Community Engagement in Support of Housing for Complex Clients

Includes:

Final Report, Survey Questions, Informed Consent, Tables Ranking Barriers and Important and Features

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Community Engagement in Support of Housing for Complex Clients

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Abstract

The purpose of this research is to create a housing model to increase access to and maintenance of stable housing for complex clients. In order to do this, the current barriers, key areas for support, and important features to include in the model were determined using a literature review, survey, and interviews. The survey was distributed to organizations and individuals who work with complex clients in the Peterborough region, and the interviews were 1-on-1 discussions with participants who volunteered in their survey. The top seven identified barriers were, in order from greatest to least; cost of housing, limited availability of housing, high demand for housing, difficulty navigating resources, bias and stigma against complex clients, and lack of knowledge/ understanding of complex clients. Primarily, this model must incorporate 24/7 wraparound support in order to meet the needs of complex clients. The nine most important features for inclusion in this model are, in order from most to least; support in using external services, partnerships and collaboration across organizations, activity programming and support groups, community education and awareness, facilitation of social connections, facilitation of client engagement in the community, providing diverse opportunities, facilitation of employment/ volunteer opportunities, and support in continuing education.

Key Terminology and Definitions

Complex clients, for the purposes of this project, are individuals with Accquired Brain Injuries with other co-occurring conditions, including but not limited to, mental health and/or substance use issues (MHSU), and a history of contact with the criminal justice system. An Accquired Brain Injury (ABI) is brain damage that occurs after birth due to a traumatic (ie., head injury from assault or accident) or non-traumatic event (ie., stroke, aneurysm) (Brain Injury Association Peterborough Region, n.d.b.). ABIs are not congenital nor progressively degenerative, but they do generally have complex and long-lasting effects, also called sequelae (Brain Injury Association Peterborough Region, n.d.b.). A TBI is a traumatic brain injury and refers specifically to ABIs caused by a traumatic event. While there are varying definitions of homelessness, this project utilizes the definition from Peterborough Social Services (2022), which is a lack of safe, stable, affordable, and appropriate housing. Chronic homelessness is defined as when an individual is homeless for six or more months in a one-year period (Peterborough Social Services, 2022).

The Brain Injury Association Peterborough Region (BIAPR) is a not-for-profit organization that provides support and services to complex clients in the Peterborough, Kawartha Lakes, Haliburton, and Northumberland Regions (Brain Injury Association Peterborough Region, n.d.a.). Their services empower complex clients, improve their life satisfaction, and engage in their communities to the fullest extent possible (Brain Injury Association Peterborough Region, n.d.a.). Their services include social, recreational, and leisure activities, support for the community, support for clients to integrate into the community, education for clients and families, and public education and awareness (Brain Injury Association Peterborough Region, n.d.a.). This project represents an extension of these services with the aim of better supporting their complex clients by attempting to fill a major gap; the lack of accessible stable housing, and the struggle to maintain that stable housing if individuals are able to access it.

Introduction & Background

Purpose

The purpose of this project is to create a model specifically designed to increase access to and maintenance of stable housing for complex clients in the Peterborough region. This will include identifying current barriers to stable housing, determining what features will be important to incorporate into the model, and designing a model that accounts for both the identified barriers and incorporate the key features.

Significance

On October 14th, 2022 former Mayor of Peterborough Diane Therrien declared a state of emergency on homelessness in Peterborough (Bui, 2022). In November 2018, Peterborough joined Built for Zero Canada (BFZ-C) as Built For Zero Ptbo (BFZ-Ptbo) as one of 33 Canadian communities committed to ending chronic homelessness by December 31st, 2025 (Built For Zero Ptbo, 2020). Over 50% of unhoused individuals have a history of brain injury, compared to 12% of the general population, and there is a temporal association between an individual acquiring a brain injury and losing stable housing (Stubbs et al., 2020; Stubbs et al., 2021). Individuals with an acquired brain injury face more barriers to accessing stable housing than the general population, and the current supports in Peterborough to help individuals exit homelessness fail to adequately support complex clients. Combined, these facts demonstrate how

great the need for a housing model specifically designed for complex clients is, and highlights the significance of this research in its role of establishing said model. For these reasons, this model is key to accomplishing the goal of Built For Zero Ptbo to end chronic homelessness in Peterborough by December 31st, 2025 (Built For Zero Ptbo, 2020).

The healthily environmentally complex environment that stable housing provides is beneficial in easing recovery and improving outcomes post-brain injury (Henst et al., 2019). This category of improved outcomes also includes a reduction in interactions with the criminal justice system as complex clients are overrepresented in the prison population with 35.7-88% of the prison population having diagnosed brain injuries, compared to 12% of the general population (Matheson et al., 2020; Stubbs et al., 2020). Individuals with a brain injury have a 14-39% higher risk of incurring serious charges than the general population (Matheson et al., 2020). This indicates that better supporting complex clients through a housing model specifically tailored to their needs would contribute to reducing crime rates, specifically, rates of serious crimes. History of incarceration is also a major risk factor for difficulty accessing stable housing, and lack of stable housing is a major risk factor for incarceration (Garduño-Ortega et al., 2022).

Background Context

General barriers to stable housing including affordability issues, limited housing supply, and high demand affect everyone, but more strongly impact complex clients partially due to the bias and stigma against complex clients (Estrella et al., 2021). The City of Peterborough (2022) contextualizes these barriers by explaining exactly how they exist in Peterborough; a significant increase in the need for housing supports, lack of funding for permanent supportive housing, long wait times for affordable Community Housing, lack of affordable rental options, increased violence in shelters, and unsafe living conditions in outdoor encampents. After a brain injury, individuals most often struggle in four primary areas: communication, emotional dysregulation, behavioural (ie., impulse control), and cognitive functioning (Matheson et al., 2020). These are all areas which are necessary to navigate the complex systems required to access stable housing, complete the necessary tasks to maintain stable housing (ie., paying bills, managing relationships with a landlord or other tenets, etc), and access the existing services and supports that would make the first two tasks more achievable. Establishing an understanding of these barriers aids in explaining how and why complex clients are disproportionately represented in the homeless

population. It also provides guidance on how this model must be designed in order to overcome these barriers.

Estrella et al. (2021), Hengst et al. (2019), and Shaikh et al. (2019) all provide insight into what features should be incorporated into the creation of this model. Hengst et al. (2019) explain the concept of environmental complexity (EC); while there is no singular definition of EC, it describes and guides the design of a living environment that emphasizes the use of multiple dimensions of communicative interactions (physical, social, temporal), social contact, stimulation, variety in activities (social, cognitive, perceptual, physical) and opportunities, and voluntary participation. Fundamentally underlying all of these is the flexibility and ongoing development that enables EC to be individualized to each person at each stage of their recovery; an EC living situation will grow with the individual, thus providing a strong foundation (Hengst et al., 2019). EC is also associated with easing recovery and improving outcomes post-brain injury because it is positively correlated with the restoration of neural responses, the addition of synapses, preservation of brain tissues, neuroprotective responses to limit secondary degeneration, and off-setting cognitive function decline (Hengst et al., 2019). For these reasons, it is important to ensure that EC is incorporated into this model. Both Estrella et al. (2021) and Shaikh et al. (2019) highlight the importance of ensuring that this model emphasizes community integration, building social connections, and encouraging engagement in meaningful activities. It will also be important to consider how this model can support complex clients in navigating and utilizing other services and the importance of collaboration across organizations in the efficacy of this model (Estrella et al., 2021).

The Housing First (HF) model provides access to housing without requiring any additional treatments or supports (ie., mental health services or substance abuse treatments), and is currently the most commonly used and considered to be the most effective model worldwide for ending homelessness and improving the quality of life of previously unhoused people (Lancheros et al., 2020). This would serve as an effective starting point for this model, as it is effective in easing access to and providing longer-term housing stability, which inherently increases individuals' access to and the efficacy of other supports and services (Lancheros et al., 2020). However, the sequelae of brain injuries can make it difficult for complex clients to navigate complex systems and different services, simply providing them stable housing with HF does not necessarily inherently increase their access to other services the way it would for the

general population (Lancheros et al., 2020). HF is an effective starting point and foundation for this model but does not adapt to the continuum of support required by complex clients.

Methodology

Variables and Factors

This research aimed to discuss and address the following factors regarding accessing and maintaining stable housing for complex clients: current barriers, how a housing model can encourage this, and what the benefits of this would be too complex clients, support organizations, and the larger Peterborough community.

Sources of Information

First, a literature review was conducted in order to establish a foundational knowledge of existing research. Current rates of homelessness in the Peterborough region, the benefits of stable housing and the relationship between acquired brain injuries and lack of stable housing were researched to contextualize and establish the significance of this research. Previous research establishing important characteristics of a housing model for complex clients were studied in order to evaluate them for potential inclusion in this model.

