North East **LHIN** | **RLISS** du Nord-Est

Innovative Housing with Health Supports in Northeastern Ontario

Strategic Plan: 2016-2019

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Acknowledgements

The North East Local Health Integration Network (NE LHIN) Expert Panel with support from the Northern Ontario Service Deliverers Association (NOSDA), Housing Services Corporation, SHS Consulting, Canadian Mental Health Association Manitoulin-Sudbury formulated this Strategic Plan to guide ***Innovative Housing with Health Supports in Northeastern Ontario***. As a social determinant of health, housing is an all-government agenda item and has been identified by the NE LHIN as a key element supporting health care transformation and quality of life.

The NE LHIN sponsored a forum entitled "***Building for the Future***" in October, 2015. That first forum on housing and health in Northeastern (NE) Ontario was dedicated to fostering partnerships, identifying barriers and opportunities, as well as exploring creative solutions to meet the future housing and health needs of NE Ontario communities. As a result of that forum, there was a request for the NE LHIN to undertake additional work on the matters of housing and health. The NE LHIN created an expert panel on the matter and has sponsored this innovative housing and support-related, strategic initiative.

The Expert Panel chaired by Gary Scripnick, NE LHIN Board member and Past Chair of NOSDA, led a second housing forum (see Appendix 1) in June 2016 which was attended by over 100 participants. The draft plan was further discussed at the forum and was circulated to community partners for comment and feedback. The final version will be presented to the NE LHIN Board in September 2016.

This strategic plan is the result of significant community engagement, consultation and collaboration. The vision, mission, values, goals and objectives as put forth by the Expert Panel are clear and actionable. Further to NE LHIN Board endorsement, it is recommended that the plan be brought forward to the City of Greater Sudbury (CGS) and DSSABs across NE Ontario for endorsement.

August, 2016

Executive Summary

General population health is dependent upon appreciation and investment into social determinants of health. As such, the NE LHIN has taken a leadership role in the conversation about housing and health. A dialogue with experts in housing, health, development, and government in the fall of 2015 resulted in the formation of an expert panel on housing and health. Consideration of the facts, opinions, and opportunities in NE Ontario has resulted in this strategic plan.

The foundation of this strategy is the recognition that there is a shortage of affordable and/or appropriate housing stock across NE Ontario. In addition, with growing pressures on the acute care sector and appreciation of the importance of housing individuals in community with appropriate supports to advance quality of life and population health has resulted in a series of recommendations to increase the housing stock, and to provide adequate supports in community.

The intention of the expert panel was to stretch limits, leverage opportunity and funding to support investments into housing, and health and enable care close to home.

The values guiding development of the plan include:

- *Client-Centered, People-Oriented*
- *System Driven, Service Provider Sensitive*
- *Mutually Accountable*

Four overarching themes from were identified during the course of planning and include:

1. *Clients / People*
2. *Innovative Housing and Infrastructure*
3. *Innovative Health / Social Support Provision*
4. *Innovative Leadership and Sponsorships*

Within this report, the expert panel has prepared a comprehensive list of objectives that cascade from the overarching themes. It is proposed that the expert panel will meet on an annual basis to be briefed on the progress on the strategy and advise the NE LHIN accordingly.

Background

Northeastern Ontario includes the Districts of Sault Ste. Marie, Algoma, Manitoulin-Sudbury, the City of Greater Sudbury, Cochrane, Nipissing, Temiskaming, James Bay Coast and Parry Sound. To say the population in NE Ontario, indeed all Northern Ontario, deserves special attention when it comes to developing innovative housing with health supports is an understatement.

It is well documented that Canada's population is aging. This is especially evident in the demographic makeup of Northern Ontario. The proportion of senior households is increasing relative to its' overall population. One reason is that younger people are moving out of the North in search of education and employment, while older people tend to stay in their communities

Fewer young and working aged adults (e.g. aged 15 to 54) results in a tax burden on older adults who may be on fixed incomes. Further, high numbers of seniors in communities put pressures on municipal services (e.g. EMS, Housing) which are funded by the municipal service manager. Seniors may have a reduced ability to pay the resulting increased costs of the property tax burden due to fixed incomes. An aging population has implications on social housing as persons on fixed or low incomes may have increasing difficulty maintaining and living in their own homes. An aging population has implications on Emergency Medical Services as need for medical services increases with age.

Historically, culturally or linguistically appropriate specialized health or social services have been developed where there have been critical masses of demand. This means that services are diffused throughout the region, and that people with specific health or social service needs often have to travel great distances or sometimes move to access specific, needed services.

Over ten percent of the population in the North is Indigenous, representing about 40% of all indigenous people in Ontario. 26% of Ontario's Francophones live in Northern Ontario. There are 15 Friendship Centres and one satellite office located in Northern Ontario – six of which are located across the NE (including one satellite office). Friendship Centres are community hubs, providing multi-sectoral services to urban Indigenous people and in many cases have been serving the community in their respective towns or cities for over 20 years and may be the only urban Indigenous organization in their location.

Considering that 84.1% of Indigenous people in Ontario live off-reserve[1], and that Indigenous people represent one-third of the total population in northern Ontario[2], urban Indigenous engagement in creating social service delivery in Northern Ontario is crucial. Key factors influencing the increased migration to urban centres by Indigenous people are the perceived educational and employment opportunities, the perception of greater access to supports and

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[1] Statistics Canada., *National Household Survey* (Ottawa, ON: Statistics Canada, 2011).
[2] Service Canada., *Client Segment Profile: Aboriginal Peoples, Ontario* (Ottawa, ON: Service Canada, 2014).

services, and the hope of adequate housing. Nonetheless, for many, the socio-economic challenges that have influenced their migration continue to impact their daily lives and a disproportionate percentage of urban Indigenous people continue to live below the poverty line.[3]

Another issue affecting housing and services in the North is the regular need to evacuate communities in the Far North to more southern communities in Northern Ontario due to climate change and fires. This puts, short term, but severe pressure on housing and support services.

In the rural areas of the region, there is a higher than national/provincial average dependency on government transfer payments (pensions, assistance, etc.) due to a lack of earning opportunities. There is relatively high mobility of younger families across the region and into and out of the North in search of education and employment. They are adversely affected by externally driven, resource-based cyclical economic downturns, limited economic diversity and job opportunities, an aging-in-place workforce reducing upward occupational mobility, lower literacy, at-risk youth, lower than average family incomes and higher than average low income families and single parents. Poverty rates are higher due to a lack of employment opportunities; disability is more prevalent in Northern Ontario. This also has a negative impact on the availability of informal caregivers to address the needs of aging relatives and neighbors. These determinants of health factors have an impact on the health status of Northern Ontarians: on average the health status of Northern Ontarians is lower than their Southern Ontario counterparts. As a result of these phenomena, northern communities are generally more immediately and severely affected by economic and demographic changes. All of these challenging factors are affecting the long-term viability of some depopulating, de-serviced municipalities.

As noted in the research conducted by SHS Consulting for this project(see Appendix 2), there is great concern across the province regarding the lack of supports for the growing number of vulnerable individuals being housed within social housing portfolios and particularly in Northern communities. There are many vulnerable populations in communities across the NE LHIN who are at risk of suffering poor health outcomes and, at the same time, likely to experience difficulty managing those outcomes. While the Housing First policy is strongly supported and there is widespread agreement that social housing provides a critical foundation for helping reduce poverty among these individuals, these providers are finding a widespread lack of supports for addressing their clients' needs. It is also worth noting that indigenous housing providers have noted Housing First is too narrow a focus to holistically address social housing needs. In addition to the need for supportive services, investments are required across the housing continuum starting with both homelessness and emergency housing and supportive and transitional housing. Staff responsible for operating social housing, such as property managers and building superintendents, or volunteer boards themselves, are often left to try and cope with meeting these needs; most are lacking in the required skills and resources and are not trained

[3] OFIFC, OMAA, ONWA, *Urban Aboriginal Task Force: Final Report* (Toronto, ON: Ontario Federation of Indigenous Friendship Centres, Ontario Métis Aboriginal Association, Ontario Native Women's Association, 2007). 185-186

to fulfill this role. This issue is being experienced not only among the mainstream population; Indigenous housing providers and agencies such as Ontario Aboriginal Housing Services are also finding similar concerns within their social housing portfolios as well.

At the same time, the support system for these individuals consists of a dizzying array of services, programs and agencies that can be difficult for clients to navigate. Clients often have to tell their story over and over. There isn't dedicated, long-term funding for such services and no coordinated approach to providing a consistent and effective level of support for these individuals between and among the various services a client may need at a given time. On top of that, data on which to plan appropriate services is disparate and limited.

Findings from research activities suggest that there is a need to enhance home and community care across the NE LHIN and indeed across Ontario. This includes increasing access to in-home services and expanding the supply of specialized supportive housing. This housing with health support services should provide long-term, flexible and, when necessary, more intensive supports to particular population groups who may not be appropriate candidates for long-term care. Currently, it appears that there are significant populations of vulnerable groups suffering from multi-vulnerability. Their unmet needs many not only create a risk for poor health outcomes and potentially avoidable health crises for these clients, but also could lead to a loss of independence through an inability to sustain their housing, a frequent use of emergency services, increased demand on Alternative Levels of Care, increasing caregiver burnout and can lead to premature admission to long-term care homes. This may or more likely may not be a good fit for the individual.

All levels of government along with the private sector need to strategically plan and execute projects that bring social housing and services together across Ontario to maximize the impact of scarce public resources. Nowhere is this initiative more urgent than in NE Ontario, where the population of seniors and persons with low income is higher than the provincial average. The NE also contains numerous small communities with aging populations and few options for people who require supports to live in their own homes and remain in their own communities. The concept behind planning for the development and/or integration of social housing with health supports is to take advantage of the current climate and growing need for affordable housing in this region of the province.

Why now? Interest rates are at historic lows in Ontario. With the stimulative budgets tabled by the Federal and Ontario governments earlier this year, it's time to address social housing and infrastructure deficits that have accumulated in this province over the past number of years. Further, integrated health and service delivery should be less expensive to the taxpayer to deliver. However, these plans must recognize that the historical approach of funding infrastructure and putting increasing demands on local property taxes is insufficient to meet the challenges ahead. The monies for social housing required are substantial, and will require judicious project evaluation and selection.

Innovative LHIN-funded Housing Models

Creativity and innovation are critical to meeting the varying health care needs of the population. More creativity is required to tackle the shortage of affordable housing. The NE LHIN has supported a number of innovative programs and some are listed below and were also identified at the October, 2015 Forum:

Carruthers Home (Permanent Housing Model)

Three men have moved from North Bay Regional Health Centre to live in this community home for clients living with acquired brain injury. The core transition team from the hospital is a registered nurse, social worker and behavioural therapist, with additional access to an occupational therapist, with peer support staff from People for Equal Partnership in Mental Health (PEP) to complement the clinical staffing of the home.

North Bay-based Physically Handicapped Adults' Rehabilitation Association (PHARA)

PHARA started providing supports to people with physical disabilities in 1982. Its services have expanded to providing housing opportunities for low to moderate income families. It owns and operates three housing complexes in North Bay with a total of 143 housing units. There are 36 totally accessible units for people with physical disabilities and the persons in these units are part of the Attendant Care Program. The Outreach program provides supports to people in their home in communities from Mattawa to Warren. In partnership with the North Bay Regional Health Centre, PHARA has a Transition to Home program that enables people to leave the hospital and enter the program for a period of 90 days.

Wade Hampton House, March of Dimes

The renovated former Ridgemount Public School now houses 10 people, the majority under the age of 44, with moderate to severe brain injuries. Prior to its construction, most of these young adults would have ended up in long term care homes. Wade Hampton House is now the only congregate care home for individuals with an acquired brain injury (ABI) between Etobicoke and Thunder Bay.

Moonlight Residential Home

The Sudbury residence supports up to eight people as they transition back into community after being in hospital. This housing model represents a unique partnership between the North Bay Regional Health Centre, the CMHA Sudbury-Manitoulin and the Northern Initiative for Social Action (NISA). The home uses a Peer Support staffing model. Peer Support Workers are those who have lived experience of mental illness and who offer recovery-based support using their own experience.

A further example of innovation undertaken by the NE LHIN is the development of a behavioural support program for individuals who have been traditionally housed in hospital but who can be supported in long term care with enhanced staffing support. It is examples such as these which provide incentive to continue to seek appropriate accommodations for individuals.

Strategic Planning

Key to planning for systems change in government is identifying areas of alignment with the goals and aspirations of potential partners. The proposed Innovative Housing and Health Supports Strategy has been developed in the context of the Ministry of Health and Long Term Care's new ***Patients First*** initiatives, the NE LHIN's ***Integrated Health Services Plan 2016-2019,*** the Ministry of Housing's March, 2016 ***Long Term Affordable Housing Strategy*** and its July, 2016 ***Housing and Homelessness Policy Statement,*** as well as NOSDA's November, 2014 ***Consolidated Pan Northern Housing and Homelessness Report*** and its' most recent ***Strategic Plan (2013-2016).*** Another key component of the current provincial policy and program context is the Province's ***The Journey Together: Ontario's Commitment to Reconciliation with Indigenous Peoples*** (2016), which highlights the collective responsibility to work with Indigenous communities to address the range of social service gaps that face these communities in the North.

Aligning this strategic plan with the above initiatives and plans will maximize their collective impact and improve quality of life for those requiring housing with health and social supports in NE Ontario.

While there is considerable variety in the form, content, process and duration of strategic plans in the public and not-for-profit sectors, each tend to have some common elements. First, the process reflects on recent history, current accomplishments and future challenges. Most include an internal diagnostic – a so-called SWOT analysis – looking at the organization's Strengths-Weaknesses-Opportunities-and-Threats and in this case, an external assessment – also referred to as a PEST review – looking at relevant Political, Economic, Social and Technological impacts that have a direct bearing on the local operating environment. This information provides a frank assessment of current issues and future trends.

Next, the organization reviews the activities with which it is involved – its reason for existing. These mandates are then expressed in a Mission Statement. In parallel with this exercise, the organization determines the direction that their leadership wishes to take over the term of the strategic plan. This Vision Statement sets the overall direction for the organization in a way that all those involved can understand.

Finally, the strategic planning process describes what is to be achieved as well as the manner in which to achieve it. The Strategic Plan aims to establish broad Goals for the organization. To achieve these goals, the plan then identifies Objectives that will either achieve or advance the goals. These objectives require action plans on the part of all system players with identified lead organizations for accountability purposes.

The Strategic Plan addresses the ways in which progress will be driven, actions taken and measured, course corrections made and overall achievements evaluated when the Strategic Plan comes up for renewal. Successful strategic planning is a shared process – it's about engagement.

Strengths, Weaknesses, Opportunities and Threats

The Expert Panel and ex-officio advisors were surveyed and the following is a summary of the panel's assessment of the strengths, weaknesses, opportunities and threats that have significant impact on the development of Innovative Housing with Health Supports in NE Ontario.

Strengths

Strengths identified by the Expert Panel included:

- *Communities are its greatest strength*.
- *Well-developed infrastructure*
- *Northern people are a strength (resilient, growing Indigenous population both on-reserve and off, etc.)*
- *Generally positive and cooperative relationships among providers and between sectors*

Weaknesses

Weaknesses identified by the Expert Panel included:

- *Large geographic area*
- *Higher construction, service and energy costs/affordability*
- *Cyclical economy*
- *Low population densities and an aging population with slow to negative population growth.*
- *Lack of expertise/understanding in a wide variety of areas – lack of people with the right skills to develop appropriate housing and/or support service networks in all communities*
- *Lack of coordination/bureaucracy/silo mentality between ministries, sectors, organizations*
- *Discrimination – against race, gender, age, ability, sexual orientation, persons with mental health issues by service providers, landlords, other tenants, general public*
- *Lack of volunteers to assist people (diminishing informal support networks)*
- *Long-term care not always able to handle some individual behaviours*
- *Alternative levels of care needs are growing*
- *Lack of housing with adequate levels of support*
- *Service gaps between rural and urban population*

Opportunities

Opportunities identified by the Expert Panel included:

- *Alignment with other levels of government/timing is 'right'*
- *Cooperation/collaboration between senior levels of government, municipalities, housing service providers, health and social services, private sector*
- *Addressing the needs of an aging population*

- *Use of a wide variety of educational facilities to develop knowledge, training opportunities, research on better housing techniques, better data for planning of health and social services delivery*
- *Use of technology*
- *Affordable, serviced land is available in many communities across NE Ontario*
- *Need for cross-sectoral funding support*

Threats

Threats identified by Expert Panelists included:

- *Aging public housing stock*
- *Lack of funding for 'bricks and mortar' and supports*
- *Geography – vast rural and isolated areas*
- *Aging population and declining population*
- *Capacity – widely distributed, low population base leads to many areas not having people with needed expertise*
- *Discrimination*
- *Disparity of availability of housing/services*
- *Silos/leadership that will witness the continued diminishment of delivery capacity in NE Ontario*
- *Inadvertent creation of care homes in social housing – as social housing residents continue to 'age in place' increasing pressure is put on social housing staff to provide support services*

Political, Economic, Social and Technological Implications for Innovative Housing with Health Supports in NE Ontario

The Expert Panel identified political, economic, social and technological trends that impacts Innovative Housing with Health Support development in NE Ontario.

