ontario Human Rights Commission, *Minds that Matter: Report on the Consultation on Human Rights, Mental Health, and Addictions*, 2012.

62 In 2010, the LeSage Report recognized that there were a reported 8,900 tenants in Toronto Community Housing with mental health issues, but that the actual number is likely much higher. Patrick J. LeSage, *Report on the Eviction of Al Gosling and the Eviction Prevention Policy of Toronto Community Housing*, May 2010, p. 10

63 Dementia is not a specific disease but instead refers to a set of symptoms that are caused by brain disorders. The most common form of dementia is Alzheimer’s disease, followed by vascular dementia caused by a stroke. For more information: <http://www.alzheimer.ca/en/About-dementia/What-is-dementia>

64 Toronto Community Housing, “Serving Seniors and the Needs of an Aging Population,” Accessed from: <http://www.torontohousing.ca/Seniors>.

65 In Ontario, home care is currently delivered through a system of 14 Community Care Access Centres (CCACs). Some CCAC services are provided directly, but the majority are delivered through private and non-profit organizations. All services are free to all patients that are deemed eligible. In December of 2015, the Ministry of Health and Long-Term Care released Patients First: *A Proposal To Strengthen Patient-Centred Health Care in Ontario*. The Discussion Paper noted gaps in Ontario’s current health system, and recommended a number of changes.

66 Grant and Church, 10 July 2015

## Absence of informal caregivers

Aging at home initiatives acknowledge the important role played by informal caregivers. These family members and close friends, who often live with or near the senior in question, provide a significant amount of the care and support that allows seniors to age independently in their homes. Research on frail seniors has shown that even when seniors receive care from outside services, it is often complemented by assistance from friends and family<sup>67</sup>.

Seniors living in social housing are significantly more likely to live alone than other seniors<sup>68</sup>. Many of these senior tenants do not have friends and family to fulfill the caregiver role. A survey of Toronto seniors living in social housing found that 46 per cent reported having visitors less than three times a week, while 11 per cent had visitors “once a month or less”<sup>69</sup>. Seniors that are both low-income and that live alone have been recognized as the most vulnerable of all senior groups<sup>70</sup>.

The absence of an informal caregiver can be difficult for seniors, many of whom rely on someone to assist with their health and medical needs. Reading and understanding relevant medical information is a significant challenge for some seniors, and low-income seniors are more likely to have a low level of health literacy<sup>71</sup>. When seniors have no one to help them with their medication, or to remind them to eat and exercise regularly, their health suffers.

In addition to providing direct support, informal caregivers are often responsible for coordinating outside services on seniors’ behalf<sup>72</sup>. In Ontario, the home care system is notoriously complex and difficult to navigate due to multiple points of contact and inconsistent procedures across agencies<sup>73</sup>. For many seniors, informal caregivers are their connection to support services. This role as a manager of services and advocate is especially integral for seniors that are marginalized due to poverty, lack of education, isolation, and cultural or linguistic differences<sup>74</sup>.

Without this assistance, seniors struggle on their own to comprehend the home care system – which often results in receiving limited care, or no care at all<sup>75</sup>. Privacy legislation limits landlords’ ability to access health information about their tenants, so social housing providers have to rely on self-disclosure or partnerships with informal caregivers. In the absence of this, providers are often unable to know what services their tenants need or how to best assist them. The result is that seniors who live alone in social housing are less likely to have the strong system of supports that would help them age in place.

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67 Iecovich, 2014, p. 26

68 In Toronto Community Housing, 70 per cent of senior tenants live alone. In Ottawa Community Housing, 64 per cent of seniors live alone. In Peel Living properties, 57 per cent of seniors live alone. This is compared to 25 per cent of seniors in the general population. Figures provided by TCH, OCH, and Peel Living; Statistics Canada, “Living Arrangements of Seniors,” date modified: 2013-12-18.

