HEADS TOGETHER

Proceedings of the
2020 BC Heads Together
Think Tank Initiative

HEADS TOGETHER THINK TANK

CONSTABLE Gerald Breese
CENTRE FOR TRAUMATIC LIFE LOSSES

Acknowledgements

The Constable Gerald Breese Centre for Traumatic Life Losses would like to acknowledge the support of the BC Ministry of Mental Health & Addictions and the Vancouver Foundation for their financial support of this critical initiative. Special thanks to Shauna Fenwick of Lead in Complexity, Niki Campbell of Light Your Fire Events, Aidan Henry and Stephanie Meine with Brink Events, Jason Guille of Sunset Labs, Kylie Hutchinson of Community Solutions Planning & Evaluation, and Tom Norman of Kapow Creative.

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FOREWORD

Dr. John Higenbottam
Clinical Professor, UBC Dept. of Psychiatry
Editor-in-Chief, Canadian Journal of Community Mental Health

The theme of the BC Heads Together Think Tank - addressing the intersections of mental health, addiction and brain injury, is both important and significant. It recognizes the reality that many people with mental illness have complex needs with concurrent substance use issues as well as histories of brain injury. They and their families need access to effective, wrap-around, integrated treatment and rehabilitation services. Instead of no open door, they need no closed door.

Unfortunately, this reality is not well understood or translated into action at the policy, decision making and service levels, despite well written reports and recommendations and a substantial body of scientific knowledge validating effective approaches. As a result, many current services are difficult to access, fragmented and focused on diagnosis. While attempts have been made to integrate mental health and substance use services at the Ministry level, this has not led to significant integration at the service level. Additionally, there is little integration of sparse community brain injury services with mental health and substance use services.

This lack of effective, responsive and integrated services is not only a serious problem for underserved people at the intersection and their families but for society in general. Many become the “frequent flyers” who are stressing our emergency rooms, and police and social services in our communities. Many are homeless. Many are addicted to street drugs to deal with their mental illness and history of trauma.

This is why the BC Heads Together Think Tank was so important in raising awareness and shining a light on the path to recovery for people with complex needs and their families. We must now continue to address and meet the needs of these people at the intersections of mental health, addiction and brain injury.

island health

Excellent care for everyone,
Everywhere, every time.

November 30th, 2020

To whom it may concern:

For too long substance use, mental health and brain injury have been respectively separated into different service delivery models. Clients with brain injury and substance use struggle to access appropriate supports.

We do not know how many individuals that suffer a non-fatal overdose have lasting deficits due to brain injury. We do know, anecdotally, that clinicians are encountering more individuals who have suffered a hypoxic brain injury due to opioid overdose. We do not yet have the epidemiologic data to quantify how many people this may be; Dr. Perry Kendall, interim head of the British Columbia Centre on Substance Use, estimates that hundreds to thousands of individuals may be so affected.

The few housing options that I know of in southern Vancouver Island for folks with brain injury count substance use as an exclusionary factor. We know that individuals who use substances prior to a brain injury are greater than 10 times more likely to return to substance use than a peer without brain injury. We also know that mental health is worsened by ongoing substance use and brain injury. Rehabilitation post brain injury is negatively compromised by substance use.

Some folks post hypoxic brain injury due to opioid overdose require assistance for daily living; some require admission into a care facility. We know from the statistics that most individuals suffering opioid overdose are young, otherwise healthy men. We do not have age appropriate facilities incorporating harm reduction available for these young men to live their lives safely.

It is devastating that individuals suffering repeated hypoxic brain injury due to overdose are falling through the cracks of the medical system. It is of the utmost importance that during the opioid crisis, we anticipate that many more folks with brain injury, substance use and mental health issues will be crossing paths with healthcare. It is also vitally important that the healthcare team have the tools and knowledge base to meet the needs.

The Heads Together Think Tank events brought together folks from the various sectors to discuss how we might meet the needs of individuals impacted by brain injury, substance use and mental illness. This conversation is just beginning. It is my hope that ongoing funding for this type of work be allocated, so as to further understand the nature of the issue and more importantly, to provide compassionate, evidence based care that supports our vulnerable clients.

Sincerely,

Elizabeth Plant, BA MD CCFP dISAM

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Executive Summary

According to the World Health Organization, Traumatic Brain Injury (TBI) will surpass many diseases as a major cause of death and disability by 2020 (Hyder et al, 2007). There are an estimated 160,000 new cases of brain injury annually in Canada, and an estimated national prevalence of 1.5 million cases (BrainTrust Canada, n.d.).

In 2020, the Constable Gerald Breese Centre for Traumatic Life Losses (CGB Centre) hosted a series of Think Tanks in response to growing concerns about the intersection of mental health, addiction, and brain injury. The purpose of the *BC Heads Together Think Tank* initiative was to collaborate with brain injury survivors, family members, service providers, decision-makers, and other stakeholders on how to improve and expand brain injury services in British Columbia, with a special focus on mental health and/or substance use services. This initiative was important to the CGB Centre because siloed services do not create gaps - they create massive chasms for individuals and families living with brain injury and concurrent disorders.

> **“The annual incidence of acquired brain injury in Canada is 44 times more common than spinal cord injuries, 30 times more common than breast cancer, and 400 times more common than HIV/AIDS. The incidence and prevalence of brain injury surpasses that of HIV/Aids, spinal cord injury, breast cancer and multiple sclerosis combined.”**

The *BC Heads Together Think Tanks* comprised four virtual sessions, each addressing a different focus. The ***Real People, Real Stories*** session shared the lived experience of individuals and families impacted by brain injury. The ***Rehabilitation and Community Supports*** speakers provided a snapshot of services for individuals living with the intersections of mental health, addictions, and brain injury in various health authorities. The ***Research and Prevention*** session featured new knowledge in brain injury research and prevention. Finally, ***Reinforcing Communities*** explored ways to ensure everyone living with a brain injury and mental health and/or substance use challenges has access to evidence-informed, client-centred, and integrated services.

Recurrent Messages from Presenters and Participants

The need

- Brain injury impacts families and communities, not just survivors.
- Brain injury has many causes, is often a hidden condition with complex needs and serious social and economic consequences and is the leading cause of death and disability under the age of 40.
- Many individuals with a brain injury experience challenges with depression and anxiety and/or substance use. When these issues are not addressed, many fall through the cracks of our siloed healthcare system at an alarming rate, which can lead to unemployment, homelessness, and/or criminality.

Current situation

- Thirty years of research and policy reports have not improved health and social system care for people with brain injury.
- Significant barriers to accessing mental health or substance use services exist for individuals with a brain injury and their families, including:
  - poorly coordinated and not-well-known services
  - lack of services outside major urban centres
  - challenges navigating the care and services system
  - denial of services to individuals actively using substances
  - lack of understanding on the part of health and social services providers
  - underfunding of community-based services and supports.

Addressing the chasms in care

- The lived experience of survivors and families must be included when developing policy and services.
- Access to community-based support is often dependent on a medical diagnosis. This creates a barrier for individuals who sustain a brain injury from intimate partner violence, non-fatal overdose(s), or repeated traumatic experiences.
- Funding is grossly insufficient for community-based support and rehabilitation.
- Community-based priorities for care include appropriate, affordable, and accessible housing with evidence-based, integrated, wraparound supports such as counselling, life-skills, vocational support, and family respite.

- Successful community-based models such as the Community Navigator and Assertive Community Treatment (ACT) Teams need to be expanded across the province.
- More research is needed in British Columbia to determine best practices in serving individuals with a brain injury and concurrent mental health conditions and substance use disorders.
- More education of health and community service providers is needed re: the concurrent disorders of brain injury, mental health and addiction.

> “Include the lived experience of survivors and families when developing policy and services.”

Call to Action

The Canadian response to the COVID-19 pandemic has been an amazing example of rapid response and cooperation. All levels of government have worked together to address the health, social and economic issues that arose during the pandemic. This demonstrates that intergovernmental cooperation is possible to address the interconnected impacts of health issues on social and economic well being.

While post-brain injury needs are different than those related to COVID-19, the impact of brain injury goes well beyond physical recovery. Impacts are felt by the survivor, the family, the workplace and in the community.

What's Needed

Federal Government

- Include the lived experience of survivors and families when developing policy.
- Develop a national brain injury strategy in collaboration with provinces, territories and other areas of federal health jurisdiction (First Nations, veterans, etc).

Provincial Government

- Include the lived experience of survivors and families when developing policy.
- Expect cabinet ministers to champion the integration of services for people with brain injury across multiple portfolios including health, mental health, community services, addictions, public safety, indigenous services, higher education.
- Foster partnerships between publicly funded and non-governmental support services to integrate policy and care.
- Mandate an integrated model for brain injury services at all health authorities.
- Improve funding for broad based community multi-service agencies and brain injury associations.
- Enhance provider education regarding causes, consequences and care of individuals and families experiencing brain injury.