Political Implications

- *Limited political representation/voice in senior levels of government*
- *Need for inter-ministerial cooperation and understanding and the reduction of 'silos'*
- *Need for inter-agency cooperation*
- *Need for recognition of limitations of municipalities to fund housing and/or health in the North off of local property tax bases*
- *Need for First Nations Accords in health and housing funding agreements*

What are the Economic Implications?

- *Housing and healthy population are economic drivers*
- *Lack of economies of scale, higher construction costs*
- *The need for a poverty reduction strategy specifically in the North*
- *The need for capital grants and more public/private partnerships and new ways to fund and deliver housing and health and social supports*

What are the Social Implications?

- *Aging population*
- *Cultural diversity*
- *Geographical isolation and the need for transportation*
- *Vulnerable populations*
- *Health and social programs and the private sector have not historically worked together in NE Ontario*
- *Social isolation*

What are the Technological Implications?

- *Opportunities for technology in housing construction and renovation*
- *Opportunities for technology in health care – telemedicine/record keeping*
- *Opportunities for technology applications in telecommunication (need for speed)*
- *Issues/concerns about technology – lack of adoption by aging Northern population; variety of vendors and formats; FOI concerns*

Mission

The Mission of the Expert Panel is to enable progress toward achieving the goals and objectives contained within this Innovative Housing with Health Supports Strategic Plan, to meet on an annual basis to develop and maintain activity in these sectors in NE Ontario and to advise the North East Local Health Integration Network, the Northern Ontario Service Deliverers Association, DSSABs, the Ministry of Housing, City of Greater Sudbury, the Ministry of Health and Long-Term Care and others as appropriate on related issues.

Vision

The vision of the Expert Panel is that every person in Northeastern Ontario has an affordable, suitable and adequate home to provide shelter with high quality and well-coordinated health and social services available to support independence.

Values

Values identified by the Expert Panelists, through focus group and stakeholder research and during the June 8, 2016 Forum are highlighted below:

Client-Centered, People-Oriented

The Expert Panel values a 'People First', anti-racist, non-discriminatory, Indigenous cultural competency-trained approach, which fosters trust between clients and service providers and which ensures that no client is ever turned away because they tried to access services through

the ‘wrong door’. Cooperation between service providers is valued as is a willingness to make organizational or corporate cultural changes for the betterment of the well-being of clients.

System Responsive, Service Provider Sensitive

The Expert Panel values a system which is collaborative, communicative, coordinated and adaptable, and which encourages flexible funding and information sharing among all service providers. The care system must be responsive and supportive of clients and their informal networks. Bureaucratic barriers and ‘red tape’ needs to be eliminated. The housing, health and social service network in NE Ontario needs to be accessible, responsive and respectful of all clients (including but not limited to First Nations, urban Indigenous, Lesbian, Gay, Bi, Trans-sexual, racialized, mentally or physically challenged persons, victims of violence, youth at risk, seniors and other marginalized populations). The service network and the services provided should be community-driven; responsive to objective measures (i.e. data); and open to changes that data supports; and be affordable to users and accountable for monies spent. Most importantly, the dignity of the individual – including both staff and clients – must always be respected.

Mutually Accountable

The Expert Panel would value a new approach to government funding which promotes longer-term funding that is flexible enough to deal with unforeseen issues or opportunities. Funding decisions should be data driven, applying a ‘wellness’ lens, encourage the breaking down of silos and be made in a thoughtful, logical fashion. Mutual accountability of funders, service providers and clients is valued as is open, ongoing and clear communications. These values promote a ‘pro-active, can-do’ attitude among service providers and are reassuring to clients. Finally, service providers should take all possible steps to engage the private as well as the public sectors, promote affordability, energy efficiency and above all, service integration for the benefit of clients and the public.

Goals and Objectives

There are more than 10,000 vulnerable tenants who live in social housing and many other vulnerable adults who live on their own across NE Ontario (SHS, 2016). It is critical that a coordinated system of innovative housing with health supports be in place to help meet the needs of these vulnerable persons. To support this, parties involved need to engage in a collaboration of committed public and private partners with shared responsibility to better, objectively meet the needs of clients. This can be done through the development of innovative solutions and addressing District Housing and Homelessness Ten Year Plan directions and service provider housing gaps developed by DSSABs and the CGS. Below are four goals and related objectives:

- Goals provide a broad set of themes
- Objectives are categorized by related Goals and identify observable activities. They are further broken down by Time to Implement: Immediate Term (less than 6 months); Short Term (six months to one year); Intermediate Term (one year to two years) and Long Term (over two years).
- There will need to be further definition of this strategy by assigning prioritized objectives to leads / organizations.

GOAL 1: Clients/People

To develop a 'People First' approach to the development of Innovative Housing with Health and Social Supports in NE Ontario, citizens must be involved in a meaningful, ongoing way in the design and provide input into that development process.

Objective:

1) Develop strategies to engage, reduce and prevent the number of people experiencing chronic homelessness and homelessness among vulnerable persons, youth and Indigenous peoples, as appropriate to the local context incorporating innovative approaches and a Housing First philosophy (INTERMEDIATE TERM)

GOAL 2: Innovative Housing and Infrastructure

Identify a range of innovative funding mechanisms to aid in the development /creation, renovation or re-purposing of a range of adequate, affordable, safe and energy efficient housing through the judicious and accountable use of government, public and private sector funds to reduce/eliminate homelessness and/or inadequate housing.

Objectives:

1) Explore and develop innovative funding and construction/renovation/repurposing/energy conservation methodologies (ONGOING)

2) Develop/use consistent, objective methods of measuring need, including households experiencing homelessness/inadequate housing. These methods must go beyond the Housing First policy's reliance on Point in Time counts, which ignore issues of 'hidden homelessness' (INTERMEDIATE TERM)

3) 'Bench test' and modify the financial analysis tool developed by Housing Services Corporation, with a view to maximize its utility for communities/organizations considering developing innovative housing in NE Ontario (IMMEDIATE TERM)

4) Engage the private sector to seek innovative ways to involve them in investing in affordable housing (ONGOING; INTERMEDIATE TERM)

5) Housing builders and providers need to know how to engage Home Care and/or service providers if they are to develop or provide units for the "frail" community members or a hospital discharge program. This link needs to exist to emphasize the connection between integrated service delivery and the development of community homes for high needs citizens (INTERMEDIATE TERM)

6) Mandate more education for property managers/building superintendents to help them link tenants with service providers. If a social housing provider or developer doesn't want to invest in expanding the role of their staff, they could partner with a support services agency who could a) provide assessments b) deliver care/interventions where appropriate. Property owners could accelerate this process by offering some space in their building where agencies delivering care (could be multiple agencies) can write their reports/share information with other caregivers where appropriate as well as reach out to tenants or provide several units that an agency is responsible to fill and provide care. This approach allows for a natural nucleus of service delivery in the building while respecting the fact that there will be all levels of independence represented in the housing (INTERMEDIATE TERM)

7) Where there are buildings housing vulnerable citizens such as frail seniors, or adults with physical disabilities and where a minimum of 4 individuals require personal support care services and there are a minimum of 12 individuals living in that building:

    a. A single provider be contracted to service all personal support needs to the citizens of the building
    b. Personal support hours are extended for each eligible individual in that location to enable variability and flexibility on a daily basis to care of all individuals in that building.
    c. Consistency in attendant care be a standard of expectation
    d. Flexibility in range of type of services provided be pursued and supported

e. The facility be utilized as a ‘community hub’ to serve the health needs of neighboring residents – volume permitting
f. A model that supports these concepts be developed by the NE LHIN by December 31, 2016 and implemented by April 1, 2017 (SHORT TERM)

8)
Where there are buildings and neighborhoods where this is a high concentration of vulnerable citizens:

a. Satellite support offices be positioned within a close geographic proximity
b. Social housing complexes be encouraged to provide rental arrangements to such support agencies using a variable cost recovery for rent
c. The LHIN and local health service providers commit to supporting a community hub model which is premised upon improving the social determinants of health be prioritized for the most marginalized neighborhoods across the NE LHIN in particular in alignment with the rural health hub strategy and urban areas of the NE LHIN
d. When new health care models are being developed such as community health centres they be prioritized to areas where there are a high concentration of vulnerable citizens.
e. Within the social housing portfolios of local communities where there are units that are 3-4 bedrooms and identified as surplus, they be identified as sites supported for accommodations for individuals identified as Alternative Level of Care (ALC), pending service commitment (SHORT TERM)

9) Where there are long term care, hospital, or agencies providing concentrated health services within close proximity to assisted or retirement living or social housing projects, these organizations coordinate health and ancillary services (INTERMEDIATE TERM)

10) Ensure energy efficiency is prioritized (SHORT TERM)

11) The funding complexities at start-up could be eased if there was a basic Memorandum of Understanding that assigned a matrix of funding available for the creation of Home Care units e.g. "*5+ Bachelor apartments with Home Care available will be awarded $7,000 each for initial construction costs*." Having such a commitment would encourage easier facilitation of loans or grants for the builders and still allow the actual amount of funding to be controlled with-in predetermined limits (INTERMEDIATE TERM)

GOAL 3: Innovative Health/Social Support Provision (Service Design and Delivery)

Goals for the development of innovative health and social supports in NE Ontario include:

-The development of effective, innovative and inclusive partnerships/networks that are responsive and flexible in addressing client needs and apply a No Wrong Door approach. These ‘Resource hubs’ should employ ‘best practice’ identification, capture and communication of these practices. These groupings should be adequately resourced and have skilled workers.

-These organizations are oriented to providing early intervention/prevention (i.e. assessment tool), provide appropriate transitional support, responsive crisis care and use a 'wrap around', integrated care team approach/continuum of support (prevention/early intervention to life skills to intensive care to crisis support).

-These organizations provide equal access to support services that provide accessible and available support systems in all communities. They make effective use of technology, 211 services and mobile options to address geographic, physical and psychological isolation.

Objectives:

1) Develop a system of support for social housing tenants/providers to allow streamlined access to health and social services to allow them to remain in their homes (LONG TERM)

2) Address collaboration with community partners and provincial ministries to reduce and prevent homelessness amongst those transitioning from provincially funded institutions and service systems, as appropriate to the local context (ONGOING; IMMEDIATE TERM)

3) A System and Patient 'navigator' or a Transitional Support Worker approach should be pilot tested between agencies providing services in housing, including First Nations and Urban Indigenous organizations with a view to improving quick access to services for clients and early resolution of issues clients face (SHORT TERM)

4) Develop coordinated 'success teams' which could include housing, financial, health, system navigation, employment or other support(s) to provide 'wrap around' service to clients where warranted (SHORT TERM)

5) Where managed alcohol programs are implemented across the NE to deal with the chronic homeless issue crossing over the housing and health continuum, the shelter component be prioritized by the DSSABs and the City of Greater Sudbury, and the supports funded by the NE LHIN (INTERMEDIATE TERM)

6) A Central Client Registry of persons requiring health or social supports and/or housing should be established, using 'best practice' technology to maximize support and minimize wait times (SHORT TERM)

7) Develop standardized data on clients. Develop a common intake form that identifies all services a client is receiving. Work in collaboration with First Nations/Urban Indigenous organizations to develop appropriate methods of data collection (SHORT TERM)

8) Enhance use of 211 system technology to provide coordinated and timely health and social service information and referral (INTERMEDIATE TERM)

9) Mandate that front-line service and health care treatment promotes well-being by ensuring all service providers are trained in human rights and Indigenous cultural competency. Implement human-rights based frameworks that are incorporated in

service delivery operations and audited regularly for compliance (INTERMEDIATE TERM)

10) Support the training, hiring and promotion of service providers and health care professionals who reflect the community they serve (INTERMEDIATE TERM)

GOAL 4: Innovative Leadership and Sponsorships

Funding should come with appropriate, flexible, objective oversight and advice and both the funder and funded agencies should be accountable for monies spent. Funders/sponsors should be pro-active, responsive and listen to community needs, engaging service providers, cultural and Indigenous groups and clients. Funders/sponsors should promote integration, energy efficiency and affordability of housing and/or supports. There should be ongoing engagement with communities and local level partnerships should be encouraged. Finally, cultural competency training should be promoted.

Objectives:

1) Intensify the link between housing and health and support services and continue the work of the Expert Panel. The Expert Panel should meet annually and report to the NE LHIN on action associated with this strategic plan. A 'report card' should be developed to report results back to the community for transparency and accountability(IMMEDIATE TERM)

2) Prioritize action for housing and health which supports Alternative Levels of Care solutions. (ONGOING; SHORT TERM)

3) Pilot projects should be evaluated for Return on Investment and other objective measures and if value is proven, longer term funding should be allocated. Pilot projects should not exceed eighteen months (SHORT TERM)

4) Coordination, consultation and collaboration amongst DSSABs/CGS and the NE LHIN should occur with respect to new capital housing considerations for investments and LHIN considerations for supports for assisted living and/or other support services within affected communities or client groups. LHIN contracts with existing service providers should have built in mechanisms to allow collaboration between organizations and use of collective resources is to be encouraged/incentivized (e.g. nursing, cafeteria, maintenance, custodial, etc.) (INTERMEDIATE TERM)

5) Funding should be transferable between line items to achieve outcomes as identified in work plans. Make Service Agreements more flexible, provide more flexibility to expend funds (SHORT TERM)

6) Service providers should be allocated funds for longer than one year intervals in order to leverage these funds by evidencing stability to enable housing and service development in their areas (INTERMEDIATE TERM)

7) Align service boundaries between health and social services to promote efficiencies in service delivery for clients (INTERMEDIATE TERM)

8) Where the NE LHIN receives community investment dollars on an annual basis

   a. 25% of the community funding envelope be allocated to supports and services for vulnerable populations across the NE LHIN and half of those investments be for services in the new builds in communities, with long term commitments to housing providers.
   b. New investments in supports be cognizant of the holistic needs of individuals recognizing health, social, cultural and spiritual differences (INTERMEDIATE TERM)

9) The NE LHIN educate service providers and front line staff on alternative support services available to citizens within their communities with the purpose of assisting vulnerable citizens transitioning to varying levels of support closest to home (SHORT TERM)

10) Identify ways to reduce bureaucracy and develop a simplified regulatory framework (INTERMEDIATE TERM)

11) Promote communication between NE LHIN, DSSABs, City of Greater Sudbury, hospitals, housing providers and health and social service providers at the local level. Develop clear lines of communication between those writing policies and those whose work is governed by those policies. (SHORT TERM)

12) Ensure rural and urban differences are taken into account when planning expenditures to ensure equity (LONG TERM)

13) Research and develop options between institutional care and home care. Fund pilot projects that provide the most promise. (INTERMEDIATE TERM)

14) Fund a system 'navigator' pilot test across the NE LHIN catchment between agencies providing service including First Nations and Urban Indigenous organizations to help clients with a view to improving quick access to services for clients and early resolution of issues clients face (SHORT TERM)

15) Where the ALC continues to pressure access to acute care services across the NE, a commitment from the NE LHIN and health service providers needs to be given, in order to:

   a. Develop urgent priority wait lists for social housing for persons without shelter or with inadequate shelter or supports prioritize individuals identified as ALC in hospital to return to community via urgent local priority status for social housing, and provide NE LHIN assistance for their personal care and support needs in that setting.
   b. Consideration be given to determine what is required to assist individuals in ALC who do not quality for social housing to be given incentive to move to non-subsidized units in the community (SHORT TERM)

16) Recognizing variability in eligibility for support care hours:

a. The Provincial Government permit equitable service level maximum for care regardless of an individual's type of residential setting.
b. The NE LHIN coordinate a regional policy discussion amongst sector leaders which seeks equity and patient centred care regardless of the individual's residential type by December 31, 2016 and implemented before April1, 2017 (SHORT TERM)

17) The document, "**Community Hubs in Ontario: A Strategic Framework & Action Plan**" suggested that an action item for removing barriers and creating incentives could be, "*Increase Local Health Integration Networks' capital approval authority for community health projects*." p. 38. This Provincial recommendation should be pursued as a method of promoting and controlling more investment in supportive housing/ community and health hubs creation (SHORT TERM)

18) The NE LHIN, CGS and DSSABs lead efforts for the continuation of the community paramedicine program which supports individuals in their homes (INTERMEDIATE TERM)

19) The NE LHIN establish a coordinated roster of college and university placements and promote placements in the health and social services fields through the development of partnerships via Memoranda of Understanding with post-secondary institutions to address health professional capacity shortages.

20) The NE LHIN provincially escalate the importance of additional housing and health investments as a means of keeping individuals in their homes longer which is in keeping with the provincial directives for access to care close to home (Poverty Reduction Strategy, Patients First, Policy Statement on Housing and Homelessness, etc.) (ONGOING; SHORT TERM)

21) This document be sent to DSSABs and the City of Greater Sudbury (IMMEDIATE TERM)

Conclusion

It is the Expert Panel's hope that supports to housing will improve over the next three years. This improvement will only occur if all stakeholders – the NE LHIN, DSSABs, CGS, Mental Health and Addictions specialists, First Nations, urban Indigenous organizations, francophone health providers, their respective associations and a host of others work together. .