69 Janet A. Lum, Simonne Ruff and A. Paul Williams, *When Home is Community: Community Support Services and the Wellbeing of Seniors in Supportive and Social Housing*, United Way of Greater Toronto, April 2005, p. 41

70 Canadian Council on Social Development, *Seniors and Housing: The Challenge Ahead*, Federation of Canadian Municipalities, 2015, p. 28

71 Alisha Sanders and Robyn Stone, “Supporting Aging in Place in Subsidized Housing: An Evaluation of the WellElder Program,” *Leading Age Centre for Applied Research*, January 2011, p. 1

72 Bookman, November 2008, p. 423

73 Expert Group on Home & Community Care, *Bringing Care Home*, March 2015, p. 11

74 Williams, et al., 2009, p. 15

75 Seniors who do have the benefit of an informal caregiver may also not be receiving sufficient care, however. According to the B.C. Seniors Advocate, only about half of informal caregivers are able to access public home or community care services for the senior they assist on a regular basis – which has led nearly a third of unpaid caregivers reporting that they are in “distress.” Elizabeth Church, “Elder Care is the New Child Care, Professor Says,” *Globe & Mail*, 3 January 2016.



## Social isolation

For seniors in social housing, physical barriers and unmet support needs can exacerbate mental health challenges and result in negative outcomes. Social involvement and participation are recognized as central to seniors' ability to age in place<sup>76</sup>. When these opportunities are limited, or when seniors are struggling with personal challenges, they can become socially isolated.

The National Seniors Council, which defines social isolations as “a situation [that] involves few social contacts and few social roles, as well as the absence of mutually-rewarding relationships,” has identified it as a significant challenge of aging . Seniors in social housing are more likely to be low-income, live alone, and have more chronic health needs than the general population – three of the main risk factors for social isolation<sup>78</sup>.

While social isolation results in increased mental health challenges, it also has adverse effects on physical wellbeing. In Scotland, a parliamentary committee recently reported that social isolation is as detrimental to health as poverty or inadequate housing . Socially isolated seniors are more likely to drink, smoke, have unhealthy eating habits and a sedentary lifestyle, and are at a greater risk for heart disease and strokes<sup>80</sup>. Due to these and other factors, they are four-to-five times more likely to be hospitalized than seniors who do not experience social isolation<sup>81</sup>.

The lack of safety and security that some seniors report feeling in their social housing community can result in reduced social activity, furthering isolating them. Seniors that lack a supportive social network are also significantly more likely to experience dementia and cognitive decline than those that have a strong social network<sup>82</sup>. For these reasons, it's important that social housing providers have the resources to directly address social isolation.

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76 Iecovich, 2014, p. 29

77 Ibid.

78 Government of Canada, *The National Seniors Council Report on the Social Isolation of Seniors*, October 2014, p. 9

79 STV News, “Loneliness ‘as Damaging to Health as Poverty and Poor Housing’,” 6 January 2016.

80 Government of Canada, October 2014, p. 8

81 Ibid.

82 Ibid, p. 10

## Elder abuse

To age in place successfully, seniors must be able to grow old in a safe and secure environment. Elder abuse, meaning “any act or omission that harms a senior or jeopardizes his or her health or welfare”<sup>83</sup>, is a growing issue as our population ages. The number of Canadian seniors that have experienced elder abuse is estimated at between four and 10 per cent<sup>84</sup>. Elder abuse can manifest in many forms, though the most common is financial exploitation<sup>85</sup>.

While seniors of all income levels are vulnerable to elder abuse, there is a strong connection between elder abuse and poverty. In a U.S. study that followed seniors over a nine-year period, having a low income was highly associated with experiencing abuse or neglect as a senior<sup>86</sup>. Other challenges that are often elevated among seniors living in poverty, such as mental health and addictions challenges and difficulties with activities of daily living, have also been identified as risk factors for elder abuse<sup>87</sup>. Moreover, seniors who have limited social networks or experience social isolation are more likely to be victims of elder abuse<sup>88</sup>.

Social housing providers have expressed concern about their single senior tenants, some of whom have been vulnerable to exploitation. In extreme cases this exploitation can manifest in a “home takeover,” wherein a tenant begins to feel unsafe in their unit due to the presence of people they feel unable to remove<sup>89</sup>. A survey of frontline workers in Ottawa found that the vast majority of home takeovers occur in social housing units, and that tenants who are single and elderly are most at risk<sup>90</sup>. Home takeovers are usually instigated by acquaintances of the tenant, and most often result in illegal activity such as drug dealing taking place in the unit (though theft and property destruction are also common)<sup>91</sup>.

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83 Government of Ontario, “Ontario Government Working to Combat Elder Abuse,” Newsroom Release (archived), 27 February 2006.