In Communities

- Include the lived experience of survivors and families when developing policy and services.
- Meet with local federal, provincial and municipal politicians to raise awareness of local needs.
- Reach out to other brain injury providers in your community to discuss needs for integration and possible first steps.
- Volunteer with local brain injury services.
- Connect with local media to raise awareness of local brain injury needs.

Heads Together Think Tank

- Establish a coalition of survivors, families, providers, funders, government champions and community leaders and others to give input to development, expansion and integration of brain injury services.

> **“Brain injury can be a silent disability. I would like to have a way...to tell people the challenges I am facing. Too many times I am taken as stupid, avoiding or lying when I can’t do or understand something.”**

About the CGB Centre

CONSTABLE Gerald Breese
CENTRE FOR TRAUMATIC LIFE LOSSES


Constable G.V.M. Breese
September 10, 1953 – October 24, 1990

On May 19, 1990, while responding to a report of a stabbing incident, Constable Gerald Breese's police motorcycle was hit broadside by a car which had moved across two lanes of traffic. Although his lights and siren were on, the person in the vehicle failed to perform a shoulder check and hit him. Unfortunately, he suffered a significant brain injury and was in a coma for five days. It was unlikely he would return to work in the capacity he had. On October 24, 1990, Cst. Breese died at home of complications from the motorcycle crash. He left behind his wife, Janelle and two daughters, Myriah and Dale.

To commemorate the 25th Anniversary of Constable Breese's death, his family started the Constable Gerald Breese Centre for Traumatic Life Losses (CGB Centre) as a way to serve individuals and families who have suffered a catastrophic loss through death, injury, or other life-altering events.

Our Vision

A world where people thrive through traumatic life experiences.

Our Mission

Providing individualized and relevant support.

Board of Directors


Janelle Breese
Biagioni


Lyle
Biagioni


Dale
Breese


Myriah
Breese


Tori
Dach


Matthew
Woodford


Shirley
Johnson


Jessica
Gelowsky


Diana
Rahmany

Advisory Council

Trena Black/Ta Liais,
Indigenous Educator

Barbara Butler,
Brain Injury Survivor

Toni King,
Brain Injury Survivor

Derrick Forsyth,
Brain Injury Survivor

Cathy Stacey,
Family Member

Dr Don Castaldi,
Forensic Psychologist

BC Heads Together Planning Committee Team Leads

Janelle Breese Biagioni

Myriah Breese

Dale Breese

Diana Rahmany

Tori Dach

Introduction

In 2019/2020, the CGB Centre received funding from the BC Ministry of Mental Health and Addictions and Vancouver Foundation to host a series of think tanks in response to growing concerns about the intersection of mental health, addiction, and brain injury.

BC Heads Together Think Tanks

The purpose of the *BC Heads Together Think Tank* initiative was to collaborate with brain injury survivors, family members, service providers, decision-makers, and other stakeholders on how to improve and expand brain injury services and in particular, mental health and/or substance use services, in British Columbia.

The goals of the Think Tank sessions were to:

- share stories of real individuals and families living with brain injury
- explore ways to expand existing community supports
- discuss new knowledge in brain injury research and prevention
- explore ways to reinforce communities so that everyone living with brain injury and mental health and/or substance use challenges has access to evidence-informed, equitable, client-centred, wellness-focused, culturally safe, diversified, integrated, and flexible services.

The project initially planned for in-person events to be held in Nanaimo, Comox, New Westminster, Kelowna, Prince George, Fort St. John, and Haida Gwaii. With the advent of the COVID-19 pandemic, the event pivoted to hosting four half-day virtual events in October and November 2020, along with a website and social media strategy.

The themes of each session were:

- Real People, Real Stories
- Rehabilitation and Community Support
- Research and Prevention
- Reinforcing Communities

This report presents key highlights of each session along with specific calls to action and a short summary of the current state of knowledge regarding brain injury in British Columbia.

Overview of Sessions

Real People, Real Stories

Session Overview

What one support is most helpful to you, your family or your clients in the brain injury journey?
Real People - Real Stories
October 20, 2020

> **“Brain injury impacts families and communities, not just survivors. The lived experience of individuals is a vital lens when developing policy.”**

Real People, Real Stories shared the lived experience of individuals and families impacted by brain injury.[1] These stories informed listeners of the varied causes of brain injury and the impacts of these injuries on the self and families. Causes include, but are not limited to, physical trauma, toxic trauma, developmental delays related to childhood trauma, and organic injury, e.g., stroke and aneurysm.

Four survivors and three family members provided an up-close and personal look into the impact of brain injury on their lives. They described their struggles with physical, emotional, mental and interpersonal adaptations following injury. They also described significant challenges accessing services, especially when faced with mental health issues and substance abuse related to adapting to their injury.

All speakers described the vulnerability of adjusting in a world and a care system that has a poor understanding of the nature and consequences of their brain injury. Each speaker mentioned their hope that sharing their story will help raise awareness enough to begin reforms of the care system and better meet the needs of people with brain injury.

Participants in the live event commented on the need for advocacy and collaboration to address gaps identified by the speakers.

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[1] For more details on the speakers and session feedback, see “Session Feedback” in the Appendix.

Key Messages Arising from the Session

The Brain Injury Experience

- There are multiple sources of brain injury, including developmental, physical trauma, organic injury (stroke, aneurysm), and toxic trauma (post-overdose).
- Brain injury is a silent epidemic; it's often a hidden condition with no outward physical indicators, yet can result in life-altering behaviours.
- Brain injury in childhood can result in developmental delays.
- Brain injury has long-term and often lifelong effects.
- Difficulty "fitting in" is a common consequence of brain injury. This can result in a reluctance to engage with others, including services.

Chasms in Care

- There is a poor understanding of brain injury and its consequences in both the health and social care systems.
- The current care system is challenging for individuals and their families to navigate.
- Barriers exist for individuals with brain injury and their families to access mental health or substance use services.

Impacts of the Chasms in Care and Barriers

- Self-medication and substance abuse is a frequent coping mechanism post-brain injury.
- Brain injury, mental health, and substance use challenges affect the entire family.
- Family support is critical in the journey of recovery.
- Individuals and families need support and counselling to adapt to new realities after brain injury.

> **“There is a large body of individuals interested in seeking help for people with brain injuries and brain trauma, and there is a lack of services to identify and treat these issues, especially when these conditions co-occur with chronic drug use.”**

Participants Said

“Many of the persons I know with TBI/ABI are alone. People have given up on them for a variety of reasons. Or the people who haven’t are far away. So, these wounded/broken/hurt people are alone. They need HOPE to begin to heal and to reach out and to believe there can be change. Someone to come alongside and listen and ‘touch’ their lives. It sounds simplistic, but I think it’s huge.”

“I feel like brain injury services of any kind are too siloed - people can’t find the info they need...everyone is working towards their understanding of what is needed, but until now I’ve not seen a collaboration between agencies and services - we need an information clearinghouse.”

“Increasing funding to open and expand services in all communities, reducing barriers to access, such as cost and co-occurring disorders, etc.”

“Provide brain injury education for medical/healthcare professionals and Mental Health and Addictions counsellors.”

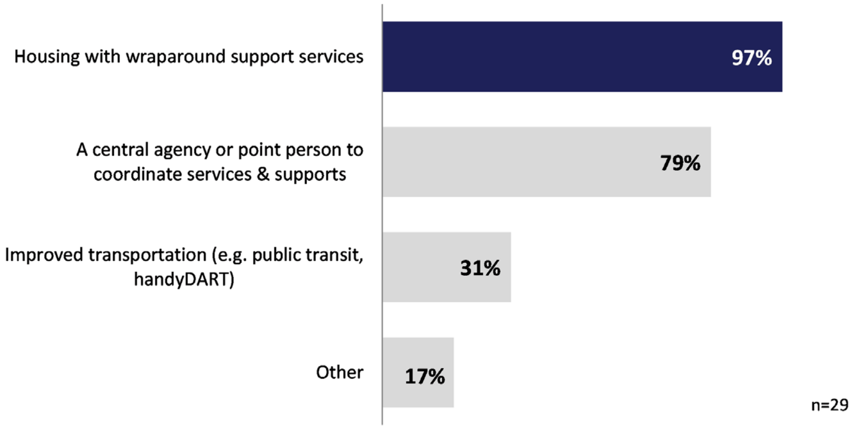
> **“Having a brain injury is hard, can be lonely, isolating, and leads to further issues such as mental health, addiction, and homelessness.”**

View the *Real People, Real Stories* segment here:
Heads Together Think Tank - Real People, Real Stories.

Needed Services

Individuals providing post-session feedback strongly indicated that housing would be the most helpful service in their community to support people living with a brain injury and mental health and/or addictions.