As outlined in this plan, important next steps will include stakeholder review of the plan. Following that a focused effort to prioritize and assign the objectives in order to ensure that the plan is actionable and achievable needs to be undertaken.

The physical and mental well-being and sense of independence of citizens will improve and our local communities will be stronger as a result of such effort. This collective effort will make for a stronger and healthier Northern Ontario.

Appendix 1: Housing Expert Panel Member List

	Name	Title	Organization
Panelists			
1	Andrea Lee	Director of Rehabilitation and Community Care Program	Health Sciences North
2	Angele Desormeau	Executive Director	South Cochrane Addiction Services
3	Brian Marks	Director Housing Services	Cochrane DSSAB
4	Dan O'Mara	Retired CEO MICs	Retired
5	Don McBain	Executive Director	Ontario Aboriginal Housing Services
6	Gail Spencer	Homelessness Coordinator	City of Greater Sudbury
7	Gary Scripnick	Board Liaison	NE LHIN Board
8	Janice Bray	Manager of Housing and Community Services	Parry Sound DSSAB
9	Janice Newsome	Director of Planning, Town of Hearst	Secretary, Town of Hearst Non-Profit Housing Corp.
10	Jeff Barban	Service Manager	City of Sault Ste. Marie/District of SSM Social Services Board
11	Jeff Perry	President	Perry + Perry Architects Inc.
12	Joe Bradbury	CAO	Nipissing District Social Services Admin. Board
13	Joe Dipietro	President	Autumnwood Mature Lifestyle Communities
14	Sharad Kerur	Executive Director	The Ontario Non-Profit Housing Association (ONPHA)
15	Kris Longston	Acting Manager, Community and Strategic Planning	City of Greater Sudbury
16	Lisa H. Meawasige	Mental Health Expert	Maamwesying North Shore CHS
17	Lyle Hall	Mayor	Mayor of Sundridge
18	Marion Quigley	CEO	Canadian Mental Health Association S/M
19	Marliese Gause	CEO	The Friends
20	Maury O'Neill	CEO	Economic Development Corporation of Wawa
21	Michael Cullen	Executive Director	United Way Sudbury & Nipissing Districts
22	Michel Mayer	Executive Director	Centre de santé communautaire de Sudbury Est
23	Padraic Taaffe	Support Services Manager	Service de santé de Chapleau Health Services
24	Tanya Nixon	Vice President - Mental Health	North Bay Regional Health Centre
Ex-Officio Members & Resources			
25	Bill Bradica	Chief Administrative Officer	District of Thunder Bay SSAB
26	Catherine Matheson	Senior Director	NE LHIN
27	Chris Stewart	Expert Panel Coordinator/ Executive Coordinator	Northern Ontario Service Deliverers Association (NOSDA)
28	Cindy Couillard	Team Lead - Regional Housing Services	North Municipal Service Office, MMAH
29	Denis Desmeules	Director of Housing Services	City of Greater Sudbury
30	Ed Starr	Principal	SHS Consulting
31	Fern Dominelli	CEO Lead	NOSDA
32	Howie Wong	CEO	Housing Services Corp.
33	Jeff Kolibash	Affordable Housing Consultant	Canada Mortgage and Housing Corporation
34	Kate Fyfe	Senior Director	NE LHIN
35	Mike O'Shea	MHA Officer	NE LHIN
36	Siobhan Farrell	Senior Planning and Integration Consultant (MH and Addiction Lead)	NW LHIN

Appendix 2

North East LHIN and Canadian Mental Health Association Sudbury/Manitoulin:
Vulnerable Tenants Research Study

Key Findings Report
DRAFT: July 2016

Submitted by:

Acknowledgements

The Vulnerable Tenants Research Study was undertaken on behalf of NE LHIN in partnership Canadian Mental Health Association Sudbury/Manitoulin, NOSDA, and Housing Services Corporation (HSC). We would like to thank Marion Quigley, Chief Executive Director at CMHA Sudbury/Manitoulin, Karen Henze, Manager of Community Development and Housing at CMHA Sudbury/Manitoulin, Mike O'Shea, Senior Officer – Mental Health at the NE LHIN, Catherine Matheson, Senior Director, Health System Transformation & Implementation at the NE LHIN, Chris Stewart, C.J. Stewart Consulting, as well the members of the Northern Ontario Service Deliverers Association (NOSDA) - Expert Housing Panel for their input and direction during the preparation of this report and throughout all research activities.

We would like to also thank local District Social Services Administration Boards (DSSAB)/ Consolidated Municipal Service Managers (CMSM) for providing data on the supply and demand of social housing across the study area and for their assistance in identifying and engaging local stakeholders.

We would also like to thank local housing providers and support service agency staff for completing our study survey and attending focus groups. In particular, we would like to acknowledge and thank the twenty social housing tenants who completed a tenant questionnaire and shared their experiences with us.

Together, the experiences from this range of stakeholders coupled with other research activities has contributed towards a better understanding of the support needs of tenants currently living within social housing across the NE LHIN and provides a foundation for moving forward in developing a coordinated service delivery model.

Thank-you.

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2.0 Background

Ontario's social housing stock plays a particularly significant role in helping vulnerable individuals, such as those with mental health and addictions challenges and the frail elderly, reduce the risk of poverty by providing a stable, secure and affordable place to live. Across the province, aided by the Housing First policy that is the foundation for most of the Ten Year Housing and Homelessness Plans developed by Ontario's 47 Service Managers and approved by the Ministry of Municipal Affairs and Housing, a growing number of these individuals are being housed within social housing being operated by Local Housing Corporations (which have Service Managers as their sole shareholder) and other social housing providers, providing a crucial element towards the goal of poverty reduction among these segments of the population.

At the same time, however, discussions with Service Managers and other housing providers have found great concern across the province about the lack of supports for the growing number of vulnerable individuals being housed within social housing portfolios. While the Housing First policy is strongly supported and there is widespread agreement that social housing provides a critical foundation for helping reduce poverty among these individuals, these providers are finding a widespread lack of supports for addressing their needs. Staff responsible for operating social housing, such as property managers and building superintendents, or volunteer boards themselves, are often left to try and cope with meeting these needs; most are lacking in the required skills and resources and are not trained to fulfill this role. This issue is being experienced not only among the mainstream population; Aboriginal housing providers and agencies such as Ontario Aboriginal Housing Services are also finding similar concerns within their social housing portfolios as well.

At the same time, the support system for these individuals consists of a "mishmash" of services, programs and agencies. There is no dedicated funding for such services and no coordinated approach to providing a consistent and effective level of support for these individuals.

To better understand the above concerns and to identify solutions, in June 2015, CMHA Sudbury-Manitoulin submitted a proposal under the Ontario Local Poverty Reduction Fund. Funding from this proposal was to be used to develop an innovative and coordinated service delivery model, or system, to assist vulnerable individuals living in social housing to maintain their housing, thereby reducing the risk of homelessness and improving housing security. While the submission was not successful in getting funded, more recently, CMHA Sudbury-Manitoulin has been given the opportunity to work in collaboration with the NE LHIN to conduct research that would help lay the foundation for the proposed system; in particular conducting a needs analysis and capacity assessment of vulnerable tenants living within social housing across the NE LHIN. This research would then form the foundation of a more well-informed submission to the Poverty Reduction Fund for the funding to move ahead with development of an effective support system across the NE LHIN service area.

2.1 Innovative Housing and Health Strategic Models for North Eastern Ontario

Further to the above context, the NE LHIN has created an expert housing panel under the guidance of the Northern Ontario Service Deliverers Association (NOSDA) to create a strategy entitled: *Innovative Housing and Health Strategic Models for North Eastern Ontario*. This initiative stems from the NE LHIN 2016-2019 Strategic Plan and the commitment to building a better future for housing and health across communities,

The Northern Ontario Service Deliverers Association (NOSDA) is an incorporated body of Service Managers in Northern Ontario who are responsible for local planning, coordination and delivery of a range of local health and social services. The Panel includes representation from housing, health, private, public, and not-for-profit organizations at the senor administration level.

The strategic plan was initiated in in February 2016 with a housing forum held in June 2016. The strategic plan will be completed and presented to the NE LHIN Board in September 2016. The research and findings conducted as part of this study – *Vulnerable Tenants Research Study* – will inform direction of the strategic plan.

3.0 Study Purpose and Approach

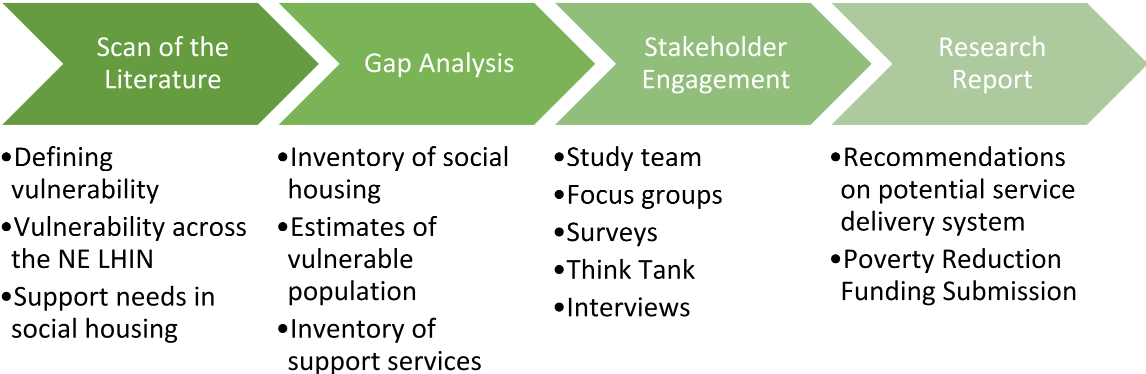
The purpose of this study is to create an improved understanding of the support service needs of vulnerable persons living in social housing, and to evaluate these needs within the current capacity of housing providers and support agencies. Ultimately, it is the goal of this research study to identify opportunities for a regional approach to meeting the support service needs of vulnerable persons living within social housing across the NE LHIN.

To realize this, the study aims to achieve the following objectives:

1. To identify the current support needs of vulnerable persons living in social housing within the NE LHIN service area
2. To identify the current capacity for meeting the identified needs
3. To conduct a gap analysis
4. To recommend a methodology for the development of a service delivery system, aimed at maintaining housing for vulnerable tenants, that would form the basis of a revised funding submission to the Poverty Reduction Fund

3.1 Study Approach

In order to achieve the above objectives, a number of activities were undertaken as part of this research study. These include:



The following sections will present a summary of the above initiatives and outline the key findings in understanding the support needs of vulnerable people currently living within social housing across the NE LHIN. Following this summary, a series of recommendations are put forth for consideration in moving forward in creating a regional service delivery system.

4.0 Context for Vulnerability within the NE LHIN

This section introduces the North East LHIN (NE LHIN) in terms of its geography and population distribution and sets out the context for vulnerability within the NE LHIN service area.

4.1 Demographics

The NE LHIN is divided into five Hub Regions: Sudbury, Manitoulin & Parry Sound, Algoma, Nipissing-Temiskaming and the James and Hudson Bay Coasts. These are shown below, in a map prepared by the NE LHIN.

As pictured in grey in the map below, the NE LHIN is bordered immediately to the south by the North Simcoe-Muskoka LHIN, and to the west by the Northwest LHIN.

In terms of population distribution, the LHIN's 2013-2016 Integrated Health Services Plan provides the following breakdown by hub region using data from the 2011 National Household Survey:

Table 1: Population of NE LHIN Hub Planning Areas, Statistics Canada (2011)

Hub Planning Area	Total Population	% of NE LHIN
Algoma	115,870	20.95
Cochrane	76,856	13.90
James Bay & Hudson Bay Coasts	6,213	1.12
Nipissing & Temiskaming	117,370	21.22
Sudbury, Manitoulin & Parry Sound	236,782	42.81
NE LHIN Region	553,091	100

Important to note is that approximately 9.5% of the LHIN's population identifies as Aboriginal / First Nations / Metis and over 100,000 residents are seniors aged 65+ years. North Eastern Ontario is aging much quicker than the Province of Ontario, overall.

Figure 1: Map of the North East LHIN by Hub Region

The Sudbury-Manitoulin & Parry Sound District is the largest hub region; about twice the size of Nipissing & Temiskaming, which is second largest, followed closely by Algoma. It should be noted that, due to challenges counting on-reserve First Nations populations, the population of the Coasts may be under-estimated here; by our estimates the First Nation population in the Coasts hub region is closer to 10,000. Of the southern hub regions in the NE LHIN, Cochrane is by far the smallest, with Timmins, the hub's Census Metropolitan Area, and comprising over 43,000 people. The table below compares the population of the four largest hub regions to the population of the largest urban centres within each, to illustrate the size of the population that is more remote.

Table 2: Population of NE LHIN Hub Planning Areas Compared to Largest Urban Centres, Statistics Canada (2011)

Hub Planning Area	Total Population	Largest Urban Centre		Population Residing Outside	
		Name	Population	Number	Percent
Algoma	115,870	Sault Ste. Marie	75,141	40,729	35%
Cochrane	76,856	Timmins	43,165	33,691	44%
Nipissing & Temiskaming	117,370	North Bay	64,043	53,327	45%
Sudbury, Manitoulin & Parry Sound	236,782	Greater Sudbury	160,275	76,507	32%

It is noted that the boundaries of the NE LHIN's hub regions do not correspond to boundaries used by Statistics Canada in collecting and analyzing Census data, nor do they correspond to provincial boundaries used to delineate catchment areas for District Social Services Administration Boards and Consolidated Municipal Service Managers, or Public Health Units. As such, roles and responsibilities for regional health, housing and social services administration are assigned to different geographic areas.

4.2 Vulnerability

There is a long-established link between the experience of poverty and vulnerability to poor health outcomes, given that individuals and families living in poverty are likely to be exposed to multiple risk factors, as noted above. This may be referred to as "multi-vulnerability."

The concept of "multi-vulnerability" is important to understand in order to identify who is most vulnerable; whether in the NE LHIN, or any context.

The University of California San Francisco's Center for Vulnerable Populations at San Francisco General Hospital refers to vulnerable populations as those "for whom social conditions often conspire to both promote various chronic diseases and make their management more challenging."[4] This approach highlights the direct link between multi-vulnerability and multi-morbidity (i.e. multiple chronic conditions). More than one-in-five of residents of the NE LHIN have been diagnosed with multiple chronic conditions, compared to 15% in the Province, overall.

Similarly, BMC Health Services Research completed a scoping review in 2013 that looked at the interrelationship between multiple vulnerability factors and health care disparities. They found that "high levels of vulnerability (due to the co-existence of multiple vulnerability aspects) would increase health care needs and would be associated to lower health care accessibility and quality." The study's authors point out that these studies are consistent with the findings of other similar studies completed in the Canadian context.

Both sources point to the intersection not only between multi-vulnerability and negative health

[4] https://cvp.ucsf.edu/about/

outcomes, but also to experiencing greater difficulty in managing those outcomes. This helps to explain the depth of vulnerability in rural, remote and northern communities where local populations not only tend to experience a lack of access to education and income-earning opportunities, but also lack of access to health and social care.

As noted in the following chapter of the report, the literature points to particular population sub-groups as being among the most vulnerable. In the context of the North East LHIN, the following groups are likely to be among the most significant vulnerable groups, by population count:

- Aboriginal, First Nations and Metis
- Lone Parent Families
- Seniors with Support Needs
- Individuals with a Disability
- Individuals with Serious and Persistent Mental Illness
- Middle Aged Caucasian Men at Risk of Suicide
- Immigrants and Racialized Groups

The table below estimates the overall population of these vulnerable groups within the NE LHIN, and ranks the four hub regions in terms of where the populations are most and least concentrated. Please note that since data is not available through Statistics Canada by the LHIN's hub regions, we have sought data at the District level. For data collection purposes, the Districts included: Sudbury, Greater Sudbury, Parry Sound (Sudbury, Manitoulin & Parry Sound); Nipissing (Nipissing-Temiskaming); Algoma; Cochrane; and, Kenora – Unorganized (includes the Coasts).

This data provides a picture of the relative size of vulnerable population groups in each of the LHIN's hub regions, despite small differences due to the difference in geographic boundaries.

