

## REPORT

FOR

### Evaluation of Homelessness Prevention Project VISTA CENTRE BRAIN INJURY SERVICES

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Submitted to:

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## Table of Contents

1.0 EXECUTIVE SUMMARY.....	1
2.0 PROJECT DESCRIPTION.....	2
3.0 EVALUATION QUESTIONS AND METHODOLOGY.....	3
3.1 Evaluation Questions.....	3
3.2 Evaluation Methodology.....	3
3.3 Data Collection.....	4
4.0 EVALUATION RESULTS.....	4
4.1 Chart review.....	4
4.1.1 Sociodemographic profile of clients.....	4
4.1.2 Referral Source, Time in the program, Staff Time.....	5
4.1.3 Risk Factors.....	6
4.1.4 Housing.....	7
4.1.5 Source of income.....	9
4.1.6 Social support.....	10
4.1.7 Health care.....	11
4.1.8 Food insecurity.....	12
4.1.9 Employment.....	14
4.1.10 Substance Abuse.....	15
4.1.11 Cognitive/Executive Functioning.....	16
4.1.12 Illiteracy.....	17
4.1.13 Dealing with pandemic.....	18
4.2 Case Studies.....	19
5.0 Conclusions.....	23

## **1.0 EXECUTIVE SUMMARY**

Vista Centre Brain Injury Services (**VCBIS**) received a one year **Seed Grant** from the Ontario Trillium Foundation to pilot a Homelessness Prevention Project. This project was modeled on a project that had already been implemented in Toronto.

There is a strong correlation between Acquired Brain Injury (ABI) and homelessness. Research has shown that approximately 50% of the homeless population have some form of ABI, and 70% of these individuals became homeless after their injury. Because of their condition, these individuals are at greater risk of homelessness, and face additional challenges to accessing services to prevent homelessness. The main goal of the project is to provide a range of specific supports to this population that will enable them to acquire and maintain stable housing.

Through the OTF funding a Homelessness Prevention Coordinator was hired for one year (ending March 31, 2022). The Program served 20 clients during this period. At the time of referral all of the clients were either homeless or at risk of homelessness. The clients for this program were complex, experiencing a wide range of challenges that would make it difficult for them to find and maintain housing. For example, 100% of the clients experienced challenges with executive/cognitive functions (which makes it difficult to schedule, budget and organize); 56% had substance abuse issues; 56% experienced food insecurity; all were managing on very limited incomes; and one-third of clients had no other social support.

Many of the clients were able to live semi-independently, with some support. The problem is that many programs and service providers are not aware of the specific challenges faced by people with ABIs, so that non-participation in programs is often interpreted as a lack of interest or defiance, rather than behaviour associated with the condition, and clients are sometimes dropped from these programs.

The Homelessness Prevention Program had a positive impact on the clients' housing situation. As a result of the HPC's work, 30% of the clients were able to move into a stable housing situation, and a number of others were able to enter into transitional arrangements. Many were able to also increase their skills and knowledge necessary to live independently (e.g. in areas such as shopping, food preparation and budgeting), and were able to participate in programs and access care.

The HPC played three important roles in supporting clients:

- Direct client support
- Case management
- Education/support to other service providers

The Homelessness Prevention Program seemed to fill a unique need experienced by persons with ABI, and was able to help many clients to stabilize their housing situation and find support for some of the complex challenges they were facing. The open question is what would have happened to these clients if this program had not been in place. It seems likely that a number of the clients would have lost their housing and either become homeless or moved into the shelter system. It is uncertain how well existing programs might have addressed the various needs

experienced by the clients, except to say that we know such programs already experience challenges in meeting their needs.

## **2.0 PROJECT DESCRIPTION**

Vista Centre Brain Injury Services (**VCBIS**) received a one-year Seed grant of \$75,000 from the Ontario Trillium Foundation to implement and evaluate a Homelessness Prevention Project for people with Acquired Brain Injuries (ABIs). The funding was intended to develop a service model to assist people with ABIs to find and maintain access to safe and affordable housing.

The case for funding this work was based on; 1) the very high correlation between people with acquired brain injuries and homelessness; and 2) a successful pilot project funded in Toronto with the same population. The case for the project is presented below:

“The Homelessness prevention coordinator (HPC) project is a service initiative that will assist people with brain injuries to retain and sustain access to safe, affordable housing. These individuals struggle with short-term memory impairment, organization, insight, literacy, comprehension, impulse control. These individuals experience profound and long-term barriers in housing. These individuals struggle to access medical and support services. Long-term homelessness, shelter stays, incarceration, and frequent hospitalization are commonplace, and are made more likely by the cognitive barrier. Along with creating support services, we aim to enhance education for stakeholders to better comprehend the role cognitive impairment contributes to homelessness.”<sup>1</sup>

The funding supported the work of a full-time Homelessness Prevention Coordinator (HPC), whose role was to act as a case manager and provide a broad range of supports to clients, including housing, but going beyond this to address a number of other issues they face as economically vulnerable people. The role of the HPC is described as follows:

“This will employ a full-time mobile support position to provide services that are flexible, agile and adaptable to each individual's unique needs related to housing procurement and stability.

- live in the Greater Ottawa/Champlain area
- identify themselves as an individual with a cognitive disability or barriers relating to memory, literacy or areas of executive function, that impacts on the ability to manage their health, income, housing, or basic personal needs without support
- Assist in completing housing applications for rent geared to income, landlord canvassing/liaison, landlord tenant tribunal support in conjunction with local legal clinic, housing search and connection to wrap around services related to needs:
  - provide assistance with income applications and process, including completion of income taxes.
  - Community services navigation and connection
  - medical connection and support to connect to health services
  - support to address basic needs i.e. food security
  - Provide education to community partners and stakeholder about brain injury”<sup>2</sup>

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<sup>1</sup> From Vista’s 2021 application to Ontario Trillium Foundation

<sup>2</sup> Ibid.

The stated target for the year was to serve 30 clients.

### 3.0 EVALUATION QUESTIONS AND METHODOLOGY

#### 3.1 Evaluation Questions

This summative evaluation is intended to document lessons learned from implementing the Homelessness Prevention Program pilot and the impact of the initiative. In the OTF application, Vista proposed the following as a basis for what they hope to learn from the project:

##### What do you expect to learn from this project?

- Understand specific barriers related to brain injury and cognitive impairment within housing/homelessness in the Ottawa/Champlain community
- We expect to develop an enhanced service model and strategies to address challenges related to homelessness and brain injury in the Ottawa/Champlain communities.
- We will grow our knowledge and data collection to expand research and create best practices address inform poverty reduction practices and decrease homelessness.
- How to promote education and practices to community partners and community stakeholders to reduce barriers to services and increase social, economic, and housing opportunities in the community for those living with brain injury.

