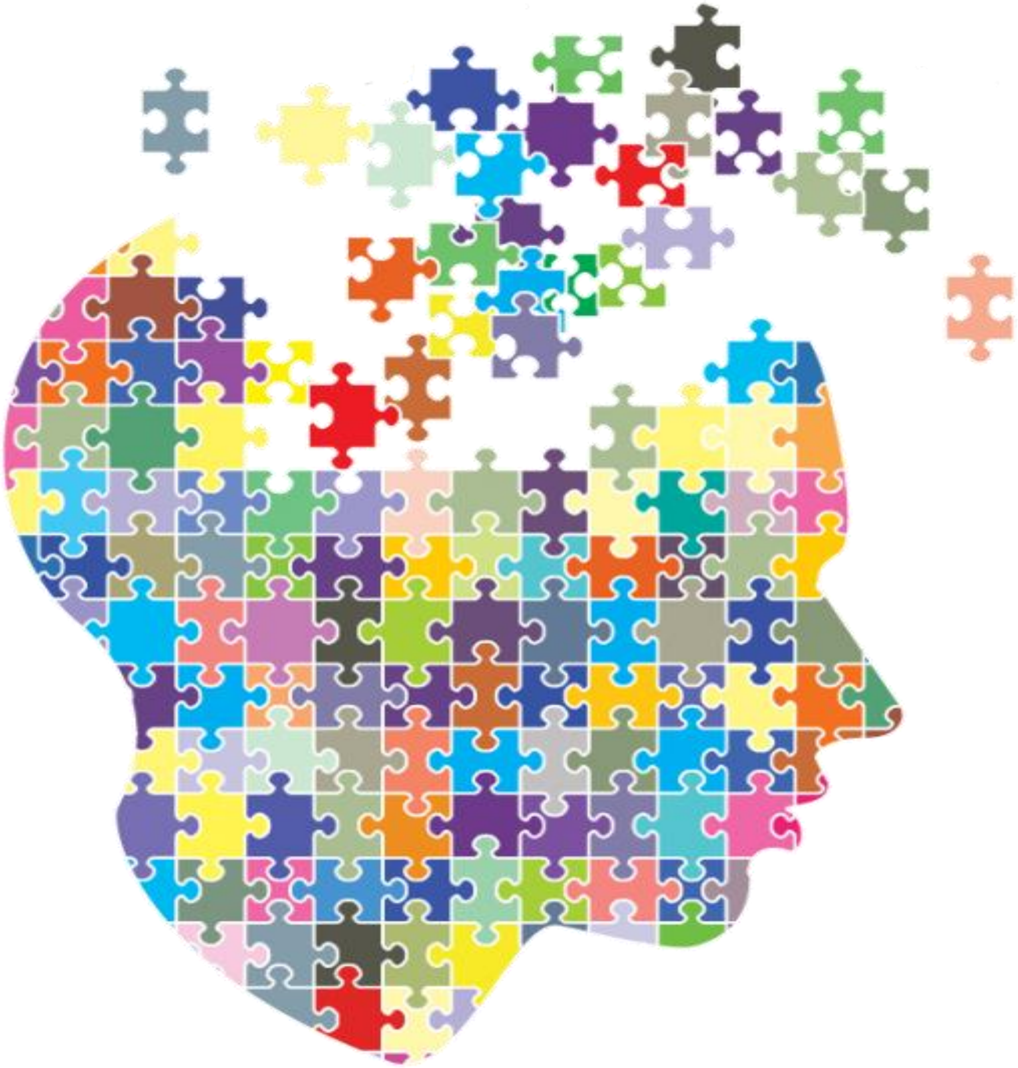

Community Brain Injury Service Integration Project Report
January 2026

A collaborative project between Interior Health and the University of British Columbia Okanagan

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Acknowledging Our Advisory Council

The Community Brain Injury Service Integration (CBISI) Project was guided by an Advisory Council whose insight, experience, and collaboration were essential in shaping this work. The Council brought together voices from across health, research, housing, community, and lived experience, ensuring that the work reflect a shared understanding of both the challenges and opportunities in improving care for individuals living with brain injury (BI).

We extend our sincere gratitude to each member for their time, expertise, and commitment to advancing equitable, coordinated BI services across the Interior region. Their guidance helped ensure that this project remained grounded in community needs and informed by diverse perspectives.

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Land Acknowledgement

We would like to recognize and acknowledge the traditional, ancestral, and unceded territories of the Dãkelh Dené, Ktunaxa, Nlaka’pamux, Secwépemc, St’át’imc, syilx, and Tŝilhqot’in Nations where we live, learn, collaborate and work together.

Indigenous Partnerships

We recognize those whose ways of being and knowing contribute to the Interior region Indigenous landscape and humbly thank the Traditional Keepers of these lands, past, present, and future, and recognize our role as allies in the pursuit of reconciliation and justice.

Executive Summary

BI is a prevalent and high-impact health condition that intersects with health, housing, mental health and substance use (MHSU), justice, and social services. Despite BI's profound and lasting impacts, BI supports remain fragmented, inconsistently accessed, and poorly coordinated across sectors. Individuals and families are often required to navigate complex systems, and structural barriers that limit access to specialized or BI-informed supports and undermine recovery outcomes.

The Community Brain Injury Service Integration (CBISI) project was initiated to bring a coordinated, cross-sector lens to understanding and strengthening BI service and supports across the Interior Health region. Led by IH's Trauma Services Network, in partnership with the University of British Columbia Okanagan (UBCO), and supported by the KGH Foundation, the Pritchard Foundation Fund, and Mitacs, the project brought together health, academic, and community organizations alongside individuals with lived experience to explore opportunities to strengthen BI service delivery across the region.

Approach

CBISI used a community-engaged, mixed-methods approach guided by a 30-member Advisory Council representing health services, brain injury organizations, academic partners, Indigenous partners, and individuals with lived experience.

Data collection methods included:

- A co-designed survey completed by BI-specific and non-BI-specific service providers
- Semi-structured interviews with individuals with lived experience and service providers
- Community focus groups to validate findings and refine preliminary recommendations

Four communities reflecting the diversity of the IH region were engaged: Kelowna (urban), Cranbrook (regional), Nakusp (rural), and the Thompson Cariboo Shuswap region (remote).

Qualitative data was analyzed using an iterative thematic approach led by UBC Okanagan researchers, with findings reviewed and refined in collaboration with the Advisory Council and community partners.

Key Findings

Across regions and sectors, the CBISI Project identified nine consistent system-level themes including:

1. Fragmented Systems and the Need for Coordinated, Person-Centered Supports
2. Navigating the Complex Realities of BI
3. Pathways Toward Improved Services
4. Gaps in Knowledge and Understanding of Brain Injury
5. Systemic Constraints Limiting Service Delivery
6. Service Gaps and Accessibility Challenges
7. Housing Options and It's Role in Supporting Recovery
8. Care Experiences Shaped by Stigma and Bias
9. Lack of Funding or Finances

These findings highlight that BI is a system-wide issue requiring coordinated, cross-sector approaches rather than isolated program responses.

Recommendations and Next Steps

In response to these findings, the CBISI Advisory Council developed nine evidence-informed recommendations, supported by associated action items, that together build a framework for strengthening coordination and continuity of BI supports across the Interior Health region.

Recommendations span health, community, housing, justice, and rural partners ensuring ownership and solutions are shared across sectors. Ongoing collaboration will be required to implement recommendations as opportunities arise. Together, these recommendations provide a phased roadmap to support more coordinated, equitable, and person-centred BI supports over time.

CBISI Recommendations

1. Service and Support Pathways
2. Develop Centralized Virtual Intake Coordination
3. Develop and Implement Brain Injury Specific Education
4. Develop a Regional Concussion Management Strategy
5. Implement a Team-Based Care Model for Moderate to Severe and Complex Brain Injury
6. Integrate Stable Housing as a Foundational Element of Brain Injury Rehabilitation
7. Explore Opportunities to Improve Current Resource and Funding Models
8. Improve Ability to Capture, Share and use Brain Injury Related Data
9. Establish a Strategic Brain Injury Council

Introduction

About the Community Brain Injury Service Integration Project

The Community Brain Injury Service Integration (CBISI) Project is one of the first of its kind in the Interior Health (IH) region, bringing together health, academic, and community organizations in a coordinated partnership. Made possible through the collective effort of partners across health, housing, justice, community sectors, and individuals with lived experience each contributing local expertise the project reflects a shared commitment to strengthening brain injury (BI) service delivery across the region. Led by IH's Trauma Services Network, in collaboration with the University of British Columbia Okanagan (UBCO) and generously supported by the KGH Foundation, the Pritchard Foundation Fund, and Mitacs, the CBISI Project identified service gaps and co-developed practical recommendations to strengthen and expand BI supports. Grounded in a shared vision of a more connected, person-centered, and sustainable system of BI support, IH recognizes that lasting solutions depend on the continued leadership, collaboration, and partnership of community organizations.

Through collaborative mapping and analysis, CBISI identified service gaps and co-developed practical recommendations to strengthen and expand BI services. The strength of this work is the cross-sector partnerships and a shared commitment to building a roadmap toward a more connected, person-centered, and sustainable system of BI support.

Purpose of the Project and this Report

The purpose of the CBISI Project was to bring together lived experience, health, and community partners in a coordinated way to co-create recommendations that improve access, continuity, and equity of supports for people living with BI, ensuring these recommendations are both evidence-informed and grounded in lived realities. The recommendations serve as a roadmap to guide future care, highlighting opportunities to strengthen service provision, improve coordination, and inform long-term planning across IH and community partners.

