

**Homeless Prevention Coordinator  
Homelessness and Brain Injury -  
Program Findings  
The Brain Injury Society of Toronto  
October 2019**



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## Agency Overview

The Brain Injury Society of Toronto (BIST) is a non-profit organization that was established in 2004. BIST provides education, support, advocacy and awareness to survivors of brain injury, their families and members of the community. Our non-profit organization provides a variety of programs and services including support groups (for women, men, adults with brain injury, and parents/caregivers of brain injury survivors), drop-in and community programs, educational workshops and series, advocacy and individualized support for persons experiencing financial hardship and housing crises.

In 2018 BIST received Ontario Trillium Seed Grant funding for a Homelessness Prevention Coordinator (HPC) whose role was to assist individuals with cognitive disabilities with housing issues. This report discusses the current homeless crises and its relation to the findings of this project.

## Information on Brain Injury

There are currently half a million Ontarians living with brain injury (BI) and over 45,000 new cases are added every year. Brain injury is the number one killer and cause of disability in Canadians under the age of 40.

A brain injury is damage to the brain that can be acquired (ABI) after birth due to factors such as: stroke, brain tumour, suffocation, substance abuse or poisoning. A brain injury can also be traumatic in nature (TBI) and may be caused by incidents such as a car accident, fall, assault, domestic abuse or sports injury.

Brain Injuries can be mild, moderate or severe. Any brain injury can have devastating effects on the person's quality of life including their ability to participate in a social network, employment and day-to-day activities. Often invisible in nature, brain injuries can impact one's cognitive functioning, emotional regulation, sleep, pain levels, fatigue and mental health. ABI-related impairments in cognitive-communication and social communication can include difficulties with information processing, new learnings, memory, language and literacy, hearing, regulation of emotion, reasoning and problem solving. Cognitive-communication refers to a cognitive impairment that results in difficulties with any aspect of communication such as: listening, understanding, speaking, reading, writing and thinking. This also includes behavioural challenges and issues with self-regulation that impact social communication.

When dealing within financial and housing systems, these communication impairments can be misinterpreted as poor motivation, disengagement, rudeness, inattentiveness and acts of defiance rather than symptoms of brain injury requiring appropriate treatment. Currently there is a general lack of public and professional awareness regarding the devastating impact a brain injury can have, which results in environmental, attitudinal and information barriers, thus further marginalizing this population.

Unfortunately, despite the staggering numbers, ABI survivors are largely invisible to the general public and are forgotten in provincial health care and social service systems.

Because of their invisibility, the presenting symptoms and impairments suffered by survivors are often minimized, misdiagnosed or ignored and as such they are not provided with the appropriate level of support required to ensure their safety and wellbeing. Housing programs geared towards supporting individuals with ABI are underfunded and specialized ABI housing programs in Toronto currently have a ten-year waitlist, leaving individuals' health, safety and general well-being at ongoing risk.

## Homelessness and Brain Injury

Across Canada, homelessness has always existed but with the creation of statistical reporting across the country the awareness of the pressure this puts on Canadian society is more apparent. The statistics on homelessness are staggering and understanding the path to homelessness, included by those who have experienced brain injury, is a critical piece in the prevention strategies that must be implemented in order to solve the issues.

For front-line service workers, who are entrenched in the day to day support of individuals, it is easy to surmise the cumulative effects that have led an individual to precarious housing, unsafe housing, or homelessness. Homelessness is not something that happens overnight, it is not a person's fault, or often choice, nor is there one specific solution that fits all. For all levels of government, services and support streams and most importantly the individuals living in the day to day, this is going to require strategies, solutions and changes that are ever evolving and agile. When we step back and look at complexities in the contributing factors, addiction and mental health are often the most cited health conditions in relation to homelessness. A holistic picture needs to be determined in order to realistically create the strategies to support a positive outcome. If we are developing strategies based on systems that are supporting individuals, change needs to occur on a grass roots level. Policy development and Canadian laws may continue to be a barrier to effecting real time change, but when we explore this on a micro level, we can inform policy change, develop practical solutions, and collect data that will in time affect broader systems.

As noted above, Brain Injury and Cognitive impairment are a vastly underserved population and yet could be the most vulnerable to the rising epidemic of homelessness across Canada. The following outlines some of the growing research findings in this field:

- A large representative study in Australia found that individuals with brain injuries had some of the worst socioeconomic outcomes relative to individuals with other types of disabilities (Kavanagh et al. 2015).
- Almost half of all homeless men who took part in a study by St. Michael's Hospital had suffered at least one traumatic brain injury in their life and 87 per cent of those injuries occurred **before** the men lost their homes (Topolovec-Vranic, 2014).

- Studies find that 60% of homeless individuals with TBI report multiple injuries (Hwang et al. 2008; Oddy et al. 2012)
- The majority of first TBIs occur prior to homelessness suggesting that brain injury is a risk factor for homelessness, but homelessness has also been found to be a risk factor for subsequent TBIs (Hwang et al. 2008; Barnes et al. 2015).
- TBIs have been linked to increased mental health problems, physical health problems, and drug problems among the homeless (Hwang et al. 2008).
- Homeless individuals with TBIs appear to have worse cognitive impairment than homeless individuals without TBIs (Andersen et al. 2014).
- In a study of women with TBI in Canada, poverty was found to be a significant barrier to accessing health care (Toor et al. 2016)

As brain injury is a lifelong condition, the strategies related to support and change need to address barriers and supports across a continuum to create opportunity for individual independence and address social health determinants. The prevalence of TBI related to intimate partner violence and vulnerable populations who are victims of violence are also risk factors to experiencing poverty/homelessness. Understanding barriers and risk factors will foster the development of practical strategies and supports related to the identified needs of individuals living in poverty. Further exploring the avenues of reducing economic and social costs associated with brain injury and poverty will be a key area of development. The long-term plan should include building standardized support models that can be duplicated in various communities and will be cost-effective strategies to address needs and provide appropriate long-term solutions to homelessness.

## Hidden Homelessness in Canada

A 2016 study by Statistics Canada, published the below findings on “hidden” or “concealed” homelessness, terms that refer to people who have had to live with family members, in their car, or in other temporary locations because they didn’t have housing of their own.

- In 2014, 8% of Canadians aged 15 and over reported that they, at some point in their lives, had to temporarily live with family, friends, in their car, or anywhere else because they had nowhere else to live—a situation referred to as ‘hidden’ homelessness.
- Of those who experienced hidden homelessness, about 1 in 5 (18%) experienced it for at least one year, 55% for less than one year but more than one month, and 27% for less than one month.
- Canadians with a history of childhood maltreatment were more likely to have experienced hidden homelessness. For example, among those who were victims of both physical and sexual abuse before age 15, 1 in 4 (25%) experienced an episode of hidden homelessness.

- Frequent movers and persons with a lower level of social support were more likely to have experienced hidden homelessness. For example, among those who moved at least four times in the past five years, 21% experienced hidden homelessness at some point in their life.
- Canadians with a disability were more likely to have experienced hidden homelessness. More particularly, those who reported at least three disabilities were four times more likely to have experienced hidden homelessness (26%) than those with no reported disability (6%).

Information reproduced from: <https://www150.statcan.gc.ca/n1/pub/75-006-x/2016001/article/14678-eng.htm>

Although not cited in the above research, it is safe to surmise that some of the physical abuse outlined in bullet three (3) could very likely be a cause of brain injury and thus create subsequent cognitive impairments. Similarly, although the type of disability wasn't specified as brain injury, ABI is a disability and thus some of this population would be included in this statistic.

### **How many Canadians are homeless in a given year?**

In the State of Homelessness in Canada 2016 report, it was estimated that at least 235,000 Canadians experience homelessness in a given year. The actual number is potentially much higher, given that many people who don't have a residence live with friends or relatives, and do not come into contact with emergency shelters.

Cited from: [https://homelesshub.ca/sites/default/files/SOHC16\\_final\\_20Oct2016.pdf](https://homelesshub.ca/sites/default/files/SOHC16_final_20Oct2016.pdf)

Within BIST's Homelessness Prevention program, this was a common experience for our participants, some of who would find occasional or temporary shelter using a social dating app (i.e. tinder/grinder).

### **How many Canadians are homeless on a given day?**

The Homeless Hub ([www.homelesshub.ca](http://www.homelesshub.ca)) reports that the number of Canadians who experience homelessness on any given night in Canada is estimated to be 35,000 individuals. This is cited as the best estimate of homelessness developed in Canada to date, and includes people who are:

I. Staying in Emergency Homelessness Shelters (14,400). There are approximately 15,467 permanent shelter beds, and in 2009 an average of 14,400 were occupied (Segaert, 2012:27) Between 2010 and 2014, the number of people using shelters decreased. However, the occupancy rates at shelters have increased from 82% of beds being full in 2005, to 92.4% of beds being full in 2014. The duration of stays beyond 30 days have also increased, from 9.1% in 2005 to 12% in 2014.