##### What key questions will you need to answer to achieve your expected learning?

- What are the barriers to housing for individuals who have sustained a brain injury in Ottawa?
- How to effectively address the challenges in the Ottawa community for this population?
- What is the social economic cost for this community related to the cost of poverty for this population?
- How to create public awareness and education tools to further inform poverty reduction for brain injury within shelters and community services across Ottawa.
- Can access to support decrease reliance on other more costly services/ health programs?
- Can this program model prevent individuals from entering long-term care, incarceration and costly emergency housing placements?

#### 3.2 Evaluation Methodology

The evaluation will address the following elements and the sources of data are noted below:

Evaluation element	Source of data
Description of the program: <ul style="list-style-type: none"> <li>• Rationale for program</li> <li>• Program Goals</li> <li>• How the program was intended to operate</li> </ul>	Review of documentation Interview with Program Manager and Coordinator
Determine evaluation questions: <ul style="list-style-type: none"> <li>• What are the questions to be addressed in this evaluation?</li> </ul>	Interview with Program Manager and Coordinator
Evaluation results: <ul style="list-style-type: none"> <li>• Profile of clients – Who did Vista hope to reach with this initiative? Who did they actually reach? What were the</li> </ul>	Consultant will develop a data collection framework.  Coordinator will review clients’ case notes to

<p>characteristics of the clients (age, sex, etc.)? What challenges were they facing?</p> <ul style="list-style-type: none"> <li>• Supports provided – What specific services were provided by the initiative? What were the most common types of supports provided?</li> <li>• Impact – What difference did this program make? In what ways did this program have an impact on homelessness of clients?</li> </ul>	<p>collect the necessary data.</p> <p>Consultant will analyze the data.</p>
<p>Case stories:</p> <ul style="list-style-type: none"> <li>• 3-4 short case stories to illustrate how the Coordinator worked to address more frequent/important issues faced by clients, and the impact of the program.</li> </ul>	<p>Consultant will interview Coordinator and partner organizations (and potentially clients)</p>
<p>Lessons learned:</p> <ul style="list-style-type: none"> <li>• What did we learn about the issues that clients are facing?</li> <li>• What did we learn about this type of intervention?</li> <li>• What changes would be recommended if the program continues?</li> </ul>	<p>Reflection on data and conversation with Program Manager and Coordinator.</p>

**3.3 Data Collection**

Data was collected by the HPC from the clients’ charts. She inputted the data from each client into a survey on Survey Monkey where it was analyzed by the evaluation consultant.

**4.0 EVALUATION RESULTS**

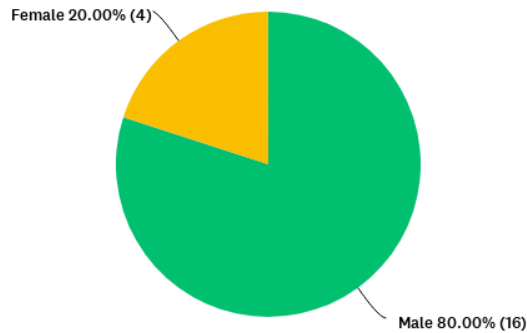
Results are based on 11 months of operation (April 2021 – February 2022). A total of 20 clients were in the program over this period. Two types of data are presented in this report. The first comes from the review of clients’ charts, and the second is a series of case studies to provide a more comprehensive picture of the challenges faced by several clients, and the role of the HPC to address these challenges.

**4.1 Chart review**

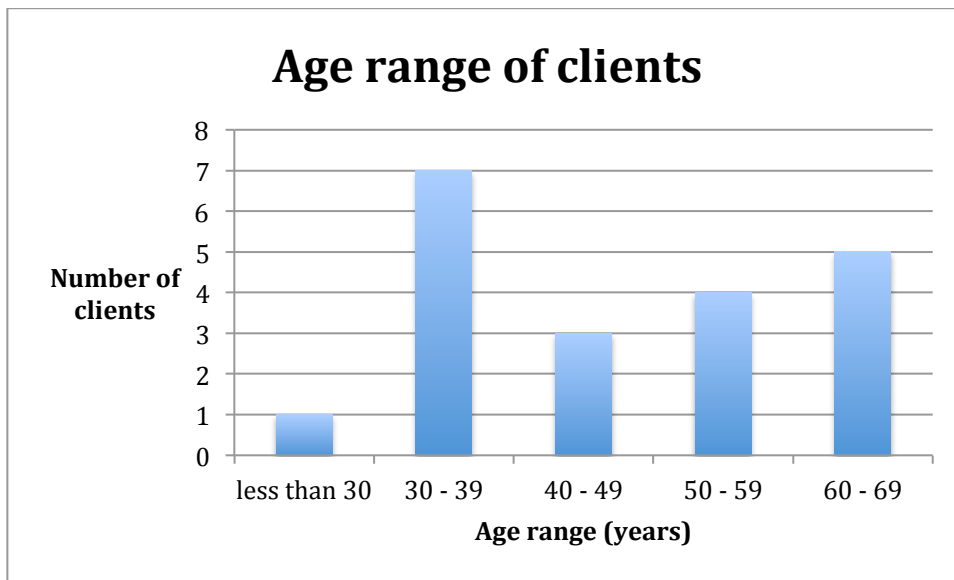
**4.1.1 Sociodemographic profile of clients**

The 20 clients were predominantly male (80%).

Q3 Gender of client (how client self-identifies)



They ranged in age from 27 to 67 years old, with a median of 43.5 years. The largest group of clients were in the range of 30-39 years old (7 clients or 35%).



**4.1.2 Referral Source, Time in the program, Staff Time**

Clients were referred to the program from a wide variety of sources, with the most common being CFS Ottawa (7 clients or 35%), followed by family/friends (3 clients or 15%) and hospital (3 clients or 15%).

Referral source	# of clients
CFS Ottawa	7
Family/Friends	3
Hospital	3
Self	1
Physician	1

Vista waitlist	1
Case manager	1
CMHA	1
West Carleton Family Services	1
Lawyer	1
<b>TOTAL</b>	<b>20</b>

Clients spent between 2 and 13 months in the program; four of the 20 clients had been discharged at time of this report.

The HPC spent a total of 1430 hours working with the clients, for an average of 75 hours/client (hours were recorded for 19 clients). The number of hours/client ranged from 2 hours to 414.5 hours, with a median of 44 hours/client.