The report is not a directive for immediate implementation, rather a flexible guide that sectors and departments can draw from. Each organization may identify elements that align with their priorities and incorporate them into future work plans. In this way, the CBISI report supports long-term system improvements while fostering collaboration and sector-specific leadership.

Defining The Challenge

The CBISI project was initiated in response to the complex realities individuals face when discharged from hospital after a BI. Community partners and people with lived experience have shared that too often, people return to their communities only to encounter fragmented services, rigid eligibility criteria, and systemic barriers that undermine recovery. BI is not a single event but a chronic, life-altering condition requiring ongoing, interdisciplinary support. The challenge for both individuals and service providers is that the current systems are not designed to support the long-term, dynamic and complex nature of BI particularly when BI intersects with MHSU, housing instability, and other complex needs leaving many without access to sustained care.

One interviewee's experience illustrated these challenges. After sustaining a brain injury, they became unable to work and therefore were reliant on multiple systems of support. Cognitive impairments made it difficult to complete the paperwork needed to maintain housing subsidies, leading to eviction and repeated cycles through shelters that could not accommodate behavioral and mood changes. Substance use was an additional barrier. As years passed and initial supports weaned off, services across health, housing, justice, and community organizations concluded the individual had exhausted available resources and was considered too complex or "out of scope." Following the injury, the individual also developed significant mobility challenges and chronic pain. Their medical needs are primarily managed through the emergency department (ED) when community outreach teams are unable to provide the level of care needed. However, behavioral challenges combined with the individual's own reluctance to be admitted, and a known history of difficult interactions, can make hospital admission difficult. Now living outdoors with persistent health concerns, mobility challenges, and long waits for recovery-focused treatment, they continue to struggle to access funding and services that were not designed to meet their needs.

Their story reflects a broader reality shared by many others, where fragmented systems, homelessness, and the toxic drug supply intersect without meaningful integration.

Process For Developing the Recommendations and Report

The CBISI report was developed through a collaborative process that centred the voices of people with lived experience, their families, care providers, and community partners. An Advisory Council, composed of 30 members representing health services, brain injury organizations, academic partners, Indigenous partners, and individuals with lived experience guided the project from design to implementation.

Four communities were selected including Kelowna (Urban), Cranbrook (regional), and Nakusp (rural), along with engagement in the remote Thompson Cariboo Shuswap region (remote). These communities were selected to reflect the diversity of the IH region and the unique challenges faced across rural, remote, and urban contexts.

Survey

A survey co-designed with academic partners at UBC Okanagan and endorsed by the Advisory Council was distributed to both BI-specific and non-BI specific service providers. Forty-nine individuals completed the survey, including 19 BI–specific service providers and 30 non–BI–specific providers. Responses were received from Kelowna (n=12), Cranbrook (n=20), Nakusp (n=11), and the Thompson Cariboo Shuswap region (n=4).

Interviews

Survey respondents were then invited to participate in follow-up interviews to provide deeper context and share local realities. Twenty-six interviews were completed, with individuals with lived experience (n=15) and service providers (n=11) across Kelowna (5 individuals with lived experience, 3 service providers), Cranbrook (4 individuals with lived experience, 4 service providers), Nakusp (6 individuals with lived experience, 2 service providers), and the Thompson Cariboo Shuswap region (2 Indigenous participants with lived experience).

An initial coding process generated 38 distinct codes from the qualitative data (Appendix B), capturing a wide range of experiences, challenges, and perspectives related to BI and service provision. Through iterative analysis and synthesis, these codes were examined for patterns, overlaps, and conceptual similarity, allowing them to be consolidated into overarching themes. These themes represent the most salient and recurrent insights across participants and will be described in detail in the following section, highlighting both systemic challenges and opportunities for improving care and support.

Focus Groups

Six preliminary recommendations, developed from the survey and interview data, were then brought back to the communities for validation and refinement. Three focus groups were held with participants from Kelowna (n=10), Cranbrook (n=8), and Nakusp (n=8). In these discussions, participants explored what each sector would need to make the recommendations actionable within their local context.

Final Analysis

A final thematic analysis of survey, interview, and focus group data was conducted by UBC Okanagan researchers. Nine themes emerged from the analysis, which were further refined and shaped with the Advisory Council and community partners. The resulting recommendations and action items reflect both the evidence and the realities of community experience, ensuring the strategy is rooted in local needs and guided by those most impacted.

Current Context

Overview of Brain Injury Landscape

In Canada, an estimated 165,000 new brain injury (BI) cases occur each year, with more than 20,000 individuals hospitalized due to its effects (World Health Organization [WHO], 2022). In British Columbia alone, over 22,000 new cases are added annually to the 180,000 people already living with the impacts of BI (Canadian Agency for Drugs and Technologies in Health [CADTH], 2024). To contextualize the scale of this crisis, BI is 30 times more common than breast cancer, 44 times more common than spinal cord injuries, and 400 times more prevalent than HIV/AIDS. Despite its profound and lasting consequences, BI continues to receive disproportionately low attention in public health planning and policy, leaving significant gaps in care, equity, and awareness.

Brain injury care spans across health and community systems, requiring strong collaboration to meet the needs of individuals and families. Resources and supports are comparatively strong in acute care settings, but once individuals leave hospital, they often encounter limited and fragmented supports. Rehabilitation, BI education, housing, mental health and substance use (MHSU) services, and peer supports are not consistently available, particularly in rural and remote regions, leaving individuals and families without the supports needed for community reintegration and long-term recovery.

The BC Consensus on Brain Injury, Mental Health and Addiction (2024) captured this challenge directly: “it’s almost impossible to integrate care for people with complex needs if you don’t know who else in your community is providing service.” The consensus underscores the need for BI services to be embedded within broader systems of care, ensuring interdisciplinary collaboration among providers and sectors. Training and knowledge translation are also critical; service providers across intimae partner violence (IPV)shelters, homeless outreach programs, and MHSU services need the skills to recognize and support individuals with BI through trauma-informed and BI-informed approaches. The CBISI report emphasizes the importance of community-driven, culturally responsive solutions, ensuring that service models are designed with and for community members, people with lived and living experience, and systemically marginalized groups.

This work is happening within a broader context of social and health system pressures. The toxic drug crisis, housing instability, and rising prevalence of BI combined with inequities faced by Indigenous peoples and other marginalized populations highlight the need for cross-sector solutions. Data from the BC Provincial Overdose Cohort[1] underscores this urgency: between 2015 and 2021, individuals who experienced a toxic drug poisoning were 19.5 times more likely to develop an anoxic BI than those who did not, highlighting the significant intersection between the toxic drug crisis and BI in BC (BCCDC, 2023). Among people experiencing homelessness the prevalence of BI is alarmingly high: 66% report an acquired brain injury, with 77% injured before becoming homeless (BC Brain Injury Alliance, 2024).

At the same time, the current landscape places significant pressure on the system's capacity to deliver timely and coordinated brain injury supports. Variability in service availability across the region limits the ability to provide consistent, ongoing care and creates bottlenecks in areas where specialized services exist. These capacity challenges influence how services are organized, the intensity of supports that can be offered, and the ability of teams to respond to the complex needs of individuals living with brain injury, particularly in regions with limited specialized resources.

Addressing these challenges will require collaboration across health, housing, community organizations, and with people with lived experience to expand rehabilitation capacity, improve education, and design integrated pathways that support recovery and long-term wellbeing.

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[1] The BC Provincial Overdose Cohort is a linked administrative dataset created by the BC Centre for Disease Control. It includes all individuals in British Columbia who experienced a fatal or non-fatal overdose since January 1, 2015, based on health, emergency, and coroner records.

Alignment with IH Strategic Direction:

The CBISI Project is closely aligned with IH's 2024–2027 Strategic Plan, advancing multiple priorities across all five organizational goals. Through its recommendations, the project strengthens equity and access, supports Indigenous health and wellness, enhances quality of care, and contributes to workforce sustainability. The table below highlights the specific areas of alignment between CBISI's focus and IH's strategic priorities.

Strategic Alignment
IH 2024-2027 Strategic Plan

IH Goal	Strategic Priority	Strategic Priority Focus Areas the CBISI Project Aligns With
Improve Health and Wellness	**Advancing Equity and Access**	• Building capacity and shared understanding across IH, and using data to reveal health inequities • Changing how we deliver services to improve equity and access, including for Indigenous, rural and remote communities
	Advancing Indigenous Health and Wellness	• IH services are free from racism and discrimination • Indigenous Peoples and Communities have equitable access to culturally safe care
Deliver High Quality Care	**Mental Health and Substance Use (MHSU)**	• Strengthening staff knowledge and capacity • Co-ordinated care advancement • Continued toxic drug crisis response
	Surgical, Medical Imaging and Laboratory Services	• Timely access to services and care
	Embedding Person- and Family-Centered Care	• Implementation of the Person- and Family-Centered Care (PFCC) Framework to put individuals at the forefront of their health and care
Ensure Sustainable Health Care	**Modernizing Technology and Analytics**	• Creating people centered systems • Generating knowledge from data
Cultivating and Engaged Workforce	**Supporting Our People**	• Redesigning the way, we work • Retaining and training staff • Recruiting for the future
Approaches to How We Do Our Work	**Taking a Population Health Approach**	• Shifting efforts upstream • Using evidence to assess health to develop strategies that improve and protect the health of the population • Collaborating with partners to address the determinants of health

Alignment with Provincial Direction and Mandates

The CBISI project is aligned with the most recent 2024/25 provincial mandate letters issued by Premier David Eby to his ministers including Health and Public Safety and Solicitor General[2]. In his mandate letter to Honourable Josie Osborne, Minister of Health, the Premier requests the prioritization of several issues one being:

"Support the work of the Chief Scientific Advisor for Psychiatry, Toxic Drugs and Concurrent Disorders in delivering high-quality care for people struggling with acquired brain injury, addiction, and mental health challenges."