Table 3: Estimated Size of Vulnerable Groups in the NE LHIN

Population Group	**Estimated Size**	**Community Ranking**
		Number
Aboriginal / First Nations / Metis (includes on and off reserve)	63,277	• Sudbury, Manitoulin & Parry Sound • Algoma • Coasts • Cochrane • Nipissing & Temiskaming
Lone Parent Families (Including both Female and Male-Led Lone Parent Families)	21,220	• Sudbury, Manitoulin & Parry Sound • Algoma • Nipissing & Temiskaming • Cochrane • Coasts

Population Group	Estimated Size	Community Ranking
Seniors with Support Needs (15%-18% of seniors; use 16.5% of ~100,000)[5]	16,500	• Sudbury, Manitoulin & Parry Sound • Nipissing & Temiskaming • Algoma • Cochrane • Coasts
Individuals with a Life-Limiting Disability (15.4% of all Ontarians)[6]	86,702	• Sudbury, Manitoulin & Parry Sound • Nipissing & Temiskaming • Algoma • Cochrane • Coasts
Individuals with Serious and Persistent Mental Illness (3% of all Canadians)[7]	16,890	• Sudbury, Manitoulin & Parry Sound • Nipissing & Temiskaming • Algoma • Cochrane • Coasts
Middle-Aged Caucasian Men at Risk of Suicide (26.3 per 100,000 men in their 50's)[8]	10	• Sudbury, Manitoulin & Parry Sound • Algoma • Cochrane • Nipissing & Temiskaming • Coasts
Immigrants and Racialized Groups	1,655	• Sudbury, Manitoulin & Parry Sound • Algoma • Nipissing & Temiskaming • Cochrane • Coasts

The table above demonstrates that, by the numbers, the greatest numbers of vulnerable people reside in the Sudbury, Manitoulin & Parry Sound hub region. Given that this hub region is, by far, the largest of the five, this is to be expected. However, there is some variation; particularly in terms of the numbers of Aboriginal / First Nations / Metis people and lone parent families, which are found in greater numbers in

[5] O'Keefe
[6] Canadian Disability Survey (2012)
[7] ONPHA (2015)
[8] http://www.cbc.ca/news/health/suicide-men-50s-causes-1.3263412

Algoma than in Nipissing-Temiskaming, although the latter has a larger total population. It is also important to note the size of the Aboriginal / First Nations / Metis population in the Coasts, which is relatively large in terms of both number and proportion given the size of the hub region's total population. It is also worth noting that while the number of men at risk of suicide may appear low, the estimate only considers the risk of suicide among men in their 50's, while research suggests that men in their 40's and also senior men in their 80's are also at a heightened risk. Moreover, the proxy measure employed is based on national statistics, which do not consider risk factors that may be more pronounced locally, such as the relatively low educational attainment, higher rate of unemployment and low income and more common use of substances in rural areas, which comprise over half of the NE LHIN region. That is to say that the number of Caucasian men at risk of suicide in the NE LHIN may be higher than 10, given the influence of local risk factors.

Finally, while the number of immigrants and racialized groups may appear small, there is a trend of diversification in the NE LHIN that decision-makers should consider. Research on rural health outcomes in Canada has found a link between areas where immigrants comprise over 5% of the local population to poorer overall health outcomes. Recently, the NE LHIN, and other regions in Canada, welcomed a number of Syrian refugees, including a single mother with nine children.[9]

Some of these same estimates have been prepared to determine the size of the vulnerable population residing in social housing in the NE LHIN. These findings are presented in *Section 6.4.5* of this report.

Background Report Two: Assessing Vulnerability in the NE LHIN further examines other elements of multi-vulnerability including the co-occurrence of housing issues with other risk factors, relative deprivation, and access to health and social care.

Some key findings include:

- Individuals experiencing housing issues, such as homelessness, also have multiple co-occurring issues, such as mental health issues, alcohol use, physical health needs, challenges meeting their basic needs, drug use, anti-social / negative behaviour, and risk of suicide or criminal involvement, which place their overall health and wellbeing at risk.
- Results from the provincial Deprivation Index highlight that areas within the NE LHIN are among the most deprived in the province.
- Challenges to meeting the health and social care needs of residents in the NE LHIN are compounded by the fact that the out-migration of young people appears to have destabilized the base of traditional informal caregivers in rural and remote communities.
- Consultation results point to caregiver burnout as a key driver of admissions to hospital, and a lack of appropriate community care options for persons with complex needs create challenges in discharging from hospital.
- Data on the number of missed shifts by CCAC practice area shows that of all missed shifts reported in the large communities of the NE LHIN, 94% were by personal support workers.
- In many cases over one-third of all hospital days are dedicated to ALC in both 2014 and 2015.

[9] https://www.baytoday.ca/local-news/new-refugee-family-coming-to-north-bay-268654

4.3 Summary

Overall, there are many vulnerable populations in the NE LHIN who are at risk of suffering poor health outcomes and, at the same time, likely to experience difficulty managing those outcomes.

Findings from research activities suggest that there is a need to enhance home and community care across the NE LHIN, including increasing access to in-home services and expanding the supply of specialized supportive housing that provides long-term term, flexible and, when necessary, more intensive supports to particular population groups who may not be appropriate to long-term care homes. Currently, it appears that there are significant populations of vulnerable groups suffering from multi-vulnerability whose unmet needs many not only create a risk for poor health outcomes and potentially avoidable health crises, but also lead to loss of housing, frequent use of emergency services, caregiver burnout and premature admission to long-term care homes, which may or may not be a good fit.

5.0 Findings from the Literature

The literature scan is aimed at providing a greater understanding of the needs, issues and gaps of vulnerable tenants living in social housing with a particular focus on mental health and senior support services needed to help maintain successful tenancies.

The review is based on online resources from educational institutions, health care agencies, government bodies, support services agencies and community organizations.

The following section presents a summary of the findings from the literature scan. A full report is available as a separate document: ***Background Report One: Literature Scan***.

5.1 Defining Vulnerability in Social Housing

Based on a brief scan of available literature, vulnerability is a dynamic term that tends to be used in reference to particular population groups who, due to their exposure to one or more risk factors, are predisposed to adverse social, economic and/or health outcomes; sometimes in the context of a particular set of circumstances. For the purposes of this research study the following definition from the Ontario Non-Profit Housing Association (2015) is most applicable:

*"**Anyone who needs additional support – for any reason – to maintain a successful tenancy**. Tenants may be, or may become, vulnerable because of a mental or physical illness or disability, an addiction, trauma, dislocation, isolation, experience of violence or a history of homelessness or institutionalization. A tenant's need for support may be episodic or increase or decrease over time, and may be exacerbated by the absence of support or a reluctance to accept support when offered."*

5.2 Support Needs in Social Housing

The following section provides an overview of key findings from the literature review. Findings are organized by research topic and are aimed at identifying particular needs of various population groups.

Social Housing and Mental Health

For individuals living in social housing and suffering from mental health illness, there is a gap in the availability, consistency and coordination of health services. There is a need for a clear understanding of roles in the provision of housing and the related support services. It is important that housing staff are adequately trained with the sensitivity, support and skills needed to deal with tenants suffering from a mental illness. There is a need to redefine the basket of services to address the range of determinants of health. A holistic basket of service will include services in 3 key areas: housing, clinical and peer supports. Sub-populations with mental health challenges living in social housing that are underserved include individuals with concurrent disorders, people with dual diagnoses, young adults under the age of 24, and immigrants.

There are areas of opportunity to address these gaps and needs. The introduction of on-site supports in housing may be beneficial in buildings with a high number of vulnerable tenants. Front line staff and tenants could be trained to spot emerging problems. Certain tenants require individualized and intensive supports. A peer-based support system in partnership with mental health agencies could be introduced. There is an idea to delink support services from housing to permit the flow of people through the housing system and meet the changing level of support need. Three levels of prevention were identified, (1) community building (2) identify & address problems immediately (3) provide on-going support for tenant needs. An area of opportunity from a different angle is to address not only the needs of individuals suffering from the effects of mental illness, but neighbours and staff who suffer the effects as well.

Seniors in Social Housing

From the literature scan it was revealed that seniors living in social housing face several barriers. There are built form challenges because the aging social housing building stock cannot easily accommodate modifications for accessibility. The community environment is a barrier because seniors feel unsafe in mixed-age buildings, the sites are not pedestrian friendly, and the lack of amenities nearby leads to social isolation. Seniors have increased support needs and are underserved. Forty-one percent (41%) of seniors with disabilities reported either not receiving the help they needed or need more. They are likely to live alone without the support of informal caregivers and no one to help them with medication, meals, exercise, or to recognize mental health challenges. Factors such as physical barriers, low-income, living alone, chronic health needs, and feeling unsafe in the building can lead to social isolation; and the lack of a supportive social network can lead to dementia and cognitive-health decline.

Aboriginal / First Nation / Metis Populations in Social Housing

Aboriginal, First Nation and Metis populations face higher rates of chronic diseases, co-morbidity, lower life expectancy, higher infant mortality, greater incidences of suicide, and higher rates of infectious diseases. This population group is nearly twice as likely to be living on low income, resulting in higher rates of diabetes, arthritis and chronic health conditions. The high rate of chronic diseases has led to faster aging; therefore, care needs to be extended to this younger group of older adults.

Aboriginal women are nearly three times more likely than non-Aboriginal women to report being victims of a violent crime. Women fleeing abuse and trauma can serve as indicators of vulnerability in social

housing. Aboriginal, First Nation and Metis populations have unique cultural needs that need to be targeted through linguistically and culturally appropriate health care services, and partnering with Aboriginal health service providers.

Northern, Rural and Remote Communities

Northern, rural and remote communities experience increased physical, mental health and addictions issues and have a higher rate of individuals with complex care needs compared to the rest of Ontario. There are fewer health professionals per capita in Northern communities and the population is underserved by family physicians. As a result, diagnoses of mental health issues may go untreated.

Remote housing providers highlighted the need for (1) adequate staff training and (2) identification of lead agencies to address housing and support needs. They also identified the following barriers that prevent people from accessing support needs which contributes to housing instability:

- Existing service models do not meet aging needs
- Existing service models do not meet youth-specific needs
- Lack of transition aged youth services
- Criminal justice support needs
- Culture and gender specific needs
- Non-existent inter agency partnerships
- Insufficient staff training /skill level
- Fragmentation of service delivery systems

Areas of opportunity for Northern, rural and remote communities include making effective use of technology and implementing a Tele-Mental Health initiative.

Lesbian, Gay, Bisexual and Transgendered (LGBT) Communities

There are steps that can be taken to provide the LGBT community with an inclusive living environment in social housing. It is key to adopt a comprehensive approach to promote and implement inclusivity. A comprehensive approach will include elements such as: providing LGBT sensitivity training for staff; having a paid staff member mandated to address the needs of LGBT tenants; including visual affirmations of LGBT presence; outreaching to the LGBT community to enrich programming; ensuring language used in all communications is inclusive; having inclusive hiring policies; and engaging in networking and information sharing.

A point of contention in addressing this unique community's needs is that LGBT initiatives are usually geared towards lesbian women and/or gay men. Bisexual and transgendered residents are often overlooked. It is important to ensure that the concerns and aspirations of LGBT residents are heard and responded to.

6.0 What We Heard

Understanding the opportunities and priorities to better meet the needs of vulnerable tenants requires the perspective of stakeholders who connect with residents and families on a regular, sometimes daily, basis. As part of this study, a number of community engagement initiatives were undertaken. In-person focus groups with both housing providers and support service agencies were held in Sault Ste. Marie, Sudbury, North Bay, and Parry Sound[10]. In addition, two online (web-based) focus groups were held with stakeholders in the Cochrane District. Overall 10 focus groups were held and two supplemental interviews. Forty housing providers and 59 support service agencies participated in focus groups.

Given the vast geography of the research study area, questionnaires were also used in an effort to gather input from a broader range of housing providers and support agencies across the NE LHIN. In total 281 surveys were distributed across the area. Forty-seven housing providers and 51 support service agencies completed a survey.

To supplement these surveys, a third questionnaire aimed at social housing tenants was created and distributed through the local DSSAB/Service Managers. In total 20 tenant surveys were completed and submitted. While this is not nearly representative of the approximate 20,000 individuals living in social housing across the NE LHIN, the aim of the questionnaire was to hear from people living in social housing on where they felt the opportunities existed to better support tenants.

A summary of findings from all of the above-mentioned activities is described in detail within ***Background Report Three: "What We Heard" Consultation Summary Report.*** This report provides a summary of results by consultation activity, by stakeholder group, and by area.

A number of key issues, challenges and opportunities were identified by stakeholders throughout the consultation activities. These are summarized below.

Rental Arrears and Hoarding Identified as Top Reason for Evictions

Rental arrears was identified by all stakeholder groups as the main reason for eviction or risk of eviction. Mental health and addiction challenges were also emphasized by both housing providers and support service agencies. Hoarding was a particular challenge identified putting tenants at risk of eviction.

Housing Providers Often Find Themselves in Role of Support Provider or Advocate

There are growing concerns about the number of individuals housed in social housing who need support services. Housing providers/landlords and volunteer staff often find they are in the position of first responder to tenants in need of assistance or in crisis, and typically do not have the resources or skills to meet these needs.

Some Tenants Do Not Want Assistance, Even if Needed

A particular challenge within social housing communities, is that a need for support might be identified but some tenants do not want support. This puts landlords in a particularly difficult situation and several stakeholders, housing providers and support service agencies, expressed that there is little they can do to help.

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[10] Of note, the Parry Sound session was a combined group of both housing providers and support service agencies.

More ‘Life Skills’ Support Needed

All stakeholder groups identified the need for more support with life skills (i.e. budgeting, cooking, housekeeping). Many times tenants are living on their own for the first time and have not developed the skills needed to live independently.

More Housing Options Identified as a Priority

In general, stakeholders expressed the need for more affordable housing options across the NE LHIN. Several stakeholders noted that while ‘new’ social housing units would be helpful so would having portable rent subsidies. Accessible housing was also identified as a need.

Other housing forms, such as supportive housing models including models with 24 hour support, were identified as a need in many communities.

Need for Early Intervention

Several stakeholders expressed that early intervention with tenants can be critical. It was suggested that some form of centralized assessment tool or mechanism could be really helpful. The tool or mechanism would evaluate life skills, mental health, physical health and social support needs. Some suggested that an access point could be at the time of the housing application.

Partnerships Exist But Greater Collaboration and Coordination Needed

While several partnerships are in place and many are working successfully to better meet the needs of residents, stakeholders expressed the need for more coordinated work, more sharing of ideas, and more awareness of the partners and stakeholders in the ‘system’.

Stakeholders also identified that partnerships and coordination of services should be broad and include a full range of support agencies/staff including primary care, hospitals, para-medicine, community agencies, housing providers, and informal support networks.

Not Enough Support for Persons in Crisis

Although early intervention is identified by stakeholders as a strategy to reducing the number of people in crisis, there is still a strong need for more support persons for individuals in crisis. Stakeholders also emphasized that recruiting, training and maintaining staff with specialized training is essential.

More Support for Persons with Mental Health and Addiction Challenges

Persons with mental health and addiction issues were identified as a key population in need of more support. Stakeholders acknowledge that there are good supports available such as ACT but often this is not enough and is not available in all communities.

Persons with dementia was also identified as a specific population where it can be difficult to get the supports needed within social housing.

Inequality of Access to Support Services across NE LHIN

The geography of the NE LHIN is vast and includes large urban centres, small urban centres, rural and remote communities. This presents a particular challenge in the delivery of support services. Several stakeholders in remote areas expressed that support services, such as in-home care, are simply unavailable, delivery is inconsistent,

or they have to 'fight' to get them. Other stakeholders expressed feeling 'underserved' in their community.

Greater "Access" and "Presence" of Support Staff Fundamental

Several stakeholders emphasized that having better access to support services can have a very positive impact on maintaining successfully tenancies by getting people connected to the right supports at the right time. Greater presence of support agencies on site was also seen as positive in getting people more involved in their community and supporting one another.

More Coordination with Hospitals Identified as Priority

Tenants being discharged by hospitals back to social housing was a critical issue identified by many stakeholders, both housing providers and support service agencies. Often support services needed, upon release from hospital, to support tenants' transition back to home are not in place. Stakeholders also emphasized the need for better communication between housing providers, support agencies, and hospital staff.

Lack of Family Support and Need for "One Person for Everyone"

Lack of family support, or the support of an informal (i.e. unpaid) caregiver was seen as one of the greatest risks for people living alone in social housing (or housing in general). If there is no formal support in place, and no advocate for the tenant, often needs can go unnoticed and a person's health and well-being deteriorate. Isolation was identified as a particular challenge for many tenants.

This need for informal support was emphasized in the tenant survey results, where most respondents (16) identified family as part of their support network. Many also noted friends and neighbours.

One of the largest priorities identified by participants is the need for tenant navigators, advocators or 'success teams'. Having "someone for everyone" was a key message to preventing evictions, and improving the overall health and well-being of tenants. The tenant navigator/success team would assist tenants in identifying and accessing support services, assisting with life skill development as appropriate and simply being a 'go to person' for a tenant. Participants further described 'success teams' as helping connect landlords with support services and conducting assessments to best determine supports needed by tenants.

7.0 Social Housing Needs Analysis

7.1 Introduction

Social housing plays an important role maintaining healthy communities. It provides affordable rental housing for low to moderate income families who are otherwise unable to afford housing in the private rental market. Rents are typically set at 30% of gross household income (rent-geared-to-income (RGI) housing) or market rent – whichever is lower.