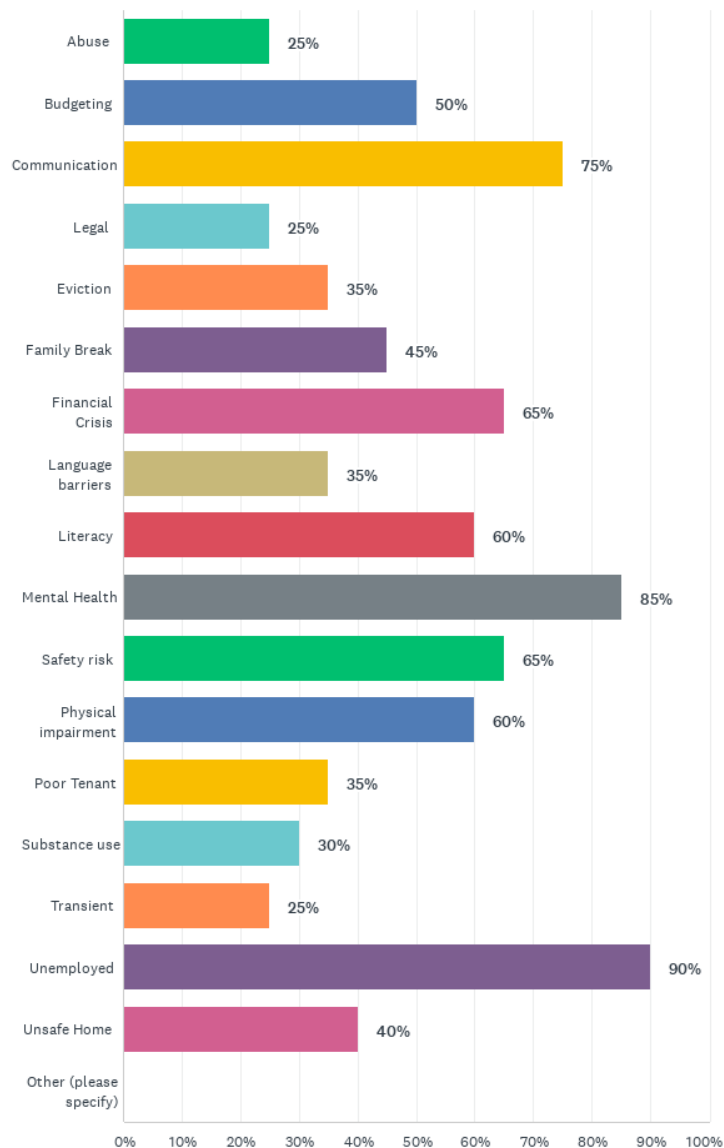
Of this total of 1430 hours, 1026.5 hours (72%) were spent in providing direct service to clients, and 403.5 hours (28%) were spent in preparatory or follow-up work with clients.

#### **4.1.3 Risk Factors**

Clients experienced a wide variety of risk factors for homelessness on entering the program. The most commonly identified risk factors were: unemployment (90%), mental health problems (85%) and communications problems (75%). A high percentage of the clients experienced multiple risk factors, which makes it challenging for them to participate in other established programs in the community.



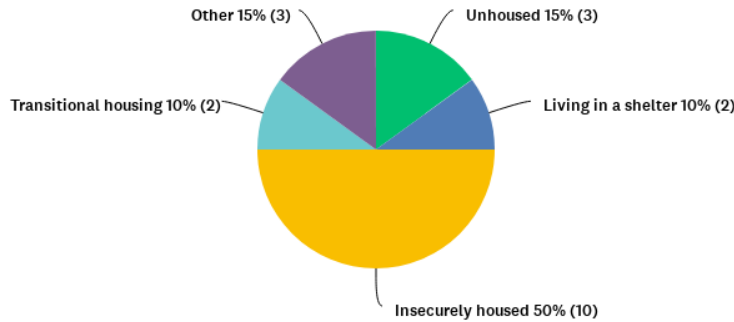
Q8 Which of the following risk factors did the client present with? (check all that apply)



**4.1.4 Housing**

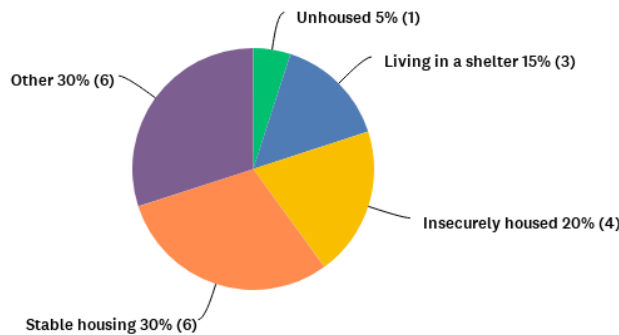
All of the HPC clients were either homeless or in an unstable housing situations when they entered the program, with ten clients (50%) in an insecure housing situation (where they were at high risk of eviction or losing their housing due to factors such as an unstable or risky relationship); three (15%) were unhoused and two (10%) were living in a shelter.

Q9 What was the client's housing status when entering the program?



After having participated in the Homelessness Prevention Program, many clients improved their housing situation. Six clients (30%) were in stable housing, and the number insecurely housed fell to four (20%), with three (15%) living in a shelter.

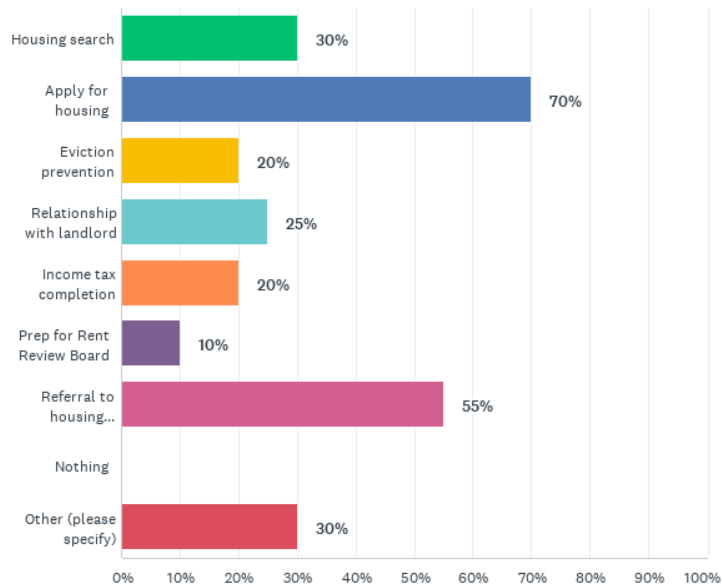
Q11 What is client's housing status now?



Clients with ABI face a number of challenges with respect to housing. They are not employed and most are living on a very limited income (Ontario Works or ODSP), which makes it difficult to find an affordable apartment. Executive functioning challenges make budgeting difficult, and personality challenges/anger sometimes result in problems with landlords.

The HPC performed a number of roles to help clients to improve their housing situation. The most common roles were to assist the clients to apply for social housing or housing registry (70% of clients), followed by referral to other housing supports (55%). It is also important to note the role that the HPC frequently played to mediate between the landlord and the tenant (25%), and assisting the client with income tax completion (20%), which is a prerequisite to apply for social housing. In several cases the HPC dealt with emergency situations to find short-term housing solutions for clients.