In his letter to Honourable Garry Begg, Minister of Public Safety and Solicitor General, the Premier asks that Minister Begg:

"*Ensure safe and strong communities by working with colleagues across ministries to support efforts and proactively intervene with individuals struggling with mental health, addiction, and brain injuries*."

In addition, the 2024/25 Interior Health Authority Mandate Letter from the Ministry of Health calls on the health authority to

"*Continue our work to build and deliver a seamless system of care for people seeking mental health and addiction services in the province on both an inpatient and outpatient basis, including services responsive to the unique needs of Indigenous peoples."*[3]

Taken together, these directives emphasize the need for integrated pathways that connect acute, rehabilitation, and community care with social supports such as housing, peer networks, and income supports, all areas that CBISI recommendations address. Together, these directives highlight the provincial priority of building seamless, coordinated systems of care that address BI alongside mental health and addictions, and require collaboration across ministries and sectors. This direction aligns with CBISI's recommendations, including developing an integrated MHSU/BI system of care, developing a housing strategy that addresses the unique needs of people living with BI, and investing in provider and community education to strengthen awareness and capacity.

The BC Consensus on Brain Injury, Mental Health, and Addictions (2022–2025), a multi-year participatory action research initiative, brought together partners from across the province to co-create shared priorities for individuals living with BI

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[2] See *Mandate Letter to Honourable Josie Osborne, Minister of Health* (2024/25) and *Mandate Letter to Honourable Garry Begg, Minister of Public Safety and Solicitor General* (2024/25). Available at: gov.bc.ca/mandate-letters

[3] Government of British Columbia. Ministry of Health. (2024/25). *Mandate Letter to the Interior Health Authority.* Retrieved from https://www2.gov.bc.ca/gov/content/governments/mandate-letters

and intersecting challenges. These priorities closely mirror CBISI recommendations, including integrated service and support pathways, housing and wraparound care models, improved data capture and coordination, peer support, and multi-sector collaboration. For example, the top action item identified on day three of the Consensus was to "*Improve accessibility and affordability of supportive housing for those living with brain injury*." This alignment demonstrates that CBISI's recommendations are not isolated but reinforce a province-wide consensus on the path forward.

Alignment with National Directions

At the national level, the introduction of Bill C-206: The National Strategy on Brain Injuries Act (2025) reinforces the timeliness of this work by signaling growing federal recognition of BI as a critical public health issue. The Bill calls for a coordinated national strategy to improve prevention, care, rehabilitation, data collection, and cross-sector collaboration. Its objectives directly align with CBISI's recommendations, particularly around integrated service and support pathways, housing and wraparound supports, education, improved BI data collection, and system-wide coordination. Although still early in the legislative process, Bill C-206 shows that federal and provincial priorities are aligning creating an opportunity to make sure BI is built into broader systems planning.

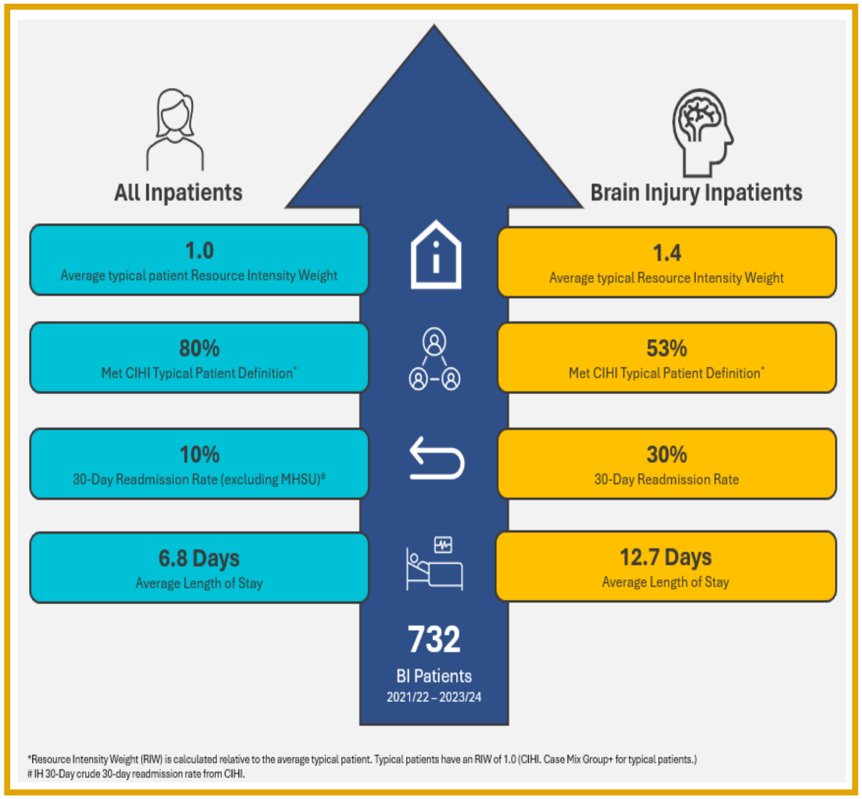
These mandates highlight alignment with CBISI recommendations and point to opportunities for advancing coordinated BI supports across the system

The Case for Change

The CBISI case for change is grounded in evidence from multiple sources, including surveys, interviews, focus groups, and the published literature. Together, these sources highlight persistent gaps and opportunities to increase BI service provision.

Nine themes consistently came forward in the data, engagement and literature:

1. Fragmented Systems and the Need for Coordinated, Person-Centered Supports
2. Navigating the Complex Realities of BI
3. Pathways Toward Improved Services
4. Gaps in Knowledge and Understanding of Brain Injury
5. Systemic Constraints Limiting Service Delivery
6. Service Gaps and Accessibility Challenges
7. Housing Options and It's Role in Supporting Recovery
8. Care Experiences Shaped by Stigma and Bias
9. Lack of Funding or Finances



*Resource Intensity Weight (RIW) is calculated relative to the average typical patient. Typical patients have an RIW of 1.0 (CIHI. Case Mix Group+ for typical patients.)
IH 30-Day crude 30-day readmission rate from CIHI.

These nine themes included input from individuals with lived experience, families, service providers, and community partners who spoke about fragmented systems, the complex realities of living with BI, and the need for coordinated pathways to services. Findings also highlighted gaps in knowledge, systemic constraints, access barriers, housing, care experiences shaped by stigma and bias, and unstable funding.

The alignment across lived experience, service provider input, and the published evidence creates a strong case for change. The following sections take a closer look at each of the nine themes, weaving together what we heard, what the literature shows, and how these findings shaped the CBISI recommendations. Above each theme, the banner shows how many times the theme was mentioned in the data; the full codebook can be found in Appendix B.

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Fragmented Systems and the Need for Coordinated, Person-Centered Support

Participants described how siloed and poorly coordinated services create redundancy, service gaps, and variability in care for BI survivors. For example, one service provider highlighting the service gaps between acute hospital care and community notes: *“If we had more of a case management model where we could pull in these extra supports, we would have a lot more wrap around care. We could go from acute hospital care to rehab to community and have more support ongoing rather than this very fragmented model... there's no actual like proper channel for a handover. There's no good or right way to hand over when somebody's discharged from acute care.”*

80% of survey respondents agreed that system complexity, communication challenges, and fragmented referral processes act as barriers to accessing services

Participants highlighted how recovery is often interrupted by **scattered supports, unclear next steps, and services that prioritize tasks over person-centered needs**. For example, when asked about what services a person with lived experience accessed, they responded: *“Oh, I didn't know there was services available.”* Another participant with lived experience shared: *“There needs to be more access. People need to be more aware of it. If you go somewhere and you reach out for help and the door is closed in your face, there isn't another one that's open. It's not like, ‘Okay sorry, we can't, we can't help you, but this person can’. It's like, ‘We can't help you. That's that’.” A service provider described the tension between person-centred care and task-oriented service delivery, noting that workers are often restricted to completing only the tasks formally delegated to them, even when small, additional actions could meaningfully improve a client’s day. As they explained: “in an ideal world it should be the client [needs]absolutely, 100% first and the tasks second. So if, if it makes a difference to do a four second task that you know turns a person's day around or makes them feel like they have a little bit more independence or a little bit more, you know, humanity, right?”*

All survivors and providers interviewed emphasized the potential value of dedicated care navigation. One family member explained: “The biggest gap, the biggest frustration has been the lack of navigation.....wouldn't it be amazing if there was somebody who was able to hold our hands through all of this and tell us this is what's available to him? This is what you can do for him. These are the services that are available ....it would be helpful if someone could reach out to us and explain to us where we go.”

Participants further emphasized that **improved communication across sectors, along with stronger integration of family and peer supports**, would ensure continuity and collaborative recovery. These local perspectives align with findings from a Canadian-led study that examined the barriers and facilitators to housing and healthcare for people experiencing homelessness with concurrent brain injury, mental health, and substance use challenges (Warren et al., 2024), which called for the **implementation of system navigation roles** together with integrated or co-located services to ensure easier system navigation.