Secondly, service providers were surveyed in order to gain first-hand, Peterborough-specific information from those working on the front lines with the complex clients that this model aims to support. Nine (9) complete survey responses were collected. This survey was an online Qualtrics form and was distributed via email by sharing information about the project and a link to the survey. It was distributed to executive-level directors of organizations to distribute amongst their staff, as well as directly to front-line staff whose contact information was available. The survey was sent to individuals within the following organizations: the BIAPR, Canadian Mental Health Association, John Howard Society, Brock Mission/ Cameron House, Elizabeth Fry Society, Kawartha Participation Projects, Fourcast Addiction Services, OneCity, Peterborough Social Services, the 360 Nurse Practitioner-Led Clinic, PARN, the Peterborough Police Service, the Ontario Provincial Police. This survey was entirely voluntary and anonymous; Qualtrics did not automatically collect any information from participants, so the only information known about each participant was the information they voluntarily provided in their answers. There were 19 total survey questions; one was a yes-or-no

question about consenting to participate in the survey, one was an optional box to input contact information to volunteer for a survey, and the other 17 were research-related questions. Of those 17 questions, five were multiple-choice, two were ranking questions, and the other 10 were short answer questions. The first five questions asked participants the context in which they work with complex clients, their organization's definition of complex clients, how frequently they work with clients with co-occurring conditions, what co-occurring conditions those are, and a numerical self-rating scale on the participant's knowledge of brain injuries. The following three questions ask for participants' feedback on the current housing support systems that they work with through their employment. Two of the remaining ten questions ask participants about barriers to accessing and maintaining stable housing based on their experience. The eight other questions ask participants for their input regarding the design of a new housing model, including what features would be important to include, factors to consider, and the actual style of housing. The features listed in a rank-order question for the importance of inclusion in this housing model were based on the features previously established as important through the literature review. Images of the survey are included in Appendix A, Figures 1 to 8.

Concurrently with and after the completion of the survey, participants who volunteered through their surveys were interviewed as well as participants who requested to only complete an interview. Five (5) interviews were conducted. These were 1-on-1 interviews conducted via Zoom, and each interview lasted approximately 45 minutes to 1 hour. There were two different sets of questions; one set for participants who had completed the survey beforehand, and one for those who did not. The questions for participants who had completed the survey asked them about any of their survey answers that they wanted to expand on, as well as answers I wanted them to expand on. These questions also reviewed potential standardization of the term *complex clients,* the availability of support organizations and services for complex clients, and if Peterborough has the resources to implement another housing model. The questions for participants who had not completed the survey included both survey questions and the interview questions described above; specifically, their organization's definition of complex clients and potential standardization of this definition, feedback on their organization's current housing supports, their input regarding the design of a new model (ie., features, factors such as current barriers, and actual housing styles), and if Peterborough has the resources to implement another housing model. In both sets of interview questions, the interview ended by providing participants

with the opportunity to provide any additional feedback or thoughts that they felt had not been covered by another question.

Analysis of Information

All data obtained from this research is qualitative and therefore was analyzed using a thematic, qualitative approach. There are four question types within the survey: multiple choice, select-all-that-apply, rank order, and short answer. For the multiple-choice and select-all-that-apply answers, the most and least commonly selected answers were identified. For the rank order questions, the average ranking of each option was determined in order to determine an overall average ranking most reflective of each individual answer. The short answer questions, including those following up on other questions, were analyzed by identifying the major themes and keywords in the answer. The interviews were analyzed in a similar manner to the survey answers. Any questions that overlapped with the survey questions for participants who did not complete the survey were analyzed the same way as the corresponding question in the survey was analyzed. Any questions that were novel to the interview were analyzed in the same manner as the short answer survey questions.

Biases

One potential manner in which participants' responses could have been biased was the fact that they were aware that the purpose of the research they were participating in was to create a housing model for complex clients, which could have caused them to focus more heavily on the gaps and failures of current supports than on their strengths. This was accounted for by directly asking about the strengths, not just the weaknesses, of current supports, and asking for specific ways in which they believed those current systems are beneficial to complex clients.

There are also potential biases associated with the participant pool being active employees of the organizations whose supports and programs this research assesses and aims to improve upon. Individuals may have preferential opinions regarding their own organization's programs, and be less likely to provide negative feedback. Interviews have been found to be more effective in combating this than surveys, and therefore the conduction of interviews represented an effort to account for this potential bias. However, all survey responses volunteered ways in which current supports were inadequate, and therefore it is likely that

courtesy bias did not have a significant effect. Additionally, individuals with different training and different experience levels working in the field may hold differing opinions, and only having individuals with the same training and/ or experience level may lead to data that is not representative of the field as a whole. Therefore, it is best to have a participant pool with as diverse backgrounds and experiences within the field as possible. This was accounted for in this research by sending the survey to organizations and individuals with a variety of different backgrounds, objectives, and purposes, and seemed to be effective as the organizations from which respondents are highly varied and represent numerous different roles within the field of support complex clients.

Numerous types of bias are associated with the phrasing of questions; in order to account for the potential of any of these to arise, all questions for both the survey and interviews were phrased neutrally and non-judgementally.

Ethics Statement

This research project was approved by the Trent University Research Ethics Board (REB), file number 28294, prior to the distribution of the survey and commencement of the interviews. Ethical standards were maintained by ensuring that the survey was entirely voluntary and inherently anonymous; the survey was distributed via email so participants had the choice to participate, and no question on the survey required the provision of identifying personal information. This enabled participants to provide only as much information as they were comfortable volunteering. Since the interviews could not be conducted anonymously, these were also entirely voluntary, and volunteering for the interview required participants to input their contact information. Participants were also given numerous opportunities to opt out of an interview after volunteering, and any record of the interviews (ie., notes, recordings) is entirely confidential. Participants were made aware of their rights prior to completing both the survey and the interview.

Results & Major Findings

Current Housing Models

A number of different globally-used housing models were assessed for this project (ie., Housing-First, Treatment-First, and private organizations); however, the current research on the

majority of them indicates that they are ineffective for complex clients. Additionally, none were found to have any features that were unique to a specific model that would also be effective for use in this model except for the Housing First (HF) model. The Housing First (HF) model, and HF-Based interventions, are the most widely used and are considered to be the most effective model for ending homelessness worldwide (Lancheros et al., 2020). HF has proven to be effective in providing long-term housing stability (Lancheros et al., 2020). HF provides access to housing without requiring any concurrent treatment (ie., for MHSU), but is often used in combination with mental health support services (Lancheros et al., 2020). Interventionally, HF provides housing and aims to guide individuals to other services (Estrella et al., 2021). Philosophically, HF calls for person-centred, holistic services, and is guided by core principles such as ensuring immediate housing and services, de-linking housing and clinical services, recovery-oriented support, and encouraging community reintegration (Estrella et al., 2021). HF is generally associated with positive outcomes including improved housing stability, improved quality of life and community integration, and reduced service use; however, individuals with brain injuries generally report lower well-being than individuals without brain injuries when using HF (Estrella et al., 2021). HF reduces the risk of individuals experiencing a greater number of violence-related brain injuries; however, it does not significantly reduce the probability of a violence-related brain injury occurring in general (Lancheros et al., 2020). Admittedly, reducing the risk of violence-related brain injuries is incredibly difficult due to the number of associated factors (ie., poverty, domestic violence, and addiction) both distinct and linked with homelessness (Lancheros et al., 2020). HF alone also does not significantly reduce an individual's risk of being incarcerated but does reduce contact with the criminal justice system more than any other model (Luong et al., 2021). Overall, HF provides an excellent foundation for this housing model, but HF alone is inadequate in supporting individuals with multidimensional needs such as complex clients (Lancheros et al., 2021). HF-based interventions also enable easier access and enhanced efficacy of other services to address those multidimensional needs (Lancheros et al., 2021).

Within the city of Peterborough, certain organizations have housing programs; these are managed by either an individual organization or a group of organizations collaborating. A number of these programs utilize something called the By-Name List to house individuals. The By-Name List, also called the By-Name Priority List, is a real-time, constantly updated list of

people experiencing homelessness in Peterborough (Built For Zero Ptbo, n.d.). The goal of the By-Name Priority List is to prioritize the most vulnerable individuals by their level of need and match individuals with the most appropriate supports and services in the community; the most vulnerable individuals are essentially placed at the top of waiting lists and prioritized in accessing these services (Built For Zero Ptbo, n.d.). In this way, it works almost like an organ transplant list, but with community supports (Built For Zero Ptbo, n.d.). Theoretically, this By-Name List should ensure that individuals of greatest need receive housing first in the community; this has proven true and effective for the individuals registered to the By-Name List. Individuals with complex needs are prioritized as being of higher acuity and are more likely to be picked up from the By-Name List sooner, according to the experience of one participant. However, multiple participants identified one major issue preventing the By-Name List from properly supporting all unhoused individuals in Peterborough: the fact that individuals must be registered on the By-Name List by an organization or individual with the ability to add people to the By-Name List. This means that in order to be added to the By-Name List, an individual must have contact with an organization that utilizes the By-Name List, which is a major barrier to being added to the By-Name List for many unhoused individuals. These organizations may be inaccessible, unapproachable, or the individual may be unwilling to be in contact with them; whatever the reason is, the most vulnerable individuals and those with the most complex needs are more likely to be left off the By-Name List. Therefore, it is likely that housing programs that take individuals only off the By-Name List are likely missing a large portion of homeless individuals in Peterborough, specifically complex clients.

Other organizations in Peterborough run housing support services that are not based on the By-Name List. For one participant's organization, this allows them to support more individuals, and provides their existing tenants with greater control over their living situations by allowing them to have a say in who they live with, increasing individuals' sense of ownership, accountability, and building relationships. However, the downside of not utilizing the By-Name List is the inability to access funding that requires the use of the By-Name List, which leaves them with fewer funding opportunities and less funding overall than organizations that use the By-Name List.

Several of the currently existing models in Peterborough described by participants are Transitional Housing Models. Transitional Housing Models provide individuals with temporary

housing in order for them to stabilize, assess their needs, and plan their next steps. There is no standardized time frame for Transitional Housing; it varies by the program and the individuals' needs. With Transitional Housing, the individual is aware from the beginning that this housing is temporary, and a plan is in development for them to move on eventually. The advantage of Transitional Housing is that it not only provides individuals with the time to stabilize, but also to develop skills, gain references that will help them secure permanent housing, determine their needs, identify what supports and services are most effective, and build relationships. However, the downside of Transitional Housing is that it is temporary; overall, Peterborough does lack supports and services to provide individuals with permanent housing that is accessible, affordable, and appropriate to their individualized needs.