Participants overwhelmingly indicated that housing would be the most helpful service in their community to support people living with brain injury and mental health issues and/or addiction followed by a central agency or point person to coordinate services and supports.

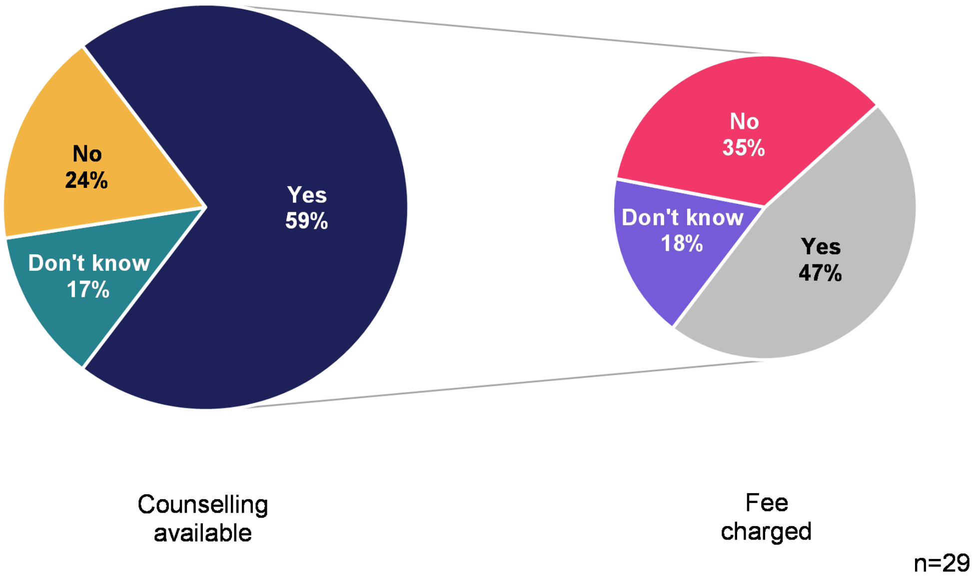


Additional services suggested were:

- affordable counselling, including trauma counselling
- common advocacy and awareness messages
- more specialised resources, i.e., addiction services appropriate for people with impaired cognition
- more training for people in healthcare and social services as well as the general public
- governmental commitment to providing services to those with brain injury as a priority
- provision of support services as soon as possible post-injury.

> **“Brain injury advocacy and support services are very important and need a bigger focus in front of Canadians and levels of government/ funders.”**

More than half of participants responding indicated that counselling for survivors of brain injury and/for family members was readily available in their community. Half of these indicated there was a fee for this counselling.



Rehabilitation and Community Support

> **“The longer people are disconnected from supports, the harder it is to get them connected.”**

Session Overview

The *Rehabilitation and Community Supports* speakers provided a snapshot of services for individuals living with the intersections of mental health, addictions, and brain injury in various health authorities.

The first panel of speakers described the Navigator model currently used at the provincial, regional and local levels which could expand throughout the province for brain injury. Other speakers addressed funding for brain injury services in BC. They highlighted the poorly linked, poorly coordinated, and not widely known services in communities, especially outside major urban centres.

The final speaker addressed the importance of safe, holistic, and relationship-based care that focuses on the needs of the client and not only the agenda of the provider.

Participants’ feedback indicated a high level of difficulty in accessing mental health and/or addiction services in their communities. They attributed these difficulties to a siloed system, referrals being challenging, excessive wait times, and restricted access. Service providers reported, *“...many hoops to jump through for our clients”* when attempting to access mental health and/or addiction services for clients living with a brain injury.

Key Messages Arising from the Session

Accessibility

- **Siloed services do not create just gaps, but massive chasms for individuals and families living with brain injury and concurrent disorders.**
- The Navigator model may be a good model for improving access, coordination, and integration of services across brain injury, mental health and/or addictions needs.
- Individuals living outside major urban centres have little, if any, access to support services.
- Some communities have some services, but these are often poorly linked, poorly coordinated, and not widely known.
- Significant barriers exist for survivors of brain injury and their families to receive counselling for brain injury, mental health conditions, and substance use disorders.
- Clients who are actively using substances are often denied services.
- Half of the participants who provided feedback reported difficulty accessing mental health and/or addiction services in their community. Where they exist, obtaining a referral can be challenging, wait times can be long, and access is often restricted.

Funding

- Funding is more directed towards acute care/crisis services than community-based supports, which results in people returning home without ongoing care.
- There is limited funding within health authorities for community-based supports for brain injury services in the health authorities.

Services

- Community-based priorities for care include appropriate, affordable, and accessible housing with wraparound supports such as counselling, life-skills, employment, brain injury services specific to women fleeing violence, and family respite.
- Collaborative, client-centred, and accessible care is the ideal with a focus on relationship-building when serving people with a brain injury.

Participants Said

“Many of the mental health services require doctor referral... but it is extremely difficult to find a doctor... and many mental health services won’t accept someone who is an active user of drugs or alcohol...There are no addiction treatment options readily available that don’t cost an absurd amount of money... and the brain injury resources and supports are not receiving anywhere near enough funding to be trained in mental health/addiction too...”

“There are no brain injury-specific organisations based on the West Coast (Ucluelet, Tofino). Accessing support requires travel to larger communities or access to technology which is a hardship for many. Accessing MH/SU services is possible, but they operate “business hours” and only now are expanding to outreach supports which are a long time coming.”

“I can refer a client to MHA services, but it may take months just for an intake. We have outreach services that help people with addictions and some harm reduction components, but no detox or treatment or transition programs in the Northwest region. People have to travel far, and waitlists are long. The whole Northwest region has only ONE remote Acquired Brain Injury Case Manager that can provide education and strategies and connect people with other medical and community services, but there are no concussion clinics, no resident neurologists or neuropsychologists, and it is very hard to connect a client with an occupational therapist or a speech pathologist. There is one other agency in one city that has a limited number of hours paid by Northern Health for helping brain injury survivors but hard to access.”

“I still feel barriers to service need to be reduced (whether that is from funders or agencies). Asking someone to seek addiction services only if they are not under the influence is not coming from a harm reduction or trauma-informed place. Perhaps money should be reallocated to larger needs, such as accessible counselling, rather than being distributed into smaller subsections.”

“I really took home the message that, although I might wish to plow ahead with a plan that makes sense to me, I need to pay attention to what the client wants/needs and that might mean something completely different from what I had envisioned for them.”

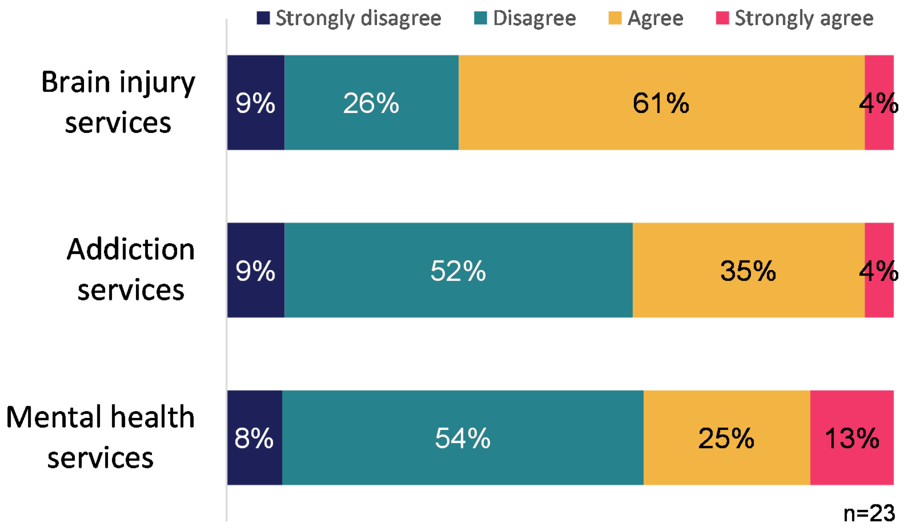
> **“There are so many hoops to jump through for our clients to access mental health services and addiction services.”**

View the *Rehabilitation and Community Supports* here:
[Heads Together Think Tank - Rehabilitation and Community Supports.]()

Accessibility of Services

Seventy-eight percent of participants providing feedback on this session indicated they were professionals versus families and survivors. These professionals felt that brain injury services are more accessible in their community than mental health or addiction services.

Participants responding believed that brain injury services were more easy to access in communities than mental health or addictions services.



> **“The outpatient support following stroke and other brain Injury is very limited in the North. And addictions services generally require moving to a large centre, such as Prince George.”**

Additional Supports Required

Ideas from participants regarding additional supports needed include:

- low-income or supportive housing
- housing outreach worker
- free or accessible personal, family, and group counselling, including trauma counselling
- non-time dependent case management
- post-detox addiction services
- a clearinghouse for one-stop shopping so that when people receive a diagnosis, they don’t have to go on a quest to find services
- brain injury walk-in
- family respite.