One service provider suggested what a coordinated model might look like *"like if you could go to one website that had all of the things and you could just, you know you could click on the links and you could basically, if you could have one form that you filled out that said: Here's me. Here's my brain injury. Here's my medical diagnosis. All of it. And then internally you know it gets disseminated to all the different agencies and then poof, you end up with whatever you're supposed to get as far as referrals."*

Overall, we heard from the data, engagement, and literature that fragmented and siloed systems hinder recovery and continuity of care for individuals living with BI**.** The absence of clear pathways and coordinated transitions between hospital, rehabilitation, and community settings contributes to duplication, service gaps, and inconsistent access to supports. Both individuals with lived experience and providers emphasized that establishing well-defined, person-centered pathways supported by navigation roles and cross-sector communication would improve integration, reduce fragmentation, and enable smoother recovery journeys along the service and support pathways.

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Navigating the Complex Realities of BI

Individuals with BI consistently described the challenges of navigating daily life and accessing care, particularly when their injuries intersect with mental health concerns, substance use, housing instability, or histories of trauma and violence. The often invisible nature of BI contributes to stigma, disbelief, and dismissal, leaving many **excluded from services or misunderstood by providers**. One individual with lived experience shared that they felt as though they were "*just too much for the service providers.*" Families and caregivers echoed these concerns, reporting high levels of stress as they tried to **navigate fragmented systems** without adequate guidance or advocacy.

Service providers acknowledged that clients with BI and co-occurring needs are frequently labeled “too complex” and excluded by **rigid eligibility criteria**, **In many regions, these criteria require individuals to be between 19–64 years of age, have a documented moderate to severe BI, demonstrate BI as the primary diagnosis of concern, and provide formal medical confirmation of the injury, requirements that often exclude those with co-occurring MHSU concerns, undocumented injuries, or fluctuating levels of impairment.**. One service provider explained: *“I just feel like we don't fit that narrow referral criteria. I don't know who BI programs are offering services [to] or, you know, wanting to even connect with. It just seems like everyone I've had in mind just doesn't really fit the check boxes.”* Community partners emphasized the need for peer navigation, integrated supports, and collaborative approaches that bridge silos across programs and sectors.

> “We need to find a place where they can have that heavy wrap around support for the rest of their lives, because that's what they need exactly. Without the stigma, [helping you with] mental health and the fact you got a brain injury.”
> **Individual with lived experience**

Indigenous peoples, individuals experiencing homelessness, and those living with concurrent MHSU conditions are most likely to be excluded under program mandates that are not designed to support people with concurrent disorders and complex needs. National data shows that 20–25% of people experiencing homelessness in Canada live with both severe mental illness and substance use disorders, with Indigenous peoples disproportionately affected (54% compared to 43% of non-Indigenous individuals) (Government of Canada, 2023).

The toxic drug crisis further intensifies these inequities, as many individuals with BI also live with substance use disorders or face heightened risk of overdose due to cognitive impairments, social vulnerability, and fragmented care pathways. Evidence shows that people living with BI are more than twice as likely to develop a mental health or substance use disorder compared to the general population (Topolovec-Vranic et al., 2017). However, strict eligibility criteria does not only affect those who are considered ‘too complex’ for BI services. Individuals also describe being turned away for appearing too high functioning. One individual shared “*I was told that I had too much ability, that I was taking up too much”* despite having a diagnosed BI and need for services such as home care and transportation. For marginalized populations already navigating poverty, trauma, substance use, and systemic racism, these gaps reinforce cycles of exclusion and prevent access to supports needed for recovery and reintegration.

Together, these accounts show how rigid eligibility frameworks create barriers at both ends of the spectrum, leaving people seen as either **“too complex**” or “not impaired enough” without the care they need. Without the right supports, survivors often end up cycling between hospital, unstable housing, and the justice system. This highlights the need to align BI and MHSU services through coordinated, inclusive pathways that reflect the realities of survivors and needs of service providers.

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Pathways Toward Improved Services

Participants highlighted both constructive recommendations for system change and examples of positive service experiences. These insights demonstrate not only what is working well but also provide direction for how services and systems could be strengthened to better meet needs.

A recurring theme was the importance of **integration and continuity of care**. One service provider emphasized: *“[We need] wrap around care, integrated care. If we're able to set up a model where people aren't going from somebody's care to another person's care to another person's care. Families [need] more support. Patients [need] more support, [that then] reduces hospitalizations.”* This perspective points to the need for coordinated models that reduce fragmentation, minimize service duplication, and ensure individuals and families are not left navigating complex systems on their own.

Equally important was the recognition of **effective communication practices within teams**. As one provider shared: *“I think our communication process is going really well. We do like family meetings. We are very connected to each other. We have our discharge dashboard, so we're able to kind of know what the others are doing. And kind of what gaps are there.”* This example highlights how clear communication, intentional information-sharing, and regular case discussions can bridge service gaps and promote collaborative problem-solving.

Taken together, these reflections along with many others shared throughout the engagement process suggest complementary pathways for system improvement: building stronger, integrated networks of support across organizations and strengthening communication practices within teams. Participants emphasized that these strategies not only improve client and family experiences but also contribute to better health outcomes, reduced strain on hospitals, and more sustainable service delivery across the region.

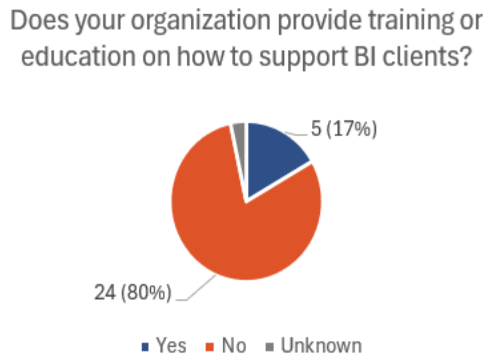
116
mentions

Gaps in Knowledge and Understanding of BI

> “I think education would be helpful. I think that that's very reasonable to have a brain injury program come in and do an in-service to develop and provide that tangible education, I think that's completely reasonable, and I don't think that it would take that much money.”
> **Service provider**

Both service providers and individuals affected by BI experience significant gaps in awareness and understanding. For providers, **insufficient training limits their ability to recognize and respond to BI**, particularly when it intersects with other complex needs such as substance use, mental health, or IPV. For survivors, a lack of clear information, diagnosis, or recognition of symptoms leaves them and their support networks struggling to understand the injury and its impacts on daily life. These **knowledge gaps contribute to miscommunication, stigma, and unmet needs across the system.**

In community and rural settings, primary care teams, allied health, and community-based providers frequently take on ongoing management, yet may lack the knowledge or tools to recognize BI symptoms, adapt clinical practice, or connect individuals to appropriate supports. One service provider described their experience when being hired onto a BI team. “I had to reread my textbook on BI and use a free app … it’s been a lot of learning on the fly. There have been no real learning opportunities … education is so challenging; if I want to attend a course, I have to spend about $1,000 to travel to Vancouver for hotels and everything.” The literature further highlights this need for standardized BI education among medical providers. A recent article in the *BC Medical Journal* reported that concussion care across Canada remains inconsistent due to provider knowledge gaps and limited dissemination of evidence-based guidelines (Babul & Sun, 2024). More concerning, a 2023 study at Memorial University of Newfoundland reported that fewer than half of medical students and residents had received concussion education (Bray et al., 2023). Although limited to one medical school, this study emphasize the need for standardized BI education across medical and allied health curricula, as well as ongoing professional development, to ensure providers at every level can support individuals living with BI.



These knowledge gaps become even more pronounced when BI intersects with other complex conditions. Participants consistently expressed a need for **guidance on how to best support individuals with cooccuring conditions of BI and**

MHSU. One service *provider shared "my experience primarily with BI within the hospital has been in the context of substance use, and so the substance use in combination with the acquired brain injury... that's the barrier that's the sticking point of. They're not able to participate in physical rehab or cognitive rehab because of the brain injury or because of the substance use. And so I think finding the right program, it seems like mental health and substance use programs will kind of pin everything on the brain injury and then brain injury will talk about the substance use piece as being the barrier to participation, and there's just no like cohesion and no integration in the supports that are available from either of those."* The limited supports and services contributes to siloed systems resulting in people receiving care for one condition or the other, leaving providers uncertain about how to meet both needs together.

Similar challenges were echoed from housing providers, who are often the most consistent supports in a person's daily life yet described struggling to meet the needs of individuals with BI. Without an understanding of BI, staff may misinterpret cognitive or behavioral changes as noncompliance rather than injury-related challenges. This limits their ability to adapt care approaches or advocate for additional supports. Over time, these misinterpretations can contribute to housing instability, greater reliance on emergency services, and increased interactions with the justice system. The lack of education for service providers across sectors continues to create **barriers to accessing appropriate supports**.

Participants with lived experience also shared feelings of having limited knowledge and understanding, both relating to their own injury as well as navigating the complexities of the healthcare system. Many individuals shared **difficulties in understanding their injury** whether that be due to lack of knowledge or lack of information shared by their service providers. Participants with lived experience asked questions like *"What is a brain injury? How do you define brain injury? What does it take to recognize that this brain injury is more than what it looks like?"* This line of questioning highlights several important points. First, it underscores a gap in accessible knowledge and education about BI as participants often struggled to understand the definitions and markers that differentiate a brain injury from more common or less severe symptoms. Second, it reflects the invisible nature of many brain injuries, where outward appearances may not accurately represent the severity or complexity of the condition. Finally, these questions point to the lived experience of uncertainty and the challenges individuals face in advocating for themselves, accessing appropriate care, and having their symptoms recognized and validated by healthcare providers or support systems. Another patient shared *"I couldn't get any answers. I couldn't figure it out, I really tried to figure out kind of what was going on... and I wasn't getting any answers. So, I left the hospital and from that point on I really did [have to] advocate for myself from that day on."* Highlighting a gap in communication between this individual and their care provider. When trying to initiate BI services, one participant with lived experience shared *"I never think [sic] to go and look [there] 'cause I never needed it and that's new turf for me. I didn't even know 'cause I didn't know what to ask or what to look for."* For many, this lack of clarity created a sense of isolation and uncertainty, leaving them to shoulder the responsibility of self-education and self-advocacy at a time when they were most vulnerable. Without clear, accessible explanations about their condition or guidance on how to navigate available supports, participants described feeling abandoned by a system that seemed unwilling or unable to meet them where they were. This not only placed an undue burden on individuals already coping with the challenges of BI, but also perpetuated inequities in access to care, as those with fewer resources or less capacity to advocate for themselves were left at even greater disadvantage.