Additionally, participants identified a lack of supports and services that are capable and/or willing to take on individuals with complex needs such as MHSU and ABI. These individuals often require more supports and a wider variety of services that organizations may not provide or be equipped to accommodate. Additionally, the behavioural and cognitive sequelae of brain injuries can lead to individuals being unwelcome in programs or entire organizations due to behavioural issues.

Barriers

Estrella et al. (2021) conducted a literature review and synthesized a number of barriers previously proposed as preventing complex clients from receiving optimal services that are applicable to this research. First, limited knowledge on how to best support complex clients; second, a lack of knowledge about brain injuries by housing/ mental health professionals; and third, individuals co-occurring conditions affecting their eligibility for supports/ services (Estrella et al., 2021). Additionally, in the Canadian integrated care systems ABI and MHSU are generally treated separately, requiring complex clients to utilize a siloed system that forces them to navigate several separate departments, organizations, practitioners, services, and systems (Estrella et al., 2021). Siloed healthcare systems are barriers to treatment for most patients, and are especially obstructive for complex clients (Estrella et al., 2021). From their survey of both service users and service providers, Estrella et al. (2021) identified three major structural barriers: limited housing supply coupled with high demand leading to affordability issues, negative attitudes and lack of understanding of ABIs, and fragmented service systems (Estrella et

al., 2021). Shaikh et al. (2016) also identified structural barriers; physical inaccessibility of the environment or living arrangements, financial status, and difficulty accessing services and information.

The temporal and severity associations between the occurrence of a brain injury and the loss of stable housing suggest that the sequelae from a brain injury may contribute to the loss of stable housing (Stubbs et al., 2021). These sequelae include difficulty with daily tasks, difficulty managing relationships and conflict, triggering environments, difficulty communicating, fear of stigma, and lack of motivation (Estrella et al., 2021). Stubbs et al. (2021) found that a brain injury occurring near the initial loss of stable housing was associated with longer durations of unstable housing, indicating that a brain injury may represent a barrier to exiting unstable housing. Stubbs et al. (2021) reviewed previous research, and identified mixed results on the relationship between brain injuries and the duration of unstable housing; two studies found an association between brain injuries and longer periods of unstable housing, while two found no relationship. However, there are a number of potential explanations as to why the relationship is unclear; individuals with an ABI generally have co-occurring conditions which may mask the ABI, and the consideration of survivorship bias may mean that individuals with more severe ABIs are inadequately represented due to death or severe disability requiring long-term care (Stubbs et al., 2021). Considering these factors, it is likely that there is a relationship between brain injuries and unstable housing, and that a brain injury represents a barrier to exiting unstable housing (Stubbs et al., 2021).

Through the literature review, seven major barriers were identified, and on the survey participants were asked to rank those barriers from one (most obstructive) to seven (least obstructive) for complex clients accessing and maintaining stable housing. Table 1 presents the seven major identified barriers, and represents the average ranking based on all nine survey answers. Both the survey and interview also included open-ended questions allowing participants to discuss any barriers they believe were not listed in the ranking, and participants provided the following as additional barriers: hostile unit takeovers, exploitation of vulnerable individuals, potential proximity to dangerous situations, lack of public transportation limiting accessibility, and long waiting lists for existing supports and services.

Table 1. Ranking of the barriers to stable housing for complex clients.

Ranking	Barrier
1	Cost of housing
2	Limited availability of housing
3	High demand for housing
4	Difficulty navigating resources
4	Bias and stigma against complex clients
6	Difficulty managing relationships (ie., with landlords or other tenets)
7	Lack of knowledge/ understanding of complex clients by the larger community

Key Features

From their survey, Estrella et al. (2021) also identified key characteristics of housing supports for complex clients, which can be grouped into two main themes: first, overcoming structural barriers and second, enabling client engagement in meaningful activities and social connections. In order to overcome structural barriers, a housing model must support and facilitate clients coordinating and navigating different supports, increase education and raise awareness about brain injuries, and utilize partnerships and collaborations between different individuals, organizations, and sectors (Estrella et al., 2021). In order to enable client engagement, a housing model must create opportunities for different activities and social interactions, support them in living independently and comfortably, provide training and skills development, and consider the design and features of the larger environment/ community (Estrella et al., 2021). In order to be effective, any housing model must also build rapport and trust with clients as a foundational basis for all further support (Estrella et al., 2021),

Community integration is becoming increasingly emphasized as an important goal post-brain injury (Shaikh et al., 2019). While the definition of community integration varies across the literature, it generally includes actively participating in the community including having a social role, living independently, engaging productively, and having a job or educational pursuit (Shaikh et al., 2019). This means that a housing model for complex clients should include

features that encourage independence, provide a safe place to live, foster social connections, encourage occupational performance, assist with adjustments, and provide a sense of belonging (Shaikh et al., 2019). Community integration is an ongoing process, so it is important that these features are constantly and continually readily accessible (Shaikh et al., 2019). The literature provides a distinction between community integration and community participation; however, this distinction is more academic than practical so the terms are used interchangeably in this report (Shaikh et al., 2019).

Hengst et al. (2019) establish that enriching, communicative environments have been proven in rodent models of brain injuries to increase neural activity, structural connectivity, neuroplasticity, and neurogenesis across multiple regions of the brain (Hengst et al., 2019). Additionally, it has been linked to improved rates and final levels of motor behavioural improvements, as well as greater social, cognitive, perceptual and physical activity (Hengst et al., 2019). However, it should be noted that not all behavioural impairments improve equally, and it is likely that EC promotes compensation for these impairments rather than actual recovery from them (Hengst et al., 2019). In applying this to humans, specifically through this housing model, a rich communicative environment is one of significant but manageable complexity, provides opportunities for individuals to voluntarily participate in personally meaningful activities, and is optimized for each individual (Hengst et al., 2019). In order to be a rich communicative environment, this housing model must also include multiple different methods of communication, encourage interactions of different natures (ie., problem-solving, completing tasks, achieving goals, etc.), build on clients' individuality, support the ongoing development of relationships between clients, and remain current and socioculturally relevant (Hengst et al., 2019). An enriching environment presents a method of enabling social learning and the re-development of cognitive and communicative functioning, which are generally impaired post-brain injury (Hengst et al., 2019).

The key features from the literature were identified and compiled into a list of nine, which participants on the survey ranked from one to nine, with one being the most important feature and nine being the least important feature. Table 2 presents these nine features and the average ranking based on all nine survey answers. Other features identified as being important to include in this model are supporting stabilization, integrated community support built on existing collaborations, encouraging client accountability and ownership, treatment-focused not just

housing-focused, requirements to participate in available programs, multi-disciplinary team, scalable support, and a range of housing style options.

Table 2. Ranking of the key features of this housing model.

Ranking	Feature
1	Support in coordinating and navigating different supports/ services
2	Partnerships and collaboration across organizations
3	Activity programming and support groups
4	Providing community education and awareness
5	Facilitation of social connections between clients
6	Facilitation of client participation in the larger community
7	Providing diverse opportunities
8	Facilitation of employment and volunteer opportunities
9	Support and assistance in continuing education

Potential Benefits

In interviews, participants were asked what the potential benefits of a housing model specifically designed for complex clients would be to complex clients themselves, to organizations that support complex clients (such as BIAPR), and to the Peterborough community. Participants identified the following benefits to complex clients: easing access to different supports, increased feelings of inclusivity, ability to build a community and support system, increased safety and security, and potentially increased awareness from and acceptance by the Peterborough community. For support organizations, it would potentially help to ensure they have appropriate and knowledgable staff, long-term cost savings, ease their job of finding clients appropriate and liveable housing, and improved efficacy of other supports by meeting individuals' basic needs. For the community, reduced crime rates, increased community safety, overall reduced costs, and increased education about brain injuries were all identified as potential benefits. The literature also establishes that a properly-designed housing model will aid in easing

recovery and improving outcomes post-brain injury, both in the physical healing of the brain as well as coping with sequelae (Estrella et al., 2021; Hengst et al., 2019; Shaikh et al., 2019).

Potential Housing Styles

The actual style of housing which the model could utilize was also considered and a list of eight potential styles was created based on discussions with the host organization. Table 3 presents these eight potential styles and their average ranking based on all nine survey answers. In this ranking, one is considered the most appropriate/ beneficial for complex clients, and eight is the least appropriate/ beneficial. In open-ended questions from the survey and the interviews, participants also discussed that the optimal style of housing varies between individuals. Additionally, a common comment was that, in participants' experience, group home style settings (ie., roommates, housemates) were less than ideal for complex clients. It was repeatedly highlighted that the housing style chosen must emphasize individual privacy while providing an option for shared spaces. Additionally, the importance of having on-site support built into the housing model was highlighted by a participant stating that housing complexes without support typically require more police interventions than housing complexes with support. In housing with support, the staff are generally able to handle incidents independently as they occur and only require police interventions when things escalate to an emergent situation.

Additionally, while many of the top-ranking housing styles would fall into the category of communal living, there must be a balance between group living, independent living, and privacy. One participant stated that while group housing and communal spaces are beneficial to allow individuals to build social connections and improve their quality of life, they also create the potential for increasing interpersonal tensions and varying stabilization rates of individuals. Therefore, it is important to optimize the number of individuals sharing any communal space to maximize the benefits while minimizing the risks.

Table 3. Ranking of the potential housing styles.