II. Staying in Violence Against Women shelters (7,350). In 2010, there were 9,961 beds for women and children fleeing violence and abuse. This includes not only emergency shelters, but also transitional and second stage housing. A Point-in-Time count conducted on April 15, 2010 showed that 7,362 beds were occupied by women and children (Burczycka & Cotter, 2011). A 2017 survey found that 44% of Violence Against Women shelters were full on a given day.

III. Unsheltered (2,880). If one draws from the data comparing homelessness in Canadian cities, one can estimate the unsheltered population. On average, for every one hundred people in the shelter system, there are 20 people who are unsheltered.

IV. Temporary institutional accommodation (4,464). Of those communities that count some portion of the provisionally accommodated, there are 31 people in this category for every 100 staying in emergency shelters.

Reproduced from: <https://homelesshub.ca/SOHC2016>

In relation to the above, it is important to note that recent research on domestic violence has shown that:

- 92% of women living in domestic violence shelters reported:
  - Their partners hit them in the head more than once
  - Up to 83% reported being both hit in the head and severely shaken (Sojourner Centre).
- There are over 20 million women in the U.S. who have an undiagnosed TBI
- Brain injury is common in domestic violence victims, but many people refuse to speak out or ask for help, preventing them from receiving the treatment they require

## **Canadians and Chronic Homelessness**

In the State of Homelessness in Canada 2016 report, the total number of people experiencing homelessness who use shelters on an annual basis was estimated at 200,000. Through this number, the following numbers of chronic, episodic and transitionally homeless persons in Canada was projected:

- Those experiencing chronic (long-term) homelessness: 4,000 to 8,000
- Those experiencing episodic homelessness (moving in and out of homelessness): 6,000 to 22,000
- Those who are transitionally homeless (enter the shelter system for a short stay and usually for one stay only): 176,000 to 188,000

Although those who are chronically or episodically homeless “form a smaller percentage of the overall homeless population...(they) use more than half of the emergency shelter space in Canada and are most often the highest users of public systems”.

Reproduced from: Stephen Gaetz, Jesse Donaldson, Tim Richter, & Tanya Gulliver (2013). The State of Homelessness in Canada 2013. Toronto: Canadian Homelessness Research Network Press.

Through running this HPC pilot program in Toronto, it quickly became apparent that those with significant cognitive disabilities required wrap around supports, even after finding housing, to ensure that they would be able to maintain it and not return back to the streets.

## Homelessness In Toronto (Street Needs Assessment April 26th, 2018)

Based on the 2018 SNA (Street Needs Assessment), it is estimated that there were 8,715 people experiencing homelessness in Toronto on April 26, 2018. This includes those outdoors, in City-administered shelters and 24-hour respite sites (including 24-hour women's drop-ins and the overnight Out of the Cold program), in VAW shelters, health and treatment facilities, and correctional facilities. These results are consistent with the increasing demand for homeless services over the past year.

The STA report provided the most important supports that increase income and housing affordability as follows:

1. Increased social assistance rates 21.7%
2. More affordable housing available 20.6%
3. Subsidized housing or a housing allowance 16.2%
4. Help finding an affordable place 9.8%
5. Help finding employment or job training 7.0%
6. Help with settlement and immigration issues 4.5%
7. Other housing help services 3.1%
8. Help to keep housing once you have it 2.8%
9. Help with housing applications 2.0%
10. Help getting identification 1.3%

As documented in the below outline of BIST’s HPC program, all of our program participants required support in at least one of the above areas.

<https://www.toronto.ca/wp-content/uploads/2018/11/981e-2018-SNA-Results-Highlights-Slides.pdf>



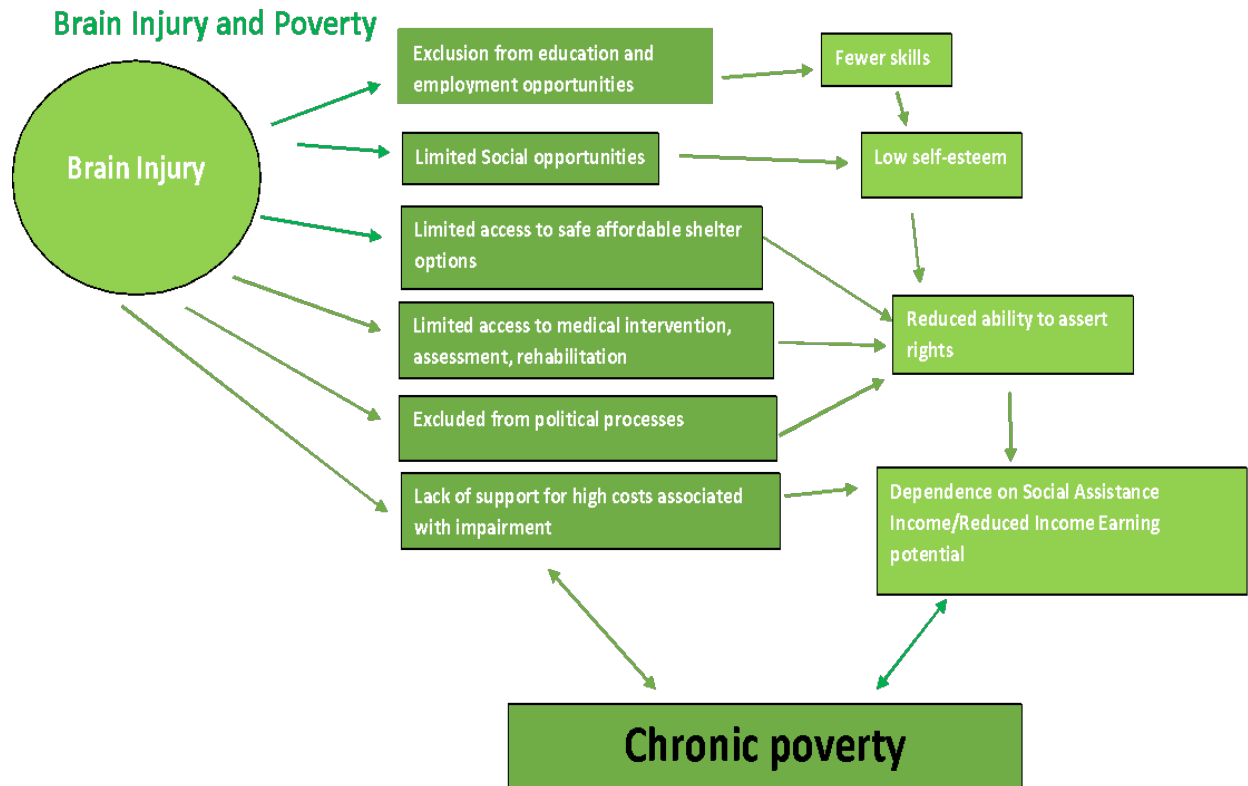


Chart adopted from The Vicious cycle of Poverty in Developing nations, reprinted from "Including Disability in Poverty Reduction Work, "Nothing about us, Without us," by R. Yeo and K. Moore, 2003 World Development, 31(3), pp 572-573

## Housing First Model and Brain Injury

The homelesshub.ca provides an overview of the Housing First Model with an accompanying Canadian Housing First Toolkit. This model focuses on providing permanent housing to individuals despite their circumstance and needs. This in turn provides them with the first stage of stabilization so that they are in a more secure place to receive wrap around supports and services.

The Homelesshub.ca advises that *"the basic underlying principle of Housing First is that people are better able to move forward with their lives if they are first housed. Housing is provided first and then supports are provided including physical and mental health, education, employment, substance abuse and community connections"*.

In terms of individuals with brain injury, this model would include providing them with housing and built in support to ensure that they are able to maintain their housing, either with live-in, or check-in support. Depending on the level of cognitive impairments and behavioural issues, support could include: having a mediator to resolve any issues with

landlords/other tenants, assistance with budgeting to ensure rent is paid, and ensuring additional needs such as medication management and food security are met.

Housing First in Canada: Supporting Communities to End Homelessness says, *“Housing is not contingent upon readiness, or on ‘compliance’ (for instance, sobriety). Rather, it is a rights-based intervention rooted in the philosophy that all people deserve housing, and that adequate housing is a precondition for recovery.”*

Reproduced from <https://www.homelesshub.ca/solutions/housing-accommodation-and-supports/housing-first>

### **What kind of housing?**

*“A key principle of Housing First is Consumer Choice and Self-Determination. In other words, people should have some kind of choice as to what kind of housing they receive, and where it is located.”* Reproduced from <https://www.homelesshub.ca/solutions/housing-accommodation-and-supports/housing-first>

Currently in Ontario, the ABI population are often inappropriately placed in long-term care facilities and psychiatric hospitals, which are not equipped to provide them with the rehabilitation required or assistance to implement/reinforce any compensatory strategies learned. When working with the ABI population, it is important that their specific physical, cognitive, behavioural and mood related needs are taken into consideration.

### **Does Housing First work?**

Yes. The body of research from the United States, Europe and Canada attests to the success of the program, and it is being described as a model for 'Best Practice'.