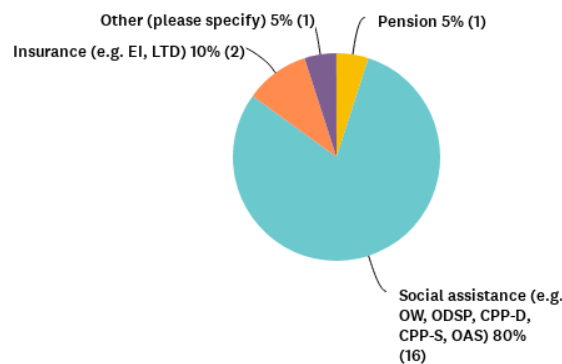
Q10 What did you do to try to help the client address housing issues? (check all that apply)



#### 4.1.5 Source of income

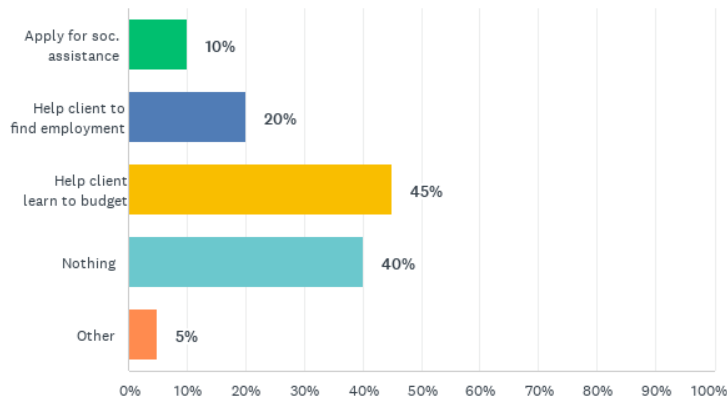
The primary source of income for the vast majority of clients (80%) was some form of social assistance.

Q13 What was the client's main source of income when entering the program?



The primary support that the HPC provided to clients related to their finances was to help them develop budgeting skills (provided to 45% of clients) and, for those who are ready, referring them to help with finding employment (20%).

Q14 What did you do to try to help client address financial issues? (check all that apply)

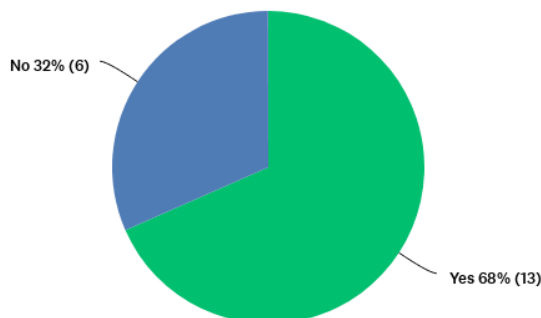


The most important impacts of the financial support work of the HPC have been that: some clients have improved their budgeting skills; some have been able to reduce outstanding debts (after the HPC had negotiated settlements with creditors); and some have been able to improve their financial situations by qualifying for additional benefits (e.g. ODSP and HST benefits) after filing their income tax.

#### 4.1.6 Social support

Although most of the clients (67%) had some social support when they entered the program (defined as family or friends who could help them with things like attending appointments or completing forms), one-third of clients had no such support, making them potentially very isolated.

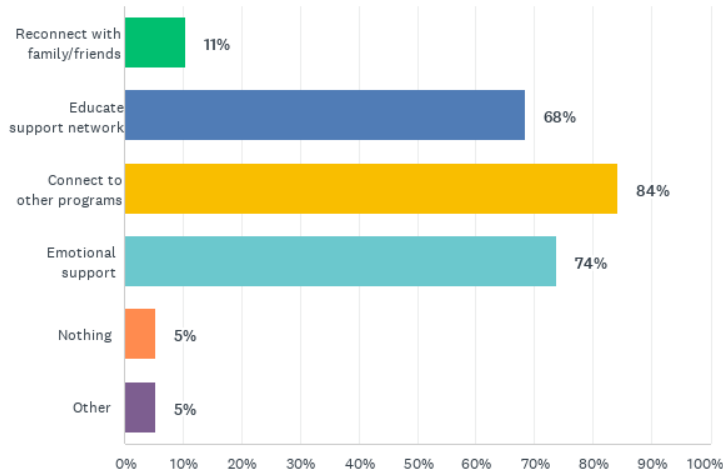
Q16 Did client have any other source of social support when entering the program (e.g. family, friends who could help with things like attending appointments, filling in forms)?



The HPC assisted the clients in social support in a number of ways. She helped clients to connect to other programs to reduce their isolation (84% of clients), provided emotional

support to clients (74%) and helped to educate the clients' support network about ABI and what they could do to support their friend/family member (74%)

Q17 What did you do to help client to increase their social support? (check all that apply)

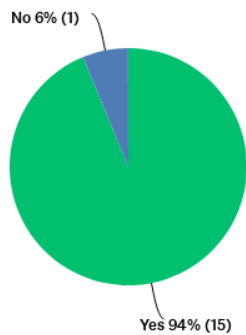


Some of the impacts of the HPC's work in social support were: to get clients connected to programs where they would have a chance to meet other people; and work to help strengthen and support the relationship between the clients and their existing support networks, often by helping the supports to understand ABI and how to be an effective support.

#### 4.1.7 Health care

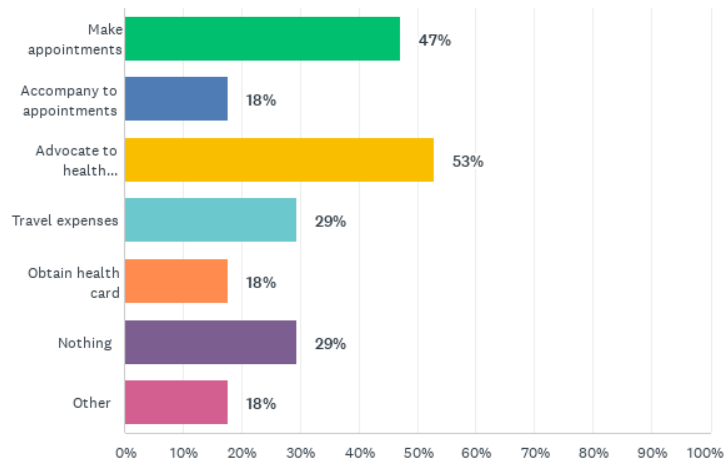
Virtually all of the clients had a primary health care provider when they entered the program.

Q19 Did client have a primary health care provider when entering the program?



The HPC performed a number of important roles to help the clients access health care services, including helping the client to advocate to their health care practitioner (53% of clients), helping the client to schedule and keep their appointments (47%), and helping them to cover travel expenses to get to and from medical appointments (29%).