> **“While there are services available, there are waitlists, restrictions on accessing services, challenges of the referral process, and eligibility criteria.”**

Participants Said

"Organisations that don't turn people away because they have a brain injury or mental health issues."

"Addiction services that fit someone other than government workers. Programs for people who don't fit the box."

"A commitment to breaking down silos and accessing both forms of support in the community. Long-term mental health supports are needed as there are easily accessible short-term crisis-oriented services, but long-term contact for those experiencing mental health stress for a "regular person" is almost non-existent without a proper access [and a] diagnosis."

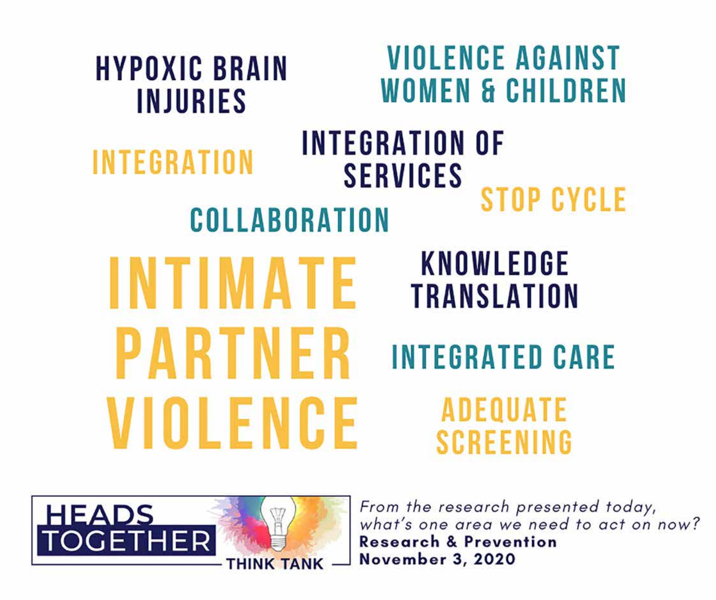
"Services for high functioning brain-injured as well. Too often the services are geared to those who are obviously injured, while those who can pass for 'looking normal' are overlooked. This is especially true when it comes to securing gainful employment post-injury. Many employers don't walk the walk of supporting the person with an invisible ABI. I'd love to see more services around gainful, meaningful employment for the brain injury survivor."

"A resource that bridges the gaps for individuals who have multiple things to deal with."

"Multiservice agencies... let's have more of those!!!"

Research and Prevention

Session Overview



From the research presented today, what's one area we need to act on now?
Research & Prevention
November 3, 2020

> **For every one NHL player who suffers a concussion in sport, more than 5,500 Canadian women sustain the same injury from domestic violence.”**

The *Research and Prevention* session featured reports from three different researchers. It began with an overview of the national environmental scan conducted by the Canadian Agency for Drugs and Technologies in Health (CADTH, 2020). This research surveyed 22 stakeholders in four provinces and conducted a focused literature review. Both survey results and literature findings signalled a need for greater integration of brain injury, mental health, and addiction services as key to improving care and patient outcomes. The report's survey respondents identified unmet needs, including limited funding or budget and associated resource impacts, timeliness to treatment, and patient access to treatment. Many of the barriers to treatment are structural, related to the siloed organisation of many health and social services.

Dr Julia Schmidt reported on her research that examined the significant impact on self-identity after brain injury and the need for counselling support.

Dr Paul van Donkelaar and Karen Mason reported on the number of women who have sustained a traumatic brain injury because of domestic (intimate partner) violence. Many of these women and their partners are living with the intersections of mental health and/or addiction challenges.

Key Messages Arising from the Session

Research

- The CADTH's environmental scan of services identified systemic barriers related to gaps in funding, access to care, a lack of integration of services across silos, and how people move across services.
- Systemic barriers may stem from a sense of protectionism and territorialism that continues to hold the silos in place.
- Recent research validates the experience of survivors and the impact of brain injury on self-identity and subsequent difficulties re-integrating into family and community life post-injury.
- Additional research highlights the incidence of brain injury related to intimate partner violence and that the aggressors may also have sustained a previous brain injury themselves.
- There is no research regarding recovery services for people with brain injury, addiction and mental health issues.
- More research is needed in British Columbia to determine best practices in serving individuals with brain injury and concurrent mental health conditions and substance use disorders.

Access to Substance Use and Mental Health Services

- Fifty to sixty percent of brain injury survivors experience challenges with substance use.
- Depression and anxiety is common among brain injury survivors.
- The criteria to access brain injury, mental health, and substance use services can be a barrier for individuals who may not have medical documentation, e.g., victims of domestic violence.
- More education and cross-training of professionals is needed regarding the intersections of brain injury, mental health, and substance use.

Participants Said

"Integrative education for brain injury workers, mental health and/or addictions workers [would improve services]. Especially brain injury education, [which is] needed for mental health and/or addictions service providers."

"Greater access to funding and support services to meet ALL needs of clients."

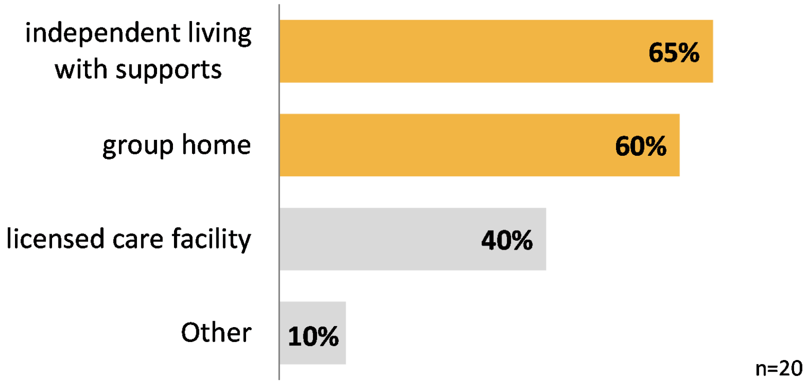
"...more applied research is required to support sustainable cross-jurisdictional funding models for integrated services and supports."

View the *Research and Prevention* segment here:
Heads Together Think Tank - Research and Prevention

Housing Supports

Participants providing post-session feedback indicated that independent living with supports and group homes were the most common types of housing available in their communities.

Independent living with supports and group homes were the most common types of housing available in communities.



Additional Supports

Ideas provided by participants for improving services for people with brain injury in their community included:

Access

- Greater access to funding and support services.
- Easier access to medical assessments.
- Better transportation.
- More frontline workers.
- More housing options for low-income individuals.
- One-stop services.
- Continuing support.

Other

- A livable income.

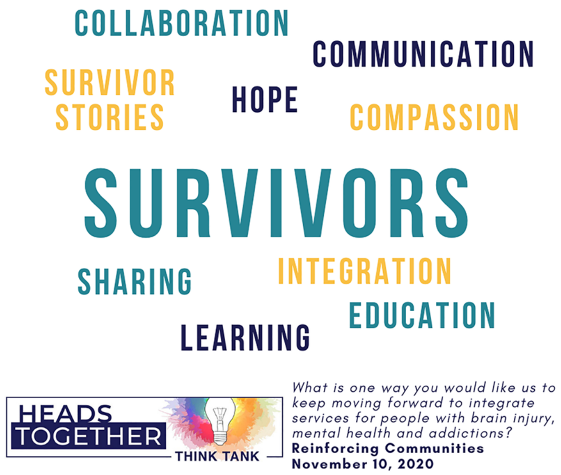
Education

- Integrative education for brain injury workers, mental health and/or addictions workers.
- Education for survivors and families about locally available services.
- More public education on understanding people that have survived a brain injury.

Provider improvements

- Collaboration between professionals.
- Less monopoly of providers.
- Integrated care for brain injury survivors and families.
- Coordinated case management.
- Neuro-psychologists and neuro-psychiatrists experienced with brain injury.
- A post-concussion clinic that is not just about physiotherapy.

Reinforcing Communities



What is one way you would like us to keep moving forward to integrate services for people with brain injury, mental health and addictions?
Reinforcing Communities
November 10, 2020

> **“Care should be focused on needs, not on diagnosis, as diagnostic-focused care perpetuates gaps and silos.”**

Session Overview

In this final event, Dr John Higenbottam, Faculty Emeritus, Douglas College, Clinical Professor, Department of Psychiatry, UBC, and Editor in Chief, Canadian Journal of Community Mental Health, began by presenting an outline of research and reports on brain injury published over the last thirty years.[2] Most studies demonstrated major problems and planning issues for brain injury services in BC. Studies also highlighted how the needs of survivors and their families have remained consistent and for the most part, unresolved. He concluded by suggesting that, given the poor integration of care across services, the focus be on client needs rather than a diagnosis.