Ranking	Housing Style
1	Supported living facilities
2	Shared housing with support

3	Assisted living facilities
4	Apartment complexes
5	Tiny homes
6	Long-term care facilities
7	Shelters
8	Shared housing with no support

Discussion and Conclusions

The assessment of current housing models, specifically Housing First (HF), indicates that current models are failing to adequately support complex clients. The general benefit of HF is clear and simple: providing individuals with stable housing enables them increased access and encourages increased usage of other supports and services in order to address their other co-occurring conditions (ie., ABI, MHSU). The reason that this is less effective for complex clients is that it requires that individuals independently navigate the various systems and supports external to HF in order to receive that support, and difficulty doing this exact thing was identified as the fourth most obstructive barrier to stable housing for complex clients (see Table 1). Complex clients have a continuum of support needs, and some require more support than HF provides; enabling access to additional supports is simply not enough, complex clients require assistance in going through the process of actually accessing those supports. This is why coordinating and support navigating different supports and services was identified as the number one most important feature of this model (see Table 2) to include.

The determination of the actual housing style this model could utilize is more difficult to conclude due to a combination of a lack of clear research results and the limitations of Peterborough as a location. As previously established, the limited availability of housing in Peterborough is one of the major barriers to stable housing for complex clients. Additionally, there is not currently a housing model specifically designed for complex clients, and combined with a lack of current research on the optimal style of housing for complex clients, makes it difficult to state with any confidence what specific style from those listed would be best. Rankings of housing styles varied between surveys, but the two styles which most commonly ranked in the top two are supported living facilities and shared housing with support.

Additionally, as previously established, it is important that each person has their own space, and that the use of communal spaces is available but not required. Therefore, a set-up where each individual has their own bedroom, bathroom, living space, and kitchen is ideal. However, this may not be practical in the Peterborough region with its current housing stock and resource allocation. Recognizing this, each individual should at minimum have their own bedroom, and a scheduling system should be used for shared living spaces as much as possible in order to ensure that each individual has independent usage of those spaces.

The housing units could be all together in one location (ie., an apartment building or tiny house community) or separated; together is ideal for maximizing the efficacy of the model, but separated is likely more practical for implementation within Peterborough. If the units are together, a minimum of one unit should be reserved for staff use in order to implement 24/7 support. If the housing units are separated then the staff housing should be centrally located and easily accessible from each client's housing. Having a unit for staff members to rotate through can allow for staff to be there and provide support at any time. There should be a communal space for clients to gather socially, run activities and support groups, hold continuing education classes, as well as job skills training and other life skills workshops. If the housing units are together then this space would be part of the building design; if the housing units are separate, then this space should be centrally located and easily accessible from each client's housing. This 24/7 support is also critical to reducing client contact with the criminal justice system by reducing the frequency of police interventions. Specifically, reducing negative interactions between clients and the criminal justice system, which allows for building greater rapport, trust and overall community.

The top three identified barriers (cost of housing, limited availability of housing, and high demand for housing) affect everyone but are more impactful for complex clients. These three barriers are larger issues within the Peterborough community, and unfortunately, this model cannot significantly address these issues. Addressing the cost, availability, and demand barriers is outside the scope and capability of this model; it would require larger, more generalized action. However, this model can aim to ease the generally greater impact these barriers have on complex clients. For many complex clients, government assistance (ie., Ontario Disability Support Programs and Ontario Works) are their only source of income, and therefore housing must be available on the limited budget this affords. In terms of overcoming the cost barrier in

this model, rent and associated costs must be scaled to each client's income. Additionally, there must be some form of rent control to prevent it from increasing to unaffordable levels and causing the client to lose stable housing due to affordability issues.

The other four barriers (difficulty navigating resources, bias and stigma against complex clients, difficulty managing relationships, and a lack of knowledge/ understanding of complex clients) can be addressed in this model, and are more specific to complex clients. These barriers are intertwined in obvious and subtle ways, meaning that if this housing model aims to overcome any of them, it has to address all of them. This all-or-nothing approach is intimidating but necessary and effective.

The cognitive, communicative, and perceptual impairments that frequently affect individuals post-brain injury make it difficult for complex clients to coordinate and navigate the fragmented siloed Canadian care system (barrier four in Table 1), in order to access the necessary resources for them to work towards recovery and improve their life satisfaction. Ensuring that this model provides 24/7 wraparound support in its design, coordinates external supports, and assists clients in navigating said external supports are key to it properly supporting complex clients. The dedicated case managers built into the model would be responsible for determining, in collaboration with the clients themselves, the most appropriate external supports (ie., MHSU, physical therapy, etc). These case managers would then be responsible for contacting the external organizations that provide said support, through the pre-existing partnerships (the second most important feature, as shown in Table 2) in order to make the necessary arrangements for their clients to participate in those supports. These arrangements could include but are not limited to, getting clients on wait lists, scheduling appointments, and obtaining necessary paperwork. This is more beneficial than case managers simply telling clients how to access these resources, as figuring out how to do that and doing that is a major barrier for complex clients utilizing them. This represents the incorporation of the two most important features to incorporate into this housing model as identified in this research.

The bias and stigma against complex clients (fourth-ranked barrier in Table 1) primarily stem from a lack of knowledge and understanding of brain injuries (seventh-ranked barrier in Table 7). In this model, partnerships could be made with local businesses and organizations for complex clients to get jobs or volunteer. This would incorporate key feature eight from Table 2, and the involvement of the model in managing the employment/ volunteering of complex clients

and would hopefully reduce hesitancy from businesses and organizations about working with individuals with complex needs. Through these partnerships, the community would gain knowledge and understanding about complex clients first-hand by working with them; providing information pamphlets is educational, but allowing complex clients to work alongside community members will build understanding and social connections more effectively. This therefore also facilitates client participation in the larger community (identified as the sixth most important feature as seen in Table 2), ensures clients are provided with diverse opportunities, (the seventh most important feature in Table 2), and facilitates community education and awareness (the fourth most important feature in Table 2).

Another avenue for partnerships and collaboration is with organizations that provide continuing education and organizations that special in education for special-needs individuals. Complex clients have complex needs, and therefore it is important to ensure that their educational pursuits are tailored to those needs for them to succeed. In order to accomplish this, the model could arrange for specific classes to be run for complex clients in a location that is easily accessible for complex clients. Transportation was identified as another barrier to accessing additional support, so it is important to ensure that the organizations that this model collaborates with are easily accessible. Arranging classes specifically for complex clients can help to ensure that those classes are tailored to their needs and help make clients feel more comfortable with attending. Classes and educational spaces inherently provide opportunities for collaboration and building relationships between clients as well, thus facilitating the formation of social connections between clients (the fifth most important feature). This incorporates building partnerships and collaborating (the second most important feature), providing diverse opportunities (the seventh most important feature), and providing opportunities for continuing education (the ninth most important feature).

Additionally, for clients who struggle with communication and managing relationships as a result of their brain injuries, this housing model must ensure that neither is an inherent requirement to accessing housing while also providing opportunities to work on these skills. If the pre-discussed features were to be included, these opportunities will be inherent in the employment/ volunteering, the educational opportunities, as well as through the individualized external supports arranged by a case manager. Additionally, the inclusion of programming and support groups, such as those provided by the BIAPR through their Day Service program and CC

Cafe, was identified as the third most important feature of this housing model and would also present valuable opportunities to improve those skills as well as form social connections (the fifth more important feature in Table 2).

If landlords outside of the organizations who manage/ work collaboratively with the model are involved, then case managers would act as an intermediary between the clients and the landlords until the clients are comfortable with managing that relationship themselves. Additionally, one concern mentioned by multiple participants was hostile unit takeovers and the exploitation of complex clients into sharing or giving up their housing. Having case managers as an intermediary in the landlord-tenant relationship would help to prevent hostile unit takeovers. If the resources were available for the model itself to own the housing it occupied, that would be the most effective method of preventing hostile unit takeovers. Preventing the exploitation of complex clients is more difficult, and would primarily rely on ensuring that complex clients understand and recognize the signs of exploitation, and how to protect themselves from exploitation. This would also be another benefit of having the housing units in one location such as an apartment building because a staff member could act almost as a receptionist to help ensure non-residents are not moving in and leaving when asked to.

It is difficult for this housing model to address certain barriers identified by participants but not included in the ranking; for example, the long waiting lists for existing supports and services as identified by the City of Peterborough (2022). The major contribution of this model to overcome that barrier is by increasing the efficacy of support in order to reduce the number of individuals actually on the wait lists. Specifically, by reducing the number of individuals who re-enter waitlists after leaving them initially due to a lack of ongoing support. However, more general and widespread efforts to reduce this barrier require reform outside the scope of this model. It is also difficult for this housing model to address the barrier of a lack of public transportation; this also requires more general and widespread reform that is outside the scope of this model. This model can make the best efforts to reduce this as a barrier by ensuring that all supports and housing units are easily accessible to each other by walking, public transit, or organization-provided transportation.

The identified key features all represent the formation of an environmentally complex (EC) foundation for this model. EC is centred around the multiple dimensions of communicative interactions, social contact, stimulation, variety in activity and opportunities, and voluntary

participation (Hengst et al., 2019). All of the key features identified for this housing model contribute to one or more of the fundamentals of EC. The support in coordinating and navigating different supports and services goes towards multiple dimensions of communicative interactions, stimulation, variety in opportunities, and voluntary participation. The inter-agency collaboration goes towards variety in activity and opportunities. The facilitation of community education and awareness goes towards the multiple dimensions of communicative interactions, social contact, and variety in activity and opportunities. Activity programming and support groups, the facilitation of social connections between clients, client participation in the larger community, providing diverse opportunities, facilitation of employment/ volunteering, and support in continuing education all go to all of the elements of EC. These key features also incorporate the principles outlined by Estrella et al. (2021) and Shaikh et al. (2019) of community integration, building social connections, and encouraging engagement in meaningful activities. Therefore, this model incorporates the features and fundamentals outlined in the existing literature as well as by participants of the survey and interviews.