The following sections provide a summary of the inventory of social housing across the NE LHIN as well as the inventory of support service agencies across the NE LHIN. Following these inventories, an analysis of the number of vulnerable people living in social housing across the NE LHIN is presented.

7.2 Inventory of Social Housing

This section of the report focuses on the supply and demand of social housing in the North East Local Health Integration Network (NE LHIN) area. Data was collected from current reports, local housing and homelessness plans and local District Social Services Administration Boards and Service Managers. The inventory focuses on the number of social housing units by size and mandate.

Data was collected for the following 8 service managers within the NE LHIN study area:

1) Algoma District Services Administration Board
2) Cochrane District Social Services Administration Board
3) Manitoulin-Sudbury District Services Board
4) District of Nipissing Social Services Administration Board
5) Parry Sound District Social Services Administration Board
6) District of Sault Ste. Marie Social Services Administration Board
7) City of Greater Sudbury Consolidated Municipal Service Manager
8) District of Temiskaming Social Services Administration Board

7.2.1 Supply of Social Housing across NE LHIN

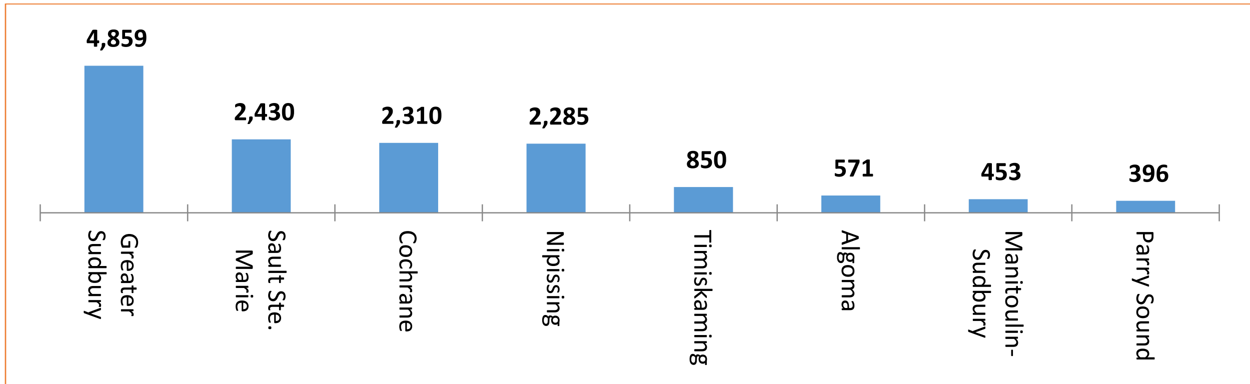
The total number of social housing units for each service area is based on information provided in housing and homelessness plans. Where housing plans were not available, counts were taken from social housing registration forms and websites.

The **total supply** of social housing in the NE LHIN is 14,154units[11]. Over one-third of the supply is located in the City of Greater Sudbury (34.3%). Sault Ste. Marie (17.2%), Cochrane (16.3%), and Nipissing (16.1%) each have about half of the proportion found in the City of Greater Sudbury. Temiskaming (6.0%), Algoma (4.0%), Manitoulin-Sudbury (3.2%), and Parry Sound (2.8%) each have less than 10% of the total social housing stock and the fewest amount of units.

The findings are generally consistent with population distribution across the NE LHIN. Sudbury-Manitoulin (6.7%) and Algoma (7.9%) have a slightly higher proportion of social housing units when considering the proportion of total population for the NE LHIN while Parry Sound (1.1%) and Sault Ste. Marie (14.6%) have a slightly lower (1.1%) proportion.

[11] Based on total counts provided in area housing and homelessness plans, housing reports/documents, or provided directly by area DSSABs/Service Managers where available.

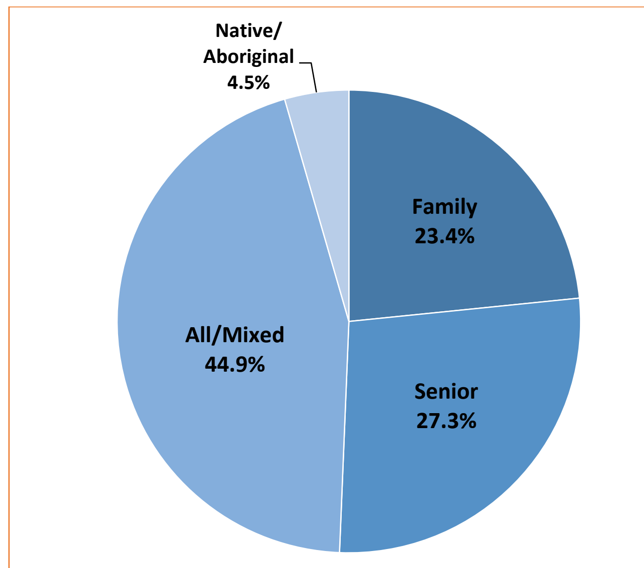
Figure 2: Total Number of Social Housing Units by Service Area; NE LHIN, 2016



Sources: ADSAB Housing and Homelessness Plan, 2013; Cochrane DSSAB Community Profile Data Report, 2014; City of Greater Sudbury, 2016 (Email Reply); MSDSB Revised 10-Year Housing and Homelessness Plan, 2014; MSDSB Subsidized Housing Providers; DNSSAB Putting People First: 10-year Housing & Homelessness Plan - Current Housing Supply in Nipissing District. Sub Report #5, 2013; DPSSSAB Application for Rental Accommodation, 2012; District of Parry Sound Housing and Homelessness Plan, 2013; DSSMSSAB Housing and Homelessness Plan Update, 2014; Source: DTSSAB Your Guide to Rent Geared to Income Housing, 2011

Close to half of the social housing units in the NE LHIN have an 'all' or 'mixed' mandate (44.9%). More than a quarter of the units are mandated for seniors only (27.3%), followed by family housing (23.4%). A small proportion of the housing is designated Natives and/or Aboriginals (4.5%). A small proportion of all social housing units have been modified to be accessible.

Figure 3: Estimated Proportions of Social Housing Units by Mandate; NE LHIN, 2016



Sources: ADSAB Project Listings Update Form, 2016; ADSAB Housing Unit Locations, Accessed March 26, 2016: http://www.adsab.on.ca/en/social-services/housing/housing-unit-locations/; CDSSAB Application for Housing, 2012; City of Greater Sudbury Application for Rent Geared to Income Assistance, 2015; City of Greater Sudbury, 2016; MSDSB Subsidized Housing Providers; MSDSB Revised 10-Year Housing and Homelessness Plan, 2014; MSDB Social Housing Locations, Accessed March 25, 2016: http://www.msdsb.net/sh-housing-locations; MSDSB Subsidized Housing Providers; MSDSB Revised 10-Year Housing and Homelessness Plan, 2014; MSDB Social Housing Locations, Accessed March 25, 2016: http://www.msdsb.net/sh-housing-locations; Nipissing District 10-Year Housing and Homelessness Plan, 2013; DPSSSAB Application for Rental Accommodation, 2012; DPSSSAB Summary Chart of Housing Providers in the District; DPSSSAB Details of Housing Units in the Service Area; DSSMSSAB, 2016; DSSMSSAB Housing Application Package, 2015; DSSMSSAB Rental Locations, Accessed: March 27, 2016: http://www.ssm-dssab.ca/HousingProviders/index.cfm; DTSSAB, 2016; DTSSAB Your Guide to Rent Geared to Income Housing, 2011

7.2.2 Supply of Social Housing By Community

The supply of social housing by mandate is estimated using information provided on District Social Services Administration Board/ social housing websites, RGI application documents and information from housing providers. The social housing unit counts by mandate differ from the total amounts provided in the various housing and homelessness plans, generally due to variations in the type of unit recorded by different providers (i.e. Investment in Affordable Housing Program units, rent supplement units, Aboriginal/Native housing portfolio).

Algoma

About two-thirds of the social housing stock in Algoma is mandated as mixed for singles & couples (29.8%) and singles & families (29.7%). A small proportion of housing is dedicated for seniors (13.9%) and an even smaller proportion for Native Housing (3.9%).

Table 4: Estimated Number of Social Housing Units by Mandate; Algoma, 2016

Mandate	Number of Units	Proportion of Total Units
Single / Couple	182	29.8%
Single / Family	181	29.7%
Family	138	22.6%
Senior	85	13.9%
Native Housing	24	3.9%
Total	**610**	

Source: ADSAB Project Listings Update Form, 2016; ADSAB Housing Unit Locations, Accessed March 26, 2016: http://www.adsab.on.ca/en/social-services/housing/housing-unit-locations/

The number of units by bedroom size was not reported by all housing providers and therefore has not been reported.

Cochrane

Nearly half of the social housing stock in Cochrane has a mixed mandate for families & singles (45.9%). This is followed by a mixed mandate for seniors & singles (26.6%), and seniors-only units (21.1%). A small proportion of units are for Native families (4.3%). Cochrane is the only service area to specifically mandate units as supportive/accessible. There are a total of 48 social housing units dedicated for those with supportive and/or accessibility needs, which make up 2.1% of Cochrane's social housing supply. Other units within the portfolio have been modified to be accessible as well.

The number of units by bedroom size was not available.

Table 5: Estimated Number of Social Housing Units by Mandate; Cochrane, 2012

Mandate	Number of Units	Proportion of Total Units
Family / Single	1,069	45.9%
Senior / Single	620	26.6%
Senior	492	21.1%
Native	100	4.3%
Supportive / Accessible	48	2.1%
Total	**2,329**	

Source: CDSSAB Application for Housing, 2012

City of Greater Sudbury

The City of Greater Sudbury has a greater proportion of its social housing stock mandated for families (36.8%). This is followed by a mixed mandate for seniors, couples & singles (24.4%), seniors-only (19.2%), all household types (17.5%) and lastly Aboriginals (2.0%).

Table 6: Estimated Number of Social Housing Units by Mandate; City of Greater Sudbury, 2016

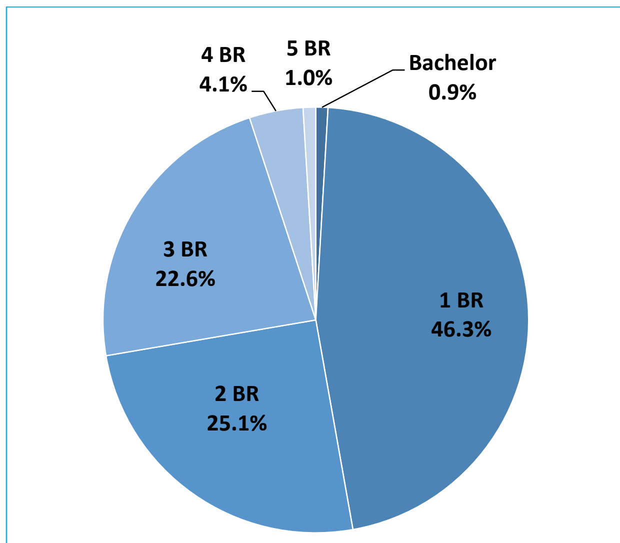
Mandate	Number of Units	Proportion of Total Units
Family	1,690	36.8%
Seniors / Couples / Singles	1,123	24.4%
Seniors	884	19.2%
All	806	17.5%
Aboriginal	93	2.0%
Total	**4,596**	

Source: Application for Rent Geared to Income Assistance, 2015; City of Greater Sudbury, 2016

The City of Greater Sudbury reported a total of 4,859 social housing units within the service area. Unit sizes were not available for the 59 rent supplement units and are therefore removed from the unit size break down.

The remaining 4,800 units range in size from bachelor to five-bedroom units. Close to half of the units are one-bedrooms (46.3%). A quarter of the units are two-bedrooms (25.1%); followed by three-bedrooms (22.6%). A small proportion of the social housing stock is made up of four-bedroom (4.1%), five-bedroom (1.0%), and bachelor (0.9%) units.

Figure 4: Proportion of Social Housing Units by Bedroom Size; City of Greater Sudbury, 2016



Source: City of Greater Sudbury, 2016

Manitoulin-Sudbury

There are a total of 453 social housing units in Manitoulin-Sudbury. Over half of the units are mandated for "all ages" (55.6%). These units are made up of one-bedroom (246 units) and bachelor (6 units) apartments. Seniors-only housing makes up 19.9% of the social housing stock; followed by Aboriginal/Native housing at 16.6%. Family units make up the smallest proportion of all household types at 7.9%. Family units have two-, three- and four-bedroom sized units.

Table 7: Number of Social Housing Units by Mandate; Manitoulin - Sudbury, 2016

Mandate	Number of Units	Proportion of Total Units
All Ages	252	55.6%
Seniors	90	19.9%
Aboriginal/Native	75	16.6%
Family	36	7.9%
Total	**453**	

Source: MSDSB Subsidized Housing Providers; MSDSB Revised 10-Year Housing and Homelessness Plan, 2014; MSDB Social Housing Locations, Accessed March 25, 2016: http://www.msdsb.net/sh-housing-locations

The number of units by bedroom size was not reported by all housing providers and therefore cannot be accurately reported.

Nipissing

There are a total of 2,285 units in Nipissing's social housing portfolio. The social housing stock is split between family (48.6%) and seniors-only (45.8%) units. The small remaining portion of units has a mixed mandate for both families & seniors (5.6%). It was noted that of the total units, 56 units are native housing for families and seniors, which equals to 2.5% of the total social housing stock.

Table 8: Number of Social Housing Units by Mandate; Nipissing, 2013

Mandate	Number of Units	Proportion of Total Units
Family	1,110	48.6%
Seniors	1,046	45.8%
Family / Senior	129	5.6%
Total	**2,285**	

Source: Nipissing District 10-Year Housing and Homelessness Plan, 2013

The number of units by bedroom size was not available.

Parry Sound

There are a total of 396 social housing units in Parry Sound. Over half of the social housing supply has an all-inclusive mandate for singles, families & seniors (51.3%). The remaining stock is made up of seniors' only units (40.4%) and Aboriginal family units (8.3%).

Table 9: Number of Social Housing Units by Mandate; Parry Sound, 2012

Mandate	Number of Units	Proportion of Total Units
Single / Family / Senior	203	51.3%
Seniors	160	40.4%
Aboriginal	33	8.3%
Total	**396**	

Source: DPSSSAB Application for Rental Accommodation, 2012; DPSSSAB Summary Chart of Housing Providers in the District; DPSSSAB Details of Housing Units in the Service Area

The number of units by bedroom size was not reported by all housing providers and therefore cannot be accurately reported.

Sault Ste. Marie

There are 2,234 social housing units in Sault Ste. Marie. Half of the units have a mixed mandate for families & singles (49.6%). Seniors housing makes up a larger portion of the social housing stock at 37.7% compared to Aboriginal & Native (5.7%), family (5.3%), and single (1.7%) units which make up considerably smaller portions of the social housing supply.

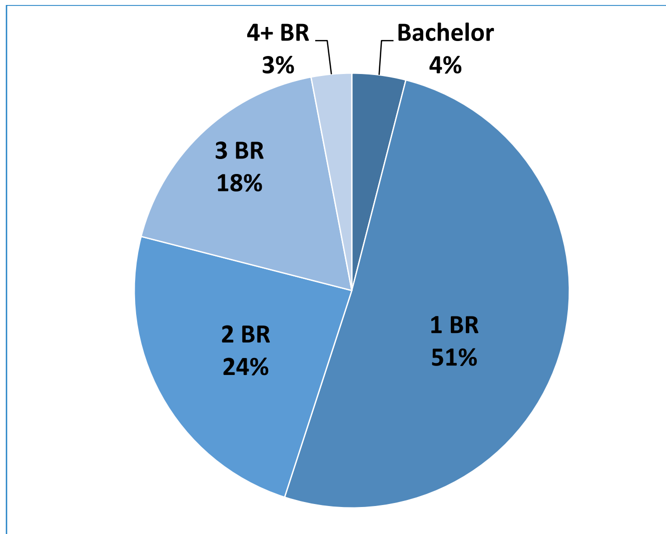
Table 10: Number of Social Housing Units by Mandate; Sault St. Marie, 2016

Mandate	Number of Units	Proportion of Total Units
Family / Single	1,107	49.6%
Senior	843	37.7%
Aboriginal / Native	127	5.7%
Family	118	5.3%
Single	39	1.7%
Total	**2,234**	

Source: DSSMSSAB, 2016; DSSMSSAB Housing Application Package, 2015; DSSMSSAB Rental Locations, Accessed: March 27, 2016: http://www.ssm-dssab.ca/HousingProviders/index.cfm

The Sault Ste. Marie *Housing and Homelessness Plan Update (2014)*, identifies that there are 2,430[12] units in the social housing portfolio. The report breaks down the total number of units into percentages. Over half of the units are one-bedrooms (51%) followed by two-bedrooms (24%), three-bedrooms (18%), bachelor units (4%), and four or more bedrooms (3%).