Dr Elizabeth Plant, a mental health and substance use physician, spoke about how survivors of brain injury following non-fatal overdose are falling through the cracks at an alarming rate. She also pointed out how delayed neurological consequences after an overdose results in a greater potential of missed diagnosis and treatment. The need for appropriate housing and support for individuals surviving a non-fatal overdose and living with a hypoxic/anoxic brain injury is high. Communities across the country are experiencing an increase in overdose survivors.

Patty Flaherty of Connect Communities spoke about Connect’s community-based model, Life Redesign, and Scott Froom from Island Health spoke about mental health and/or substance use case management models in Nanaimo, such as the Assertive Community Treatment Team (ACT) model.

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[2] For an overview of these reports view “What We Currently Know” in the Appendix.

The session closed with a brain injury survivor speaking to the lifelong impacts of brain injury and the difficulties navigating mental health, substance use, criminal justice and homelessness as a survivor.

As a finale to the series, speakers called on all participants to advocate for capable, specialised, comprehensive, integrated, and needs-based, on-demand, community-based services for people with brain injury and their families.

Key Messages Arising from the Session

- Despite thirty years of reports and studies, individuals with brain injury continue to fall through the cracks at an alarming rate.
- The societal impacts of brain injury can include homelessness and criminality and is the leading cause of death and disability under the age of forty.

Service Needs

- Services need to be developed and integrated for people living with complex needs following brain injury.
- ACT (Assertive Community Treatment) teams are available in some communities. They support individuals with serious mental health needs.
- Access to services based on diagnosis creates barriers for individuals with an acquired brain injury and concurrent mental health conditions and substance use disorders.
- Housing supports with wraparound services such as Connect Communities are valuable.
- Survivors of brain injury are best served by therapeutic support teams.
- Support hubs with comprehensive services may be an approach in some communities.
- Education and cross-training for providers and greater public awareness are needed to address the intersections of brain injury, mental health, and addictions.
- Communities have similarities and differences. There is a need to influence policy and practice change in communities.
- Change requires a government champion with a mandate, resources, and commitment.

> **“They are falling through the cracks at a very disturbing rate.”**

Participants Said

"...legal advocacy, case management, counselling, family support services, social work, support worker contracts for community engagement and skills training, occupational therapy, adapted recreation services, and long-term resource hub rather than time-limited services."

"... the thing that stands out for me is the actual breadth of items that are listed as mental health or brain injury - and how poorly it is funded across the board!"

"In Nanaimo, we hosted a community dialogue on brain injury and opioid overdose in 2019, which included peers, health professionals, politicians, families, etc. We produced a report that included recommendations. How do we influence policy and practice change in our communities and across the province?"

"What stood out for me is [the] description of the need for 'whole person', long term support rather than silo thinking and supports. Also, his reminder that just because someone grows, it doesn't mean that they no longer need support. His reminder about the intense challenges of loneliness is important right now."

"...once again, and in agreement with all of the presenters, we need to tear down the silos...We have and build resources that work both for people with mental health issues and brain injury as well as addictions...although I sometimes wonder if the subject matter is too wide for one umbrella.... How do we logistically help them all? The statistics are simply mind-boggling."

> **“Family supports to assist all members, for their own benefit, and to educate them as to how to help the member with the brain injury. It would be of great value to also make them aware of all programs that can provide the services that they need (for themselves and the member with the brain injury).”**

View the *Reinforcing Communities* segment here:
Heads Together Think Tank - Reinforcing Communities

Reducing Homelessness

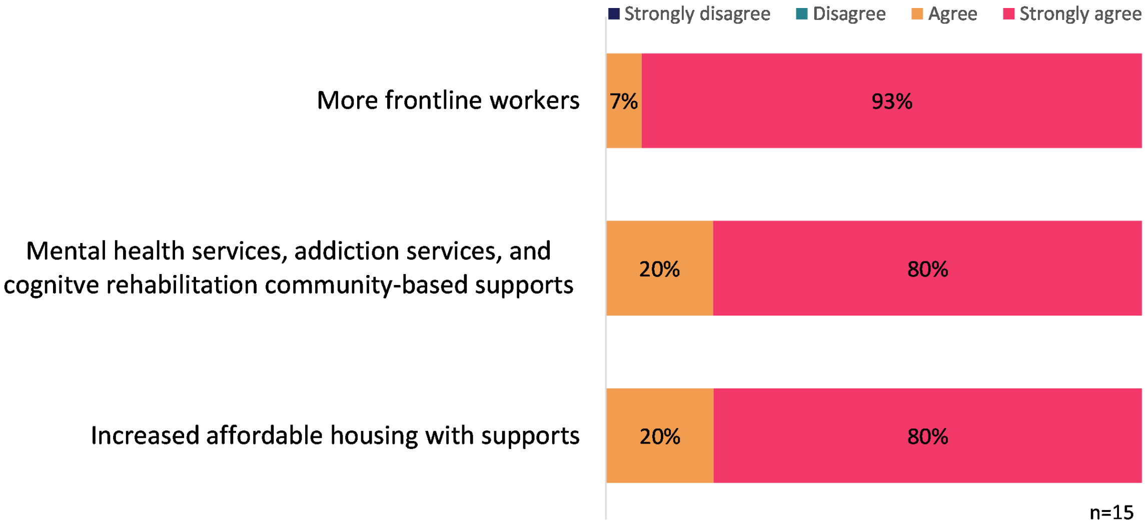
Respondents who provided post-session feedback strongly indicated that to reduce the number of people with brain injury who become homeless, communities need:

- more frontline workers
- more affordable housing with supports
- more mental health, addictions, and cognitive-rehabilitation community-based supports.

Other supports indicated by respondents to reduce the number of people with brain injury who become homeless include:

- building a caring community
- family supports to assist all family members with how to help someone with a brain injury
- education regarding supports available for survivors and families
- more open conversations in the household
- legal advocacy
- case management
- support worker contracts for community engagement and skills training
- occupational therapy
- adapted recreation services.

Participants responding strongly agree that communities need more frontline workers, mental health services, addiction services, and cognitive rehabilitation community-based supports, and increased affordable housing to reduce the number of people with brain injury who become homeless.



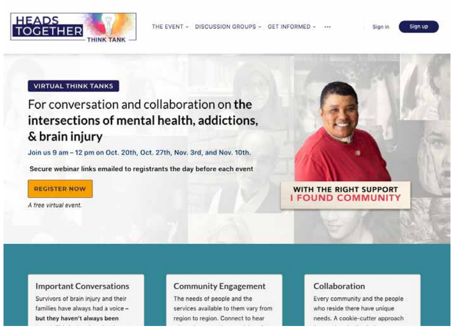
Community Integration and the Formerly Incarcerated

Over 80% of prisoners have suffered a brain injury (John Simpson, Cridge Centre for the Family, 2016). Respondents providing post-session feedback strongly indicated that community integration requires supportive housing, vocational training, ongoing counselling, and increased funding for community supports.

Additional supports mentioned for community integration for the formerly incarcerated include:

- acceptance and support rather than punishment
- long term specialised care and/or tertiary treatment, cognitive support and rehabilitation plans
- incorporated transition plan for medical team coordination and funding for addressing the brain injury.

Website and Social Media Response



VIRTUAL THINK TANKS

For conversation and collaboration on **the intersections of mental health, addictions, & brain injury**

Join us 9 am – 12 pm on Oct. 20th, Oct. 27th, Nov. 3rd, and Nov. 10th.

Secure webinar links emailed to registrants the day before each event

A free virtual event.

WITH THE RIGHT SUPPORT
I FOUND COMMUNITY

Important Conversations

Survivors of brain injury and their families have always had a voice – **but they haven't always been**

Community Engagement

The needs of people and the services available to them vary from region to region. Connect to hear

Collaboration

Every community and the people who reside there have unique needs. A cookie-cutter approach

In addition to supporting the four virtual sessions, the CGB Centre designed a *BC Heads Together* website as a province-wide hub for survivors, families, service providers, professionals, and community stakeholders to come together and share their experiences within the five health authorities.

Website and Social Media Use

Website (September 1, 2020 - December 10, 2020)	**1,882 visits from 1,601 users**
Website Discussion Groups	**14 groups, 215 members**
Facebook (September 30, 2020 - November 30, 2020)	**Total Reach: 10,842**[3] Organic Reach: 8,693 Paid Reach: 2,184 Total Impressions: 14,250 Organic Impressions: 10, 344 Paid Impressions: 3,906

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[3] Reach is the number of people who saw any content from a Facebook page or about a Page. This metric is estimated. Impressions are the number of times any content from a page or about a page entered a person's screen.

Calls to Action

The Canadian response to the COVID-19 pandemic has been incredible - all levels of government have worked together to address the health, social and economic issues that arose during the pandemic. This demonstrates that intergovernmental cooperation is possible to address the interconnected impacts of health issues on social and economic well being.