*“The At Home/Chez Soi project, funded by the Mental Health Commission of Canada, is the world’s most extensive examination of Housing First. They conducted a randomized control trial where 1000 people participated in Housing First, and 1000 received ‘treatment as usual’. The results are startling: you can take the most hard core, chronically homeless person with complex mental health and addictions issues, and put them in housing with supports, and they stay housed. Over 80% of those who received Housing First remained housed after the first year. For many, use of health services declined as health improved. Involvement with the law declined as well. An important focus of the recovery orientation of Housing First is social and community engagement; many people were helped to make new linkages and to develop a stronger sense of self”.*

Reproduced from <https://www.homelesshub.ca/solutions/housing-accommodation-and-supports/housing-first>

In our one-year pilot project we saw that when we met the participants where they were at, without any barriers to service (i.e. no punitive measures were taken if they missed appointments), they were more engaged in the process and more likely to remain connected to our services. When you provide the tools for people to make independent choices they are more likely to feel as though they have control over their situation, which can be a rarity in their day-to-day lives. ABI is a lifelong, permanent disability that doesn't fit within a recovery model. As such housing supports need to take into account that goals may not always be attainable and as such their housing should not be contingent on their ability to meet them. Similarly, as there are a high number of ABI survivors with addiction issues, it is unreasonable to expect that these issues would be resolved prior to securing housing and as such should be addressed in conjunction with or after housing goals are met.

Every person who had experienced a brain injury has undergone some form of trauma and as such a trauma-informed approach needs to be implemented during the housing process. For example not rushing people into decision making, providing non-judgemental services/support and maintaining an open door policy to return to services if they need a break from support.

*“While the case studies in Housing First in Canada have shown that it is possible to develop a successful Housing First program even in a tight rental housing market, they were primarily successful through the use of rent supplements to increase affordability. Partnerships with existing private landlords were shown to be very important. However, it is acknowledged that there is a housing shortage in Canada – especially safe, secure and affordable housing”. Reproduced from <https://www.homelesshub.ca/solutions/housing-accommodation-and-supports/housing-first>*

Additionally, along with affordability there remains a lack of accessible housing, especially housing with live-in or built in support. In Toronto, specifically, our program found that the Housing First approach might be difficult due to limited safe choices. Due to financial limitations, many of the individuals that serviced only have access to rooming houses, shelters, and shared accommodations (either with family, friends, or strangers). Due to their issues with environmental simulations that can accompany a brain injury, these conditions are not ideal and can often trigger episodes of depression, overstimulation or verbal/physical outbursts.

## Costs of Homelessness

A 2005 study by Pomeroy which looked at costs in four Canadian cities of institutional and health centres found the following annual costs:

- Institutional responses (jails, hospitals, etc.) cost \$66,000-\$120,000
- Emergency shelters cost \$13,000-\$42,000
- Supportive and transitional housing cost \$13,000-\$18,000
- Affordable housing without supports \$5,000-\$8,000

<https://www.homelesshub.ca/about-homelessness/homelessness-101/cost-analysis-homelessness>

To tie this in to the ABI population, it has been noted that living with a brain injury and being homeless harms a person's wellbeing and as such this population is:

- 5 times more likely to have visited an emergency room in the past year
- Twice as likely to have been arrested in the previous year
- 53% of homeless adults with a history of mental illness have a reported history of brain injury (St Michael's Hospital).

This population is more likely to:

- Report unmet health care needs
- Have contact with the criminal justice system
- Be suicidal or have previously attempted suicide
- Use emergency departments

## Homelessness Prevention Coordinator (HPC) - Program Overview

After launching a Transitional Support Program in 2018, a program to improve the financial wellbeing of our members, BIST endeavoured to expand its umbrella of support to the brain-injured community of Toronto to include the homeless population.

As noted in the above sections a 2014 study published by St. Michael's Hospital found that over 50% of Toronto's Homeless population had sustained a brain injury, and 84% of these injuries happened BEFORE they became homeless – showing a significant correlation between brain injury and risk of homelessness. Despite this devastating fact, individuals with ABI continue to be underserved and often under diagnosed.

These staggering numbers prompted BIST to work to address this need, and, in collaboration with the Brain Injury Association of Durham, we received a [one-year Seed Grant from the Ontario Trillium Foundation](#) in October 2018 to develop and deliver a homeless prevention program. This program was tailored to individuals identifying with a brain injury and/or cognitive impairment who were experiencing homelessness or were at risk of losing their housing. The goal of the program was to assist with finding and/or stabilizing housing to mitigate risks of further injury, isolation, and health impairments. Throughout the duration of the program, 32 participants were supported. This report outlines some of our learnings from this project.

Of the 32 participants 19 entered the program insecurely housed (i.e., at risk of homelessness) and 13 were unhoused (homeless/invisible), of which 11 have now been stabilized and 7 have secured housing.

The remaining 14 individuals received assistance through community support, referrals and connections to service providers, however, for reasons that will be further explored throughout this document, their housing needs went unmet. For 8 participants, housing stabilization remains a significant issue preventing them from engaging with the community and addressing health related issues. Of the 6 program participants who remain homeless, 1 has transitioned to long-term case management with a Ministry Funded ABI program, 3 were connected to BIST's Transitional Support Program and will receive ongoing support and 2 have lost contact with our agency.

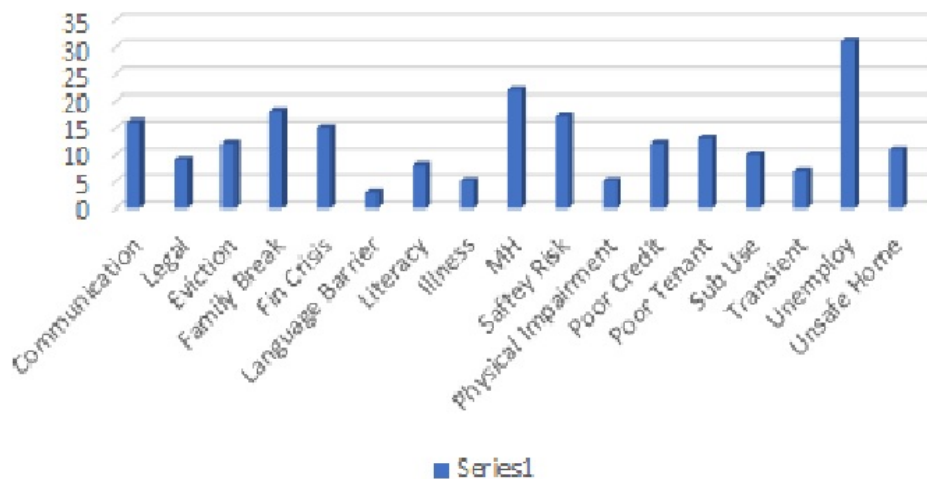
## Homelessness within BIST's Service Model – Poverty Reduction

The Homelessness Prevention Coordinator (HPC) initiative looked at the barriers and challenges facing those with a diagnosed or suspected ABI who were experiencing a housing crisis and supported them with applications for rent geared to income, supportive, and market rent housing. This was an agile service that provided person centered support. The HPC also worked with service recipients to conduct housing searches, connected with landlords to facilitate viewings, coordinated moves, contacted

financial institutions and mediated landlord/tenant issues that were posing risk of eviction. In addition, the program addressed some basic needs required by these individuals including help with finding a family doctor, attending medical appointments, obtaining medical records, acquiring identification, improving food security, completing medical/agency referrals and providing accompaniment to service provider intake interviews.

The below sections will focus on participant identified needs that were supported in tandem with addressing homelessness. An outline of the program support and findings is structured using the social determinants of health (Social and Economic Environment, Physical Environment and Personal Characteristics/Behaviours), as defined by the World Health Organization (WHO). This is done to illustrate the specific barriers and factors influencing poverty, as well as several additional factors specific to the ABI population. These factors are discussed in relation to the experience of the HPC and the strategies that were used to successfully support participants. Finally, some recommendations are provided for policy makers, those trying to replicate the program, and anyone wanting to understand more about the impact that invisible disabilities have on accessing housing, financial, social and medical support.

Factors that contribute to homelessness for BIST HPC participants



Specific examples of factors experienced by 32 Project Participants:

Abuse: historical intimate partner violence and/or abuse by roommates or close friends/family

Budgeting: challenges balancing limited income to address all basic needs and well as difficulties with prioritizing need

Communication: Communication impairment related to ABI such as processing information, communicating needs, self-advocacy and disinhibition.

Legal: Criminal legal issues and/or family law issues

Eviction: Not opening mail for eviction notices and proceedings along with failure to follow up or communicate with landlord.

Family Break: Estrangement/strain on family systems due to challenges faced by individual.