Q20 What did you do to help client access health services? (check all that apply)



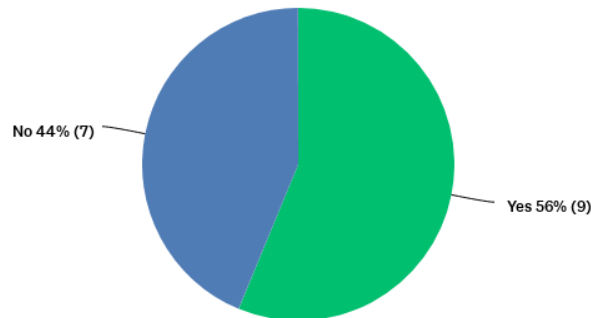
Accessing care in the health care system is not easy, and some of the ABI clients have complex medical histories that requires them to see several practitioners and specialists. As they do not have other case managers, they require someone who is able to assist them to manage the organization and logistics to attend appointments.

The HPC was able to play an important role in assuring the clients could actually access the health care system. In several cases this involved helping the clients to obtain their health card. Scheduling and transportation were also important issues where the HPC played a role. In addition, the HPC was an important intermediary between the health care providers and the clients – helping the health providers to understand the specific challenges of ABI, and helping the client to understand and prepare for the appointments, and to ensure that follow-up happened (e.g. client obtaining and taking medication, or arranging follow-up appointments).

**4.1.8 Food insecurity**

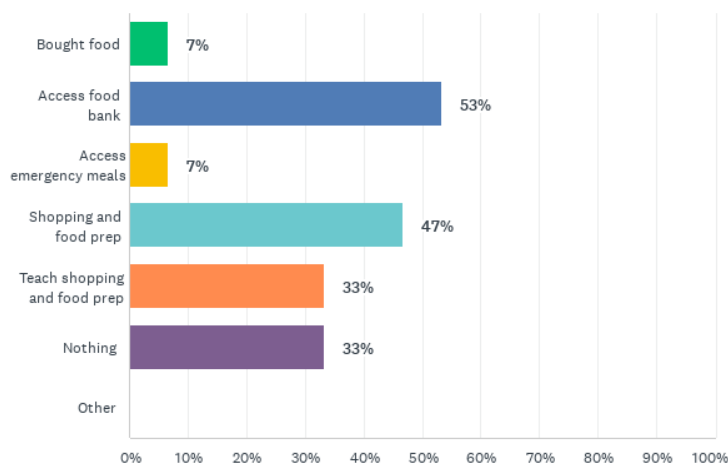
Food insecurity was a significant issue for over half of the clients (56%).

Q22 Was client experiencing food insecurity when entering the program?



The HPC worked to help the clients address their food insecurity in a number of ways, including: helping the clients to address the food bank (53% of clients); helping them with shopping and food preparation (47%); and helping them to learn skills for shopping and food preparation on a budget (33%).

Q23 What did you do to help client address food insecurity? (check all that apply)

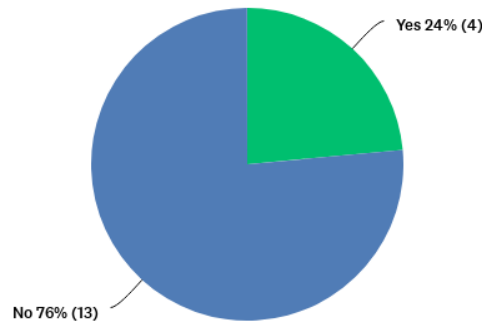


Many of the clients experienced food insecurity because they were unable to manage on a very low income and relatively high rent, leaving very little for food; they also had not developed the organizational and budgeting skills necessary in such a situation. As a result, the HPC often had to intervene urgently by helping clients to access food banks, and then to help them to develop the skills to manage their food situation over the longer term. Some of the clients became more independent in this regard, but many will require ongoing support.

#### 4.1.9 Employment

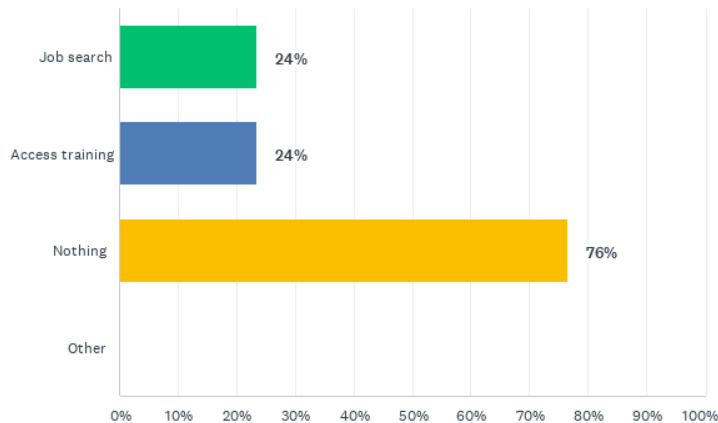
None of the clients were employed when they were referred to the Homelessness Prevention Program. About one-quarter (24%) of the clients were interested in finding employment.

Q26 Was client interested in finding employment?



The HPC assisted clients who were interested in finding employment by helping them with the job search (24%) and helping them to access training programs (24%).

Q27 What did you do to help client find employment? (check all that apply)



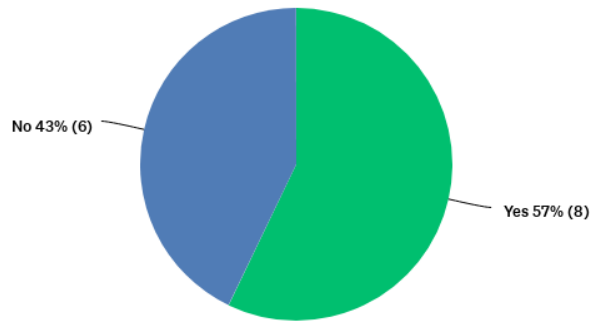
The viability of employment as an option for ABI clients is very much dependent on their individual condition. The main role that the HPC played was to help refer clients who were interested in employment to job coaches and specialized programs such as PPRC that could properly assess the clients, help them to look for suitable employment opportunities, and help to negotiate accommodations from employers.