Taken together, these findings point to ongoing gaps in BI awareness and education across all levels of care and service delivery. Both service providers and individuals living with BI described significant knowledge and awareness gaps, providers lack training and tools to recognize and manage BI, especially alongside substance use, mental health, or IPV, while individuals who have experienced a BI struggle to understand their own injuries or navigate fragmented systems. These intersecting gaps lead to miscommunication, stigma, and inequitable access to care, reinforcing systemic fragmentation across health, housing, and community services.

105
mentions

Systemic Constraints Limiting Service Delivery

Service providers described how organizational barriers limited their ability to deliver comprehensive and sustainable care. **Rigid eligibility criteria, narrow program mandates, and funding constraints** often prevented them from offering services they knew were needed. One provider explained that their "*already outstretched resources become even more outstretched because we have to pick up the service gaps from other programs for clients that oftentimes aren't even exactly BI appropriate,*" leading to burnout and frustration. **Providers described being forced into a difficult choice**: stretch their mandate to support individuals who did not meet eligibility requirements or turn people away knowing no other services existed.

These pressures not only intensified workloads but also created distress, as workers felt they were failing both their existing caseload and those left without care. The spouse of one individual shared that their service worker was supposed to be "providing life skills, support, and rehab but I think she's just so overwhelmed just trying to help him survive that really, she hasn't been able to address those things."

Fifty-eight percent of survey respondents strongly agreed that rigid eligibility criteria and system constraints limit access to BI services

Systemic barriers also created inequities in access. Individuals without a formal diagnosis were often excluded from specialized programs despite presenting with BI symptoms and functional challenges. **Age restrictions** further limited access, with those over 65 frequently aging out of

BI-specific supports even when ongoing rehabilitation remained critical to maintaining independence. Providers voiced frustration at “knowing what services were required but being unable to offer them” due to siloed funding and contractual constraints. **Restrictive program mandates** often create exclusionary practices, leaving individuals without needed support: *“I think in theory we have access, but in practice we don't. We get declined. Maybe their needs don't align with what [that provider] typically provides and then the individual doesn't have access to private resources... especially if they're living somewhere precarious, shelter, tent city or kind of precarious apartments. Whatever the case may be the limitations are definitely there.”*

47% strongly agreed that funding restrictions, are major system constraints that limit access to brain injury services

These limitations were particularly acute in rural and remote communities, where outreach and travel supports are essential. Without dedicated resources, individuals often went without timely assessment, follow-up, or rehabilitation. As one provider shared, “our program doesn't have the resources that many other programs do with regards to diversity of clinicians and so we're kind of pigeonholed in what we can do... we can't really provide as much as we want.” **The absence of flexible supports** not only placed individuals at risk of premature placement in higher levels of care, but also contributed to isolation, stigma, and worsening mental health.

Service providers face organizational barriers that restrict their ability to deliver comprehensive and sustainable care. Through the findings we heard **limited resources contribute to burnout and capacity issues, rigid organizational mandates constrain flexibility, and siloed service mandates hinder collaboration across sectors**, Together, these systemic constraints reduce the effectiveness and accessibility of services.

Collectively, these accounts reveal how systemic and organizational barriers undermine the delivery of equitable, person-centered care for individuals with brain injury. **Underfunded programs, rigid eligibility criteria, and inflexible mandates** create a system that is reactive rather than responsive leaving both providers and survivors struggling within structures not designed to meet complex or evolving needs. Service providers, caught between ethical responsibility and institutional constraint, experience moral distress and burnout, while survivors face delayed, fragmented, or entirely inaccessible care.

105
mentions

Service Gaps and Accessibility Challenges

Individuals who have experienced a BI face barriers in accessing appropriate supports due to both the absence of needed services and the inaccessibility of those that exist. In many communities, services for BI survivors are entirely lacking, while in other cases, existing programs are constrained by limited capacity, long waitlists, or restrictive funding. Geographic and transportation barriers, particularly in rural and remote regions, further compound inequities in access and contribute to unmet needs. Despite the presence of BI services within the region, geography, transportation constraints, and limited outreach capacity frequently create barriers to access, particularly for individuals living outside of urban centres.

As one provider observed, critical models of care are often unavailable: “For these concurrent disorders and these poor individuals who need that model of care, that doesn't yet exist.” Even when services are technically available, participants emphasized that practical barriers prevent access. A survivor described the challenges of relying on limited transportation options: “So really because I was on the bus services on a fixed scheduled timeline, I could never get into Nelson or Castlegar timing wise, I get there after they start and I [have to leave] before they end. Plus, I've also spent an hour to an hour and a half on the bus to get there. And so, I've blown my executive functioning before I even start.”

Access to specialized care was particularly limited in smaller or more remote communities. As one participant shared: “So we had a neuropsychologist in Nelson. They have since retired, and so Nelson's about 3–4 hours away [from us], and that was the closest one. Now there may be somebody in Kelowna which is 7 hours away [from us] and then the rest are at the coast, which is upwards of like 10–12 hours away [from us].” For individuals living outside of urban centers, this meant that even the most basic assessments or follow-up care often required extensive travel, time away from work or family, and significant financial cost, these created additional barriers that many participants simply could not overcome. Service providers echoed these challenges, pointing out that even when professionals are available and willing to travel, funding and logistical supports are rarely in place to make outreach possible. One service provider shared “*if you want to provide outreach in remote areas, you need to provide funding to get the outreach worker to the remote areas. [If we have] a person willing to go, not being able to go is even more frustrating… But it's an underutilized resource if you don't send me there*.” This mismatch between available expertise and the structural supports needed to mobilize it underscores the inequities faced by rural and remote communities, where geography itself becomes a barrier to care. Ultimately, participants emphasized that without deliberate investment in outreach and sustainable service delivery models, people living outside of urban centers will continue to experience limited access, delayed diagnoses, and unmet rehabilitation needs.

These narratives make it clear that barriers to support are not simply the result of individual circumstances but are rooted in systemic inequities that shape who can access services, where, and under what conditions. Survivors are often left navigating fragmented systems that were never designed to accommodate the complexity of BI, and service providers are stretched thin trying to bridge gaps that remain unaddressed within current structures. Without targeted efforts in service infrastructure, transportation supports, and flexible eligibility criteria, survivors of BI will continue to fall through the cracks, be left to navigate a fragmented system that consistently do not meet their needs.

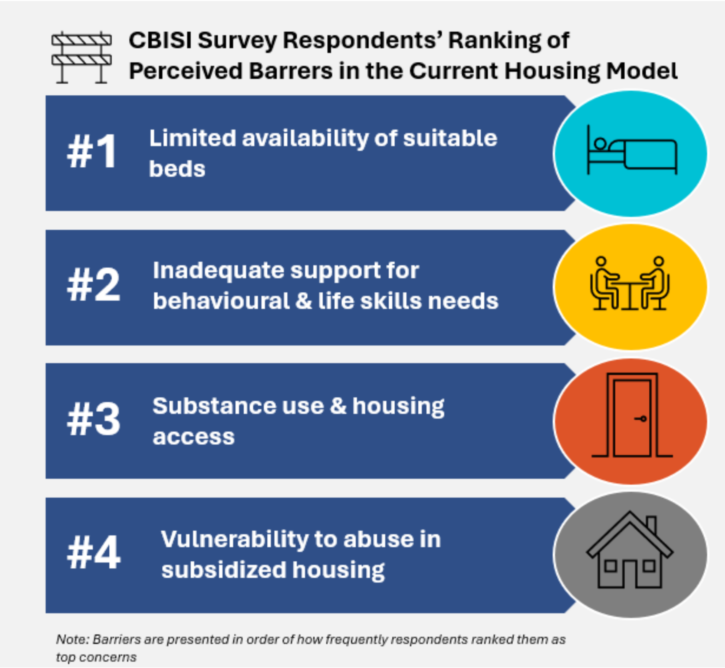
80
mentions

Housing Options and It’s Role in Supporting Recovery

Service providers and individuals with lived experience emphasized the **limited availability of housing that meets the cognitive, behavioral, and physical needs of people living with BI**. Housing was described as foundational to recovery, providing the stability and security necessary for individuals to focus on rehabilitation rather than survival. Participants stressed that when housing is precarious, access to medical care, rehabilitation, and social services becomes difficult to initiate or sustain. In this way, housing is not simply one support among many, but a prerequisite for meaningful recovery and long-term quality of life after BI.