84 Government of Canada, *Report of the National Seniors Council on Elder Abuse*, November 2007, p. 5

85 Research on elder abuse shows that seniors that live alone are often at a reduced risk, as they do not share their home with a family caregiver. While this can mean that many seniors in social housing have a level of protection from abuse, it does not necessarily hold true for issues like financial exploitation. Richard J Bonnie and Robert B Wallace (editors), *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America*, 2003, p. 9

86 Mark S. Lachs et al., “Risk Factors for Reported Elder Abuse and Neglect: A Nine-Year Observational Cohort Study,” 2003, *The Gerontologist* Vol. 37, No. 4, 469-474, p. 472

87 Government of Alberta, *Addressing Elder Abuse in Alberta*, November 2010, p. 21; Lachs et al., 2003, p. 474

88 Lachs et al., 2003, p. 474

89 Johnny-Angel Butera, *Home Takeovers of Vulnerable Tenants: Perspectives from Ottawa*, Crime Prevention Ottawa, November 2013, p. 1

90 Ibid.

91 Ibid. p. 2



# External impacts of unsupported seniors in social housing

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The process of aging, in and of itself, increases a person's vulnerability. Older individuals experience more challenges and have greater needs than the rest of the population. But for many of the seniors living in social housing, the challenges of aging are compounded by poverty, as well as reduced access to services and supports. While aging in place approaches offer a vision of old age that is appealing to seniors and governments alike, they offer little insight into what happens when seniors' aging needs are not met.

## Impact on housing providers

When seniors in social housing have needs that go unsupported, their health and wellbeing suffers. It is important to note, though, that unsupported seniors also have an impact on providers of social housing. Increasingly, providers are forced to take responsibility for seniors' health and care needs – something they receive no core funding or support for. Research on elderly adults living in public housing in North Carolina, for example, found that building managers were often the only support system available to many senior tenants<sup>92</sup>.

In a recent ONPHA survey on unsupported tenancies, the majority of housing providers reported that their own non-specialized staff often end up intervening to help tenants<sup>93</sup>. The impact of this responsibility on staff is significant: "Providing these supports can also take a toll on staff who feel ill-equipped to deal with difficult situations or can't get their own work done because they are routinely responding to emergencies"<sup>94</sup>.

Moreover, the behavioural problems of unsupported seniors can result in increased disturbances and consequences for the social housing community as a whole. One housing provider described a senior tenant who had issues with bed bugs, but was unable to access a support worker to help prepare the unit for treatment<sup>95</sup>. If the issue remains unresolved, it could end up affecting the entire building.

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92 Susan D. Yaggy et al., "Just for Us: An Academic Medical-Centre Community Partnership to Maintain the Health of a Frail Low-Income Senior Population," *The Gerontologist* Vol. 46 No. 2, p.272

93 When asked how well this was working, over 70 per cent of respondents reported either "mixed results" or "not working." Only 23 per cent found this arrangement to be "working well." ONPHA, November 2015, p. 20

94 *Ibid.*, p. 19

95 *Ibid.*, p. 42

## Use of emergency services

Many seniors in social housing have health conditions that are only manageable until they reach a point of crisis. Some tenants have no one to assist them each day with their medication, for example, which is directly linked to increased rates of hospitalization<sup>96</sup>. When seniors lack these supports, they often end up relying on emergency services.

One social housing provider kept track of emergency calls over a three-month period, noting that EMS was called to provide assistance 31 times. Fourteen seniors – more than 20 per cent of all tenants living in the building – were hospitalized, for a combined total of 98 days. With hospital stays costing approximately \$450 per day, this is a significant expense that could have been avoided if they had regular access to the supports they needed.

In worst-case scenarios, seniors with unsupported needs may end up losing their housing. Senior residents with aging challenges can face eviction due to behavioural issues or non-payment of rent, particularly if housing providers are unaware of their needs. In these instances, seniors may end up staying in shelters, cycling through emergency rooms and hospital stays, or living on the streets.

While the exact number of seniors experiencing aging-related challenges that become homeless is unclear, research on homeless seniors in Sydney, Australia found that 67 per cent of participants experienced cognitive impairments, such as dementia<sup>97</sup>. Researchers have noted that while access to affordable housing is key to ensuring that these seniors do not become homeless, it alone is not sufficient. Support services are required, both in helping seniors secure housing, and also in making sure that they remain housed.