Figure 5: Proportion of Social Housing Units by Bedroom Size; Sault Ste. Marie, 2014



Source: Housing and Homelessness Plan Update, 2014

Temiskaming

There are a total of 850 units of social housing in Temiskaming. Over half of the units have a mixed mandate for seniors & singles (51.8%) and are all one-bedroom units. Temiskaming has the greatest proportion of Aboriginal/Native housing at 18.9% compared to the other service areas in the NE LHIN.

[12] The number of units in the *Housing and Homelessness Plan Update* (2,430) is greater than the total by mandate (2,234) because it includes a number of rent supplement units that could not be identified by mandate.

Seniors-only units make up 15.9% of the social housing stock and are comprised of one-bedroom (116 units) and two-bedroom (19 units) sized units. Family units make up the smallest portion of all housing types at (13.4%).

Table 11: Number of Social Housing Units by Mandate; Temiskaming, 2011

Mandate	Number of Units	Proportion of Total Units
Seniors / Singles	440	51.8%
Native Housing (Family Units)	161	18.9%
Seniors	135	15.9%
Family	114	13.4%
Total	**850**	

Source: DTSSAB, 2016; DTSSAB Your Guide to Rent Geared to Income Housing, 2011

The number of units by bedroom size was not reported by all housing providers and therefore cannot be accurately reported. However, based on the above proportions of total units by mandate, one-bedroom units make up at least 65.4% of Temiskaming's social housing portfolio. The remaining portion is made up of two- to five-bedroom units.

7.2.3 Modified/ Accessible Units in the NE LHIN

Based on available data, there are at least 375 modified social housing units[13] in the NE LHIN, making up just less than 3% of the total social housing supply. It is likely that there are additional modified units as not all housing providers reported on this unit type.

Table 12: Estimated Number of Modified Social Housing Units by Service Area; NE LHIN, 2016

Service Area	Modified Units	Proportion of Total Units in Service Area
Algoma	16	2.6%
Cochrane	--	--
Greater Sudbury	140	3.2%
Manitoulin-Sudbury	6	1.3%
Nipissing	68	3.0%
Parry Sound	8	2.0%
Sault Ste. Marie	127	5.7%
Temiskaming	10	1.2%

[13] Data was not available for all areas.

Service Area	Modified Units	Proportion of Total Units in Service Area
Total	375	

The following section provides an overview of the number of modified units by community.

Algoma

There are 16 social housing units modified for accessibility in Algoma. The majority of the modified units are in seniors-only buildings and are identified as 'handicap' units. Additional modified units are available but specific counts were not provided.

Table 13: Estimated Number of Modified Social Housing Units; Algoma, 2016

Mandate	Modified Units
Family	3
Senior*	11
Single/Couple	0
Single Family	2
Native Housing	0
Total	**16**

Source: Algoma District Services Administration Board, 2016
* Additional units available

Cochrane

There are several modified social housing units available for all housing types in Cochrane. However, the specific number of units was not identified.

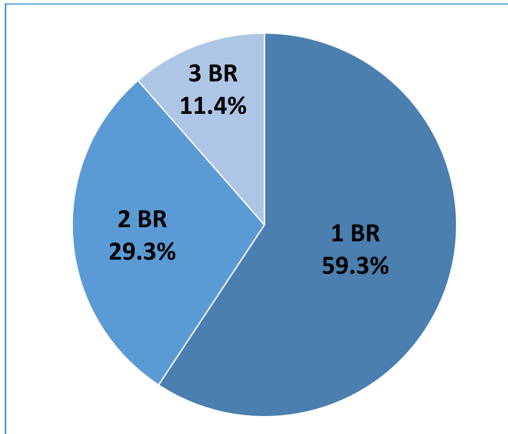
The modifications are made for wheel chair accessibility. The availability of modified units is more frequent in family/singles, and seniors-only mandated units than in senior/single units, and Native housing.

In addition to the modified social housing units, Cochrane has 48 units of social housing mandated for supportive housing/accessible units.

City of Greater Sudbury

The City of Greater Sudbury reported modified unit data on 4,448 units of its social housing stock (data was not available for 411 units of Federal Cooperative housing). Of the 4,448 units, 140 are modified units. There are a greater number of modified one-bedroom units (83 units), compared to half as many modified two-bedroom units (41 units).

Figure 6: Proportion of Modified Social Housing Units by Bedroom Size; City of Greater Sudbury, 2016



Source: City of Greater Sudbury, 2016

Manitoulin-Sudbury

There are six modified social housing units in seniors-only buildings in Manitoulin-Sudbury. In addition, there is an all-ages non-profit building in Mindemoya that is fully accessible and often houses victims of violence.

Nipissing

There are a total of 68 modified social housing units in Nipissing. The majority are for family household types (47 units; 69.1%), followed by a limited number for seniors-only household types (12 units; 17.6%).

Table 14: Number of Modified Social Housing Units; Nipissing, 2013

Household Type	Modified Units
Families	47
Seniors	12
Families / Seniors	9
Total	**68**

Source: 10-Year Housing and Homelessness Plan, 2013

Parry Sound

There are eight modified social housing units in Parry Sound, five of which belong to all-inclusive mandated units and three belong to seniors-only units.

Six of the modified units are one-bedroom units and two are three-bedroom units.

Sault Ste. Marie

There are 127 units described as “special needs / modified” in Sault Ste. Marie’s social housing portfolio. The majority of the units belong to family/single mandated units (67.7%), and seniors-only units (27.6%). The remaining small proportion of special needs / modified units are family units (3.1%) and Aboriginal / Native housing (1.6%).

Table 15: Number of Modified Social Housing Units; Sault Ste. Marie, 2016

Mandate	Special Needs / Modified Units
Family	4
Family / Single	86
Senior	35
Single	0
Aboriginal / Native	2
Total	**127**

Source: DSSMSSAB Housing Directory, 2016

Temiskaming
A total of 10 social housing units have been modified for wheel chair accessibility. Five of these belong to family mandated units and another five belong to seniors-only units. The District of Temiskaming also noted that several walk-in showers have been installed in approximately 75 single units.

7.2.4 Rent Supplement Supportive Housing Units in the NE LHIN

A number of agencies have LHIN-funded rent supplement units for tenants with mental health and addictions challenges. In 2015, there were a total of 484 units across the NE LHIN. Of the total units, 430 units were dedicated for tenants with mental health challenges (88.8%) and 54 units were dedicated for tenants suffering with addictions (11.2%). The majority of the units are located in the Districts of Cochrane-Temiskaming (33.3%), the District of Algoma (29.8%), and the City of Greater Sudbury (27.3%). The remaining units are located in Nipissing District (9.7%).

Table 16: Rent Supplement Units by Agencies; NE LHIN, 2014 - 2015

North East LHIN	Mental Health	Addictions	Total
Algoma Health Unit	130	14	**144**
CMHA Cochrane Temiskaming	149	12	**161**
CMHA Nipissing	23	12	**35**
CMHA Sudbury	116	16	**132**
North Bay Community Housing Initiative	12	0	**12**
Total	**430**	**54**	**484**

Source: Ministry of Health and Long-Term Care, 2014-2015

7.2.5 Waiting for Social Housing in the NE LHIN

Waiting list statistics are based on The Ontario Non-Profit Housing Association's (ONPHA) *2015 Waiting Lists Survey* report. The report details findings and statistics from the social housing waiting lists of the 47 municipal service managers across Ontario.

In communities across the NE LHIN, there are a total of 6,615 active households on social housing waiting lists as of December 31, 2014. Cochrane, Sault Ste. Marie, Nipissing, and the City of Greater Sudbury each have over 1,000 active households on their social housing waiting lists. Manitoulin—Sudbury, Temiskaming, Parry Sound and Algoma each have less than 500 active households.

Table 17: Active Households on Social Housing Waiting Lists by Service Area; NE LHIN, 2014

Service Area	Active Households on Waiting List	Social Housing Units
Cochrane	1,583	2,310
Sault Ste. Marie	1,274	2,430
Nipissing	1,185	2,285
Greater Sudbury	1,068	4,859
Manitoulin-Sudbury	437	453
Temiskaming	410	850
Parry Sound	350	396
Algoma	308	571
Total	**6,615**	**14,154**

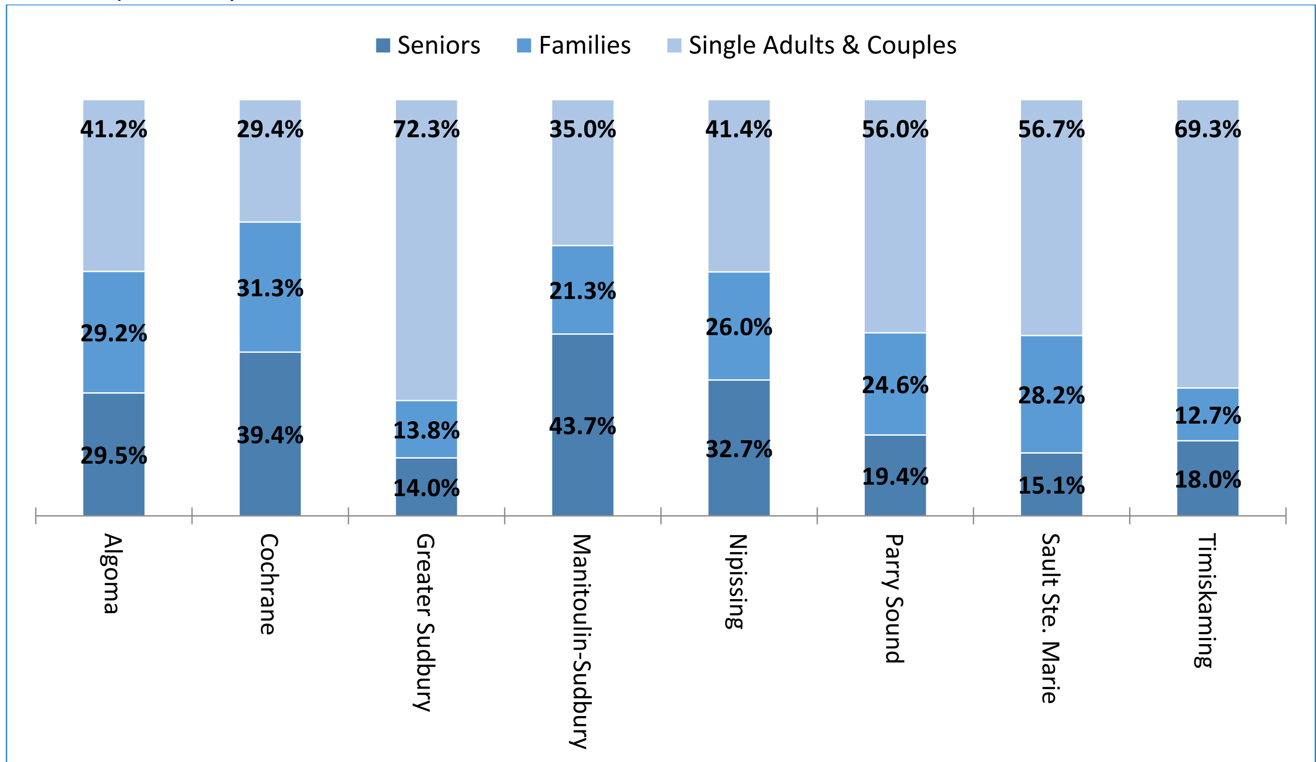
Source: ONPHA Waiting Lists Survey, 2015

Active households on social housing waiting lists are organized by the following household types: Seniors, Families, and Single Adults & Couples. The City of Greater Sudbury has the greatest proportion of single adult & couple households waiting for social housing in the NE LHIN (72.3%). The City of Greater Sudbury, Temiskaming, Sault Ste. Marie, and Parry Sound each have over half of their subsidized social housing waiting lists represented by single adult & couples family household types.

Manitoulin-Sudbury has the greatest proportion of seniors on their social housing waiting list at 43.7% in the NE LHIN. Cochrane is the only service area to have senior households as the greatest proportion of all household types waiting for subsidized housing.

Although there are family household types waiting for social housing, they do not represent the majority proportion of active households on social housing waiting lists in the NE LHIN. Of all the service areas, Cochrane has the greatest amount (495) and proportion (31.3%) of family households waiting for subsidized housing in the NE LHIN.

Figure 7: Proportion of Active Households on Social Housing Waiting Lists by Service Area and Mandate; NE LHIN, 2014



Source: ONPHA Waiting Lists Survey, 2015

7.2.6 Waiting Lists By Community

Algoma

There are a total of 308 active households on social housing waiting lists for subsidized housing. Active households on the waiting list represent 2% of all households[14] in Algoma. There are a greater number of single adult & couple household types (127) on the waiting lists and nearly equal numbers of senior (91) and family (90) households.

Table 18: Active Households on RGI Waiting Lists; Algoma, Dec. 31 2014

Household Type	Total	Average Wait Time (Years)
Seniors	91	1.04
Families	90	0.90
Single Adults & Couples	127	1.00
Total	**308**	

Source: ONPHA Waiting Lists Survey, 2015

[14] ONPHA Waiting Lists Survey, 2015
Calculation based on 2011 total household data.

Cochrane

There are a total of 1,583 active households waiting for subsidized housing. Active households on the waiting list represent 5% of all households in Cochrane. There are a greater number of senior households (623) waiting for subsidized housing followed by family households (495) and single adults & couples (465).

Table 19: Active Households on RGI Waiting Lists; Cochrane, Dec. 31 2014

Household Type	Total	Average Wait Time (Years)
Seniors	623	3.16
Families	495	1.24
Single Adults & Couples	465	3.37
Total	**1,583**	

Source: ONPHA Waiting Lists Survey, 2015

City of Greater Sudbury

There are a total of 1,068 active households on the social housing waiting list for subsidized housing. Active households on the waiting list represent 2% of all households in the City of Greater Sudbury. The number of single adult and couple households (772) waiting for subsidized housing far exceeds the number of senior (149) and family (147) households.

Table 20: Active Households on RGI Waiting Lists; City of Greater Sudbury, Dec. 31 2014

Household Type	Total Units	Average Wait Time (Years)
Seniors	149	3.24
Families	147	0.57
Single Adults & Couples	772	2.10
Total	**1,068**	

Source: ONPHA Waiting Lists Survey, 2015

Manitoulin-Sudbury

There are a total of 437 active households on the social housing waiting list for subsidized housing. Active households on the waiting list represent 4% of all households in the Manitoulin-Sudbury. There are a greater number of senior households (191) waiting for subsidized housing followed by single adults and couple (153) and family (93) households.

Table 21: Active Households on RGI Waiting Lists; Manitoulin-Sudbury, Dec. 31 2014

Household Type	Total Units	Average Wait Time (Years)
Seniors	191	2.42
Families	93	0.98
Single Adults & Couples	153	0.59
Total	**437**	

Source: ONPHA Waiting Lists Survey, 2015

Nipissing

There are a total of 1,185 active households on the social housing waiting list for subsidized housing. Active households on the waiting list represent 4% of all households in Nipissing. There are more single adult and couple households (490) waiting for subsidized housing followed by senior (387) and family (308) households.

Table 22: Active Households on RGI Waiting Lists; Nipissing, Dec. 31 2014

Household Type	Total Units	Average Wait Time (Years)
Seniors	387	1.64
Families	308	1.10
Single Adults & Couples	490	1.98
Total	**1,185**	

Source: ONPHA Waiting Lists Survey, 2015

Parry Sound

There are a total of 350 active households on the social housing waiting list for subsidized housing. Active households on the waiting list represent 2% of all households in Parry Sound. More than half of the active households on the waiting list are single adults and couples (196); followed by family (86) and senior (68) households.

Table 23: Active Households on RGI Waiting Lists; Parry Sound, Dec. 31 2014

Household Type	Total Units	Average Wait Time (Years)
Seniors	68	4.10
Families	86	3.10
Single Adults & Couples	196	3.30
Total	**350**	

Source: ONPHA Waiting Lists Survey, 2015

Sault Ste. Marie

There are a total of 1,274 active households on the waiting list for subsidized housing. Active households on the waiting list represent 4% of all households in Sault Ste. Marie. More than half of the active households on the waiting list are single adults and couples (722); followed by family (359) and senior (193) households.

Table 24: Active Households on RGI Waiting Lists; Sault Ste. Marie, Dec. 31 2014

Household Type	Total Units	Average Wait Time (Years)
Seniors	193	1.50
Families	359	0.75
Single Adults & Couples	722	1.50
Total	**1,274**	

Source: ONPHA Waiting Lists Survey, 2015

Temiskaming

There are a total of 410 active households on the social housing waiting list for subsidized housing. Active households on the waiting list represent 3% of all households in Temiskaming. The number of single adult and couple households (284) waiting for subsidized housing far exceeds the number of senior (74) and family (52) households.

Table 25: Active Households on RGI Waiting Lists; Temiskaming, Dec. 31 2014

Household Type	Total Units	Average Wait Time (Years)
Seniors	74	2.93
Families	52	0.54
Single Adults & Couples	284	1.75
Total	**410**	

Source: ONPHA Waiting Lists Survey, 2015

7.3 Support Service Inventory

This section of the report focuses on support services offered in communities across the NE LHIN area. The inventory was created based on information provided by the NE LHIN, CMHA Sudbury-Manitoulin and through an online scan. The inventory was updated based on feedback received as part of consultation activities.