This model and the incorporation of the identified key features, specifically the nature of the activity programming, can both work with and help recovery in the four primary areas that individuals most often struggle with after a brain injury as identified by Matheson et al (2020): communication, emotional dysregulation, behavioural, and cognitive functioning. The concept that this model will work with individuals is important, particularly in these areas, because recovery after a brain injury must be on the terms of the individual recovering; this model has to meet each individual at their ability level when they come in, then grow with them. This includes the fact that, fundamentally, the model must be Housing First based; as the literature established and participants re-iterated, the efficacy of other supports and services is irrevocably intertwined with ensuring that individuals have stable housing. The ultimate foundation of this model will be the collaborative work of multiple organizations, each bringing their areas of expertise and existing supports together in a more accessible, effective manner for complex clients.

Additionally, the features identified as key to including this housing model effectively address each of the major barriers, with most features effectively addressing multiple barriers. It effectively and thoroughly addresses the difficulty for complex clients to navigate resources, the bias and stigma against complex clients, the difficulties managing relationships due to the sequelae of brain injuries, and the lack of knowledge/ understanding of complex clients by the

larger community. While more generally addressing the barriers of cost, availability, and demand is outside the scope of this model, it does effectively reduce the disproportionate impact of these barriers on complex clients

This project was conducted with the BIAPR, and this model represents a novel method of achieving their vision to empower and engage individuals with ABIs to be active participants within their communities (Brain Injury Association Peterborough Region, n.d.a.). The mission of the BIAPR is to focus on the needs and concerns of individuals with ABIs, and this model is entirely focused on meeting those individuals' needs and ensuring they have the support to address their concerns (Brain Injury Association Peterborough Region, n.d.a.). This model would provide the BIAPR with another method of fulfilling their mandate to provide a range of community support services (Brain Injury Association Peterborough Region, n.d.a.). The fundamental values of the BIAPR ultimately underlie this model, as they should underlie all practices; everyone has the right to be treated with dignity and respect, everyone has the capacity to be a full citizen with rights and responsibilities, and every person is unique and valued (Brain Injury Association Peterborough Region, n.d.a.). By centring these aspects of the BIAPR within this model, it can be ensured that complex clients receive not only the support they need but also the treatment they deserve.

This housing model is fundamentally based on Housing First, and incorporates the following key features: support in coordinating and navigating different supports/ services, inter-agency partnerships and collaboration, activity programming and support groups, providing community education and awareness, facilitation of social connections between clients, facilitation of client participation in the larger community, providing diverse opportunities, facilitation of employment and volunteer opportunities, and support/ assistance in continuing education. These features, and the overall design of the model such as the incorporation of EC, all effectively contribute to reducing the impact of the identified barriers to stable housing for complex clients: cost of housing, limited availability of housing, high demand for housing, difficulty navigating resources, bias and stigma against complex clients, difficulty managing relationships, and a lack of knowledge/ understanding of complex clients by the larger Peterborough community. While the primary benefit of this model is too complex clients by easing their recovery and improving outcomes post-brain injury, there are also benefits to the support organizations and the entire Peterborough community.

Major Implications

One of the major implications of this research is that there is a significant need for this housing model, both for complex clients themselves and for the community. Another major implication is that this model is entirely feasible; the key features and systems that would underlay it already exist, they would just need to be combined into one, unified model. Organizations that serve complex clients and unhoused individuals already support them in navigating different supports and services, and many organizations have staff to assist in coordinating these services as well. There already exists a significant amount of collaboration and partnerships between organizations, with numerous participants reporting plans for increased collaboration in the future. There are also existing activity programming and support groups provided by organizations in Peterborough, for example, the BIAPR themselves. Through these programs, there is already the facilitation of social connections between clients, client participation in the larger community, facilitation of employment and volunteer opportunities, and support in continuing education. What is missing is the unification and centralization of these programs to increase their accessibility, effectiveness, and useability for complex clients, which is exactly what this housing model would offer.

This housing model also effectively addresses almost every barrier to housing for complex clients identified in this research. The difficulty navigating resources, bias and stigma against complex clients, difficulties managing relationships, and lack of knowledge/ understanding of complex clients by the larger community are all effectively addressed by the key features of this model. The cost of housing, limited availability of housing, and high demand for housing are all barriers that exist within Peterborough as a whole, and to effectively address them requires larger-scale changes than are within the scope of this model. However, this model can aid in reducing the disproportionate impact those barriers have on complex clients. The cost(s) that complex clients are expected to pay must be scaled to their income, which for many is composed of mostly or wholly government assistance (ie., ODSP or OW). However, it must be carefully considered how to ensure that clients are paying only a reasonable portion of their income towards housing; this housing model cannot take clients entire income as they are still people with things other than housing to pay for (ie., food, clothing, transportation, etc.). While this model cannot necessarily increase housing stock, unless it builds more housing structures, it

can increase the limited availability, and therefore reduce the high demand, by setting aside housing to be only for complex clients.

Additionally, this research has shown that the benefits of this housing model would far outweigh the associated costs. While the short-term costs of implementing this housing model would be greater than the current costs of programming and services, it would to a long-term reduction of other costs. For example, by reducing individuals interactions with the criminal justice system (ie., fewer arrests, fewer trials, etc.), the costs associated with the system would be reduced as well. The non-financial benefits make this worthwhile as well; the increased community safety, eased recovery and improved outcomes for clients, and ease the job of support organizations are things that do not necessarily have a dollar value but are immeasurably valuable. This model would be beneficial to complex clients, the organizations that support them, as well as the Peterborough community as a whole.

Limitations

The major limitation of this research is the lack of input from complex clients as this could unfortunately not be included in this research due to time constraints and ethical considerations. The input from the population that this model aims to serve is necessary to accurately represent said population, and the lack of that input means that this model may not accurately reflect their actual needs, wants, and struggles.

Another limitation of this research is the limited sample size; there were nine survey responses, and five interviews were conducted. The field of individuals who work with complex clients is small, so a small sample size was to be expected; however, this is smaller than hoped. Other similar studies, such as Estrella et al. (2021), had an average of 15 service providers participate, which would be a more preferable number. Small sample sizes present the risk of a lack of representation of a variety of viewpoints, opinions, and input.

The reliance on participant honesty is an additional limitation of this, and any similar, research. Many questions in both the survey and interviews required participants to criticize the organizations they work with and the programs/ supports they have worked to build, which people can be understandably hesitant to do.

Future Research and Next Steps

Future research should gather input from complex clients themselves regarding what they feel is limiting their access to and maintenance of stable housing, what features of a housing model would ensure they feel adequately supported, their feedback on current supports, and how they feel that such a housing model could be beneficial to them, the organizations they work with, and the community they live in. Additionally, complex clients could be asked for their feedback on the model created and the underlying research generated in this project.

Future research should also aim to determine and outline what resources would be necessary to implement this housing model. This would also allow for a more definite cost-benefit analysis; this research indicates that the benefits would far outweigh the costs, but a calculation of the actual costs is necessary to say this conclusively. Necessary resources include but are not limited to, costs, housing stock, staffing, community support, and organizational efforts. Once a housing model has been established that is reflective of the input from both service providers and complex clients, that model should be presented to other organizations and community partners for their review and feedback. With collaborations and partnerships established as key to the efficacy of this model, the model must be collaboratively created and edited.

The final, and arguably most important, future next step is advocating for the actual implementation of this or a similar, housing model in the Peterborough region. The research conducted and the model created is only as valuable as their value to the community, which is nonexistent if it is never actually utilized in the community.

Conclusion

This research represents the basis of the development and implementation of a housing model specifically to increase access to and maintenance of stable housing for complex clients in the Peterborough region. It includes plans for how to overcome the current barriers, as well as additional features key to include in order to maximize the effectiveness of the support provided by this model. While the exact physical space/ location required to host this model is as of now uncertain, some features of it including inter-organizational collaboration, support in navigation of different services, activity programs, and facilitation of community education have been outlined. Future research should aim to better plan this, as well as to understand the resources

required to implement the model in the Peterborough region. Additionally, further surveys and interviews should be conducted with complex clients themselves in order to ensure the model best supports them from their perspective.

If Peterborough is truly committed to the goal of ending chronic homelessness by December 31, 2025, this model is a necessity (Built For Zero Ptbo, 2020). With over 50% of the homeless population having a brain injury, providing them with the necessary support to exit homelessness is integral to ending homeless, and no current systems provide that (Stubbs et al., 2021). The resources to implement a model such as this exist in Peterborough; there are spaces to build apartment buildings or tiny home communities, there are organizations willing to support and staff it, and with more community awareness there could be community support. The major unknown factor is if the City of Peterborough has the means and willingness to provide the necessary funding.