While post-brain injury needs are different than those related to COVID-19, the impact of brain injury goes well beyond physical recovery. Impacts are felt by the survivor, the family, the workplace and in the community.

What’s needed?

Federal Government

- Include the lived experience of survivors and families when developing policy.
- Develop a national brain injury strategy in collaboration with provinces, territories and other areas of federal health jurisdiction (First Nations, veterans, etc).

Provincial Government

- Include the lived experience of survivors and families when developing policy.
- Expect cabinet ministers to champion the integration of services for people with brain injury across multiple portfolios including health, mental health, community services, addictions, public safety, indigenous services, higher education.
- Foster partnerships between publicly-funded and non-governmental support services to integrate policy and care.
- Mandate an integrated model for brain injury services at all health authorities.
- Improve funding for broad-based community multi-service agencies and brain injury associations.
- Enhance provider education regarding causes, consequences and care of individuals and families experiencing brain injury.

In Communities

- Include the lived experience of survivors and families when developing policy and services.
- Meet with local federal, provincial and municipal politicians to raise awareness of local needs.
- Reach out to other brain injury providers in your community to discuss needs for integration and possible first steps.
- Volunteer with local brain injury services.
- Connect with local media to raise awareness of local brain injury needs.

Heads Together Think Tank

- Establish a coalition of survivors, families, providers, funders, government champions and community leaders and others to give input to development, expansion and integration of brain injury services.

Appendices

What We Currently Know About Acquired Brain Injury

by Janelle Breese Biagioni, RPC, MPCC
Founder & CEO
CGB Centre

Prevalence in Canada

Approximately 1.5 million Canadians live with the diagnosis of a brain injury (BrainTrust Canada, n.d.). There is no doubt there are many more undiagnosed and untreated who live with the devastating outcome of a brain injury. It is the CGB Centre's experience that at least three people are attached to every person who has a brain injury as a caregiver, support person, family member or friend. This means that as many as 4.5 million Canadians are struggling to move forward in life with little or no brain injury services. Canada wide, the incidence and prevalence of brain injury surpasses that of HIV/Aids, spinal cord injury, breast cancer and multiple sclerosis combined (BrainTrust Canada, n.d.).

Prevalence in British Columbia

Brain injury statistics are grossly understated in British Columbia. In 1988, it was determined that approximately 4,300 to 6,400 British Columbians suffered a Traumatic Brain Injury (e.g., blow to the head) per year (BC Ministry of Health, 1988). The broader diagnosis of Acquired Brain Injury, which includes strokes, tumours, and aneurysms, was estimated at approximately 22,000 per year (BrainTrust Canada, n.d.); however, these stats only include those who were diagnosed in a hospital or documented by a physician. Over the past thirty years, the numbers of brain injury survivors have grown significantly. By 2001, the number of brain injuries occurring in British Columbia was estimated to be between 7,800 and 14,000 per year (BC Ministry of Health Services and Ministry of Health Planning, 2002). The Northern Brain Injury Association and BrainTrust Canada currently report on their website 60 new cases per day or 22,000 cases of serious brain injury per year in British Columbia (Northern Brain Injury Association, 2014). Note that these stats only include those diagnosed in a hospital or documented by a physician. Long-time members of the CGB Centre have observed the numbers of brain injury survivors to increase significantly over the past thirty years, especially when factoring in sports-related concussions, non-fatal overdoses, and brain injuries resulting from intimate partner violence.

Risk Factors and Implications

Brain injury is inextricably tied up in other pressing social issues.

Opioid Use and Overdose

- A growing number of individuals are living with a hypoxic brain injury because of a non-fatal overdose (DeRosa, 2016).
- There were 21,824 opioid-related poisoning hospitalizations between January 2016 and June 2020 in Canada (excluding Quebec) (Public Health Agency of Canada, 2020).
- Individuals living with an anoxic or hypoxic brain injury caused by an overdose are often young people who will likely require a much higher level of care for life. Currently, the healthcare system is failing to keep a record of the number of incidences and victims in this area (Vescera, 2019).

Homelessness

- Fifty-two per cent of people living with homelessness have suffered a brain injury. Over 70% of that group became homeless after their first brain injury (Hwang et al., 2008).
- The average cost per year for an individual living on the streets is $53,144 (Distasio, 2017).
- There is a significant lack of appropriate supportive housing for individuals with a brain injury. Young overdose survivors who require a high level of care have no place to go and end up in inappropriate age facilities.[4]

Mental Health & Addictions

- An estimated 60% of brain injury survivors suffer from anxiety and/or depression (BrainTrust Canada, n.d.). The risk of suicide increases by 400% for a survivor of brain injury (CGB Centre, 2017). Suicide is the ninth leading cause of death in Canada (BC Ministry of Mental Health and Addictions, 2019).
- Brain injury survivors face a 200% increased risk of struggling with addictions after sustaining a brain injury (CGB Centre, 2017).
- Although the federal government has committed to providing $11 billion over the next ten years to improving home and care community support and mental health and/or addiction services, none are specifically targeted to brain injury (Government of Canada, 2018).
- Individuals who have had a concussion in the past are also at risk of having a second and may find that it takes longer to recover (U.S. Department of Health and Human Services & Centers for Disease Control and Prevention, 2010).

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[4] Dr. Elizabeth Plant, personal communication, November 30, 2020.

Incarceration

- Over 80% of those incarcerated have a brain injury. More than 60% sustained their first brain injury as a child and often as a result of abuse (John Simpson; Cridge Centre for the Family, 2016).
- It costs $115,000 per year or $315 per day to incarcerate a male inmate (John Howard Society, 2018).

Intimate Partner Violence

- Thirty-eight NHL players suffer a concussion every year. In comparison, more than 5,500 Canadian women suffer a brain injury through intimate partner violence (van Donkelaar & Mason, 2020). Many of these women have multiple brain injuries that have spanned five to fifteen years or more.
- This population is of particular concern because of challenges in meeting the criteria to gain access to brain injury services due to a lack of medical documentation. There has also been a dramatic increase in intimate partner violence during the pandemic (Ryan, 2020).

COVID-19

- There are growing concerns about neurological complications that stem from COVID-19. At present, we don't fully understand what the physical or cognitive impact will be long-term for any individual living with such a complication or what their needs may be (Carod-Artal, 2020).

A brain injury is for life. It does not mean each person requires lifelong support, but the likelihood of them requiring compensatory strategies for life is significant.

A System with Gaping Holes

> **“Brain injury can happen to anyone, anywhere, anytime.”**

Brain injury service providers are deeply committed and passionate about serving individuals and their families. While the survivor and the family are the experts of this journey, community supports are critical in helping them to redesign their lives. This is challenging when brain injury rehabilitation has not been a priority for any level of government and has resulted in a system with gaping holes.

These gaps include a lack of:

- clear and consistent best practices
- early intervention

- adequate supportive housing
- counselling for both the survivor and their family
- a continuum of seamless and integrated support that meets the needs of the individual for the length of time they need it.

Consider that:

- Brain injury survivors who also experience mental health, addictions and/or homelessness can be denied mental health or addiction services because their needs are considered too complex. Common responses to service requests are, *"We don't deal in brain injury"* or *"Deal with the brain injury first and then we can help."*
- Most rehabilitation services for brain injury survivors in BC are provided on a short-term basis only, e.g., six months or less. It takes two to five years of ongoing support, followed by occasional outreach to attain and maintain a level of rehabilitation success. The cost of five years of community supports at $120 per month or supportive housing at $80 per day is far less than the bill to taxpayers from inaction - $1,500 a day for acute care and $323 per day for federal incarceration.
- Brain injury services, including mental health and/or addiction services, are not readily or equally available throughout British Columbia. For example, survivors living in the north or the Kootenays do not have access to any services close to home. In fact, adequate brain injury services are lacking in many cities and provinces across Canada.

Siloes and Lack of Funding

The system that individuals and families must navigate is heavily siloed. Regardless of the health authority or size of an organisation, community-based services are grossly underfunded. The funding emphasis is on acute care services versus community-based care, which results in barriers to access services.

There are also structural barriers in the way individuals move through the system. This is notable for those with a brain injury and who also experience concurrent disorders. These barriers don't just create cracks for a person to fall through, they drop them into a massive chasm with devastating outcomes.

Brain Injury is more than a health care challenge. It has been pigeon-holed as a healthcare issue when, in fact, it is more than healthcare. Brain injury is the missing link in conversations around homelessness, incarceration and mental health and/or addictions. Other ministries such as the

Ministry of Attorney General, Public Safety & Solicitor General, Finance, Social Development and Poverty Reduction and Indigenous Relations and Reconciliation and of course, Mental Health and Addictions are needed to collaborate on this urgent issue. Moreover, the way in which all levels of government came together to deal with COVID-19 is urgently required to bend the curve on the brain injury crisis as well.

As we work hard to respond to community needs, it is much like keeping our finger in the dyke.