The inventory is not a complete inventory of support services available across the area; rather, it is a starting point for support services available to assist social housing tenants either directly within the housing itself or within the community (i.e. drop-in centres, day programs).

The inventory of community service providers is organized into the following sectors.[15]

Community Care Access Centres

In collaboration with family health care providers, hospitals and other health care partners, CCACs help Ontarians of all ages to access and navigate the health care services they need, when and where they need them.

Community Health Centres

Provide primary care, health promotion, education and illness prevention services using a community development approach. Health Centres are staffed by health care professionals including physicians, nurse practitioners, nurses, counsellors, community workers and dietitians.

Community support services

Are intended for seniors, or people with disabilities who prefer to stay at home. Services can be offered at the client's home or in the community.

Hospitals

Provide a variety of inpatient and outpatient programs and services. Many provide learning opportunities for health science students and participate in the conduct of health and medical research.

Mental Health and Addictions

Community mental health programs provide a variety of services to help support people who have serious and ongoing mental health issues living in the community. Services offered include information and referral, advocacy, case management, housing advocacy, rehabilitation, employment assistance, counselling, support groups and social and recreational opportunities, and peer support services for consumers and survivors.

Public Health Units

Provide programs that protect and improve the health of the community through comprehensive efforts to prevent, control and eradicate communicable disease; eliminate environmental health hazards; and recognize, prevent and control occupational health hazards and illnesses.

[15] Definitions provided by the North East Health Line website

Data was provided and analysed based on the following regions:

1) Algoma
2) Cochrane-Temiskaming
3) Sudbury/Manitoulin (including the City of Greater Sudbury)
4) Parry Sound
5) Nipissing
6) James and Hudson Bay Coasts

The purpose of the inventory is provide a greater understanding and awareness of the support service network that is available to social housing tenants. The inventory will provide information on the existing supply of support agencies in the NE LHIN and help identify where service improvements are needed. It forms the basis of the needs analysis.

7.3.1 Support Service Network in the NE LHIN

Based on our existing inventory, there are a total of 233 support agencies in the NE LHIN area. Over half of the agencies fall under the Community Support Services sector (53.2%). This is followed by mental health & addictions (26.6%), hospitals (8.6%), community health centres (4.3%), public health units (4.7%), and Community Care Access Centres (2.6%).

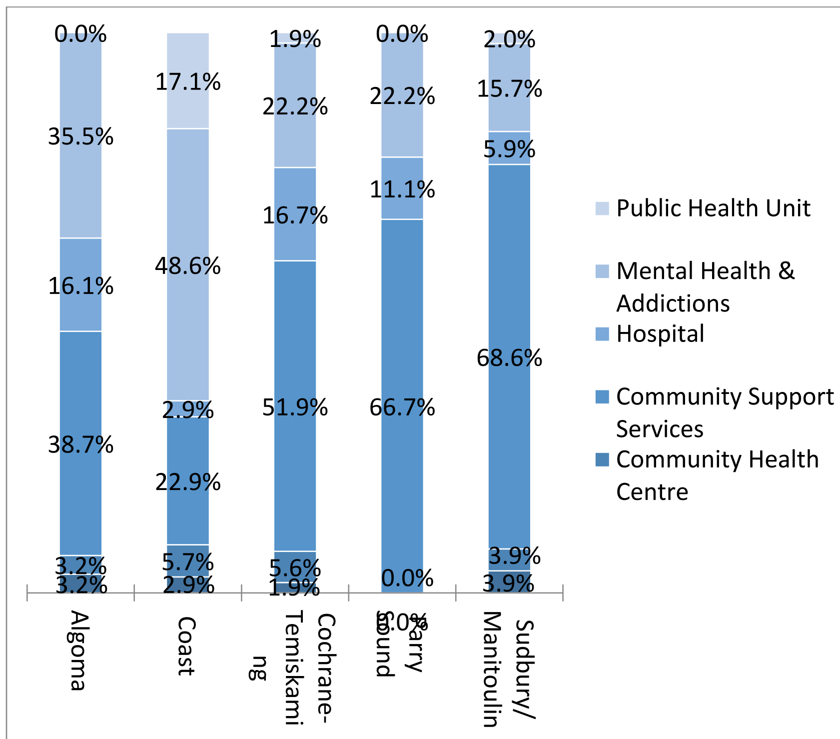
The majority of identified services are located in the Sudbury/Manitoulin (26.6%) and Cochrane-Temiskaming (26.2%) regions. The regions of Algoma (15.0%), the Coast (14.6%), and Nipissing (13.3%) have relatively the same number of agencies. Parry Sound (4.3%) has the least amount with 10 identified agencies in the area.

Table 26: Number of Support Agencies by Sector & by Region

Sector	Algoma	Coast	Cochrane-Temiskaming	Nipissing	Parry Sound	Sudbury/ Manitoulin	Total
Community Care Access Centre Sites	1	0	1	3	0	1	**6**
Community Health Centre	1	2	3	2	0	2	**10**
Community Support Services	15	8	35	16	6	44	**124**
Hospital	5	1	9	1	1	3	**20**
Mental Health & Addictions	12	17	12	8	2	11	**62**
Public Health Unit Sites	1	6	1	1	1	1	**11**
Total	**35**	**34**	**61**	**31**	**10**	**62**	**233**

Looking at communities across the NE LHIN, the Coast region has the greatest proportion identified support agencies providing mental health & addictions services at 50%. Parry Sound and the Coast are the only regions that do not have a Community Care Access Centre Site. The largest number of hospitals are located in the Cochrane-Temiskaming region (9 Hospitals).

Figure 8: Proportion of Support Services by Region and Sector; NE LHIN



A review of support services by area is provided in Appendix A.

7.4 Estimating Number of Vulnerable People in Social Housing

The following section estimates the number of vulnerable persons living in social hosing across the NE LHIN. Estimates are based on research findings from the literature and applying these findings/calculations to the supply of social housing in the NE LHIN presented in the above sections. Results are provided for vulnerable tenants in general (based on ONPHA definition and research findings), as well as particular vulnerable population groups including tenants with a serious and persistent mental illness, seniors, and persons with disabilities.

7.4.1 Vulnerable Tenants

There are 13,705[16] social housing units in the North East LHIN with approximately 20,558 tenants. While a large proportion of these tenants only require supports in the form of financial assistance, there are a proportion of tenants who require additional supports, including assistance with activities of daily living and help with life skills.

There are different approaches to estimate the number of tenants in social housing who require

[16] The number of social housing units in the North East LHIN is based on SHS Calculations from reports and email requests.

supports. For example, an ONPHA study found that in recent years, social housing providers filled vacancies with Special Priority applicants or local priority applicants including those who had experienced violence, those who were homeless or persons with special needs. This study found that 54.6% of vacancies in all social housing units were filled with people who identified themselves as vulnerable in some way[17]. Using this proportion, there are an estimated 11,224 vulnerable tenants in social housing units throughout the NE LHIN. These tenants would likely have a wide range of support service needs, from personal care to assistance with life skills. Estimates on several vulnerable population groups are further explored in the following sections.

7.4.2 Tenants with a Serious and Persistent Mental Illness

There are also tenants living in social housing with serious and persistent mental illness. Serious and persistent mental illness, or SPMI, is the term mental health professionals use to describe mental illnesses with complex symptoms that require ongoing treatment and management, most often varying types and dosages of medication and therapy[18].

It is estimated that approximately 3% of all Canadians have a serious and persistent mental illness[19,20]. In addition, research found that the prevalence rate for serious mental illness and concurrent disorders is greater for people in low socioeconomic groups, with the lowest socioeconomic groups showing rates of mental illness at approximately 2 to 2.5 times that of higher socioeconomic groups. Based on this, the ONPHA report, *Strengthening Social Housing Communities: Helping Vulnerable Tenants Maintain Successful Tenancies (2015),* estimates that 7% of tenants in rent-geared-to-income (RGI) housing and 3% of tenants in market rate social housing have a serious and persistent mental illness[21]. Using this methodology, there are between 617 and 1,439 social housing tenants in the NE LHIN who have a serious and persistent mental illness. While some of these tenants may already be receiving supports, it is highly likely that there is a proportion who are not receiving any supports and others who are not receiving enough supports.

7.4.3 Seniors Requiring Supports

As experienced in communities across Ontario and Canada, the population is aging, including the population living in social housing. ONPHA estimates that there are as many seniors living in social housing as there are in long term care and that a great proportion of waiting lists for social housing are

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[17] ONPHA (2015). Strengthening Social Housing Communities: Helping Vulnerable Tenants Maintain Successful Tenancies.

[18] UNC School of Medicine, Department of Psychiatry. Found at: https://www.med.unc.edu/psych/cecmh/patient-client-information/patient-client-information-and-resources/clients-and-familes-resources/just-what-is-a-severe-and-persistent-mental-illness

[19] ONPHA (2015). Strengthening Social Housing Communities: Helping Vulnerable Tenants Maintain Successful Tenancies AND Ontario Ministry of Health and Long Term Care (2009). Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy.

[20] It is not certain whether the definition of persons with serious and persistent mental health includes persons with addictions. This population, however, is likely captured within the percentage of vulnerable tenants outlined in Section 5.5.1.

[21] ONPHA (2015). Strengthening Social Housing Communities: Helping Vulnerable Tenants Maintain Successful Tenancies p.10

made up of seniors[22]. Indeed, our analysis as shown above finds that 1,176 senior households are on waiting lists for social housing in the NE LHIN service area, representing about 27% of all social housing applicants.

Keefe, et. al. (2007) estimates that between 15% and 18% of seniors 65 years and older will require assistance with everyday activities (e.g. shopping, personal care, housework and meal preparation) based on disability rates and the availability of supports. While the proportion is projected to remain constant from 2001 to 2031, Keefe, et. al notes that the number of seniors requiring assistance will greatly increase due to the aging of the baby boomers. Applying Keefe's estimates to the number of tenants in senior and non-family social housing units in the NE LHIN, it is estimated that there are currently 2,224 – 2,669 seniors living in social housing who require supports.

7.4.4 Tenants with a Disability

Using data from the Canadian Survey on Disability, 2012, Arim (2015) found that 15.4% of all Ontarians 15 years and older and 14% of Canadians overall have a disability that limits their daily activities. When applied to social housing tenants in the NE LHIN, this shows that there are about 3,166 tenants who have a disability which limits their daily activities. While many of these tenants likely have some supports, Turcotte (2014) found that 1.6% of the population 15 years and older who have a chronic health condition do not receive the help they require. When this is applied to the estimated number of tenants in social housing in the NE LHIN, approximately 51 tenants have a disability but are not receiving the supports they require.

The following table shows the estimates based on the approaches discussed above for the number of tenants who require supports in each of the communities within the NE LHIN as well as the total number for the entire LHIN. It should be noted, however, that there may be some double counting, particularly with regard to the estimated number of vulnerable tenants using the 54.6% proportion as well as the fact that different sources of information have been used. In addition, these estimates consider only the number of people who are currently living in social housing and do not take into account the number of people who are applying for social housing in the NE LHIN, which stood at 6,615 as of the end of 2014[23].

[22] ONPHA (2015). Ibid, p.11
[23] ONPHA (2015). 2015 Waiting Lists Survey.

7.4.5 Summary of Vulnerable Persons Living in Social Housing across NE LHIN

Based on the above findings, the following Table provides a summary of the estimated number of vulnerable persons living in social housing across the NE LHIN.

Table 27: Estimated Number of Vulnerable Persons Living in Social Housing across the NE LHIN

	Total Number of Units[1]	Estimated Number of Social Housing Tenants[2]	Estimated Number of Tenants with Serious and Persistent Mental Illness[3]		Estimated Number of Seniors Requiring Supports[4]		Estimated Number of Tenants with a Disability[5]	Estimated Number of Tenants who have Unmet Help or Care Needs[6]	Estimated Number of Vulnerable Tenants[7]
		1.5	**3.0%**	**7.0%**	**15.0%**	**18.0%**	**15.4%**	**1.6%**	**54.6%**
Algoma	610	915	27	64	101	121	141	2	500
Cochrane	2,281	3,422	103	240	491	589	527	8	1,868
Greater Sudbury	4,596	6,894	207	483	633	760	1,062	17	3,764
Manitoulin-Sudbury	453	680	20	48	77	92	105	2	371
Nipissing	2,285	3,428	103	240	264	317	528	8	1,871
Parry Sound	396	594	18	42	82	98	91	1	324
Sault Ste Marie	2,234	3,351	101	235	448	537	516	8	1,830
Temiskaming	850	1,275	38	89	129	155	196	3	696
All LHIN	**13,705**	**20,558**	**617**	**1,439**	**2,224**	**2,669**	**3,166**	**51**	**11,224**

[1]The total number of units is based on email correspondence from housing providers and data from reports and websites

[2]The estimated number of social housing tenants is based on the average number of adults per household with children and without children in Ontario from ONPHA (2015).

[3]The estimated number of tenants with a serious and persistent mental illness is based on the approach used in the ONPHA (2015) report based on a prevalence rate of 3% among all Canadians and 7% prevalence rate among adults in RGI housing.

[4]The estimated number of seniors requiring supports is based on Keefe et. al. (2007).

[5]The estimated number of tenants with a disability is based on the prevalence rate of disability in Ontario from Arim (2015) which uses data from the Canadian Survey on Disability, 2012.

[6]The estimated number of tenants who have unmet help or care needs is based on Turcotte (2014) using the rate of the population 15 years and older who needed help for a chronic health condition but did not receive it.

[7]The estimated number of vulnerable tenants is based on ONPHA (2015) which states that 54.6% of vacancies in all age social housing were filled by people who identified themselves as vulnerable.

7.5 Summary of Social Housing Needs Analysis

Based on the review of social housing across the NE LHIN there are approximately 14,000 social housing units across eight service areas. Almost half of these units (45%) are for all housing types, just over one-quarter (27%) are for seniors, 23% for families and about 4% for Aboriginal and First Nation households. Approximately 3% of the units are modified for persons with disabilities. In addition there are approximately 484 NE LHIN funded supportive housing units for persons with mental health and addiction challenges.

By area, over one-third of the supply is located in the City of Greater Sudbury (34.3%). Sault Ste. Marie (17.2%), Cochrane (16.3%), and Nipissing (16.1%) each have about half of the proportion found in the City of Greater Sudbury. Temiskaming (6.0%), Algoma (4.0%), Manitoulin-Sudbury (3.2%), and Parry Sound (2.8%) each have less than 10% of the total social housing stock and the fewest numbers of units.

These findings are generally consistent with population distribution across the NE LHIN. Sudbury-Manitoulin (6.7%) and Algoma (7.9%) have a slightly higher proportion of social housing units when considering the proportion of total population for the NE LHIN while Parry Sound (1.1%) and Sault Ste. Marie (14.6%) have a slightly lower (1.1%) proportion.

The following Table summarizes the supply and demand for social housing across the NE LHIN by area as well as estimates of vulnerability within the social housing supply.

Table 28: Summary of Demand and Supply of Social Housing across the NE LHIN

Area	Proportion of Social Housing Supply	Proportion of Social Housing Demand	Estimated Number of Social Housing Tenants[24]	Households on Waiting List	Estimate of Number of Tenants with Serious and Persistent Mental Illness[25]	Estimate of Number of Vulnerable Tenants[26]
Algoma	4%	5%	915	308	64	500
Cochrane	16%	24%	3,422	1,583	240	1,868
Greater Sudbury	34%	16%	6,894	1,068	483	3,764
Manitoulin-Sudbury	3%	7%	680	437	48	371
Nipissing	16%	18%	3,428	1,185	240	1,871
Parry Sound	3%	5%	594	350	42	324
Sault Ste. Marie	17%	19%	3,351	1,274	235	1,830
Temiskaming	6%	6%	1,275	410	89	696
All LHIN	**100%**	**100%**	**20,558**	**6,615**	**1,439**	**11,224**

[24] The estimated number of social housing tenants is based on the average number of adults per household with children and without children in Ontario from ONPHA (2015).

[25] The estimated number of tenants with a serious and persistent mental illness is based on the approach used in the ONPHA (2015) report based on a prevalence rate of 3% among all Canadians and 7% prevalence rate among adults in RGI housing.

[26] The estimated number of vulnerable tenants is based on ONPHA (2015) which states that 54.6% of vacancies in all age social housing were filled by people who identified themselves as vulnerable.

8.0 Summary of Gaps and Opportunities

Throughout the various research activities a number of common themes and key messages emerged. These key messages are organized by three critical elements to creating more successful tenancies: supports, housing, and partnerships.

8.1 Supports

Vulnerability

The definition of vulnerable tenants utilizes the ONPHA definition of vulnerability in social housing which is essentially "anyone who needs additional support – for any reason – to maintain a successful tenancy". Based on the methodology within the ONPHA Strengthening Social Housing Communities report (2015), it is estimated that there are approximately 11,224 vulnerable tenants across the NE LHIN. Particular populations were identified within the literature and through the consultations as being at a greater risk of losing their housing as a result of an unmet need. These groups include persons with mental health and addictions, seniors, persons with disabilities (in particular persons with dual diagnosis and concurrent disorders), Aboriginal and First Nation persons, youth, persons living in rural and remote communities and also persons within the LGBT community.