One service provider shared that “*housing is definitely an issue for people who cannot return to independent living. [There’s not] a safe place for them to go.”* Clear gaps in available housing in the current model were also highlighted *“I also think that housing is such a big issue, if there was more like dedicated space for even a temporary thing for ongoing rehab, I think like a step-down unit would be incredibly helpful. I think we have acute care or settings and that's it. We don't really have any in between. There's no gray area. They're either you're bad enough to be in the hospital or you're good enough to be in rehab, and then your discharged, and there's really nothing.”*

CBISI survey data reinforced these qualitative findings, showing that providers and stakeholders consistently ranked housing as one of the most significant barriers for individuals living with BI. Nearly half (46%) identified the **limited availability of suitable beds as the most pressing issue**. The **inadequate support for behavioral and life skills needs** within existing housing models was also common (32% Rank 1, 34% Rank 2), alongside challenges at the intersection of **substance use and housing access** (15% Rank 1, 31% Rank 2). While some housing programs prohibit substance use, limiting access for those who are actively using, there are also few recovery focused options for individuals seeking abstinence leaving many without environments that support stability or recovery. Concerns about **vulnerability to abuse** in subsidized housing were also reported, with 3% ranking it as the top barrier.



CBISI Survey Respondents' Ranking of Perceived Barrers in the Current Housing Model

#1 Limited availability of suitable beds

#2 Inadequate support for behavioural & life skills needs

#3 Substance use & housing access

#4 Vulnerability to abuse in subsidized housing

Note: Barriers are presented in order of how frequently respondents ranked them as top concerns

These local experiences align with a systematic review and meta-analysis led by UBC researchers. Stubbs et al. (2019) found that more than half of homeless and marginally housed individuals had a lifetime history of TBI, with rates of moderate or severe injury up to ten times higher than the general population. The authors concluded that housing instability not only increases the risk of sustaining BI but also worsens recovery trajectories, underscoring the **importance of stable, supportive housing as a determinant of health.**

When housing did exist, participants with lived experience felt supported in their recovery. One participant described how their housing *"definitely has a huge impact on how well I'm doing and just everything they offer and how much they care really makes a difference to see people that actually care and want to see you succeed."* Another participant with lived experience shared that *"every time I was given a place that supported my recovery, I thrived."* However, finding these supportive housing options for those with BI can be difficult as shared by one service provider *"when we talk about the access to their assisted living like mainstream assisted living or long term care, trying to get our clients into there versus a specialized site which we don't have is nearly impossible just because they there is a stigma that's attached to our clients."* Taken together, these accounts illustrate how **housing is not only a necessity for recovery** but a central determinant of whether recovery is even possible. While supportive housing environments can foster stability, dignity, and meaningful progress, their scarcity leaves many survivors caught in a cycle of precarious living, limited access to care, and systemic exclusion. Participants and service providers described how the **absence of BI–informed housing models** that account for cognitive, behavioral, and sensory needs often results in placements that are unsafe or unsustainable. For some, this meant repeated displacement, institutionalization, or homelessness; for others, it meant being forced into environments that hindered rather than supported recovery. Without intentional investment in accessible, adequately funded, and BI-informed housing, survivors will continue to face unnecessary barriers to rehabilitation, perpetuating inequities that undermine both individual recovery and community well-being. Recognizing housing as an integral component of the care continuum, rather than an adjunct to it, is therefore essential to creating systems that truly support healing, autonomy, and long-term recovery for individuals living with BI.

56
mentions

Care Experiences Shaped by Stigma and Bias

Participants described encounters with services that were **re-traumatizing, unsafe, or dismissive**. These included care interactions that re-triggered trauma, reinforced marginalization based on identity (e.g., sex, gender, sexual orientation, ethnicity, substance use), or reflected poor practice that felt harmful, stigmatizing, or unhelpful. These negative experiences erode trust in providers and create additional barriers to seeking or continuing care. Similar findings have been reported in a Canadian study led by researchers at the University of Victoria and the University of British Columbia, which highlighted that stigma and bias across housing and healthcare settings compound challenges for individuals living with BI and MHSU concerns (Warren et al., 2024).

Stigma is particularly evident at the intersection of BI and substance use. As one service provider shared: *"I have a few clients living at Tent City and they won't be considered for supportive housing because they're too high care needs or they have a BI. Nobody wants to work with us."* The increasing toxicity of the drug supply has driven a rise in non-fatal overdoses, exposing more people to the risk of hypoxic BI. Recent evidence from BC underscores this trend**:** individuals who experienced drug toxicity were 19.5. times more likely to develop encephalopathy than those without a toxicity event, even after adjusting for sex, age, and mental illness (Xavier et al., 2023). One service provider shared that *"I think there's a lot of stigma about substance use, about like being homeless. I think all of that impacts patient care, how people receive care and how their discharge plan is done. Yeah, I think that's a really tricky thing to shift people's attitudes and perspectives towards people who are marginalized in society."*

One participant with lived experience explained *"it's quite degrading at times, when you have to ask for help, and if the person sitting behind the desk or on the other side of the room is judgmental, which is, I think, one of the biggest gaps is lack of training for staff in the services. There's a lot of judgment and there's a lot of entitlements and a lot of assumptions made when there shouldn't be."* This account underscores how stigma, bias, and lack of staff training can compound the challenges faced by survivors of BI, creating barriers to care and **undermining trust in the healthcare system.**

Participants also described **care that may be culturally insensitive**. Indigenous participants with lived experience described seeking care providers such as *“energy healers [that do] hands on”* or care that reflected the *“medicine wheel, you need to feed all four components”* however, they found that such services or providers did not exist. Warren et al. (2024) similarly emphasized the importance of culturally grounded approaches in healthcare and housing supports, noting that culturally unsafe practices create additional barriers for Indigenous participants navigating BI, MHSU, and homelessness. These experiences highlight the need for culturally safe and responsive care that respects diverse healing practices and acknowledges the holistic needs of Indigenous survivors of BI.

12% of survey respondents indicated that their organization provides spiritual or cultural care

One participant shared a **barrier to accessing care based on their gender identity** *“As any form of trans person, I don't feel the care here is appropriate that way. I have a form here I'm supposed to fill out... based on the questions in the form, I'm not 100% comfortable with giving them my medical records and moving my care here because they asked questions that are not even gender aware whatsoever... So I already have problems with feeling safe to get care here.”* This account highlights how healthcare systems that fail to recognize and accommodate diverse gender identities can create significant barriers to access, leaving transgender and non-binary survivors of BI feeling unsafe and excluded from care.

Together, these findings show that the toxic drug crisis is contributing to a growing population of people living with BI, yet **stigma, bias, and culturally unsafe practices continue to prevent access to needed supports**. Indigenous participants emphasized the importance of culturally grounded approaches, while transgender and non-binary survivors highlighted barriers created by forms and procedures that failed to recognize their identities. Without integrated, culturally safe, and stigma-free approaches to care and housing, survivors will remain excluded from services, undermining both recovery and equity.

49

mentions

Lack of Funding or Finances

Participants consistently highlighted how **insufficient financial resources both at the individual and system levels** created major obstacles to accessing needed services and supports for BI survivors. For individuals, the lack of affordable or publicly funded options meant going without essential care. As one survivor explained, *“I have physical injuries that obviously can’t be fixed. I can’t afford physio. I can’t afford things like that to work through them, so as far as like if there was free services I am unaware.”* Another participant shared: *“You need this neuro psych assessment, but there's no way this person can afford to do anything like that.”* For many, financial limitations translated directly into prolonged pain, reduced rehabilitation, and diminished quality of life.

> “What I found is that immediately [after brain injury] you're either like isolated into poverty, homelessness or social isolation somehow. You lose your job; you lose all your old friends. If you're one of the people that turns into a monster, you lose [all of your] connections."
> **Individual with lived experience**

At the systems level, **limited funding capacity within provincial and community programs** constrained the reach and sustainability of services, particularly in rural and smaller communities. One organizational representative reflected, *“I’ve asked the program coordinator to try to allocate more for my program, but they just don’t have the ability throughout the province to kinda add more to all the smaller rural communities. And then I find it is really hard in our rural areas to find the funding for people to get the services.”* Another service provider shared: *“There doesn't appear to have been an increase in funding or resources. We still have the same group homes, the same type of service models that we had in the 90s and it hasn't really addressed the increase in and the change in the type of BI that we're seeing. So the resources are not meeting the needs of the clients that we're seeing today.”* These funding gaps left service providers unable to meet demand, further widening disparities between urban centers and rural regions.

Overall, these accounts demonstrate that **insufficient financial resources create pervasive barriers to recovery** for survivors of BI, affecting both the ability of individuals to access essential care and the capacity of programs to deliver services. At the individual level, the cost of assessments, therapy, and supportive services, or travel costs to access services directly limits rehabilitation and quality of life, leaving many to go without care that could significantly improve outcomes. At the system level, chronic underfunding constrains the availability and sustainability of programs, particularly in rural and smaller communities, preventing equitable access and leaving service providers struggling to meet growing and evolving needs. Without meaningful investment to address these financial gaps, disparities in care will persist, further entrenching inequities for survivors of brain injury across the region.

Identified Needs

Through thematic analysis of the interviews, surveys, focus groups, and both qualitative and quantitative data, nine key themes emerged as priority areas to strengthen BI service provision. These themes reflect consistent opportunities identified across participants and settings.

Rather than mapping each theme to a single solution, the recommendations work collectively to address multiple system challenges.

The matrix below illustrates the alignment between the themes and the corresponding system-level recommendations.