> **“These barriers no longer create cracks for a person to fall through but instead drops them into massive chasms with devastating outcomes.”**

A History of Inaction

Over the past three decades, there have been numerous reports and studies on brain injury services in British Columbia. The most notable ones are:

- **Program Review: Rehabilitation Services for Persons with a Traumatic Brain Injury** (BC Ministry of Health, 1988)
    - This report examined traumatic brain injury in BC, which resulted in the creation of the *Provincial Head Injury Program* with a budget of $1 million.
- **Restoring Hope** (Higenbottam, 1993)
    - This report found that many survivors of brain injury have mental health needs and problems associated with alcohol or substance use. It recommended that these comorbidities be addressed through the combination of a well-developed interdisciplinary team and effective case management.
- **Guidelines for Planning Brain Injury Services and Supports in British Columbia** (BC Ministry of Health Services and Ministry of Health Planning, 2002)
    - This report was developed to “*…guide the development of services and supports in a comprehensive, cohesive and coordinated way and to contribute to support progress in providing quality services and supports to persons with brain injury and their families.”* The Ministry of Health gave assurances that services and supports would be enhanced and would result in people getting the services they need, closer to home.

For a period of fourteen years from 1988 to 2002, these reports outlined major problems and planning issues for brain injury services in BC. They demonstrated that the needs of survivors and their families remained consistent and for the most part, unresolved.

In 2020, eighteen years since the development of the 2002 Guidelines, this situation still holds true. The needs of survivors and their families remain unaddressed, and perhaps more so when one considers the intersection of mental health and/or addictions. **There is not one person, department, funder, or politician who is currently responsible for brain injury services in the province.**

> **“Brain injury remains the orphan in our healthcare system, both provincially and federally. No one wants responsibility, yet everyone assumes someone else is taking care of it.”**

Twenty Years of Promises

Guidelines for Planning Brain Injury Services and Supports in British Columbia (2002)

In 1995 the Provincial Brain Injury Program expanded their mandate to include non-traumatic or what is now called Acquired Brain Injury (ABI) such as anoxia, aneurysm, and brain tumours. In 2002, the Ministry of Health decentralised the $10 million per year Provincial Brain Injury program among the five health authorities. The Ministry also embarked on a process to develop guidelines for planning brain injury services and supports in British Columbia. Members of The CGB Centre were invited to participate on an advisory committee as representatives for the BC Brain Injury Association and community.

Eventually, the committee declared to the government that the process of developing the guidelines was futile. They wanted action, not yet another report. Although the purpose of devolving the Provincial Brain Injury Program into the Health Authorities was intended to enhance services, it has resulted in survivors and their families attempting to navigate a siloed and fragmented system. Because the Health Authorities are autonomous, brain injury services do not sit in the same place in every health authority. For example, in Island Health, services fall under Home Care Services. In Northern Health, it sits within Mental Health & Substance Use. This translates to varying governance, community care, research and health and wellbeing practices province-wide. The services needed are not equally or readily available throughout our province as promised nearly 20 years ago.

Ignored Again

The British Columbia Neurotrauma Fund Contribution Act (1997)

In 1997, *Bill 8 - The British Columbia Neurotrauma Fund Contribution Act* was implemented. This fund is administered by the Rick Hansen Foundation. Funding from the government is capped at $2 million per year and comes from a 15% provincial surcharge on traffic violations and paid into the Victims of Crime Account and transferred to the Neurotrauma Fund. The purpose of the fund was to resource *"services and projects respecting neurotraumatic injury and victims of neurotraumatic injury."* It was announced the neurotrauma fund was to be dedicated to spinal cord and brain injury by way of *"prevention, rehabilitation, and research."*

Members of the CGB Centre sat on the committee to adjudicate grant applications for three years. In the initial years, the Rick Hansen Foundation allotted a total of only $350,000, to be paid annually to community-based brain injury programs through grants. The funds were never increased from $350,000 and in fact, were eventually terminated.

In 2014, the Northern Brain Injury Association (NBIA) put forward the report, *The State of Brain Injury in British Columbia (*Northern Brain Injury Association, 2014). The report asserts that *"…brain injury services and projects have received less than $1.5 million from the administrator of the Act, which has received over $34 million. Brain injury has not received any money from the fund since 2010."*

When the provincial government announced the Neurotrauma fund in 1997, approximately 36,000 brain injuries occurred annually in Canada compared to 1,100 spinal cord injuries. The number of brain injuries still significantly outweighs the number of spinal cord injuries in BC. The NBIA report notes that although *"brain injury occurs at a rate of 44 to 1 when compared to spinal cord injury, spinal cord injury is funded at a rate of over 60 to 1 when compared to brain injury."* While spinal cord injury does not deserve any less funding than it currently gets, brain injury deserves as much, if not more.

> **“Canada wide, the incidence and prevalence of brain injury surpasses that of HIV/Aids, spinal cord injury, breast cancer and multiple sclerosis combined.”**

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Session Feedback

REAL PEOPLE, REAL STORIES

PURPOSE

To share the experiences of survivors and families living with the challenges of brain injury, mental health and/or addictions.

Planning Committee

Myriah Breese
CGB Team Lead

Barbara Butler,
Survivor

Toni King,
Survivor

Cathy Stacey,
Family Member

Speakers

Geri Bemister Williams (Brain Injury Survivor) - "*Way Past Normal: From Addict to Advocate*"

Neil & Nicole Henderson (Brain Injury Survivor) - "*Discovering a Path Together*"

Cathy Stacey, Barbara Butler, Erin Sommerfeld, & Toni King (Brain Injury Survivors) - "*Up Close & Personal*"

> **"[This was] immensely informative. Hearing directly from those who have experienced brain injury provides insight that cannot be achieved in the theoretical world. Learning the details of the struggles on the road to victory is very eye-opening. I find it especially uplifting to know what the speakers have accomplished in spite of the challenges that they faced."**

Number of Participants: 169 registered, **83** live participants

REHABILITATION AND COMMUNITY SUPPORT

PURPOSE

To explore ways that rehabilitation and community supports can be accessed and encountered & effectively utilised by survivors, families, service providers and community members.

Planning Committee

Tori Dach,
CGB Team Lead

Sue McKinnon,
March of Dimes

Miki Flynn,
Flynn Counselling

Ashleigh Wasner,
Bill's Place

Amanda Rallings

Speakers

Tannis Cheadle (BC Brain Injury Association), Brent Page (March of Dimes), Cathryn Goodman (Interior Health), Kix Citton (Nanaimo Brain Injury Society) - "Navigator Model Panel Discussion"

Alison Hagreen & Carol Paetkau (Brain Injury Alliance of BC) - "Brain Injury, A Personal Challenge, A Community Response"

Dr Don Castaldi - "Supporting Individuals Through Valued Attachments"

> **"Very informative sessions. Illustrated the importance of client-centred support in the community for people struggling with ABI, mental health issues and/or addictions."**

> **"...there needs to be more funding geared towards general brain injury support as opposed to separating out different types of brain injury as a result of the funding."**

Number of Participants: 188 registered, **83** live participants

RESEARCH AND PREVENTION

PURPOSE

To share the results of the CADTH environmental scan and newly emerging research on intimate partner violence, brain injury and self-identity.

"Really valuable information on current research and best practices."

"Excellent presentations. Informative. I will be thinking about what I have learned, and how to apply it as I move forward in my profession."

Planning Committee

Diana Rahmany
CGB Team Lead

Kix Citton, *Nanaimo Brain Injury Society*

Dawn Waterhouse, *Island Health*

Uta Sbotofrankenstein
BC Support Unit

Wendy Young

Speakers

Kix Citton (Nanaimo Brain Injury Society) - "Ripple Effect: 2018 Symposium to CADTH Research"

Carli Wallington (CADTH) - "Care for Acquired Brain Injury and Concurrent Mental Health Conditions and/or Substance Use Disorders: An Environmental Scan"

Dr Julia Schmidt – "Doing and Being after Brain Injury"

Dr Paul van Donkelaar & Karen Mason - "Moving Ahead: Exploring Brain Injury in Intimate Partner Violence

Number of Participants: 191 registered, **68** live participants

REINFORCING COMMUNITIES

PURPOSE

To explore needs and bring innovative ideas from different areas in the province to one place for sharing, review, and expansion.

"It is so clear that more resources are needed and also that coordinated efforts are needed with the support of the leaders in government to make this more of a priority."