## Problems accessing long-term care

Social housing sites, like all communities, are home to some seniors who can no longer age in place. Seniors with serious health challenges need 24-hour nursing care and personal support, which is only available in long-term care facilities. In these facilities, the Province pays for nursing and personal care, while seniors or their families are responsible for accommodation costs. Seniors that cannot afford the cost of accommodation can apply for a rate reduction, though they are then ineligible for private or semi-private rooms.

Over the past 30 years, the proportion of Canadian seniors in long-term care has been declining. However, this is primarily due to governments' interest in controlling health spending, rather than a reduction in seniors' needs<sup>98</sup>. In 2010, the Ontario Government tightened eligibility requirements for long-term care, leading some to believe that the only way to be admitted is through the

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96 Sanders and Stone, January 2011, p. 2

97 Carol Chenco, "Homelessness and Dementia in Australia: A Literature Review," Victoria & Tasmania Dementia Training Study Centre, 2015, p. 5

98 Canadian Council on Social Development, 2015, p. 37

hospital system. Still, over 21,000 seniors are waiting for a permanent space in a long-term care facility in Ontario. The median wait time for a placement is 116 days, but can vary significantly by region<sup>99</sup>. At the same time, facilities can decline an applicant if the home “does not have the physical facilities necessary to meet the client’s care requirements; or staff members at the long-term care home lack the nursing expertise necessary to meet the client’s care requirements”<sup>100</sup>.

Social housing providers have noted that some of their tenants should be in long-term care, but either face too long of a wait or have been declined by various facilities. This is especially common for seniors with behavioural issues, often stemming from mental health and/or addictions challenges. These seniors end up remaining in their social housing unit, often without any regular supports. As one provider noted, “We see our complex care tenants get denied [access to long-term care] a lot. And if they are denied, they just remain where they are – and that becomes very hard.”

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99 Health Quality Ontario, *Measuring Up: A Yearly Report on How Ontario's Health System is Performing*, Queen's Printer for Ontario: 2015, p. 86

100 *Long-term Care Homes Act*, 2007, S.O. 2007, c.8, s.44 (7).

# Senior groups at an elevated risk

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Aging in place in social housing

Some seniors in social housing face an even greater risk for negative health outcomes and aging challenges. For many of these seniors, these risks are directly connected to high levels of poverty and marginalization.

## Senior women

Women earn less than men throughout their life, leading female seniors to rely more on government transfer payments to support themselves, while male seniors are more likely to have retirement income from pensions, investments, and employment<sup>101</sup>. At the same time, senior women are twice as likely to live alone than senior men, partially because women tend to live longer than men<sup>102</sup>. Senior women are more likely to suffer from dementia and depression than senior men, and are more likely to experience falls that result in injuries<sup>103</sup>. They are also less likely to have a healthy, balanced diet and to engage in physical activity than senior men<sup>104</sup>.

## Aboriginal seniors

Aboriginal seniors also experience unique aging risks due to systemic inequalities<sup>105</sup>. Life expectancy for Aboriginal individuals is six years shorter for men and five years shorter for women than for non-Aboriginal people<sup>106</sup>. Aboriginal seniors are also nearly twice as likely to be living on a low-income, resulting in increased rates of diabetes, arthritis, and other chronic health conditions<sup>107</sup>. At the same time, the lasting effects of colonization, racism, and the residential school system have led some individuals to experience mental health challenges, including post-traumatic stress disorder and social isolation<sup>108</sup>. The heightened health needs of many Aboriginal seniors require a unique, culturally-appropriate approach to aging<sup>109</sup>.

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101 HSC, 2014, p. 24

102 Government of Canada, *The Chief Public Health Officer's Report on the State of Public Health in Canada 2014*, Queen's Printer, September 2014, p. 11

103 Government of Canada, *The Chief Public Health Officer's Report on the State of Public Health in Canada 2010*, Queen's Printer, 2010, p. 27, 32-33

104 *ibid.*, p. 28-29

105 Stacey McDonald, *Ontario's Aging Population: Challenges and Opportunities*, Ontario Trillium Foundation: 2011, p. 7

106 Government of Canada, 2010, p. 22

107 McDonald, 2011, p. 8

108 Health Council of Canada, *Canada's Most Vulnerable: Improving the Health Care for First Nations, Inuit, and Metis Seniors*, November 2013, p. 5; 8

109 As the Health Council of Canada noted: "Health systems often fail to provide Aboriginal seniors with opportunities to communicate in their own languages, participate in ceremonies, and eat traditional foods. Participants stressed that these cultural supports are not just "nice to have"; they are critically important to maintaining the health and well-being of seniors." *Ibid.*, p. 9