Financial Crisis: Debt, poor credit, rent arrears, unable to manage all basic needs due to limited income

Language barriers: Cognitive communication issues, English as a second Language

Literacy: Unable to understand medical language/how to complete application forms, unable to utilize/navigate technology

Mental Health: Depression, Anxiety, Bipolar Disorder, And Suicidal Ideation

Safety Risk: Impulsivity, poor judgement, substance use

Physical impairment: Mobility issues, chronic pain and fatigue

Poor Tenant: Issues with property damage, smoking, relationships with tenants and landlord

Substance use: Addictions to alcohol and illicit drugs

Transient: No fixed address or telephone number

Unemployed: Unable to maintain any level of employment

Unsafe Home: Inability to safely use appliances, physical barriers within home, unsafe/unhealthy living conditions (i.e. bed bugs, mold)

## 1. Social and Economic Environment

### 1 a) Income & Social Status

Family Type	Current				New as of Sept / Oct 2018				
	OW	Basic Needs	Max Shelter	Max OCB	Total	Basic Needs	Max Shelter	Max OCB	Total
Single		\$337	\$384	\$0	\$721	\$343	\$390	\$0	\$733
Single Parent - 1 child		\$354	\$632	\$114	\$1,100	\$360	\$642	\$117	\$1,119
Single Parent - 2 children		\$354	\$686	\$229	\$1,269	\$360	\$697	\$234	\$1,291
Couple		\$486	\$632	\$0	\$1,118	\$494	\$642	\$0	\$1,136
Couple - 1 child		\$486	\$686	\$114	\$1,286	\$494	\$697	\$117	\$1,308
Couple - 2 children		\$486	\$744	\$229	\$1,459	\$494	\$756	\$234	\$1,484
<b>ODSP</b>									
Single		\$662	\$489	\$0	\$1,151	\$672	\$497	\$0	\$1,169
Single Parent - 1 child		\$805	\$769	\$114	\$1,688	\$815	\$781	\$117	\$1,713
Single Parent - 2 children		\$805	\$833	\$230	\$1,868	\$815	\$846	\$234	\$1,895
Couple		\$954	\$769	\$0	\$1,723	\$969	\$781	\$0	\$1,750
Couple - 1 child		\$954	\$833	\$114	\$1,901	\$969	\$846	\$117	\$1,932
Couple - 2 children		\$954	\$904	\$230	\$2,088	\$969	\$918	\$234	\$2,121

([incomesecurity.org/public-education/ow-and-odsp-rates-and-the-ocb-2018-les-taux-dot-du-posph-et-de-la-poe-2018/](http://incomesecurity.org/public-education/ow-and-odsp-rates-and-the-ocb-2018-les-taux-dot-du-posph-et-de-la-poe-2018/))

#### Program Statistics:

94% of program participants relied on some form of social assistance/financial benefit (e.g., OW, ODSP, CPP-D, CPP-S, OAS) or insurance benefit (e.g., EI, LTD) as their primary source of income.

As brain injury is a lifelong disability and it is often difficult for survivors to return to part or full time employment due to chronic neurobehavioral sequelae, including cognitive deficits, pain levels, chronic fatigue, changes in personality and increased rates of mental illness. As such they are often reliant on long-term financial assistance programs.



**Barriers:**

Income was a key barrier for all participants in the program. Given that the vast majority relied on some form of social assistance/financial benefit or insurance benefit as their primary source of income, funds to support their housing goals were decidedly limited from the outset.

The monthly allowance from ODSP is \$1,100 per month (excluding any additional benefits, i.e. dietary allowance). As elaborated on below, market rent in Toronto is \$1089, thus leaving few options of secure housing for those on limited income.

Additionally, having to pay first and last month's rent is unachievable for those on limited income, although there are supports in place to assist with this (i.e. rent bank, housing stabilization fund), without someone providing direct support, most of the population with cognitive impairments are unable to source out these resources, let alone navigate the application process.

**Strategies Employed:**

- Determine the current level of financial assistance, and whether other benefits can be accessed (e.g., ODSP, CPP-D) and assist with completion and submission of applications for these benefits.
- If the participant is already housed, determine if they could access the Ontario Electricity Support Program and assist with completion of required paperwork.
- For participants living in the shelter assist them to access THAP (rent support)  
*\*Note: Prior to the program losing funding in March 2018, the HPC attempted to connect participants living in shelters with a Streets to Homes Worker to access the Toronto Housing Allowance Program (THAP), which provided an additional \$450 - 550/month to use toward rent.*
- Work collaboratively with the participants to build a budget to identify spending habits and assist with identifying strategies to remain on budget. The strategies employed at this stage required taking into account ABI specific issues such as: inability to plan, memory impairments, impulse control and judgement.

**Recommendations:**

- Advocate for policy changes to reinstate THAP and increase OW & ODSP shelter and basic needs allowance to align with Toronto housing market standards
- Secure funding to support participants with the difference in rental payments for what they can afford and what the actual cost is.
- Apply for all entitlements (diet/transportation/criminal injury/trillium for drugs/DTC)
- If the participant is on ODSP - help them acquire a reduced transit pass
- Ensure income taxes are filed. This is an important area of consideration as there are a series of federal and provincial benefits to which homeless and unstably housed individuals in Ontario are entitled, but do not always access. It is currently estimated that there is \$2 billion in unclaimed tax return dollars annually. A recent study by the CRA reported on four barriers that homeless individuals face when filing taxes: verifying one's identity, obtaining and keeping

documents, communication barriers and computer literacy and technology challenges. All of these issues can play a role in the day-to-day functioning of our participants.

## 1 b) Social Supports

### **Program Statistics:**

56% of the program participants were socially disconnected. Their connections to family and friends either deteriorated throughout the program to the point of non-contact or were non-existent to begin with. This can be a common experience for individuals with ABI who have trouble maintaining relationships due to their injury-related behaviour. Behaviours such as verbal/physical aggression, impulse control, etc. are often misunderstood as intentional as opposed to a direct result of their physical injury, and as such can cause conflict amongst friends and family members.

### **Barriers:**

- As a consequence of these damaged relationships it was noted that our program participants experienced social isolation, which negatively affected their mental health and consequently decreased the likelihood of individuals initiating activity, searching for/contacting/attending medical appointments, programs and housing searches,
- In addition, outside of the HPC's support, there was no other person available to help in the community (e.g., attending appointments, assisting with advocacy). This became an issue when an appointment was made that the HPC could not attend (e.g., setting an apartment viewing). Also, although the HPC followed up on medication administration, etc. to the best of their ability, it was challenging to do this on a consistent basis without any other familial, social or agency supports in place.

### **Strategies Employed:**

- Connect participants with appropriate services/programs (ABI network, Access points). Beginning the application process is key, as there is an inherent barrier in this as many ABI services in Toronto have waitlists in place.
- Involve family where possible to engage with the participant and assist with reminders, community navigation, attending appointments (e.g. viewings). Teaching family members and friends compensatory strategies that they can employ with the participant.
- Encourage participants to attend BIST programming to decrease social isolation. *\*It is noted that attending day programs, support groups, etc. incurs a transportation cost, which participants cannot always afford.*
- Act as emotional support and piece of the participant's safety network. When issues came up we would talk through them, plan a response and set follow up meetings to deal with them so they weren't lost amongst all the other tasks that needed to be dealt with.

## **Recommendations:**

- Find service providers/programs geographically close to the individual
- Offer education and support to individuals in support network (e.g., family, friends)
- Help develop a routine based around their interests
- Advocate for a larger transportation subsidy for individuals on financial assistance
- Create more peer based/phone based programming that participants can access without leaving their home. Connect participants to existing peer programs.
- Apply for an accessibility card to help mitigate potential problems before they happen

### **Case example: Max**

Max is a 62-year-old man who suffered multiple strokes several years ago, with difficulty communicating due to expressive aphasia and depression. He was living with his wife at the time and under her care, while he recovered, however, she passed two years after his ABI. Max attempted to continue paying his rent but was soon evicted for failing to keep up the payments. He was taken in by his sister, as his children lived outside of Toronto and could not care for him. Max was referred by an Employment and Social Services office as he was recently denied ODSP and did not qualify for OW, as he was receiving funds from the CPP survivor's benefit. When he first met with the HPC, Max reported that his sister was pressuring him to move out as he had been sleeping on her couch for the past few years and often argued with her young daughter.

Support began by assisting Max with tasks in preparation for social benefits tribunal, filling out applications for subsidized housing and the ABI network. He was connected to legal aid and required assistance meeting with and speaking with the lawyer. The legal aid and Max's family physician were not communicating effectively and assistance was provided to retrieve medical documents to support Max's case. The HPC wrote a support letter, accompanied Max to the tribunal, and participated in questioning on his behalf. A few months later Max was granted ODSP. To maximize his financial benefits, additional financial assistance was applied for through CPP's allowance for the survivor, which was granted six months after applying. Unfortunately, in this time his sister kicked him out of her home, despite communicating with the HPC, and Max asked that no further efforts were made to have him move back in as the relationship had deteriorated. Max was assisted with finding a senior's shelter and connecting to local food programs. He was connected to an ABI day program that improved his social isolation and long-term case management to continue working toward his housing goals.