#### 4.1.10 Substance Abuse

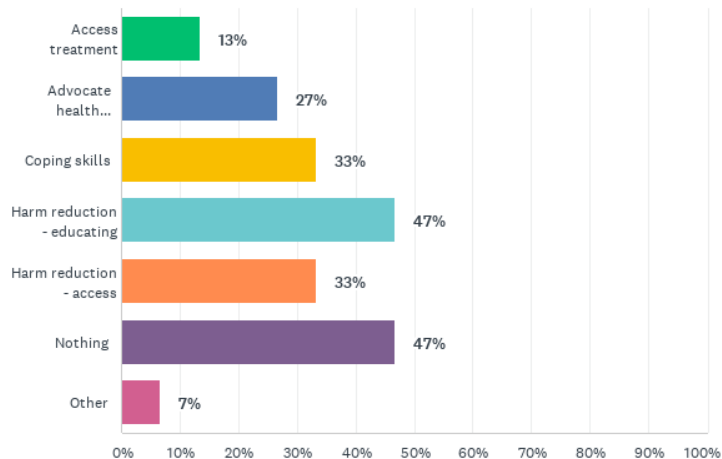
Over half of the clients were dealing with substance abuse when they entered the Homelessness Prevention Program, so this was a significant issue.

Q29 Was client dealing with substance abuse when entering the program?



The HPC helped clients to deal with substance abuse in a number of ways: she helped almost half of the clients (47%) by educating them on harm reduction; one-third (33%) of clients were helped to access harm reduction supplies or programs; she helped 33% of clients with skills in coping with substance abuse; and she assisted 27% in advocating with their health provider regarding their substance abuse.

Q30 What did you do to assist client with dealing with substance abuse? (check all that apply)



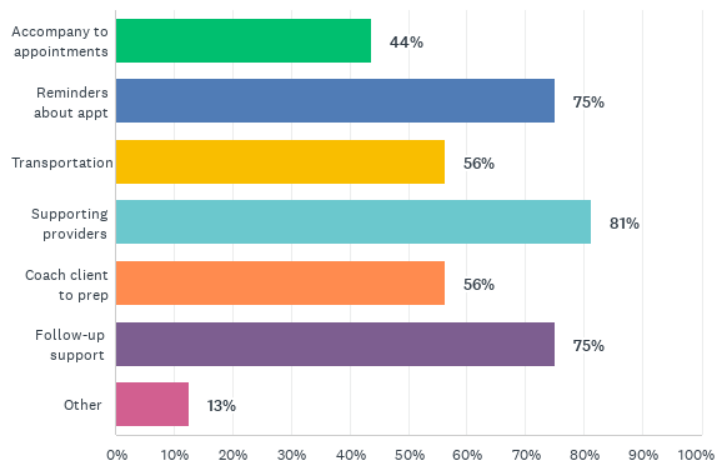
Arguably the most important role that the HPC was able to play was to provide ongoing support and checking in with clients on a consistent basis, which included education and support around harm reduction.

#### 4.1.11 Cognitive/Executive Functioning

All of the clients experienced some challenges with cognitive/executive functioning (which is extremely common for people with ABI).

The main ways in which the HPC tried to assist clients with cognitive/executive functioning challenges were: supporting other service providers in their dealing with the client (81%); reminding clients about their appointments (75%) and providing them with help to follow up from appointments (75%); coaching clients to help them prepare for appointments (56%); helping clients with transportation to enable them to get to appointments (56%); and accompanying clients to appointments (44%).

Q33 What did you do to help client to address impairments to cognitive/executive functioning? (check all that apply)

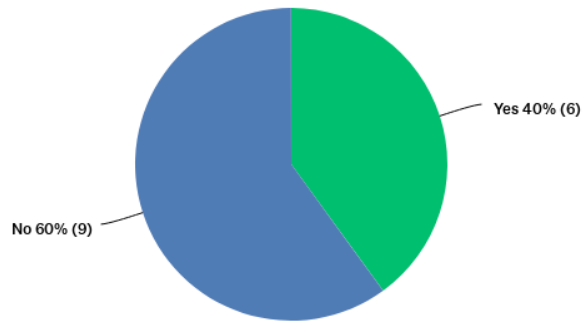


Probably the two most important impacts of this work are that: 1) clients were actually able to prepare for and attend appointments for health and social services, legal services and other programs; and 2) other service providers developed more insight into how to deal with clients with ABI, and could work more effectively with them. This work is extremely important because most people and service providers have limited or no experience in dealing with people with ABIs. Therefore, lateness, or non-compliance or other disruptive client behaviour might be interpreted as a lack of interest or a lack of willingness on the part of the client, and some programs or service providers will not continue to provide services to the client. In reality, the behaviour is one of the side effects of ABI and the intervention of the HPC has been important in helping the clients to maintain effective relationships with these service providers.

#### 4.1.12 Illiteracy

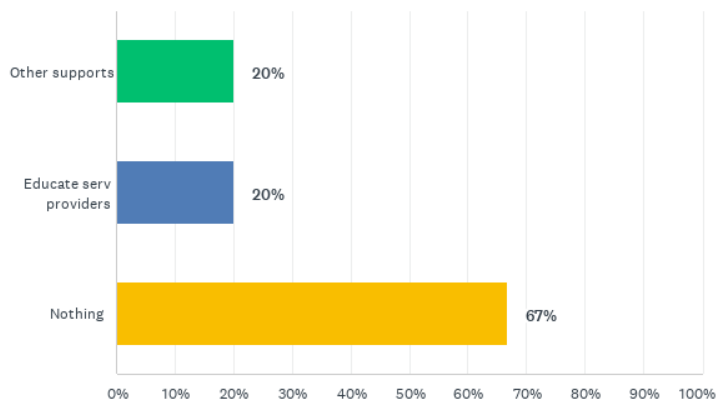
A high proportion of clients (40%) experienced some literacy challenges, which is, again, not unusual for ABI.

Q35 Was the client functionally illiterate?



The main ways in which the HPC supported clients with this issue were: to educate service providers so they could work more effectively with the clients (20%); and to try to connect clients with other supports, such as literacy programs (20%).

Q36 What did you do to help client to address illiteracy? (check all that apply)

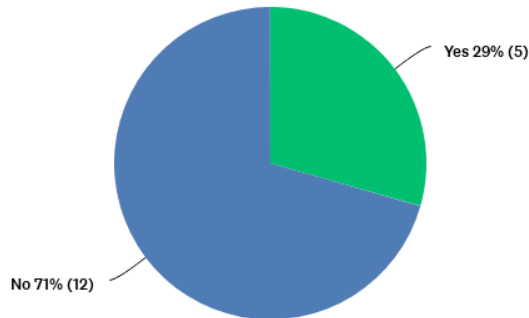


The main impacts of the HPC's work in this area were: to ensure that the service providers understand the client's limitations and get them to explain things in a way the client would understand; and to check in with the clients to ensure they really understood information they received (e.g. rental agreements, medical information, etc.)