Planning Committee

Dale Breese,
CGB Team Lead

Geri Bemister Williams
Ravenswood Consulting

Karen Mason, *SOAR*

Jessica Gelowsky, *CGB*

Whitney Macrae,
BC Centre for Ability

Speakers

Dr John Higenbottam (UBC/Douglas College)- "Reinforcing Communities: Developing Services for People with Complex Needs"

Dr Elizabeth Plant (Mental health and substance use physician) - "Toxic Brain Injury: A Hidden Epidemic in the Opioid Crisis"

Scott Froom (Island Health, ACT) - "Mental Health Substance Use (MHSU) Case Management Models with the Health Authority"

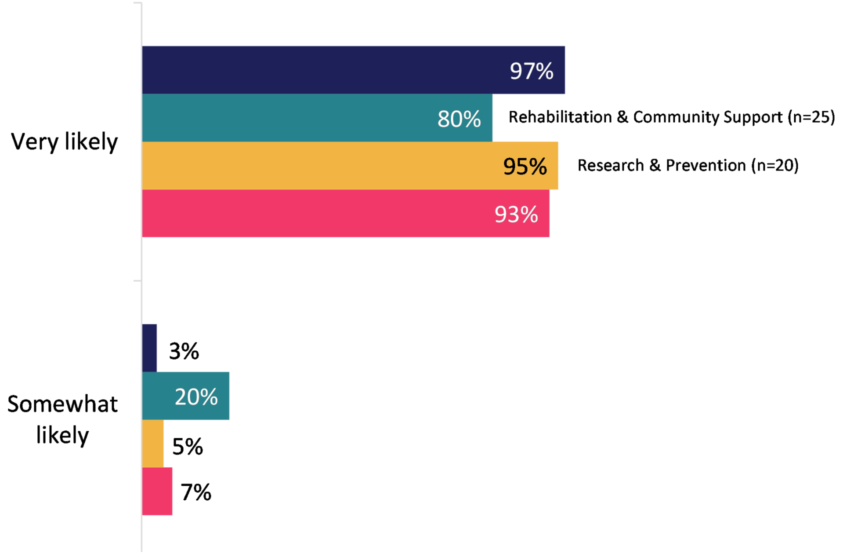
Patti Flaherty (Connect Communities) - "Life Redesign after Brain Injury and Stroke"

Derrick Forsyth (Brain Injury Survivor) - "To Care is to Cure"

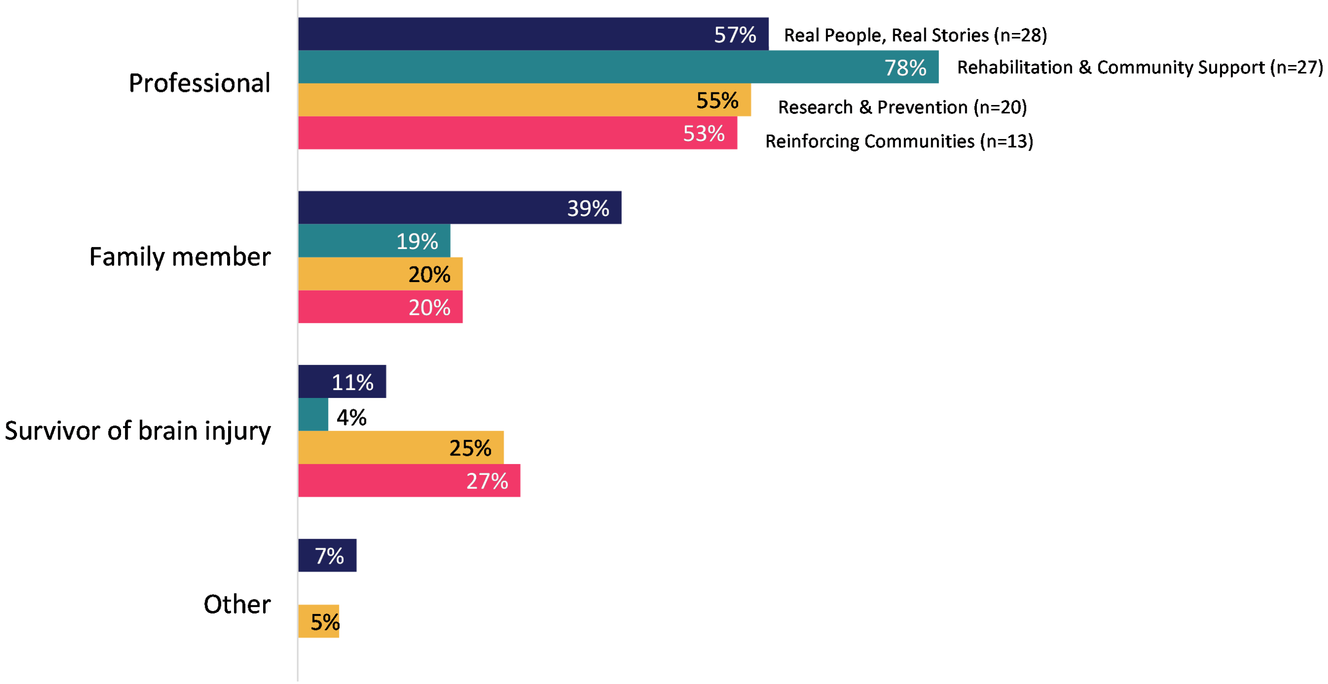
Geri Bemister Williams (Brain Injury Survivor) - "Offering Solutions to Reinforcing Indigenous Communities"

Number of Participants: 202 registered, **61** live participants

Participants were very likely to attend another Heads Together Think Tank event.



Most participants were professionals



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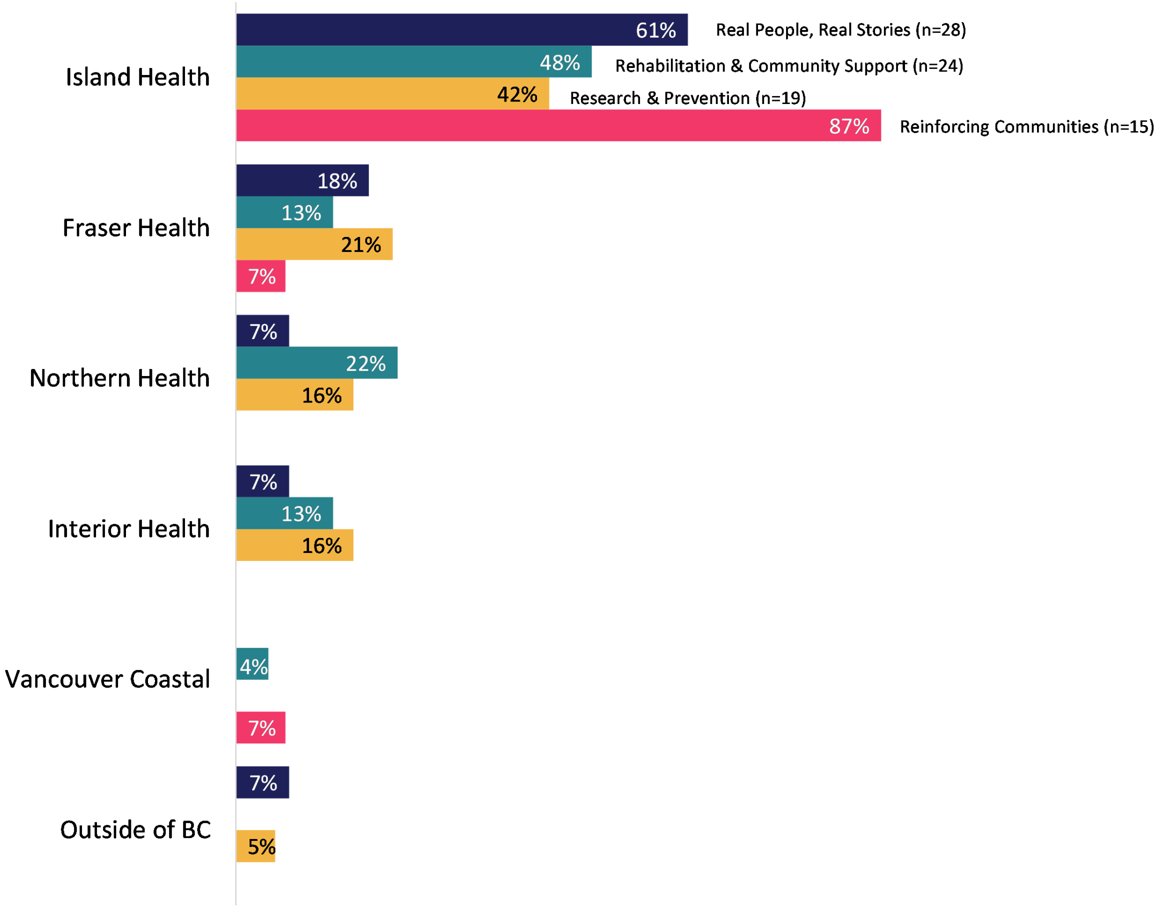

> Canada wide, the incidence and prevalence of brain injury surpasses that of HIV/Aids, spinal cord injury, breast cancer and multiple sclerosis combined.

HEADS TOGETHER
THINK TANK

CONSTABLE
Gerald Breese
CENTRE FOR TRAUMATIC LIFE LOSSES