## 1 c) Access to Health Services

### **Program Statistics:**

69% of program participants experienced issues with mental health. Unfortunately, this is not uncommon for individuals with ABI. A 2014 Danish study by Sonja Orlovská et al, found that compared to their non-injured counterparts, those with brain injuries were:

- 65 percent more likely to be diagnosed with schizophrenia.
- 59 percent more likely to develop depression.
- 28 percent more likely to be diagnosed with bipolar disorder.
- 439 percent more likely to suffer from organic mental disorders.

### **Barriers:**

- 15 of the participants were disconnected from primary health care service providers or if they were connected, had not made or attended an appointment with their GP for an extended period of time.
- Part of the reason for this was that they did not feel as though they could articulate their concerns effectively to their doctor
- 7 participants did not have a valid health card and did not know how to get one
- ABI health services were very difficult to access for individuals with cognitive impairments but no formal brain injury diagnosis. These included clinical groups, day programs, case management, and supportive housing.
- Others in the program were unable to access specific health services due to jurisdictional/catchment boundaries.
- Given that 69% of the participants were also experiencing a mental health issue, access to mental health services also became difficult for some.
- Difficulties affording transportation costs and navigating the transportation system was a direct barrier for individuals looking to access medical support. In one instance the HPC was able to advocate to get a participant with Borderline Personality Disorder into a Borderline Personality Self Regulation Clinic at Ontario Shores. However, upon her receiving entrance to the program, she realized she was unable to afford the transportation making the program inaccessible to her. Noting the importance of the program, BIST decided to cover the travel cost and provided travel-training support to teach her how to independently get to the program. The participant was successful in completing the program, and is successfully employing the strategies learned in her daily activities.
- Case Management support was required for all participants as with multiple/complex health conditions they were unable to independently manage their medical appointments/care.
- Some health services required by our participants such as neuropsychological testing, psychotherapy and so forth are not covered by OHIP and as such many of our participants are unable to access them.

**Strategies Employed:**

- Schedule and attend appointments with participants to ensure their needs are clearly communicated to health care professionals.
- Advocate on behalf of the client for services that require documentation where none was available.
- Contact GP's, health teams/health centres to connect clients to a primary care physician, preferable in clinics where they can access a multitude of supports in one location.

**Recommendations:**

- Develop partnerships with ABI service providers and develop a process for referring clients without medical and rehab documentation
- Have medical professionals write appointment summary notes for the client to take with them
- Provide clients with a list of questions to ask at medical appointments
- Help set reminders for appointment times/reason(s) for appointment
- Assist with setting up transportation or providing a route map
- Help identify and set reminders for follow through task
- Prepare medication in blister packs, request medication delivery and create a routine for taking medications
- Utilize a trauma informed approach

**Case example: Jacob**

Jacob is a 57-year-old man with an undiagnosed ABI, significant cognitive impairment and major depression. He was connected to the program through a referral from an Employment and Social Services office after being evicted from his long-time residence and entering the shelter system. In the first meeting, Jacob expressed that while housing was certainly an issue, he was also experiencing significant pain in his left leg and back, for which he had purchased a walking cane to support himself. After meeting with him in the community and watching him navigate city streets and intersections, it was clear that his ambulation issue was severe and a potential safety risk. Jacob advised that he was not currently connected with a general practitioner and had only been accessing medical services through walk-in clinics and emergency rooms. The HPC supported Jacob with finding a local family doctor, travel training to the BIST office and back to shelter, making regular reminder calls before appointments to ensure he attended, and supporting him at appointments. After connecting to the family doctor, the previous medical information began being collected to support an ODSP application. Unfortunately, at this juncture the connection with the HPC was lost and BIST has been unable to locate Jacob. This is something that can happen with transient individuals as without an address, and a disconnected cell phone, it is often impossible to regain connection once lost.

## 1 d) Food Insecurity

### Program Statistics:

41% of Program Participants required referral/connection to food programs/food banks

### Barriers:

- Given that many of the insecurely housed participants were spending most of their income on shelter, they were often without funds to secure healthy (nutritious) food each month. Many were not connected to, or aware of food programs or food banks in their area – or if they were, did not regularly access them.
- Those in the shelter system relied on food programs and food banks for their meals, however, these programs run at set hours and on specific days of the week, and are not always easy to access (i.e., transportation).
- Lack of nutritious food meant that meetings with the HPC could be stymied by low energy levels.
- Some participants lacked storage, appropriate space and the knowledge to cook. Cognitive challenges also lead to safety issues while cooking.
- Support was also required in teaching participants how to grocery shop - including information on planning/creating list and budgeting for the purchases.

### Strategies Employed:

- Identified which programs and food banks were in the area that helped to inform a portable document (Map + Schedule + transportation route) to improve awareness.
- Taught several participants how to use the chalmersbot app - an application that provides real time information about nearby food programs including meals and food banks.
- If transportation was an issue and the individual had to travel some distance, participants were advised and educated on resources near their OW and or ODSP office, whereby they could stop in and recoup their travel expenses.
- The HPC would often dispense tokens during meetings to cover travel expenses for the day, plus additional for other services/programs such as food banks, if needed.
- In meetings the HPC would buy the participant a meal/snack/coffee if it was reported that the participant hadn't eaten, or it was observed that their energy level was low and negatively impacting their engagement/productivity.

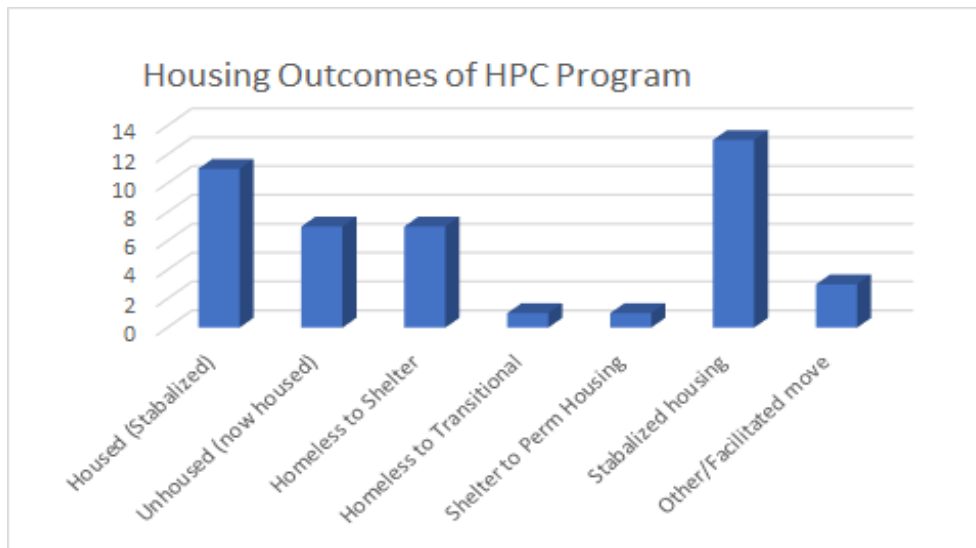
### Recommendations:

- Creating a program similar to \*Quest Food Exchange in Toronto -  
*\*Quest food exchange is a food recovery and redistribution program running in Vancouver BC, that takes surplus items from food suppliers and sells them at an affordable rate in their not-for-profit grocery markets. The program is accessed by referral for those with low income, have a disability, or are on old-age pension. <http://www.questoutreach.org/>*

- Linkage to/creation of more community gardens
- Providing assistance with meal planning and preparation
- Providing tools and knowledge on shopping on a budget: how to use technology to find coupons
- Connecting participants to Meals on Wheels programs

### **Case example: Vanessa**

Vanessa is a long-time BIST member who was referred to the program after attending a support group and discussing a recent issue she was experiencing in her apartment. Her stove had recently stopped working and was replaced with an older model that she felt uncomfortable and unsafe using. Vanessa reported that she would constantly check the stove to see if it was on, as there was no light or indicator, and often would leave the house only to return minutes later, anxious and worried, to check that it was off. She also started eating out more often as she did not feel safe cooking, she was constantly afraid she would leave a burner on and start a fire within her unit. Because of this, she was spending a lot of her basic needs budget on food and was running out of money. She attempted to contact the building's landlord and submit a service request, but found that he was dismissive of her legitimate concern. Vanessa felt discouraged and that she wasn't articulating herself enough to convey her safety needs. Support began by setting up a meeting with Vanessa and the building manager to discuss the safety issues and limitations with the appliance. The HPC worked with Vanessa to explain how the new stove was affecting her reasonable enjoyment of the unit and that she required a new stove that fit her accessibility needs. The next week the building manager replaced the stove. The HPC helped Vanessa learn the controls of the new stove (e.g., which knob controlled each burner) and that she could rely on the indicator light to know when the stove/oven was off, rather than having to readjust each knob. Vanessa is now able to return to cooking healthier and more affordable meals in her apartment.