#### 4.1.13 Dealing with pandemic

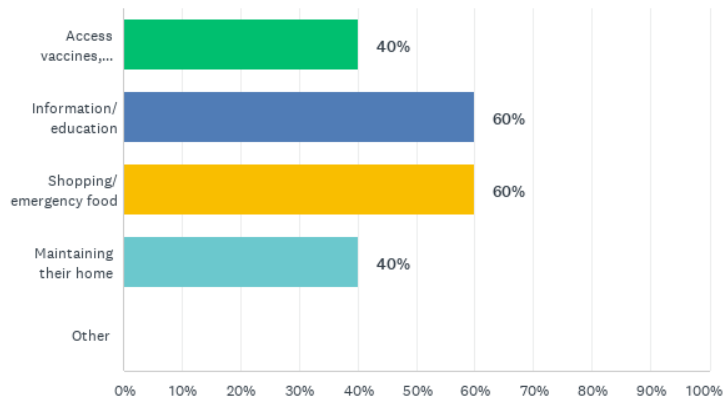
The pandemic presented a wide assortment of additional challenges for clients, above and beyond regular challenges of living with ABI. Almost one-third of clients (29%) required additional assistance to deal with issues related to the pandemic.

Q38 Did client require assistance in dealing with pandemic?



The HPC supported clients with these challenges by: providing information/education about COVID and COVID prevention issues (60%); helping them with shopping and accessing emergency food (60%); helping clients to access vaccinations, testing, PPE etc. (40%); and helping clients to maintain their home through the pandemic (40%).

Q39 What did you do to assist the client to cope with or prevent COVID? (check all that apply)



The main impact of this work was to ensure that clients had the information they needed to lower their risk of getting COVID, that they understood this information, and that they were able to access services (like vaccination and testing) that would lower their risk. In addition, clients were helped to ensure they had access to food throughout this time.

## **4.2 Case Studies**

To further illustrate the challenges faced by individuals with ABI and the role played by the HPC to help individuals address these challenges, four case studies are presented. These cases are all present clients of the Homelessness Prevention Program, and the case studies were developed based on a review of case notes and an interview with the HPC.

### **Case #1 DW**

DW is a 27-year-old female. She was diagnosed with a brain tumor at a young age, and went through chemotherapy and surgery, which left her with an acquired brain injury. She had been attending the recreation day program at the Vista Centre, where she was referred to the Homelessness Prevention Program.

She also has cognitive impairments which presented challenges to her living independently. Specifically, she had difficulty with problem-solving, planning, memory and budgeting. The client also had physical challenges and requires a wheelchair. With the wheelchair, she was semi-independent and could do transfers. There was, however, a risk of falling and, in fact, she had had several falls throughout her life. She requires support with her ADLs and IDLs.

The client had been living with her mother, and when the mother passed away she moved in with a family friend. The family friend was preparing to sell her house, which would have left the client homeless. She moved to a transitional home with support workers on an emergency basis, but this arrangement was temporary.

The HPC met with the client and her supports (occupational therapist, support staff at the home, the program staff and the family friend) to assess her situation and develop a plan of action. The goals were to stabilize the client's housing situation and put a plan in place to get the necessary ongoing supports.

Initially, the client was connected to DSO (Developmental Services Organization) as the client's family friend felt this might be the best route. The client did not identify as "developmental", however, and so did not wish to pursue this route. The client preferred to obtain services through an acquired brain injury program.

The HPC went through the process to put the client on the housing registry. In order to do this, she had to complete several steps. She had to work out a payment plan for the client to address a previous debt to a housing provider from when the client had lived in Hamilton. She also had to support the client to obtain identification documents, such as birth certificate, health card, etc., as she needed this documentation to be able to obtain medical follow-up.

The HPC supported the client with financial management and budgeting skills so she could pay her rent to the emergency housing provider. In addition, she supported the clients to be able to access her medical files and get admitted into the cancer clinic where they can follow up with her and complete ongoing tests.

She referred the client to the Robin Easey Centre, which provides transitional support to individuals with ABI. The center works with clients on their ADLs and LDLs to better prepare them for independent living. Unfortunately, after completing the application, it was discovered that the Centre could only accept clients who were able to use stairs independently, as their

elevator was not working. This meant the Centre was no longer suitable for the client, and an alternative had to be found.

The HPC was able to work with the various organizations advocating for the client to help her move to the top of the priority housing list with DSO. In addition, the HPC advocated for the client to be considered an emergency with the housing registry based on the fact that she would be homeless. With this work, the client was offered an apartment that had just been built under DSO. The client has just moved into this apartment and is now living semi-independently in stable housing. The HPC currently supports the client to maintain her in her housing with financial and budgeting support.

If the Vista homelessness prevention program had not been in place, the client would likely have tried to access DSO support services. One of the problems is that DSO programs are not intended to support people with ABIs. The HPC played an important role in helping DSO to understand the challenges faced by people with ABIs.

## **Case #2 JN**

JN is a 62-year-old male. He was referred to Vista's Homelessness Prevention Program by CFS Ottawa (Counseling and Family Services Ottawa), where he had been a participant in the New Directions program (program for individuals who have been mandated to participate by the justice system because of domestic abuse). Participation in programs such as this are often a challenge for people with ABIs. Because of challenges with executive function, they often have difficulty remembering dates or organizing their transportation to participate in program activities. Their lack of participation is sometimes interpreted as lack of motivation, which is incorrect.

The client had served in the military, but has since retired and is unable to maintain employment or a driver's license. He has no family that he speaks with, and is not involved in other groups or programs. The client has difficulty with memory, planning, problem-solving, initiation and has a high level of acuity. He requires support with understanding processes and paperwork.

The client was living in an apartment that he could not afford. He was having difficulty paying his bills and budgeting. He had been offered a new apartment by a housing provider.

The HPC provided a range of support to the client. As he did not have any furniture, she helped him purchase necessary items and reached out to organizations that were able to provide him with a bed, dressers and other items. She also ensures he had food in his fridge.

As the client had no identification, she helped him obtain a health card and is now in the process of obtaining his birth certificate and his Ontario identification card. It was challenging to obtain his personal documentation as the client has difficulty with his memory and cannot recall much of the information required for the birth certificate, so this is been a lengthy process.

As the client had not completed his tax return for several years, the HPC assisted him with that. This information was necessary for the client to apply for Trillium and GST benefits. A completed income tax form is also now mandatory to apply for some housing providers.

The HPC also supported the client with his rent review application, which was essential for him to maintain his housing.

The HPC provides the client with ongoing support with planning, organization, and budgeting. She has helped the client to develop a system for organizing paperwork, and a calendar for his appointments.

She has also assisted the client in reaching out to Veterans Affairs. He now has a case manager who is investigating to see what supports or services might be provided to the client.

One significant issue is that because the client does not have an official diagnosis of ABI, he is not able to obtain some supports. The HPC is working with the client's family physician to try to obtain this diagnosis.

The client is presently living in stable housing, but requires some ongoing support to maintain that housing. If the client had not been able to access support from the HPC, it is likely he would have not been able to maintain his housing and being forced into a precarious housing situation.