## New Canadian seniors

Seniors that are relatively new to Canada also face aging challenges that set them apart from other seniors. Immigrant seniors who have lived in Canada for less than 20 years are three times more likely to be low-income than Canadian-born seniors<sup>110</sup>. Over 15 per cent of seniors who are immigrants do not speak English or French<sup>111</sup>, which may hinder their access to services and their understanding of their own health issues. The immigration status of some seniors may also restrict them from full access to certain health services. Finally, housing providers have noted that immigrant seniors who are being sponsored by family members are often at risk for anxiety and depression, especially if they have been neglected by their relatives.

## Seniors with a history of homelessness and/or mental illness

Provincial policies of de-institutionalization and the prioritization of vulnerable clients on waiting lists has resulted in a large number of social housing tenants with mental health and addictions issues and histories of homelessness<sup>112</sup>. Currently, an estimated 23,000 tenants with a serious or persistent mental health issue live in Ontario's social housing communities – many of whom are seniors<sup>113</sup>. Stigma and marginalization can result in tenants' low usage of health care services or past experiences of poor care<sup>114</sup>.

Experiences of mental illness, addiction, and/or homelessness often intensify the aging process. Data from the U.S. revealed that people living with a serious mental illness have a life expectancy that is 25 years shorter than the general population, due to increased presence of cardiovascular disease, diabetes, respiratory disease, and other chronic illnesses<sup>115</sup>. Individuals who have experienced homelessness are at an especially elevated risk: they are 28 times more likely to have Hepatitis C, 20 times more likely to have epilepsy, five times more likely to have heart disease, and four times more likely to have cancer than the general population<sup>116</sup>.

Because social housing is home to many seniors that belong to one or more of the above groups, special consideration is necessary. The elevated aging and health challenges that these seniors face set them apart. For these seniors to age in place successfully, funding for resources and supports is required.

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110 Government of Canada, 2010, p. 34

111 McDonald, 2011, p. 6

112 ONPHA, November 2015, p. 14

113 Ibid.

114 Toronto Early Onset Illness and Mortality Working Group, *Forty is Too Young to Die*, October 2011, p. 17-18

115 Ibid, p. 6

116 Ibid, p. 7

# Ministry response to health system reform

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Aging in place in social housing

In 2015, the Ministry of Health and Long-Term Care (MOHLTC) released *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. The Proposal addressed the gaps in the current health care system and issued a number of recommendations. Central within the Proposal is an expanded role for Ontario's 14 Local Health Integration Networks (LHINs). In addition to other duties, the LHINs would take over the management of home and community care from the Community Care Access Centres (CCACs). The services would continue to be delivered by current providers and staff, but the CCAC boards would be abolished.

The Proposal recognizes that there are gaps in access to health care, and that integration of services can and should be improved. It argues that placing home and community care under the control of the LHINs could increase the consistency and accessibility of services – a problem that has long-plagued the CCACs<sup>117</sup>. The proposal also acknowledges that certain individuals, such as Indigenous Peoples, Franco-Ontarians, newcomers, and individuals with mental health and addictions challenges, all face greater difficulty accessing health and care services.

These are important and welcome admissions. However, it is unclear how much the transfer of responsibility to the LHINs would improve access to services, especially for low-income seniors. While the proposal recognizes that income level plays a role in health disparities<sup>118</sup>, it does not contain a clear framework for better meeting the needs of individuals struggling with poverty.

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117 Office of the Auditor General of Ontario, *Special Report: Community Care Access centres – Financial Operations and Service Delivery*, Queen's Printer for Ontario: September 2015, P. 5;44;46

118 Ministry of Health and Long-Term Care, 17 December 2015, p. 10

In the past, LHIN-directed initiatives such as service hubs for “high risk” seniors have faced issues due to their reliance on referrals to establish connections with clients, rather than direct outreach (which housing providers have suggested would be more effective)<sup>119</sup>. At the same time, the LHINs’ focus on moving patients through the system and reduction in use of ALC hospital beds has not always been compatible with the idea of long-term, permanent support for tenants<sup>120</sup>.

The Ministry’s Proposal should be viewed as an opportunity for the LHINs to engage in a direct conversation with social housing providers about what senior tenants need and how to better align priorities. Aside from the increased responsibilities set out in the Proposal, the LHINs also have an important role to play in allocating funding for supports for seniors in social housing to successfully age in place.