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Appendix A

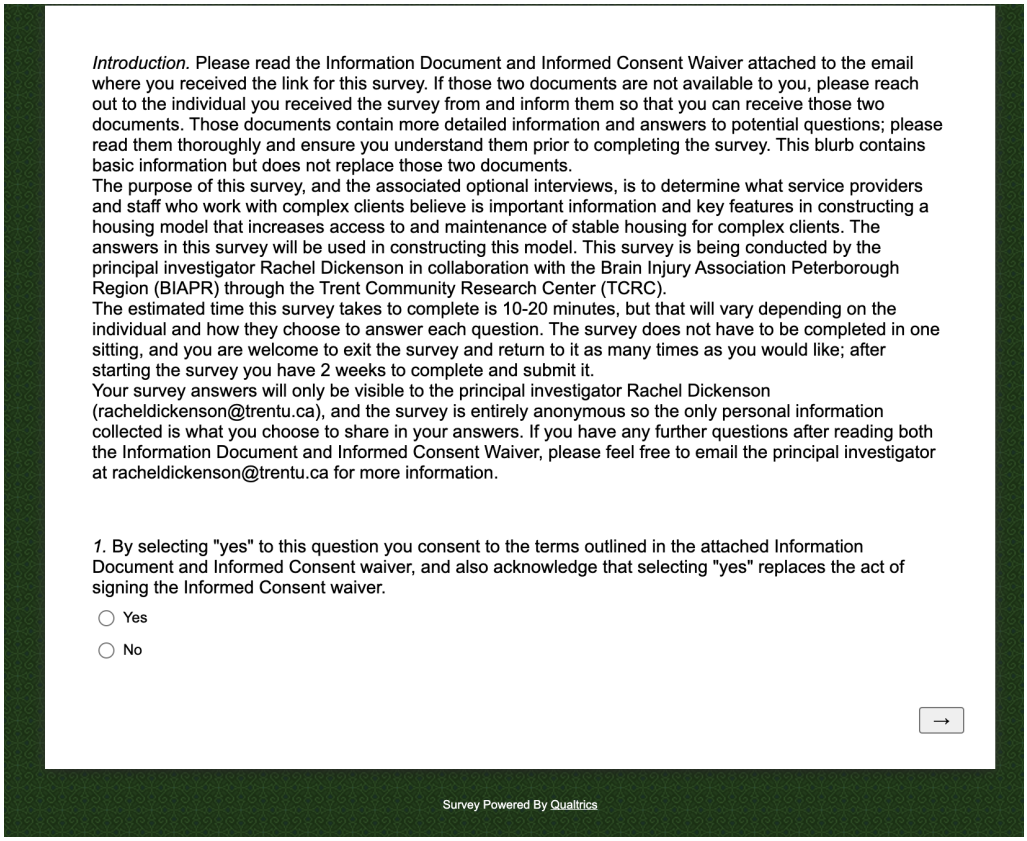

Figure 1. The first page of the survey including an information blurb and consent question.

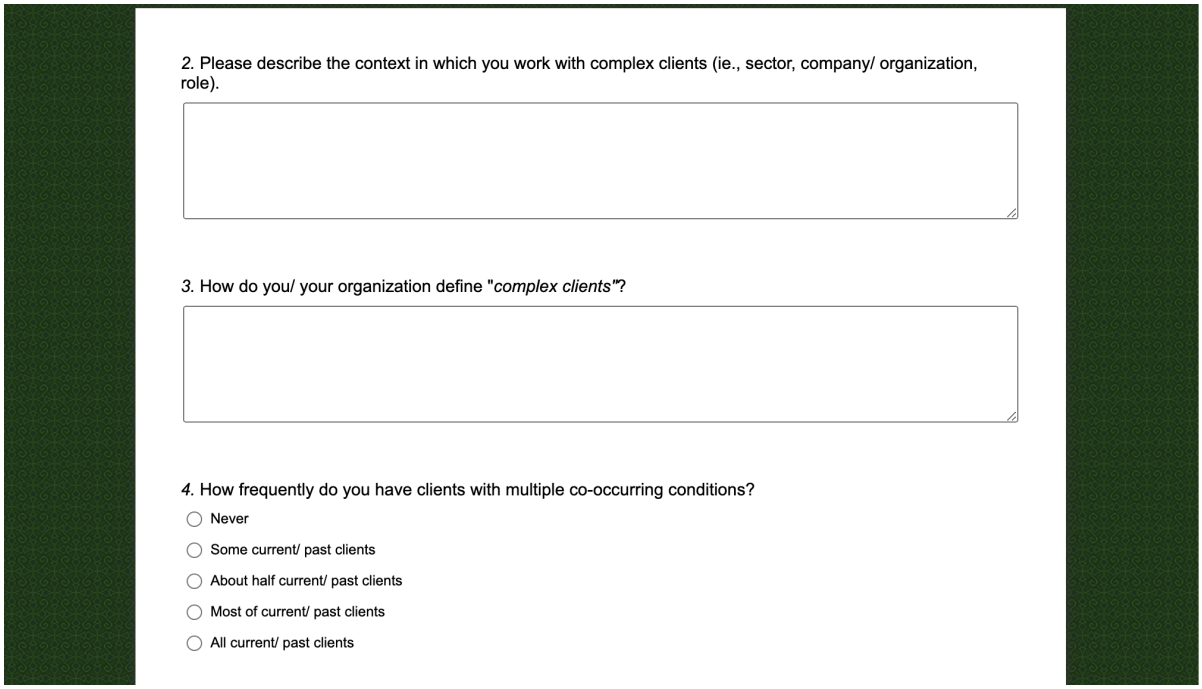

Figure 2. Survey questions two, three, and four; the first three content-based questions.

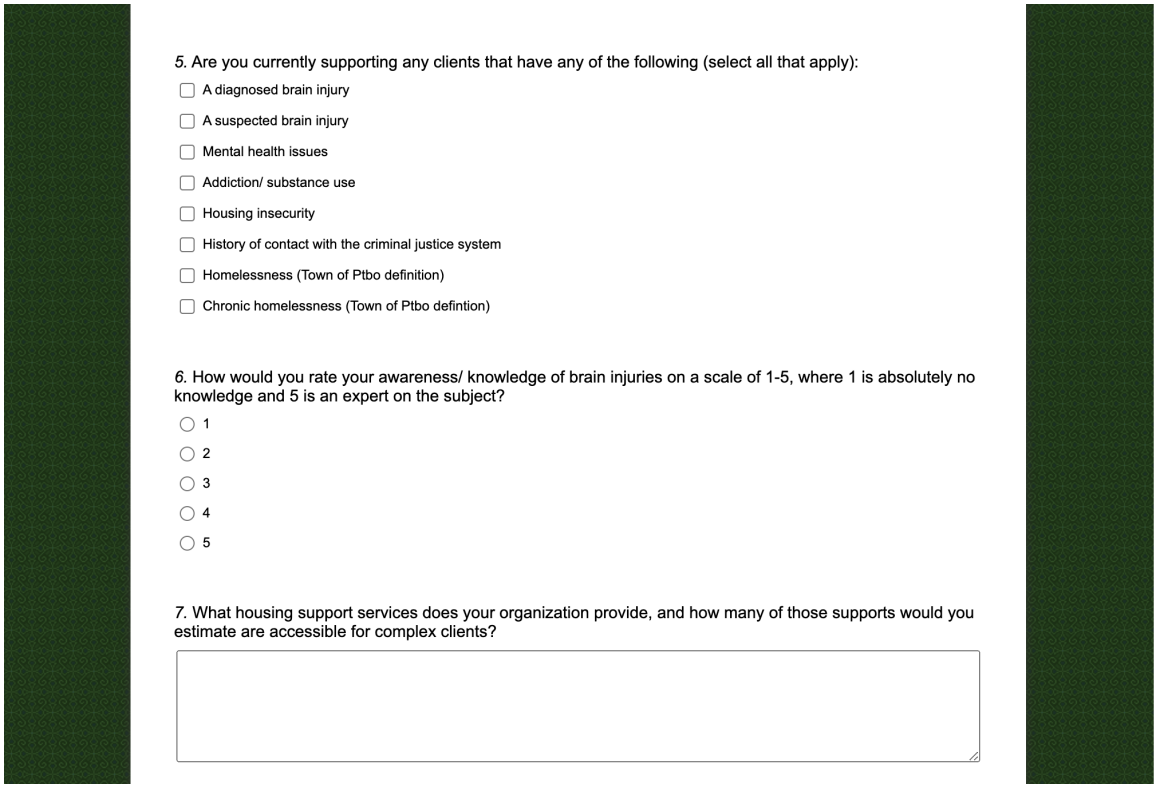

Figure 3. Survey questions five, six, and seven.

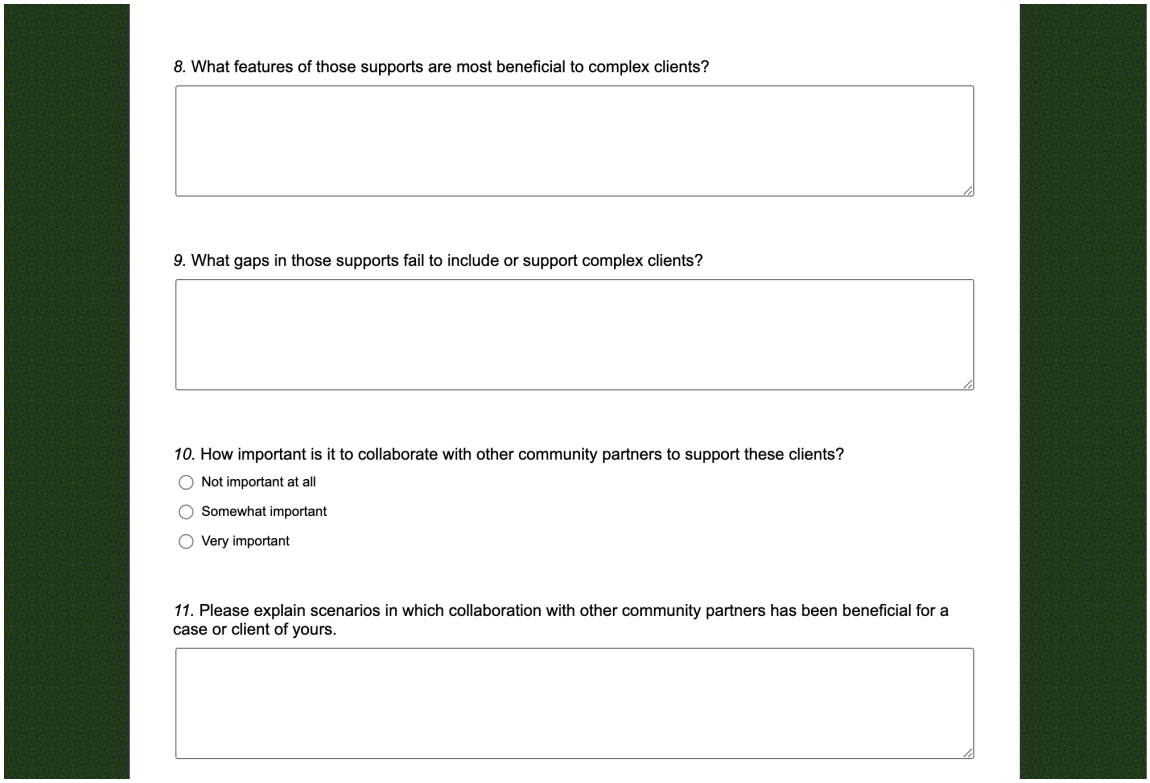

Figure 4. Survey questions eight, nine, ten, and 11.