### **Case #3 – HA**

HA is a 57-year-old male. He had a history in the judicial system and, while he was incarcerated, was assaulted, leaving him with an ABI. On his release, he was referred to Modern Occupational Therapy to provide him with some limited support. The client had been referred to the Homelessness Prevention Program by Modern OT.

The client currently lives in an apartment with his girlfriend. They have no other friends or family. They are in a situation where they are unable to continue to pay their rent, given their limited incomes (they are both on ODSP). The conditions in the rental apartment are also hazardous to their health. The apartment has rats, bedbugs, a window that opens in the winds, as well as holes and leaks.

The HPC has been able to advocate to the landlord to develop a repayment plan to avoid eviction, and the landlord has been reasonable. The HPC also advocated with the landlord to address the living conditions in the apartment. The landlord had been claiming that the increase in rent have been justified by the work he did on the apartment, and that he raised the rent with the client's permission. The HPC has been in touch with Housing Help (a housing advocacy organization) who has a lawyer that is investigating the situation.

The HPC is trying to assist the client to find new, affordable accommodation. She has helped him apply to the housing registry. As this will likely be a lengthy process, she is supporting the client and his girlfriend with researching apartments, reaching out to landlords, scheduling viewings, and filling out applications. All of these tasks are very challenging for people with ABI. In addition, it is very difficult for two people on ODSP to be able to find an apartment within their means. Another challenge is that they do not have a guarantor for the apartments so their applications are often refused.

The HPC also supported the client with completing his income tax return so that he could qualify for Trillium and HST benefits. The HPC has also been working with the client on budgeting, including rents, bills, food and other extras. She has been supporting the client in accessing the food bank, as they frequently have no money left for food.

She has referred the client to PPRC (Performance Plus Rehabilitation Care], who have started the process of supporting the client to find employment. The client is highly motivated to find a job. PPRC will work with him to prepare a resume, find a job, advocate for necessary accommodation, and support him throughout his employment experience.

While the client is still not in stable housing, the HPC continues to provide supports with budgeting, financial management, accessing emergency services such as food banks and searching for an apartment, well he waits his turn on the housing registry. The client is very happy to be beginning the process of looking for employment.

If the client had not been able to access Vista's homelessness prevention program, it is likely that he and his girlfriend which have become homeless or be living in a shelter as they would have been evicted from their apartment.

#### **Case #4**

JA is a 57-year-old female who was referred to the Homelessness Prevention Program by CFS. She was diagnosed with a brain tumor a few years ago, and is awaiting surgery. Her situation is deteriorating, and she is experiencing problems with balance, memory, function reasoning, problem-solving and executive functioning. She had completed university but is now unable to work. She has fallen several times, hitting her head, and possibly resulting in a second ABI.

She was living in a shelter, and then moved into an apartment with a roommate. However, she claims the roommate emotionally abuses her. She is depressed and suffers from anxiety. The HPC is constantly monitoring the situation with the client. They have discussed whether the client should move to an emergency shelter if she doesn't feel she can continue to live with her roommate.

The HPC provides ongoing support and refers her to services and programs. She has taken the client to the food bank to ensure she has adequate food. She has also taken her to a service to complete her income tax so she will be able to receive GST and Trillium benefits.

The HPC is working with the client to get her into a safer and more stable housing situation. She is also in the process of helping the client to apply for ODSP as opposed to Ontario Works, which would allow her to access additional benefits.

If the client had not been referred to the homelessness prevention program, there is a good possibility that she would be trapped in the current housing situation, and possibly suffer emotional abuse.



## 5.0 Conclusions

The clients referred to the Homelessness Prevention Program were all in a precarious housing situation where they were either homeless or faced a high probability of becoming homeless at the time of referral. The nature of ABI meant that these clients faced a range of challenges that made it difficult for them to find and maintain housing: all of the clients faced cognitive/executive functioning challenges; often associated with these challenges, clients experienced difficulty in the organizational and cognitive functions associated with finding and maintaining housing e.g. searching for an apartment, negotiating and understanding a lease, budgeting, and maintaining an effective relationship with a landlord. In several cases clients had entered into leases that were far in excess of what they had the capacity to pay, leaving them with very little to cover other basic monthly expenses, such as food, which led to a high proportion (56%) of clients experiencing food insecurity. The Program had a positive impact on the clients' housing situation. As a result of the HPC's work, 30% of the clients were able to move into a stable housing situation, and a number of others were able to enter into transitional arrangements.

Clients in the program were complex, experiencing a range of challenges in addition to housing (which also made it difficult for them to maintain housing). For example, 56% of clients had substance abuse issues, all were managing on very limited incomes and one-third of clients had no other social support. It was challenging for clients to access other programs and supports such as medical appointments, and to participate in group programs, partly because the clients' cognitive and executive challenges made scheduling and transportation difficult. As a result, clients experienced greater isolation and inability to effectively participate in programs that might support them.

Most of the clients were capable of living semi-independently, with some support. The problem is that many programs and service providers are not aware of the specific challenges faced by people with ABIs, so that non-participation in programs is often interpreted as a lack of interest or defiance, rather than behaviour associated with the condition, and clients are sometimes dropped from these programs.

The HPC played a number of important roles to support clients:

- Direct client support – she was able to respond quickly to emergency situations to assess the situation and sometimes defuse it, or to find emergency accommodations for clients, or to access the food bank. She helped clients with such essential tasks as acquiring birth certificates, health cards and other identification, and was able to help them to complete tax returns that were essential for accessing benefits and applying for social and supportive housing. She worked with clients to help them develop skills and systems for tasks like budgeting and food preparation. In addition, she was able to establish effective relationships with clients to monitor their health and provide emotional support.
- Case management – the HPC performed the role of case manager for many clients, helping to schedule and coordinate appointments for them, helping them to prepare for appointments, and planning transportation to ensure they could physically attend the appointments. She also provided follow-up support to clients to ensure they were able to do things like obtain and take medication, or make additional appointments.

- Education/Support to other service providers – Many service providers and programs do not have experience in dealing with clients with ABIs. They are not aware of the specific challenges that are often associated with this condition and, as stated earlier, often misinterpret the behaviour of people with ABIs. All of this means that people with ABIs may not be effectively served by some of the existing programs in the community. The HPC performed two important roles: 1) she was able to work with the service providers and organizations to help them to understand the specific needs of people with ABIs; and 2) she was able to work with the clients to make sure they understood materials and resources they received.

The Homelessness Prevention Program seemed to fill a unique need experienced by persons with ABI, and was able to help many clients to stabilize their housing situation and find support for some of the complex challenges they were facing. The open question is what would have happened to these clients if this program had not been in place. It seems likely that a number of the clients would have lost their housing and either become homeless or moved into the shelter system. It is uncertain how well existing programs would have addressed the various needs experienced by the clients, except to say that we know such programs already experience challenges in meeting their needs.