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119 ONPHA, FocusON: *LHINs and the Housing System*, December 2013, p. 31

120 *Ibid.*, p. 9; 30-32

# Opportunities for improvement

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Despite the restructuring initiatives presented in *Patients First*, many seniors will continue to require assistance in order to age in place. The Province should increase funding to facilitate successful aging in place for low-income seniors, and ensure that there is a place for them when they can no longer remain in their homes. With this in mind, we ask that the Province consider the following:

## 1. Increase supports in social housing

Many seniors in social housing would be able to age in place if they had regular access to support services. Seniors need the “right support at the right time,” meaning that supports should be scalable based on need. For seniors with low to moderate needs, a system of visiting supports that provides assistance with certain activities may be sufficient. These supports can be regular visits from a trained staff member or PSW, or an emergency-response program that provides seniors with a 24-hour help line. For seniors that require more assistance with activities of daily living, support hubs located within a building may be more appropriate. In Niagara Regional Housing, for example, four seniors buildings include “wellness centres” where tenants can access care services from the March of Dimes Canada, seven days a week.

To ensure that tenants in social housing have access to the supports they need, the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Municipal Affairs and Housing (MMAH) should commit to a joint strategy to fund supports in social housing as part of the core provincial budget<sup>121</sup>. An in-depth exploration of this recommendation is provided in the recent ONPHA publication *Strengthening Social Housing Communities: Helping Vulnerable Tenants Maintain Successful Tenancies* (November 2015).

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121 Funding from MOHLTC would flow through the LHINs, which would provide dollars to community support agencies, while funding from MMAH would be directed to service managers to fund additional partnerships.



For seniors to be able to age in place in social housing communities, improved communication and collaboration between health institutions and housing providers is also necessary. When seniors are released from emergency rooms or ALC beds, they often need special assistance to help them transition back into the community. Toronto Community Housing, for example, is urging the Province to develop an improved hospital discharge process, where hospital staff must consider the condition of a patient's home (such as the presence of pests or clutter) before they are discharged<sup>122</sup>. This partnership between the provider and hospital staff can help ensure that a unit is habitable and safe for the tenant before they return home.

## 2. Expand the supply of supportive housing

Other options are needed for low-income seniors that can no longer age independently in their homes, but do not yet require the intensive assistance of long-term care. In Ontario, supportive housing can serve as a “middle option” for these tenants, offering on-site access to services like meal preparation, housekeeping, social and recreational activities, and some therapeutic or rehabilitative assistance<sup>123</sup>.

According to a recent ONPHA survey of social housing providers, the best solution for frail seniors and tenants experiencing behavioural challenges would be an increase in the number of supportive housing units<sup>124</sup>. Currently, there only 5,600 purpose-built supportive housing units in Ontario, and average wait times can stretch up to seven years<sup>125</sup>. At the same time, there are many seniors in ALC hospital beds, and long-term care facilities whose needs could be better met in supportive housing<sup>126</sup>.

The Province has recognized the value of supportive housing, and is currently funding an additional 1,000 units for tenants of all ages<sup>127</sup>. While this is a welcome development, it is not sufficient to meet the need for supportive housing, which will only increase as our population ages. The Canada Mortgage and Housing Corporation has recognized that due to the growing number of seniors that live alone, are frail, or have disabilities, a “considerable expansion” of supportive housing options is necessary<sup>128</sup>.

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122 Toronto Community Housing, *Getting it Done: Real Change at Toronto Community Housing*, 10 September 2015, p. 36

123 In Canada, British Columbia has been the first province to regulate and publicly fund assisted living facilities, which operate like a “service-enriched form of supportive housing.” In addition to the services mentioned above, assisted living facilities must offer some “prescribed services” such as assistance with medication, monitoring of diets and food intake, psychosocial or intensive physical rehabilitative therapy, and others. Ontario has yet to regulate or publicly fund an assisted living facility system. Kimberly M. McGrail, et al., *Who Uses Assisted Living in British Columbia? An Initial Exploration*, Centre for Health Services and Policy Research (University of British Columbia), April 2012, p. 4-14