Access

Many stakeholders expressed concern with a lack of access to various support services, in particular within the NE LHIN's remote and rural communities. As identified within the literature, there are fewer health professionals per capita in Northern communities which can result in an increase in a number of health issues.

In addition to concerns regarding access to support services within particular communities, awareness and access in general to support services was identified as a critical component of maintaining successful tenancies. The literature review highlights that connecting people to the right supports at the right time is important. Stakeholders shared success stories and examples where having on-site supports or coordinated response teams can make a huge difference in maintaining tenancies and providing proper supports to residents in need.

Family and Peer Support

A lack of family support or other forms of informal support (i.e. neighbour) was seen as one of the greatest risks for people living alone in social housing. This family or peer support can be critical in identifying needs, advocating for supports, and connecting with appropriate agencies. In addition, the literature points to declines in health and well-being resulting from a lack of supportive social networks.

Early Intervention

The literature emphasizes the importance of early intervention, as did our study stakeholders. Some form of mechanism or framework for identifying and evaluating life skills, mental health, physical health and social supports was considered a key aspect in creating successful tenancies and providing the supports needed before a crisis occurred or the issue worsened.

Study stakeholders also identified that a particular challenge within social housing communities is that a need for support for a tenant may be identified, either by a housing provider or support agency, but that individual does not want help. Early intervention may help to address issues sooner when the tenant may be more open to seeking assistance.

Life Skills

As identified by stakeholders, often tenants of social housing are living on their own for the first time and do not have the necessary life skills to maintain a successful tenancy. This might include housekeeping, healthy eating and budgeting. Similar to the note above regarding early intervention, understanding these needs quickly can help maintain successful tenancies before there is any risk of eviction.

Crisis Support

While early intervention and prevention is key, also identified as equally important is the need for more support services for individuals in crisis or in need of complex care and support. Having sufficient staff and adequately trained staff was identified as a concern, and emphasized as a particular gap within rural and remote areas of the NE LHIN, by study stakeholders.

8.2 Housing

Affordable

As identified within the needs analysis there are approximately 6,615 applicants waiting for social housing across the NE LHIN, creating long waiting lists (typically several years). Stakeholders also clearly identified the need for more affordable housing options, in particular, the need for additional rent subsidies. Portable rent subsidies were seen as a preferred option as these provide choice and flexibility to tenants.

Accessible

The needs analysis also points to a gap in the number of accessible units, which was also articulated through the various consultations. The built form can have challenges for seniors and persons with disabilities as well as people with dementia and other mental health issues. In some areas, an aging housing stock cannot easily accommodate modifications for accessibility.

Supportive

In addition to social housing, stakeholders identified the need for more supportive housing options; in particular, intensive support homes for persons with severe mental health needs. While rental arrears was identified as the greatest risk to eviction, stakeholders emphasized that there are often other factors contributing to rental arrears such as mental health issues or lack of budgeting and life skills.

8.3 Partnerships

Housing Providers

Outlined clearly by housing provider stakeholders and validated within the literature review, landlords and housing providers typically do not have the resources or skills to meet the growing support needs of tenants. Yet, they are frequently in the position of responding to a need or crisis either directly through the tenant or through neighbours and family. Including housing providers within the ‘Circle of Care’ is important for the tenant and also can help providers understand what services are available in their community and how to connect tenants to the right support agencies.

Hospitals

Hospitals were identified as a key partner in providing care and supports to social housing tenants. Many stakeholders raised concerns regarding a lack of communication between support agencies, hospitals and housing providers, which can leave tenants with inappropriate or insufficient support services in place to help them transition back into their home, ultimately making them extremely vulnerable to eviction.

'System Stakeholders'

In addition to hospitals and housing providers noted above, a number of support service agencies are involved in providing care and supports to social housing tenants. While there are many partnerships across communities in the NE LHIN, study stakeholders highlighted that there is a strong need for more coordinated work, more sharing of ideas and more awareness of each other and the services provided within the 'system'. Included in the system are local agencies such as Canadian Mental Health Association, Community Living, Red Cross and many others. Also included are primary care physicians, informal support networks (i.e. family, neighbours, church), public health units and community health centres, emergency medical services, municipalities/local service managers/DSSABs, as well as CCAC and the LHIN itself. Other potential partners might include local school boards, transportation services, and post-secondary institutions.

9.0 The Way Forward

There is currently a gap in the availability, consistency and coordination of support services for persons living in social housing across the North East LHIN.

Based on the research activities described in the above sections, ***there is a strong need for a coordinated model of service delivery to persons living in social housing.*** As shown, more than 10,000 vulnerable tenants live in social housing across the area, and it is critical that this type of coordinated system be set in place to help meet their needs and reduce the risk of eviction and homelessness. Using the key findings from this research the following recommendations are put forward for consideration by CMHA Sudbury-Manitoulin, the NE LHIN and partners across the area.

Recommendation 1: Move forward in developing a coordinating service delivery model for persons living in social housing

The model should integrate a vision that there is "**someone for everyone**", that essentially each tenant has someone to call that can help identify and access support services, assist in life skill development as appropriate, or simply be a friend or a 'go to person'.

To support this vision, the model should also consider the following four principles:

COMMUNITY BUILDING – a collaboration of committed partners with a shared responsibility to better meet the support needs of residents.

Goals might include:

- Adequate resources and skilled workers
- Adequate housing
- Effective and inclusive partnerships

RESPONSIVE – identifies, responds and is flexible to changes in tenant needs.

Goals might include:

- Early intervention/prevention (i.e. assessment tool)
- Appropriate transitional support
- Responsive crisis care

INCLUSIVE – an accessible system of supports for individuals and families from all communities.

Goals might include:

- Equal access to support services
- Identification of resource hubs

CONTINUOUS CIRCLE OF CARE – that residents are supported in their unique needs and experiences which are central to planning and decision making.

Goals might include:

- Care team approach
- Continuum of support (prevention/early intervention to life skills to intensive care to crisis support)
- On-site support or access to 24 hour support
- Effective use of technology and mobile options

Recommendation 2: Conduct a review of housing options across the North East LHIN

The North East LHIN is a large geographic area with a diverse range of urban, rural and remote communities. Through this research study, an inventory of social housing was identified. However, there is little understanding and awareness of other forms of housing, such as supportive housing models, across the LHIN. Preparing housing profiles across various service areas would be helpful in understanding the housing gaps and opportunities.

Recommendation 3: Share and further develop the support agency inventory

Currently, the inventory developed as part of this study includes 233 agencies. The database is a comprehensive document which includes agency names, lead staff and contact information and can be sorted by community and by sector. Sharing this resource with stakeholders would help create a greater understanding of the services available within communities. Expanding on this database over time would also help identify resources and potential gaps in the types of services offered. This means not only adding agencies and organizations to the database but including which services they offer (such as in-home care, meal program, transportation, etc.).

Recommendation 4: Build on current best practices

A number of success stories were identified throughout this research. Moving forward in developing a coordinated service delivery model should consider and build on current best practices such as: CMHA Sudbury-Manitoulin's successful partnership with the Manitoulin-Sudbury District Services Board to offer transitional on-site supportive housing at a social housing building in Espanola; the Housing Success Team in Nipissing, which offer housing supports and referrals to individuals experiencing various housing issues in the community; and, the Community or Rapid Mobilization Teams, which involve local multi-agency, and cross-sector, partnerships to assess and respond to the needs of vulnerable individuals and families in crisis.

Recommendation 5: Leverage non-traditional and informal support options

While there are certainly a number of partnerships across the North East LHIN, there may be opportunities to leverage non-traditional and informal support options to help fill current 'gaps' in the system. For example, looking at some of the case studies, the research identifies an opportunity to work with post-secondary institutions to encourage volunteerism among neighbourhood residents, and provide on-site programs such as after school homework programs, nutrition classes, and resume writing lessons. Another example includes creating opportunities for local residents to provide services to help people age-in-home (i.e. SMILE program). Services might include laundry, assistance with housekeeping and yard maintenance, and transportation. While helping people live at home longer, it also promotes local economic development and could be of particular assistance in more rural areas.

Recommendation 6: Engage Tenants

A research limitation of this current project was the engagement of tenants. Given the timeframe and scope of the study, only twenty tenants participated in the research. For the purposes of this background research study, emphasis was placed on identifying findings from the literature and gathering feedback from housing providers and support service agencies. Moving forward in developing the coordinated service delivery model, it will be important to engage tenants within the implementation and evaluation of the model. It is recommended that the evaluation component incorporate a participatory approach incorporating several methods for the involvement and co-leadership from the people most impacted by the project.

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11.0 Appendix A: Support Services by Area

Algoma

The Algoma region has a total of 36 support agencies. It is mainly serviced by the community support service (41.7%) and mental health & addictions (33.3%) sectors. There are five hospitals (13.9%), and one Community Care Access Centre (2.8%), community health centre (2.8%), public health unit (2.8%), and women's shelter (2.8%).

Table 29: Number of Support Agencies by Sector; Algoma

Sector	Support Agencies	Proportion
Community Care Access Centre	1	2.8%
Community Health Centre	1	2.8%
Community Support Services	15	41.7%
Hospital	5	13.9%
Mental Health & Addictions	12	33.3%
Public Health Unit	1	2.8%
Women's Shelter	1	2.8%
Total	**36**	

Cochrane-Temiskaming

The Cochrane-Temiskaming region has a total of 61 support agencies. Over half the support service network is made up of community support services (57.4%). This is followed by mental health & addictions services (19.7%), hospitals (14.8%), community health centres (4.9%), one public health unit (1.6%), and one Community Care Access Centre (1.6%).

Table 30: Number of Support Agencies by Sector; Cochrane-Temiskaming

Sector	Support Agencies	Proportion
Community Care Access Centre	1	1.6%
Community Health Centre	3	4.9%
Community Support Services	35	57.4%
Hospital	9	14.8%
Mental Health & Addictions	12	19.7%
Public Health Unit	1	1.6%
Total	**61**	

Sudbury/Manitoulin

The Sudbury/Manitoulin region has a total of 62 support agencies. It is primarily serviced by community support services (71.0%). There are eleven mental health & addictions support agencies (17.7%), three hospitals (4.8%), two community health centres (3.2%), one Community Care Access Centre (1.6%), and one public health unit 1.6%) servicing the area.

Table 31: Number of Support Agencies by Sector; Sudbury/Manitoulin

Sector	Support Agencies	Proportion
Community Care Access Centre	1	1.6%
Community Health Centre	2	3.2%
Community Support Services	44	71.0%
Hospital	3	4.8%
Mental Health & Addictions	11	17.7%
Public Health Unit	1	1.6%
Total	**62**	

Parry Sound

There are a total of 10 support agencies in the Parry Sound region. There are six community support service providers, two mental health & addiction providers, and one hospital and one public health unit. There are no community health centres or Community Care Access Centres.

Table 32: Number of Support Agencies by Sector; Parry Sound

Sector	Support Agencies	Proportion
Community Care Access Centre	0	0.0%
Community Health Centre	0	0.0%
Community Support Services	6	60.0%
Hospital	1	10.0%
Mental Health & Addictions	2	20.0%
Public Health Unit	1	10.0%
Total	**10**	

Nipissing

The Nipissing region has a total of 31 service providers. It is primarily serviced by 16 community support service agencies (51.6%). There are eight mental health & addictions service providers, three Community Care Access Centres, two community health centres, one hospital, and one public health unit.

Table 33: Number of Support Agencies by Sector; Nipissing

Sector	Support Agencies	Proportion
Community Care Access Centre	3	9.7%
Community Health Centre	2	6.5%
Community Support Services	16	51.6%
Hospital	1	3.2%
Mental Health & Addictions	8	25.8%
Public Health Unit	1	3.2%
Total	**31**	

James and Hudson Bay Coasts

The Coast region has a total of 34 support agencies. The 17 mental health & addictions service providers make up half of the support service network. This is followed by eight community support service providers (23.5%), six public health units (17.6%), two community health centres (5.9%), and one hospital (2.9%). There are no Community Care Access Centres located in the Coast Region.

Table 34: Number of Support Agencies by Sector; James and Hudson Bay Coasts

Sector	Support Agencies	Proportion
Community Care Access Centre	1	2.9%
Community Health Centre	2	5.7%
Community Support Services	8	22.9%
Hospital	1	2.9%
Mental Health & Addictions	17	48.6%
Public Health Unit	6	17.1%
Total	**35**	

Appendix 3

Innovative Housing with Health Supports in Northeastern Ontario:

Financial Modelling Tool (Note: This Financial Modelling Tool can be Accessed at http://share.hscorp.ca)

Purpose:
In support of the strategy development of the Innovative Housing and Health Supports in Northeastern Ontario, the North East Local Housing Integration Network (NE LHIN) commissioned a project to develop a financial modelling tool as the first step to analyze and assess a potential range of innovative funding mechanisms to aid in the development/ creation, renovation or re-purposing of a range of adequate, affordable, safe and energy efficient housing through various funding mechanisms. This aligns with "Innovative Housing" goal of the Strategic Plan.

Housing Services Corporation (HSC) in consultation with the NE LHIN and the Expert Panel, created the financial modelling tool[27] outlined in the attached spreadsheets. The financial tool is designed to assist in developing, sustaining, enhancing and growing the affordable housing supply. The tool templates are to be utilized in undertaking financial analysis and developing a business case to support decision making when considering financing options to develop affordable housing in Northern Ontario.

The base model is designed for a new build and financing the project but also integrates four scenarios such as exploring additional revenue and municipal incentives, undertaking financing upgrades and retrofits and sub debt.

About the Financial Modelling Tool
The tool is structured to conduct financial analyses to determine the financial structure, shortfall in financing (if any) and viability of a project. In addition it allows stress testing of a project when considering various financing options. The templates integrated in the tool enable users to input information, with variables that can be changed to determine outcome.

The key components of the tool are:

- **Project capital cost**
  - Capital cost structure of a new build or retrofit
- **Project funding**
  - Proponents equity
  - Grants (federal, provincial, municipal, other)
  - Gifts/donations
  - Debt financing required to cover shortfall
- **Project operating budget**
  - Revenue
  - Expenses (building and operational expenses)
- **Debt Service Coverage Ratio (*see additional explanation for Debt Service Coverage Ratio*)**

[27] The financial modelling tool and its usability were presented to the Expert Panel and at the 2016 Forum.

The model has the ability to factor in supportive services and partnerships but the cooperative housing example used is for demonstration purposes only and does not include supportive services data (long term and flexible service agreements).

Using the base model, HSC has stress tested various scenarios as outlined in the spreadsheets and noted below (PLEASE SEE **http://share.hscorp.ca**).

Scenario (A)	Base Model of a New Build and the Financing the Project
Scenario (B)	Additional Revenue - Rental space (i.e. Shared Space) for a Service Providers
Scenario (C)	Additional Municipal Incentives
Scenario (D)	Financing Upgrades and Retrofits
Scenario (E)	Sub Debt is introduced to replace equity reduction. Equity is reduced in order leverage another property.

Users of these models are encouraged to adjust the variables identified to actual conditions and amounts in order to develop appropriate funding strategies for each of the projects under consideration. This should be done with a view to arriving at an overall funding strategy to get to a DSCR that is higher than 1.0, for the housing project they are considering.

BASE MODEL- EXAMPLE

A cooperative housing corporation in Northern Ontario would like to build 34 residential units. The assumptions used for the base model are:

- Funding for these units has been requested from the Ontario Ministry of Housing and the Canada Mortgage and Housing Corporation (CMHC).
- The proposed units will form a seniors' residence/community living environment.
- A needs analysis had been undertaken and the need for such an affordable housing facility was shown and confirmed.
- A longstanding non-profit is willing to address the need and bring forth the project.
- The local municipality offered the coop a parcel of land to develop for the proposed housing facility.

The information for the model was compiled from a variety of actual and considered projects in Northern Ontario however; the information/examples used by Housing Service Corporation are for illustration purposes only and do not reflect an actual case.

The **Debt Service Coverage Ratio (DSCR)** is an indicator of the financial viability of the project. The ratio signifies the ability of the net operating income (Earnings before interest, taxes, depreciation, and amortization (EBITDA)) to service the annual principal and interest payments.

To warrant financing and to make the business case to go ahead with developing the housing under consideration, the Debt Service Coverage Ratio (DSCR) will need to exceed a ratio of 1.0.

$$\text{DSCR} = \frac{\text{Net Operating Income (EBITDA)}}{\text{Total Debt Service}}$$

Any debt service coverage ratio below 1.0 indicates that there is not enough cash flow to cover loan payments. Debt coverage of 1.2 or higher is generally considered sufficient in these types of projects to achieve adequate funding and ensure that the project can proceed and operate in a financially sustainable manner.

North East **LHIN** | **RLISS** du Nord-Est

Ontario

Local Health Integration Network

Réseau local d'intégration des services de santé