## 2. Physical Environment

### 2 a) Housing

#### Program Statistics:

59% of Program Participants entered the program precariously housed/insecurely housed

40% of Program Participants entered the program homeless/invisible/transient

58% of Program Participants moved from insecurely housed to stabilized

64% of Program Participants were successful in securing housing

#### Barriers:

- Currently, in Toronto the average cost of a bachelor is \$1089 per month
- The average cost of 1 bedroom is \$1270
- Since 2009, the vacancy rate in Toronto has been below the 'healthy' 3% as of the writing of this report, the vacancy rate ranges from 1.1% to 0.7%
  - *"Within a rental market as tight as Toronto's, there is greater potential for price increases when units turn over, which can lead to large discrepancies in rents among different segments of the rental market"* - Canadian Centre for Economic Analysis (2019) Toronto housing market analysis: From insight to action.
- In many cases, due to the cognitive impairments of our population, housing applications were partially filled out and never submitted, or submitted without having all the necessary accompanying documentation (e.g., valid identification)



and as such they were unable to even begin the process of finding affordable housing.

**Strategies Employed:**

- Assisted participants to apply for rent geared to income subsidized housing within the city
- Assisted participants to apply for supportive and accessible housing when appropriate
- Performed regular housing searches of private market using: Kijiji, ViewIt, Padmapper, Craigslist
- Utilized the Housing first approach (see Page 10).

**Recommendations:**

- Guided housing search to support initiation, motivation and follow through for individuals struggling with ABI executive functioning impairments
- Assistance with conducting research, filtering appropriate choices for income level, physical accessibility, safety and location,
- Assistance to conduct phone calls, send emails, create a script and follow up on housing leads.
- Creating lists, or utilizing organizational strategies to keep track of information required for landlord, location and rent cost.
- Text, email or phone reminders to follow up at appointments/meetings
- Education provided to social service providers on city resources related to Rent Geared applications, housing stock, etc.

**Case example: Richard**

Richard is a 42-year-old man with a seizure disorder, severe depression, and the victim of prior assault. After living in the shelter system for the past seven years, he was connected to the homeless prevention initiative. Richard has a history of being a poor tenant and was recently kicked out of a shelter. He had been paying a friend \$30 a night to sleep on his couch but when he ran out of money he resorted to sleeping on TTC buses. Richard was denied ODSP twice and his only source of income for the past several years was OW, amounting to \$343 a month – total income.

He was without any valid identification and relied entirely on local food programs for his meals. Richard's cognitive impairments were such that his attention was limited, he exercised poor judgment (e.g., spending his limited funds on beer), was easily irritated/angered, and had poor executive functioning (i.e.. planning, organizing, working memory).

Support began by addressing his application for subsidized housing in Toronto. Richard had not updated or 'checked-in' in with Toronto Housing in the past 3 years, and the HPC found that his application had not progressed through the queue as it was missing critical information (e.g., proof of identification and 'proof of homelessness'). Richard did not have access to a cell phone and could not use the computer/email due to illiteracy,

which created barriers with communication and scheduling. After serving his probation and moving back into the shelter, a relationship was created with the shelter's housing staff to deliver messages and reminders for meetings. Through collaboration with the shelter staff, Richard began meeting with the HPC regularly. These meetings produced the acquisition of valid ID, updated housing applications, referrals to other service providers (e.g., mental health case management), and connections to additional food resources. A few months after updating his Toronto Housing application, including updated ID and support letters from the HPC and shelter staff, Richard received and accepted an offer from Toronto Housing. Richard is now securely housed with access to nutritious food and continues to be supported via long-term case management.

## 2 b) Landlord Engagement

### **Program statistics:**

Relationships were formed with **14** landlords throughout the program. These connections ensured that the HPC could intervene early should any tenant related issues arise.

### **Barriers:**

- A low vacancy rate means that landlords can be highly selective when choosing their tenants, which can open the door to housing discrimination, thus having a negative impact on our community.
- From a resource perspective, there was limited time available for the HPC to reach out to landlords to develop relationships. This would require funding for a full-time position to ensure successful, ongoing landlord engagement.
- Participants who were precariously housed often ran into problems with landlords (e.g., served N4 for not paying rent) and were not equipped with the skills or knowledge to productively manage/resolve disputes.

### **Strategies Employed:**

- HPC contacted landlords and introduced the Homeless Prevention Program
- HPC also worked to introduce BIST to some landlords and explain how the individual was attached to an organization
- HPC attended viewings with participants and facilitated the application process
- When an issue did arise with current landlord the HPC reached out and mediated the situation to avoid possible eviction.

### **Recommendations:**

- Introduce RENT SMART in Ontario. This is a Vancouver based program that teaches tenant rights and responsibilities.
- Share CLEO (Community Legal Education Ontario) as a reference point to obtain information on tenant rights and the dispute process.
- As poor executive functioning was often behind many of the legal (criminal, LTB) issues for several participants, it is imperative to identify the individual's specific deficits in order to provide appropriate help. E.g., Planning and organizing deficits

may affect an individual's ability to pay rent on time, but these needs are different from deficits of emotional control or inhibition, which may create tension when interacting with landlords.

## 2 b) Employment and Working Conditions

### **Program Statistics:**

97% of Program Participants were unemployed at the beginning and throughout the duration of support.

### **Barriers:**

- Given that ABI is a lifelong disability, brain injury sequelae such as cognitive deficits, executive functioning, etc. will always act as a barrier to gainful employment.
- The working conditions for entry-level service work (e.g., taking orders/making coffee at Tim Horton's) are such that the environment poses a real danger to the individual and others.

### **Strategies Employed:**

- Participants were informally assessed during the duration of their support on the appropriateness of part time, casual or full time employment. Due to the high level of impairments and medical conditions (pain, fatigue, etc.) employment was not a functional goal for these members. Had it appeared that an individual would have been a successful candidate for employment, referrals to agencies who could assist with the process would have been made.

### **Recommendations:**

- Help participants access resources they may already be connected to (e.g., any employment support program)
- Access free training programs where applicable
- Educate participants to be their own advocate, advising them of their rights as employees
- For those who are unlikely to re-enter the workforce, assist them to find more meaningful activity and help reduce isolation and increase feelings of productivity
- Help participants market their skills and talents (resume creation, mock interviews, etc.)

## 3 Healthy Behaviours

### 3 a) Substance Use

### **Program Statistics:**

31% of Program Participants were dealing with substance abuse

According to the Substance Use and Brain Injury literature ([www.subi.ca](http://www.subi.ca)) more than half of adults and adolescents admitted to ABI rehabilitation programs have a history of substance use

**Barriers:**

- Drug seeking and using behaviours made individuals more susceptible to sickness (which impeded their ability to show up to appointments), engage in risky/criminal behaviours (e.g., theft, violence) and spend their money before the end of the month (i.e., unable to save/budget).
- Often an inability to connect healthy choices with symptoms and wellness was present. (E.g., may not connect their poor food choices, addictive behaviours to their symptoms).

**Strategies Employed:**

- Advocating for participants to engage in programs suited to cessation (harm reduction)
- Building a budget to identify where and how quickly their funds were being spent each month to provide a concrete demonstration of the impact on their finances
- Communicating concerns to healthcare providers (i.e., discussing substance use/abuse with client when we met with doctor)
- No judgement when they did show up drunk/high. Meetings were kept short and made sure to explain that we would meet again soon and work on the task, which helped to keep them motivated and engaged in the program.

**Recommendations:**

- Motivation is key. Remaining nonjudgmental is important early on to enforce the idea that their substance use will not prevent them from accessing the program/support.
- Creating a budget is helpful for parsing the financial cost of smoking/drinking/substance use
- Teach individuals how to prioritize based on their physical needs
- Meet program participants where they are at, as some individuals are more comfortable/able to meet in the community as opposed to an office setting.
- Keep it client-directed; work should be focused on the client's individual, self-identified goals.
- Have an open door policy- if individuals aren't ready now advise them that they can contact the service provider at any point
- Educating participants on their options, but not enforcing a behaviour

### Case example: Edward

Edward was connected to the program after experiencing an assault in 2018 while living in another province. Upon learning that the assailant was being released, he was advised to relocate, if possible. His support providers attempted to connect him with ABI resources outside of the GTA; however, upon arrival Edward was only able to find refuge with a friend living in the city. His initial search brought him to the Ontario Brain Institute, whereby he was redirected to BIST for support. Upon being connected to the HPC and contacting his former supports, it was revealed that Edward had left the province a day before signing documents to receive disability support equivalent to ODSP and abandoning recently secured housing. Edward had been without his medications (anxiety/depression) for three weeks when he arrived at BIST and was unsure where he could visit a doctor and how to explain which medications he needed. His fatigue levels limited how long he could meet and his cognitive deficits combined with his lack of familiarity with the city, caused difficulty in setting appointments. In fact, although Edward did have an active cell phone and communicated reliably through it, he was often late to meetings despite several reminder text messages and phone calls as he often got lost on his way. Unfortunately, his remedy in these situations was to pay for a cab, a costly expense that exacerbated his financial strain. Whenever he felt distressed, Edward would drink and smoke excessively, and isolate himself, which made connecting and meeting almost impossible.