	Recommendations								
Nine Themes	Service & Support Pathway	Develop Centralized Virtual Intake and Coordination	Develop and Implement Brain Injury Specific Education	Develop a Regional Concussion Management Strategy	Implement a Team-Based Care Model for Moderate to Sever and Completx Brain Injury	Integrate Stable Housing as a Foundational Element of Brain Injury Rehabilitation	Explore Opportunities to Improve Current Resource and Funding Models	Improve Ability to Capture, Share and Use Brain Injury Related Data	Develop a Strategic BI Council
Fragmented systems and the need for coordinated person-centered	🟦	🟦			🟦		🟦		🟦
Navigating the complex realitites of BI	🟦	🟦	🟦		🟦	🟦			🟦
Pathways toward improved services	🟦	🟦	🟦		🟦	🟦	🟦		
Gaps in knowledge and understanding of BI	🟦	🟦	🟦		🟦	🟦		🟦	
Systemic constraints limited service delivery	🟦	🟦		🟦	🟦		🟦	🟦	🟦
Service gaps and accessibility challenges	🟦	🟦	🟦	🟦	🟦	🟦	🟦		🟦
Housing options	🟦	🟦	🟦			🟦	🟦		🟦
Care experiences shaped by stigma & bias	🟦	🟦	🟦		🟦	🟦	🟦		🟦
Lack of funding or finances * including finances for self or	🟦			🟦		🟦	🟦	🟦	🟦

Summary of Recommendations and Associated Actions

Service and Support Pathways

- Create survivor focused roadmap
- Develop service and support pathways for BI
- Provincial strategy to address gaps
- Integrate peer support navigation
- Streamline income support pathway
- Collaborate on transport challenges

Develop Centralized Virtual Intake Coordination

- Create centralized virtual intake/triage team
- Standardized cross-sector privacy approved info sharing
- Community organizations to maintain updated service directory
- Add BI stream to RACE program
- Develop transition passport tool for continuity

Develop and Implement Brain Injury Specific Education

- Develop foundational interdisciplinary BI module
- Expand educational access across community sectors
- Provide concussion care training
- Enhance neuro-rehab education
- Standardized caregiver and lived experience
- Build sustainable workforce through academic residency programs
- Strengthen BI-MHSU cross-training

Develop a Regional Concussion Management Strategy

- Implement a regional concussion strategy
- Develop and implement a concussion clinic

Implement a Team-Based Care Model for Moderate to Severe and Complex Brain Injury

- Establish interdisciplinary team-care model
- Revise eligibility criteria
- Establish non-BI specific long-term community case management
- Establish clear pathways in and out of services
- Develop integrated BI-MHSU model
- Embed psychiatry within BI teams
- Eliminate substance-related eligibility barriers
- Expand CONNECT-model

Integrate Stable Housing as a Foundational Element of Brain Injury Rehabilitation

- Ensure diverse, needs-based housing options
- Develop BI housing strategy
- Standardized housing registry policy
- Enhance housing supports through education
- Establish shared housing response protocols for individuals at risk of eviction
- Explore and expand recovery-focused housing
- Explore additional housing assessment tools
- Develop young adult LTC beds

Explore Opportunities to Improve Current Resource and Funding Models

- Shift toward sustainable/flexible funding
- Review and revise IH ABI program contracts
- Enhance flexibility of funding to address client needs
- Explore outreach travel funding opportunities
- Develop academic BI partnerships to access clinical assessments
- Evaluate BI funding return on investments

Improve Ability to Capture, Share and use Brain Injury Related Data

- Add BI conditions to CIHI Type 3 ICD-10 Diagnosis
- Implement NACRS Level 3 in ED
- Explore standardization of collection and reporting of BI data

Establish a Strategic Brain Injury Council

- Form BI Council to sustain cross-sector collaboration post-grant

Recommendation #1: **Service and Support Pathways**

The CBISI Advisory Council recommends IH's clinical experts, in collaboration with community partners, develop service and support pathways to outline the evidence-based, best practice care journey for people experiencing mild brain injury and moderate to severe brain injury.

Despite the existence of many services and supports, individuals who have experienced a brain injury frequently fall through the cracks due partially to unclear referral pathways, and fragmented care systems. A service and support pathway would outline the optimal sequence of care in a clearly defined, evidence-informed pathway, translating clinical guidelines and evidence into local care structures. By reducing the reliance on individual providers to identify next steps in the care journey, a service and support pathway enhances system efficiency, promotes consistency across providers, and supports individuals with brain injury to receive consistent, coordinated, and person-centered care. For the purposes of this recommendation, a service and support pathway refers to the optimal care journey a patient would access to address all required clinical needs from the point of discharge from an acute facility to their reintegration into their home community.

> *"I think it's difficult because we like, we'll build a plan in hospital and then once they're discharged then we have no follow up. We have no support after their discharge and so we're just trusting that everything is being done in community and so often things fall through the cracks."* **Service provider**

Recommended actions include:

1.1 Develop a transparent "service roadmap" to guide survivors, families, caregivers, and community providers through the care trajectory. This road map will help set expectations for recovery and outline access to services and should be written specifically for people with lived experience and their support network. *(Suggested Lead: [4]IH to lead with grant funded position, Individuals with lived experience and community support)*

1.2 Develop IH service and support pathways for brain injury care to guide service providers through standardized, evidence-informed steps across the continuum of care. *(Suggested Lead: IH grant funded position to lead with individuals with lived experience and community support)*

1.3 Support advocacy for a provincial brain injury strategy to identify and address ongoing service gaps between the evidence-based optimal pathway and current services available through brain injury associations and health authorities. *(Suggested lead: IH to lead with BC Brain Injury Organizations and community support)*

1.4 Expand peer support programs into regions where they are not yet established. *(Suggested lead: BI organizations, Lead of Peers Actively involved in Rehabilitation program, IH grant funded position)*

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[4] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

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1.5 **Develop direct pathways to income support agencies** to reduce administrative barriers to income supports (e.g., Ministry of Social Development and Poverty Reduction [MSDPR], Service Canada, and related agencies). *(Suggested lead: IH grant funded position to lead with MSDPR)*

1.6 **Collaborate with local transit authorities and community partners to expand transportation options** to rural residents, coordinating services to ensure access to medical and rehabilitation appointments outlined in the service and support pathway. *(Suggested lead*[5]*: Rural Transport Partners)*

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[5] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

Recommendation #2: **Develop Centralized Virtual Intake and Coordination**

The CBISI Advisory Council recommends a centralized virtual team be established to manage intake, assessment, navigation and treatment coordination for all individuals with BI providing a single point of access that streamlines entry into services and supports, and ongoing coordination across health, social and community sectors.

Individuals and providers expressed a desire for a centralized place to access supports and share information related to their BI. Building intake and coordination functions along with linking individuals and providers to existing resources and educational supports in a centralized fashion could address this need.

> "If there [was] a case management model where everybody with a brain injury was held onto by one central person… that would just be safer and just better patient care."
> **Service provider**

Recommended actions include:

2.1 Establish a centralized virtual access point for intake, triage, and connection to BI supports across health, community and social services. *(Suggested lead*[6]*: IH in partnership with BC Brain Injury Organizations)*

2.2 Develop **standardized tools, communication processes and privacy agreements** that enable secure, privacy-approved information sharing across health and community partners, reducing the need for individuals to retell their stories. *(Suggested lead: IH grant funded position, Director of Stroke Network, and Manager ABI Special Populations, BC Housing, Community Service Providers)*

2.3 Maintain an updated list of service providers in partnership with provincial BI organizations. *(Suggested lead: BC Brain Injury Organizations)*

2.4 Establish a brain injury stream within the Rapid Access to Consultative Expertise (RACE) program to improve support for primary care providers. *(Suggested lead: RACE Initiative Liaison, Interior Region)*

2.5 Create a care and service transition passport tool to support individuals with brain injury to improve information sharing between providers about topics such as transportation, daily care needs, and personal support requirements, with space for clients and families to add their own details. By centralizing this information, the passport would reduce unsafe care experiences, empower individuals, and lessen the need for survivors to continually retell their stories while helping them understand and initiate their care pathway. *(Suggested lead*[7]*: BC BI Organizations, Individuals with lived experience, IH Grant Funded Position)*

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[6] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

[7] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

Recommendation #3: **Develop and Implement Brain Injury Specific Education**

The CBISI Advisory Council recommended the development and implementation of brain injury specific education for various provider types across IH, BI specific organizations, and more broadly with service providers in the community with the education tailored to the needs of the provider type. Consider opportunities for collaboration and economies of scale.

While there is a wide range of BI education already available, some of which is high quality and evidence-informed, much of it remains introductory rather than the depth or clinical specificity needed to support consistent, best-practice care across settings or disciplines. Additionally, many healthcare and social service providers are either unaware of available resources or face financial and time constraints that limit access to education. Rather than creating new content, there is an opportunity to curate and build upon existing resources to develop a cross-discipline education strategy. This approach should focus on five primary objectives:

- Education for interdisciplinary providers working with people with a BI in any capacity, focused on how to recognize, communicate and collaborate with, and refer people with a BI.
- Cross-training between BI and MHSU teams to build shared understanding, improve coordinated care for individuals with co-occurring conditions.
- Education for those providing neurorehabilitation and focused care specifically to individuals with BI to strengthen clinical expertise in cognitive rehabilitation and neuro-behavioral care, ensuring providers are equipped with the knowledge and tools necessary to support individuals living with BI.
- Concussion education, primarily for ED and primary care teams.
- Education for individuals with lived experience and their families, focused on self-management, recovery expectations, and navigating available supports to help them take an active role in their recovery journey.

> "It's quite degrading at times, when you have to ask for help, and if the person sitting behind the desk or on the other side of the room is judgmental, which is one of the biggest gaps is lack of training for staff in the services. There's a lot of judgment and there's a lot of entitlements and a lot of assumptions made when there shouldn't be."
> **Individual with lived experience**

Recommended actions include:

3.1 Develop an interdisciplinary, foundational education module for IH and community organization staff increasing provider competency by outlining how to adapt clinical practice to support individuals with brain injury. *(Suggested lead[8]: IH Operational Knowledge Coordinator: ABI & Concurrent Disorders, BI Organizations)*

3.2 Explore opportunities for IH staff providing neurorehabilitation to access BI specific education, through regional or provincial education discounts or establish an education fund, to support staff in accessing brain injury–specific neurorehabilitation training.