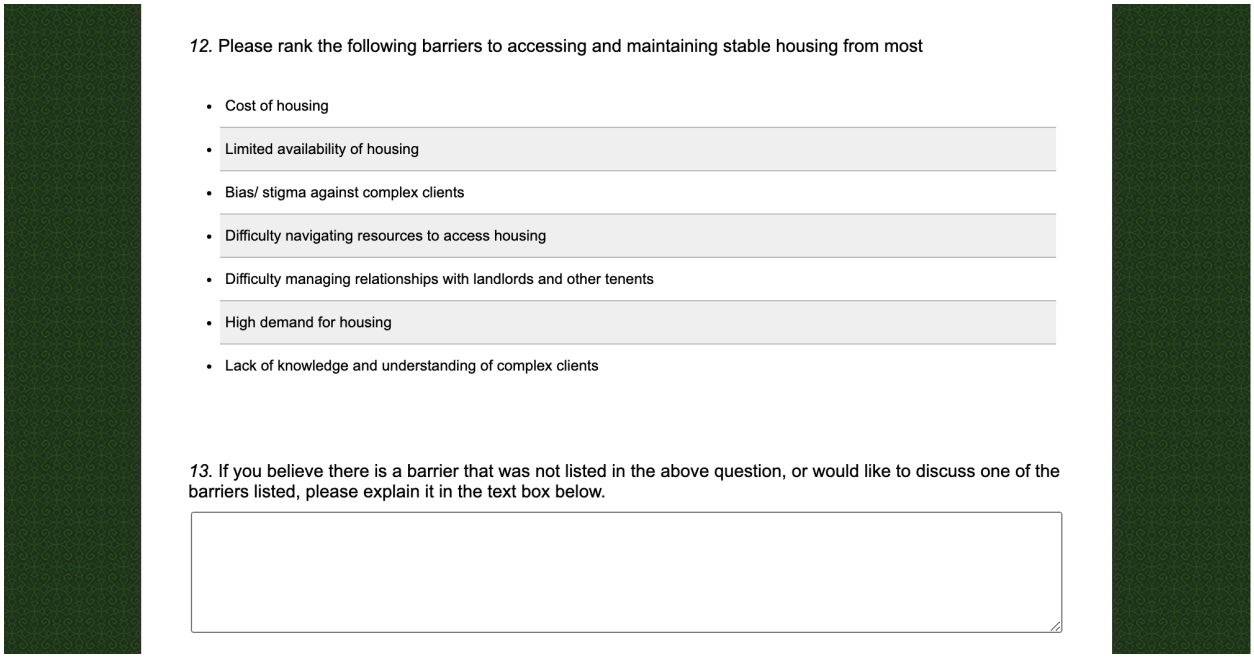

Figure 5. Survey questions 12 and 13.

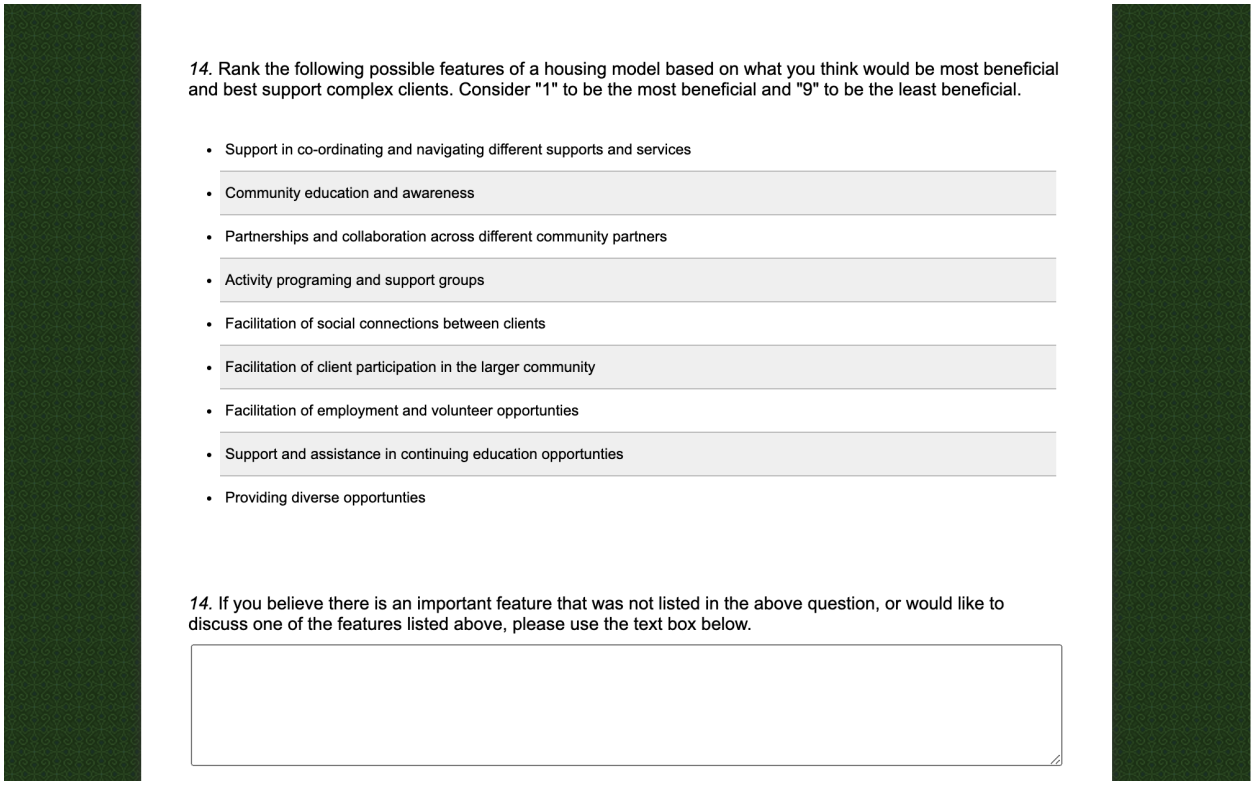

Figure 6. Survey questions 14 and 15.

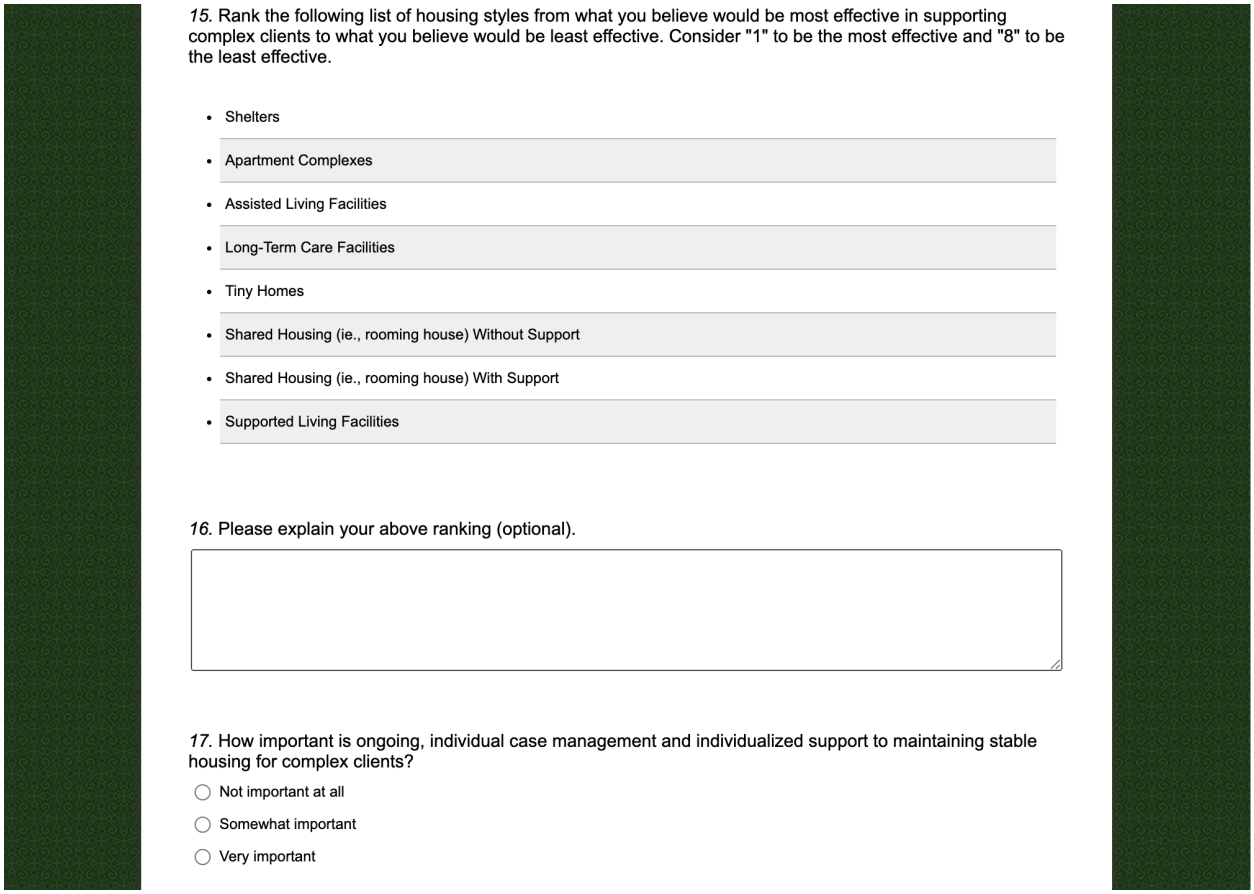

Figure 7. Survey questions 15, 16, and 17.