The HPC supported Edward by first connecting him to a walk-in clinic that would ensure he received his medications, applying to the local community health centre to expand his safety network, and applying for services through the ABI network. Edward received extensive travel training to ensure that he no longer felt anxious when using public transit and to ensure he was comfortable getting to and from meetings. Through the community health centre, Edward was connected to a family physician who helped complete applications for ODSP and WheelTrans, and referrals were made to see a psychiatrist and psychologist. He was also connected to their on-site food bank, a smoking cessation program and their on-site pharmacy.

Edward was further supported through housing searches and housing applications. After five months of working with the HPC, Edward received and accepted an offer for subsidized housing. He was then connected to the SUBI program to help manage his alcohol use and long-term case management through a Ministry Funded ABI service provider.

### 3 b) Cognitive and \*Executive Functioning

*In terms of brain injury, Executive Functioning refers to the process our brains use to organize, plan, and problem solve. Difficulties with this process are common following a frontal lobe injury.*

#### **Program Statistics:**

100% of program participants' demonstrated cognitive impairments  
100% of program participants required assistance initiating searches and contacting housing providers, medical professionals, and other service providers.

34% of participants were supported in locating a family physician

**Barriers:**

- There is a myriad of negative health consequences as a result of impaired cognitive abilities and executive functioning.
- Participant's ability to live autonomously is constrained by their capacity to direct their own care, advocate for, and access programs and services that they are in need of.
- Perhaps the most ubiquitous challenges presented in this regard include making and attending appointments, following through with verbal and written instructions, and being able to articulate important information.
- Without exception, each participant expressed that they required assistance initiating searches and contacting housing providers, medical professionals, and other service providers. Participants indicated that their difficulties with organization contributed to their poor health, as they never felt capable of seeing through a task independently.

**Strategy:**

- This barrier required intensive support to follow the participant throughout the community, meeting them 'wherever' they are (i.e., accompanying them to appointments across the city, regular reminders to ensure they kept these appointments, beginning services from a point of recognition that there is some cognitive impairment although they may have no formal ABI diagnosis, supporting other service providers, and various administrative assistance).
- This strategy proved successful in terms of their health and well being as without support there was a risk in medical care not being accessed or accessed inefficiently.
- When attending any medical appointment each program participant required assistance remembering the appointment (i.e., date, time, location), planning a transportation route to get to the location and support during the appointment to remember the intent of the appointment (needs to be addressed), and subsequent follow through.

**Strategies Employed:**

- It is a common experience for a general practitioner to greet you by asking how you are doing. Several participants in these scenarios demonstrated a lack of insight by responding that 'everything was fine'. Prior to into an appointment it was imperative to remind the participant why they are there, and request permission to share information should they forget to mention it (permission would be received again, immediately before disclosing information to the doctor).
- Support included sending reminder text messages or phone calls prior to appointments, prompting the individual to speak about their experience with the

identified issue and elaborating on their explanation with personal observations if permission was granted to do so.

- Follow through support was often provided to assist with acquiring prescriptions, ensuring the participant knew when/how to take the medication (obtaining blister packs if necessary), and assisting to follow up with any medical referrals. In times of client need, the HPC would drive to the pharmacy and pick up/deliver the medications directly to the participant.

### **Recommendations:**

In relation to the presenting issues with cognitive and executive functioning it is this project's findings that the following be considered when replicating the program:

- Provide a barrier-free approach to service access. To overcome the difficulties associated with cognitive and executive function impairment, there needs to be a true understanding of what it means to meet a client where they are, regardless of their connection to other service providers and diagnosis.
- Recognition that this level of disorganization can often leave an individual without proof of injury (medical documentation or otherwise). Understanding that the individual requires intensive support as a result of their diagnosed or undiagnosed ABI is paramount as they are otherwise certain to remain outside the appropriate umbrella of services and resources.
- Direct support needs to be provided at the most basic level. A break down of each medical appointment and issue needs to be completed to ensure the participant is: linked to a General Practitioner, has the appropriate identification to access OHIP funded supports, has a means of getting to the appointment, has support remembering appointment details (time/location) and has assistance remembering their deficits/issues and consistent follow through with any medical recommendations (prescriptions, referrals, etc.).

### **Case Example: Thomas**

Thomas is a 53-year-old man with a TBI that he experienced in a car accident many years ago. He had been living independently for several years, until he was evicted from his subsidized unit in 2018 due to a sexual assault charge. Thomas moved onto the couch of his mother's subsidized unit that night to avoid entering the shelter system, and lived there for the remainder of the year. Thomas was referred to the homeless prevention program internally after first connecting with BIST. The first meeting with the HPC revealed that the relationship between Thomas and his mother was already deteriorating, as they often argued about his behaviour and Thomas had damaged parts of her unit. Given that Thomas was staying in the unit illegally, the damage and repairs were brought to the attention of the building's manager who warned that Thomas could not stay in the unit, but took no further action. Roughly two months after the first meeting, the unit developed a bed bug infestation and the blame was placed on Thomas. The building's manager threatened to evict the mother if Thomas did not leave the building by the end of the week.

The HPC supported Thomas by exploring the cause of his eviction from his subsidized unit, seeking legal council, and advocating for rehousing to the subsidy provider. Unfortunately, no recourse was available from the Landlord Tenant Board or the Human Rights Tribunal and the housing provider refused to rehouse him. Further support was provided by connecting with the building manager and mediating the situation to ensure Thomas could remain in the unit while the HPC assisted with housing searches and rehousing, and that the mother's subsidy/tenancy was protected. Thomas was referred for mental health services, however, he was twice denied access to case management from these service as his based on his brain injury being the cause of his behavioural issues as opposed to mental health concerns. The HPC was successful in connecting Thomas to a Ministry Funded ABI service that was able to provide him with a day program and case management support. He continues to be supported through BIST via our MSW placement student to continue with housing searches.

### 3 c) Education Literacy

#### **Program Statistics:**

25 % of Program Participants were deemed to be illiterate

#### **Barriers:**

- A lack of literacy skills was observed to perpetuate social isolation
- Language fluency was a barrier including understanding the language of complex systems
- Reduced communication skills
- Limited formal education, either had to drop out of school due to impairment, or lacked literacy skills previous to the injury
- Limits of individual ability/access to technology through cost or lack of knowledge on how to utilize technology effectively.
- Understanding paperwork required for the application process
- Difficulty completing forms, filling/mailing applications

#### **Strategies Employed:**

- Connected individuals to local literacy networks
- Connected individuals to disability offices at local colleges
- Acting as their accessibility device
- Tech literacy - using phone.
  - Using tech to improve literacy access (compensatory strategy)

#### **Recommendations:**

- Educate service providers on the barriers to literacy
- Provide education on how to support the individual (e.g., explaining the language, simplifying complex terms and applications,
- Use technology when available to assist with reading forms



- Change application processes so they are more user-friendly (i.e. option to fill out the form at the agency with personal assistance).

#### Case example: Samantha

Samantha is a 66-year-old woman with a TBI and severe depression. She had been living with her two daughters in subsidized townhouse until they moved out and Samantha was relocated to a 1-bedroom unit for seniors due to over housing (i.e., she was living in a unit too large for her household occupancy). Samantha became isolated and disconnected from her family, as her two daughters rarely visited or spoke to her. Her cognitive and executive functioning impairments are such that she is disorganized, has difficulty planning, has trouble articulating herself, lives with a short attention span and is easily confused. She was connected to the Homeless Prevention Program after attending one of BIST's support groups and asking staff for assistance with some mail she received from her housing provider.

Support began by first addressing Samantha's paperwork and organizing it into comprehensible folders, as she could not find the mail she required help interpreting. Having located the mail, it was revealed that Samantha was two months past due updating information critical to maintaining her subsidized unit. The HPC and Samantha worked collaboratively to speak with the housing provider and receive an extension while the necessary paperwork was collected. *The situation was distressing to Samantha who consistently asked to give consent for the HPC to speak on her behalf, as she was too anxious to explain why she ignored the mail. The issue was resolved in a month and Samantha's subsidy was preserved.*

#### Summary:

While the HSP provides a snapshot of (32) individuals facing poverty and homelessness in the Toronto area, there is strong evidence to suggest that individuals living with brain injury will face similar systemic, community and individual barriers while facing housing, health and income related crisis in any community across Ontario. This is an underserved population with a need for strategies and services to adapt to their specific conditions. Further public education surrounding ABI and poverty is needed to ensure systems and supports are available to address the life-long realities of living with an ABI.

The housing crisis is similar in many communities across the province with limited availability, expensive rental costs and limited safe options available. In many Ontario communities there is a low vacancy rate and a high rate of competition for available units, creating a barrier to adequately compete for housing choice for individuals living on social assistance.