124 *Ibid.*, p. 47

125 The Toronto Mental Health and Addictions Access Point, which manages the waiting lists for supportive housing in the City of Toronto, reports that wait times vary but a general guideline is 5 to 7 years. Information accessed from: <http://theaccesspoint.ca/frequently-asked-questions/>

126 McGrail et al., April 2012, p. 8

127 Government of Ontario, “Ontario Investing in 1,000 Supportive Housing Units,” News Release, 16 December

128 CMHC, *Impacts of the Aging of the Canadian Population on Housing and Communities*, Research Highlight, February 2008, p. 5

### 3. Provide funding for building improvements and modifications

Social and supportive housing providers are increasingly under a legal obligation to consider the needs of their aging tenants. In addition to the duty to accommodate under the Human Rights Code, providers must ensure their properties are safe for all tenants. As the number of seniors living in social housing increases, providers are experiencing a growing disconnect between their legal obligations and their budgets.

Some providers that house a large number of seniors, for example, have recently been informed by their local fire department that their buildings may be designated “care occupancies” under the Ontario Fire Code<sup>129</sup>. This designation means that the providers must implement new capital projects, such as modernized smoke alarm and sprinkler systems, self-closing doors, and emergency lighting<sup>130</sup>. These modifications cost money, but no new funding has been made available to support these upgrades.

If providers are to house a growing seniors population in an environment that meets their needs, they need the funding to do so. The Province should establish a capital grant program similar to the 2009 Social Housing Retrofit and Repair Program, with funding available to providers for modifications and upgrades that improve accessibility for seniors. Eligible projects should range from large investments, like lifts or elevators, to smaller projects such as building-wide implementation of lowered door handles and light switches. This funding would not only ensure that housing providers are able to meet their legislated obligations, but would also be a significant investment in accessible units for future tenants.

### 4. Increase access and options for long-term care

Even with improved supports in social housing and more supportive housing spaces, some seniors will still require intensive, round-the-clock supports that are only available in long-term care facilities. In order to ensure that these seniors do not continue to remain vulnerable in social housing, or wind up in costly ALC beds in hospitals, the Province must increase the availability of long-term care. By expanding the number of spaces in these facilities, wait times for long-term care will decrease and eligible seniors will be assisted more efficiently.

At the same time, the Province must develop options for seniors who are denied access to long-term care due to behavioural challenges. One option is to increase the capacity within the long-term care system to better serve seniors that have behavioural responses due to dementia, mental health and addictions, and other cognitive challenges. By enhancing staff knowledge of appropriate responses, long-term care facilities will be better prepared to address the challenges that some residents face.

Another option is to expand support programs like LOFT Community Services’ Behavioural Support Services – Mobile Support Teams. These teams provide advice and referrals through a system of visiting support to seniors living in social housing, in private residences, and in long-term care facilities<sup>131</sup>. Expanding this program will help ensure that tenants with behavioural challenges who are waiting for long-term care placement have access to assistance, while those already living in facilities are adequately supported.

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129 ONPHA, *infoON: Care Occupancies*, June 2015.

130 Ontario Regulation 213/07, Section 9 under the *Fire Protection and Prevention Act, 1997*, Accessed from: <http://www.ontario.ca/laws/regulation/070213>

131 More information on the program is available at: <http://www.loftcs.org/programs/supports-for-seniors/behavioural-support-services/> (Accessed 13 January 2016).

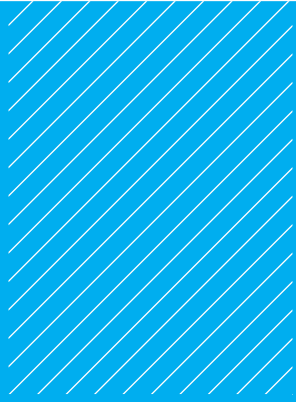
# Conclusion

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Ontario's demographics are evolving at an alarming rate. By 2041, over 4.5 million seniors will live in Ontario, each with their own aging needs and challenges.

Over the past few decades, aging in place has emerged as the dominant approach to addressing the needs of elderly seniors. Many aging in place approaches assume that seniors have access to a range of resources and supports that can ease their transition into old age. But low-income seniors, and seniors in social housing in particular, are vulnerable to additional challenges that can present barriers to a healthy aging process.

Aging in place should not be seen as a one-size-fits-all solution. Health care and housing policies that are grounded in aging in place theory should acknowledge the different outcomes seniors face due to socio-economic status, and increase funding options to assist seniors in social housing with their care and support needs.



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