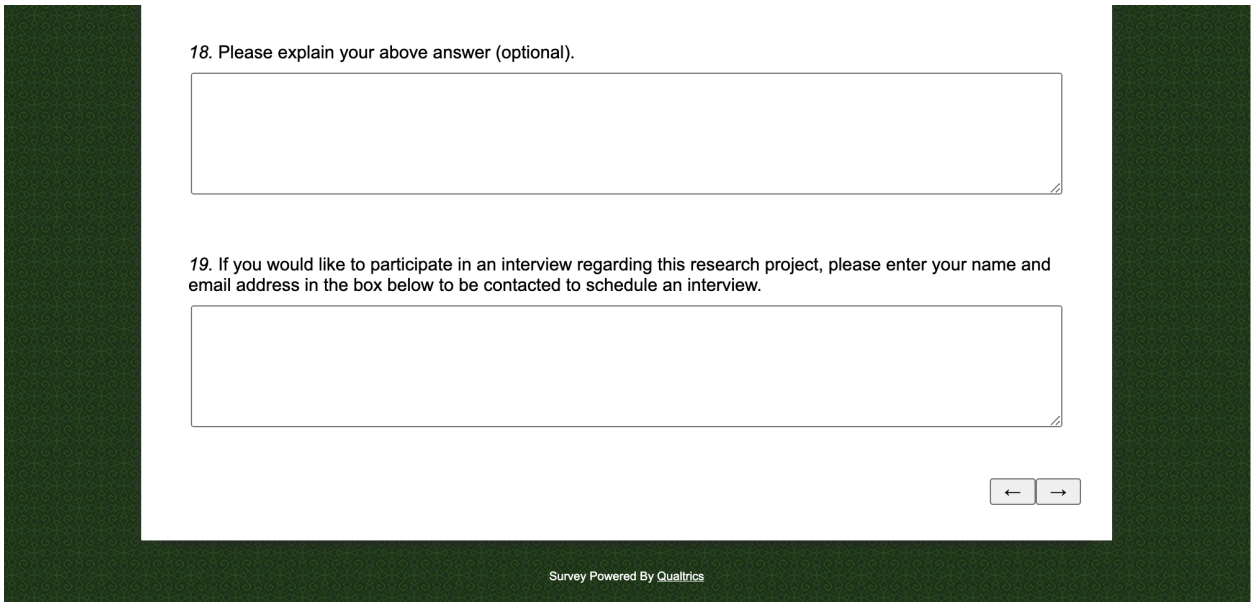

Figure 8. Survey questions 18 and 19; 18 is content-based, and 19 is the optional question to volunteer for an interview.

Appendix B

Table 1. Ranking of barriers from each survey response, part one.

Rank	Survey 1	Survey 2	Survey 3	Survey 4	Survey 5
1	Difficulty managing relationships	Cost of housing	Cost of housing	Cost of housing	Cost of housing
2	Difficulty navigating resources	Limited housing availability	Bias/ stigma	Limited housing availability	Limited housing availability
3	Cost of housing	Bias/ stigma	High demand for housing	Bias/ stigma	High demand for housing
4	Limited housing availability	Difficulty navigating resources	Limited housing availability	Difficulty managing relationships	Difficulty navigating resources
5	Bias/ stigma	Difficulty managing relationships	Lack of knowledge/ understanding	Difficulty navigating resources	Lack of knowledge/ understanding
6	High demand for housing	High demand	Difficulty managing relationships	High demand for housing	Difficulty managing relationships
7	Lack of knowledge/ understanding	Lack of knowledge/ understanding	Difficulty navigating resources	Lack of knowledge/ understanding	Bias/stigma
Other	-Clients income is lower than the Ontario Works -Prioritizing substances (not getting sick) over housing -Housing unit takeovers -Lack of support/ support people	-exploitation of vulnerable individuals (ie., wanting to help homeless friends, Hostile Unit Takeovers)	-lack of supported affordable housing -hostile unit takeovers		

Table 2. Ranking of barriers from each survey response, part two.

Rank	Survey 1	Survey 2	Survey 3	Survey 4
1	Cost of housing	Limited housing availability	Lack of knowledge/ understanding	Lack of knowledge/ understanding
2	High demand for housing	Cost of housing	Limited housing availability	Limited housing availability
3	Limited housing availability	Difficulty managing relationships	Difficulty navigating resources	High demand for housing
4	Bias/ stigma	High demand for housing	Cost of housing	Bias/ stigma
5	Difficulty navigating resources	Difficulty navigating resources	High demand for housing	Cost of housing
6	Lack of knowledge/ understanding	Bias/ stigma	Difficulty managing relationships	Difficulty navigating resources
7	Difficulty managing relationships	Lack of knowledge/ understanding	Bias/ stigma	Difficulty managing relationships
Other	-OW/ODSP income does not afford for safe housing, leading to clients being at risk of dangerous situations (ie., Hostile unit takeovers, proximity to illicit substances, loud/ busy living conditions)	-Lack of public transportation	-long waiting lists for existing supports/ services	

Table 3. Ranking of important features in each survey, part one.

Rank	Survey 1	Survey 2	Survey 3	Survey 4	Survey 5
1	Support in coordinating/ navigating different supports/ services	Support in coordinating/ navigating different supports/ services	Partnerships/ collaborations	Support in coordinating/ navigating different supports/ services	Partnerships/ collaborations
2	Partnerships/ collaborations	Community education/	Activity programming	Partnerships/ collaborations	Support in coordinating/

		awareness	and support groups		navigating different supports/ services
3	Activity programming and support groups	Facilitation of client participation in the larger community	Support in coordinating/ navigating diff supports/ services	Community education/ awareness	Community education/ awareness
4	Facilitation of social cxns b/t clients	Facilitation of social cxns b/t clients	Facilitation of social cxns b/t clients	Providing diverse opportunities	Providing diverse opportunities
5	Facilitation of client participation in the larger community	Activity programming and support groups	Facilitation of client participation in larger community	Facilitation of social cxns b/t clients	Activity programming and support groups
6	Providing diverse opportunities	Partnerships/ collaborations	Community education/ awareness	Activity programming and support groups	Facilitation of social cxns b/t clients
7	Support/ assistance in continuing education	Facilitation of employment/ volunteer opportunities	Providing diverse opportunities	Facilitation of client participation in larger community	Support/ assistance in continuing education
8	Facilitation of employment/ volunteer opportunities	Support/ assistance in continuing education	Facilitation of employment/ volunteer opportunities	Facilitation of employment/ volunteer opportunities	Facilitation of client participation in larger community
9	Community education/ awareness	Providing diverse opportunities	Support/ assistance in continuing education	Support/ assistance in continuing education	Facilitation of employment/ volunteer opportunities
Other	Stabilization once housed				

Table 4. Ranking of important features in each survey, part two.

Rank	Survey 6	Survey 7	Survey 8	Survey 9
1	Partnerships/ Collaboration	Partnerships/ Collaboration	Activity programming/ support groups	Community education and awareness
2	Support in coordinating/ navigating different supports/ services	Support in coordinating/ navigating different supports/ services	Support in coordinating/ navigating different supports/ services	Partnerships/ Collaboration
3	Activity programming and support groups	Support/ assistance in continuing education	Partnerships/ Collaboration	Support in coordinating/ navigating different supports/ services
4	Facilitation of social cxns b/t clients	Facilitation of employment/ volunteer opportunities	Facilitation of client participation in the larger community	Providing diverse opportunities
5	Facilitation of client participation in the larger community	Community education/ awareness	Facilitation of employment/ volunteer opportunities	Activity programming and support groups
6	Facilitation of employment/ volunteer opportunities	Providing diverse opportunities	Community education and awareness	Facilitation of client participation in larger community
7	Support/ assistance in continuing education	Activity programming and support groups	Providing diverse opportunities	Facilitation of social cxns b/t clients
8	Providing diverse opportunities	Facilitation of social cxns b/t clients	Support/ assistance in continuing education opportunities	Facilitation of employment/ volunteer opportunities
9	Community education and awareness	Facilitation of client participation in the larger community	Facilitation of social cxns b/t clients	Support/ assistance in continuing education

Other	-integrated community supports built on existing, working collaborations (challenge = staff are at max and struggle w/out top-down approach, high-staff turnover -> start-stop process -> backwards/ stalled progress)	-encourage taking accountability	-treatment-focused not just housing-focused -requirements to participate in programming	-multi-disciplinary team -scalable support -range of housing style options