Additionally the barriers presented by the symptoms of ABI and lack of education and awareness surrounding this "invisible" disability further complicates their choices in

attaining safe affordable housing that is accessible for individual needs. Every single person living with an ABI is unique and often complex; therefore the strategies employed must be person centered and address the myriad of concurrent health/mental health conditions that can further impact individuals and their ability for independence. As highlighted in this report, brain injury will need to be front and center when housing policy is developed in order to adequately support people in their journey. Brain Injury is lifelong, and if the individual has limited access to rehabilitation support, their recovery may be further impaired. All levels of government, policy makers, health care and social support agencies will require further resources and support initiatives to increase inclusiveness and accessibility for those living with an ABI. This will ensure “no wrong door” for individual’s living with this condition, and will assist in further ensuring all members of society have access to the same opportunities for community autonomy and independence.

## Resources and Links

### Homelessness Resources:

1. Canadian Observatory on Homelessness- Homeless Hub  
<https://homelesshub.ca/users/homelesshub>
2. Insights on Canadian Hidden Homelessness in Canada  
<https://www150.statcan.gc.ca/n1/pub/75-006-x/2016001/article/14678-eng.htm>
3. Homelessness In Toronto (Street Needs Assessment April 26th, 2018)  
<https://www.toronto.ca/wp-content/uploads/2018/11/981e-2018-SNA-Results-Highlights-Slides.pdf>
4. Toronto Alliance to End Homelessness  
<https://taeh.ca/>
5. OrgCode Consulting  
<https://www.orgcode.com>
6. Housing First  
<https://www.homelesshub.ca/solutions/housing-accommodation-and-supports/housing-first>
7. Cost Analysis of Homelessness  
<https://www.homelesshub.ca/about-homelessness/homelessness-101/cost-analysis-homelessness>
8. Brain Injury and Homelessness  
[http://www.stmichaelshospital.com/media/detail.php?source=hospital\\_news/2014/20140425\\_hn](http://www.stmichaelshospital.com/media/detail.php?source=hospital_news/2014/20140425_hn)  
<https://www.homelesshub.ca/resource/26-traumatic-brain-injury-homeless-population-toronto-study>  
<https://www.thedtgroup.org/foundation/brain-injury-and-homelessness>  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2553875/>

### Substance Abuse/Addictions:

1. SUBI - The Substance Abuse and Brain Injury (SUBI) project was initiated to study the problem of Substance Abuse and Brain Injury. This website provides information for Healthcare Providers, persons with an Acquired Brain Injury (ABI), and the General Public. <https://www.subi.ca>

## Income Resources:

1. Health Providers Against Poverty  
<https://healthprovidersagainstpoverity.ca/resources/clinical-tools/>
2. Income and Security Advocacy Center  
[incomesecurity.org/public-education/ow-and-odsp-rates-and-the-ocb-2018-les-taux-dot-du-posph-et-de-la-poe-2018/](https://incomesecurity.org/public-education/ow-and-odsp-rates-and-the-ocb-2018-les-taux-dot-du-posph-et-de-la-poe-2018/)

## Food Security:

1. Quest food exchange: <http://www.questoutreach.org/>
2. Toronto Community Garden network: <https://tcgn.ca/about/about-community-gardens/>

## Extreme Cold Weather

1. <https://www.toronto.ca/community-people/health-wellness-care/information-for-healthcare-professionals/environmental-health-information-for-health-professionals/extreme-cold-weather-alerts-information-for-health-professionals/>

## Housing:

1. Rent Smart Ontario: Rent smart is an organization that provides education to tenants and landlords with the intention of teaching skills necessary of each group to be knowledgeable of their rights and responsibilities. A certificate is provided to those who participate; and in Vancouver, landlords have 'bought-in' to the program by using the certificate as a reference on housing applications  
<http://www.rentsmartontario.ca/>
2. Raising the Roof  
<https://www.raisingtheroof.org/>
3. City of Toronto - Emergency Housing Help  
<https://www.toronto.ca/community-people/employment-social-support/housing-support/financial-support-for-renters/housing-stabilization-fund/>  
<https://www.toronto.ca/community-people/community-partners/social-housing-providers/affordable-housing-operators/current-city-of-toronto-average-market-rents-and-utility-allowances/> (For citation)
4. City of Toronto Rent Geared Income Housing  
<https://www.toronto.ca/community-people/employment-social-support/housing-support/rent-geared-to-income-subsidy/>

5. Shelters: <https://www.toronto.ca/community-people/housing-shelter/>
6. Pet Support for low income:  
[https://www.torontohumanesociety.com/pdfs/Cannot\\_Afford\\_Care.pdf](https://www.torontohumanesociety.com/pdfs/Cannot_Afford_Care.pdf)

#### Transportation:

1. Fair Pass Transit Discount Program  
<https://www.toronto.ca/community-people/employment-social-support/support-for-people-in-financial-need/assistance-through-ontario-works/transit-discount/>
2. Wheel Trans Accessible Transit  
[https://www.ttc.ca/WheelTrans/How\\_to\\_apply/index.jsp](https://www.ttc.ca/WheelTrans/How_to_apply/index.jsp)
3. Transit app- Plan your trip with real time data  
<https://transitapp.com>

#### Employment:

1. STAR - Program provides an environment for the homeless to rediscover activities that are meaningful to them. They provide opportunities for participants to develop skills (e.g., conflict resolution, interpersonal, financial basics, community engagement)  
<http://www.stmichaelshospital.com/programs/mentalhealth/star.php>

#### Recreation:

1. Access to Entertainment card: This is a collaborative partnership between Easter Seals and over 500 movie theatres, cultural attractions, entertainment venues, and recreation facilities across Canada. Designed for people of all ages who have a permanent disability and require the assistance of a support person, the goal of the Access 2 Program is to improve social inclusion and provide access to entertainment, cultural and recreation opportunities and experiences without any added financial burden  
<https://easterseals.ca/english/access-2-card-program/>
2. City of Toronto- Free and Low cost Recreation options  
<https://www.toronto.ca/explore-enjoy/recreation/free-lower-cost-recreation-options/>

## LEGAL:

1. TAX Clinics: <https://www.canada.ca/en/revenue-agency/services/tax/individuals/community-volunteer-income-tax-program.html>
2. ID clinics: <https://neighbourhoodlink.org/partners-for-access-and-identification-paid/>
3. Community Legal Education Ontario (CLEO)  
<https://www.cleo.on.ca/en>

## Accessibility Apps:

1. The Homelessness Hub: <https://www.homelesshub.ca/blog/Innovations-social-technology-inspire-your-next-hackathon-end-homelessness>
2. Chalmers Bot: The chalmersbot app gives users real time information regarding where they can find a free meal, shelter, clothing, drop-in programs, and crisis services. The application is intuitive, responds and accepts plain language and gives users results based on their current location - currently this app is only available in Toronto - given its accessibility and ease to use it is our recommendation that it become available throughout the province.
3. Flip App: [Flipp: Weekly Ad Circulars, Deals & Online Coupons](https://flipp.com/home)  
<https://flipp.com/home>
4. Checkout 51: This app gives you cash back on items you would normally buy. The offers change each week, but you shop and purchase your items, take a picture of your receipt using the app, and you are mailed a check when your balance reaches \$20  
<https://www.checkout51.com/?country=CA>

## Organization:

1. Google: creating Gmail accounts for individuals to send and receive communications, utilizing Google drive to store important documents, copies of ID for individuals who may be transient or at risk of losing important information
2. Google calendar: Use free app for organization of routine and daily appointment reminders. This can be shared with service providers to add appointments or track schedule with permission.
3. Whatsapp: free communication app for texting, video conference, and voice recording

## Health/Social Service Connections:

1. Health Care connect: Register for Health care connect and a nurse will search for a doctor or nurse practitioner who is accepting new patients in your area.  
<https://www.ontario.ca/page/find-family-doctor-or-nurse-practitioner>
2. 211 Ontario: call, email or live chat on 211 to find social service programs in your community.  
211ontario.ca
3. Big White Wall- *an* online mental health and wellbeing service offering self-help programs, creative outlets and a community that cares.  
<https://www.bigwhitewall.ca/v2/Home.aspx?ReturnUrl=%2f>

#### **Data collection/HIFIS and the National Homelessness Information Initiative:**

1. Homeless Individuals and Families Information System:  
<https://www.canada.ca/en/employment-social-development/programs/homelessness/hifis.html>

#### **Accessibility in Toronto:**

1. AccessNow: using crowd-sourced information to show how mobility-friendly buildings and public transit are across Canada  
<http://accessnow.me/>

#### **Brain Injury Services:**

1. Intimate Partner Violence and Brain Injury:  
<https://tbi.pivot.design/service-provision/screening-for-brain-injury>
2. BIST (Brain Injury Society of Toronto):  
www.bist.ca
3. ABI network:  
[www.abinetwork.ca](http://www.abinetwork.ca)
4. Ontario Brain Injury Association:  
[www.obia.ca](http://www.obia.ca)