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[8] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

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(Suggested lead[9]: IH Operational Knowledge Coordinator: ABI & Concurrent Disorders, Professional Practice Office of Allied Health, Trauma Service Network Clinical Nurse Specialist)

3.3 Provide concussion care and management training for teams such as allied health teams to improve competence and reduce variability in care as well as **all ED clinical staff, and Primary Care Practitioners as part of orientation processes** in response to and in support of the prevalence of concussions in ED and primary care settings. *(Suggested lead: Operational Knowledge Coordinator: ABI and Concurrent Disorders with Professional Practice Office of Allied Health, Primary Care Clinical Network Divisions of Family Practice, TSN Clinical Nurse Specialist)*

3.4 Ensure brain injury education for individuals with lived experience and caregivers is standardized, evidence-informed, and delivered consistently across settings *(Suggested lead: BC Brain Injury Organization, Local Brain Injury Organizations individuals with lived experience, Community Service Providers)*

3.5 Take a future-oriented approach to build long-term workforce expertise in brain injury by integrating BI-focused education into academic and residency training pathways. Anticipating future needs while ensuring a sustainable, specialized workforce prepared to meet the growing need of brain injury care. *(Suggested lead: Medical Director of MHSU)*

3.6 Strengthen cross-training between ABI and MHSU staff to build the skills and capacity needed to support individuals with co-occurring conditions, reducing instances where individuals are declined access to programs due to lack of appropriate expertise or supports within programs. *(Suggested lead: MHSU Leadership, and Operational Knowledge Coordinator: ABI & Concurrent Disorders)*

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[9] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

Recommendation #4: **Develop a Regional Concussion Management Strategy**

The CBISI Advisory Council recommends the creation of a standardized concussion management pathway to ensure timely recognition, early intervention, and coordinated follow-up for individuals with mild brain injury.

Currently, IH is one of the only health authorities in the province without a concussion care pathway. As a result, individuals with concussions are often discharged from EDs or urgent primary care centres without structured follow-up. This leaves the responsibility for diagnosis, education, and ongoing management largely with general practitioners who may not have knowledge in concussion protocols, up to date research, and best practice guidelines, leading to inconsistent care. Despite the initial mild severity, research shows that over half of mild BI cases in Canada do not fully recover within six months (MAAS et al.,2022), underscoring the need for early intervention to prevent persistent symptoms, reduce long-term impacts, and lower health care utilization.

A regional concussion pathway would address these gaps by standardizing care, improving access to education and follow-up and reducing reliance on individuals and families to self-navigate.

> "[When I was trying to access service]…. I was told that I had too much ability, that I was taking up too much."
> **Individual with lived experience**

Recommended actions include:

4.1 Develop and implement a concussion management strategy across the IH region, considering cost-effectiveness and evidence-based strategies of managing concussion. *(Suggested lead[10]: IH Trauma Services Network, Primary Care Clinical Network, Allied Health Leadership, IH ABI Program.)*

4.2 Develop and implement a standardized, comprehensive concussion clinic program for individuals with mild brain injury, incorporating a tiered management model including a graduated program where individuals are provided with self-management resources, group interventions and individual interventions for those who have persistent symptoms. *(Suggested lead: Allied Health Leadership, CNS Trauma Service Network, IH ABI Program)*

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[10] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

Recommendation #5: **Implement a Team-Based Care Model for Moderate to Severe and Complex Brain Injury**

The CBISI Advisory Council recommends implementing a team-based care approach for individuals with moderate to severe BI's to be carried through their recovery journey with proactive outreach and coordinated transitions, rather than being left to self-navigate complex and fragmented systems. Modeled after the Cancer Care System, this strategy should replace fragmented, self-navigated pathways with an interprofessional model of care that is collaborative, continuous, and person-centered.

International guidelines recognize interprofessional rehabilitation as the standard for optimizing recovery and community reintegration following brain injury. While acute sites typically provide interdisciplinary rehabilitation, access to coordinated outpatient rehabilitation across IH remains limited once acute needs are met. CONNECT Lake Country offers a step-down rehabilitation option, but capacity is limited and not always accessible for those residing outside of the Okanagan. In community, care shifts to a multidisciplinary model across multiple agencies and organizations, where each discipline works in parallel, leaving clients and families to coordinate services and determine next steps.

The strengths of a team-based care approach modeled after the cancer care system, is that the care team assumes responsibility for contacting the client, coordinating care, and guiding the recovery pathway. Rather than requiring individuals and families to self-navigate, the system itself carries the client through. This is an especially critical support for those living with BI, who may struggle with memory, organization, or insight into their care needs. A team-based care approach should include an Occupational Therapist to provide cognitive assessments, screening, and collaborative goal setting as part of the regional ABI team. Possible other team members to support BI include PT, SLP, social work, MHSU clinicians, nursing, counselling, psychiatry, physiatry, neuropsychology, and Indigenous patient navigator.

> "When there's individuals with very complex needs that are under serviced in the specific area … [of] their main challenge, then the other service providers are underutilized as well … it just becomes a bit like chaotic planning of different organizations trying to jump in and help with not enough expertise or background knowledge."
> **Service provider**

Recommended actions include:

5.1 Establish a team-based care approach for individuals with moderate to severe BI's to be carried through their recovery journey with proactive outreach and coordinated transitions, rather than being left to self-navigate complex and fragmented systems. (Suggested Lead[11]: IH ABI Program, Allied Health Leadership, Psychiatry, Psychology)

5.2 Revise eligibility criteria for IH ABI services to remove age-based exclusions and include individuals without formal diagnosis but presenting with symptomatology of BI. To ensure expanded eligibility does not exceed available resources this process should include review of medical and patient-reported history, clear criteria for ABI service

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[11] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

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involvement, and consideration for possible tiered service options based on level of need and diagnostic certainty *(Suggested Lead: IH ABI Program with support of Psychiatry and Neurology)*

5.3 Establish a dedicated team focused on long-term, community-based case management for individuals with BI whose rehabilitation goals have plateaued but who continue to require coordinated support to maintain stability in community. This would not need to be an ABI specific team. *(Suggested Lead: Home and Community Care leadership, Individuals with lived experience, IH ABI program, MHSU Leadership, Medical Health Officers)*

5.4 Establish clear transition pathways into and out of the IH ABI program. To maintain program capacity, the program should implement a formal discharge process for individuals who have achieved their rehabilitation goals, while also creating re-entry points for those who experience changes in status or function and need renewed access to services. *(Suggested Lead: IH ABI Program, Allied Health Leadership, Home Health Leadership, IH Grant funded position)*

5.5 Develop an integrated care program between IH MHSU and IH ABI Program to improve service provision for individuals with both BI and MHSU needs and enhance coordination and alignment of services. *(Suggested Lead: MHSU Leadership, IH ABI Program, Individuals with lived experience)*

5.6 Embed psychiatry within IH ABI team for consultation and 1:1 psychiatry support, modeled after the Thompson Cariboo Region, with dedicated hours for BI clients to meet in person or virtually with a psychiatrist assigned to the BI team. *(Suggested Lead: IH ABI Program, Psychiatry Leadership, MHSU Leadership)*

5.7 To ensure substance use is not a barrier to accessing services, eligibility criteria for programming should be based on individual function and ability to engage with programming. *(Suggested Lead: Director Toxic Drug Supply, IH ABI Program, Home Health Leadership, MHSU Leadership, Individuals with lived experience)*

5.8 Explore opportunities to expand and adapt the CONNECT-Lake Country model across the Interior region to provide access to step-down interdisciplinary neurorehabilitation following inpatient rehab care. *(Suggested lead[12]: CONNECT- Lake Country, IH Population Health and Housing Team, IH ABI Program)*

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[12] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

Recommendation #6: **Integrate Stable Housing as a Foundational Element of Brain Injury Rehabilitation**

The CBISI Advisory Council recommends a multi-layered housing approach be adopted, ensuring stable, affordable, and appropriately matched housing. This housing would include wraparound care that integrates brain injury supports, mental health and substance use supports, behavioral support, peer support, life skills development, and family involvement.

The most significant housing concern identified through the data was the lack of available, suitable beds for individuals who have experienced a BI with varying levels of behavioral and support needs. This shortage is compounded by limited behavioral and life skills supports in existing housing, creating additional barriers to securing and maintaining stable housing. Participant feedback also emphasized the importance of age-appropriate housing (i.e. separate housing for younger individuals and seniors) and offering a continuum of housing from semi-independent, assisted living to long term care. Affordability remains a barrier with disability payments not aligning with actual housing costs.

> "Some of the individuals that we've seen come through with brain injury have been unhoused or precariously housed, and so the brain injury has impacted their ability to function independently. So, leaving them to go back to the streets or go back to a precarious housing situation where they're put in unsafe situations on a daily basis, it creates a lot more distress."
> **Service Provider**

Recommended actions include:

6.1 Create a diverse range of community housing options with placement guided by clinical risk, age, behavioral health needs, and recovery goals, with consideration for BI-specific beds within each housing model. *(Suggested lead[13]: BC Housing, Community Service Providers, IH Population Health and Housing Team, CONNECT- Lake Country, IH ABI Program Individuals with lived experience)*

6.2 IH Health and Housing team to lead development of a housing strategy that meets the need of individuals with BI and complex needs. *(Suggested lead: IH Population Health and Housing Team, Individuals with lived experience)*

6.3 Explore standardization of BC Housing's registry requirements to have authorized contacts included in registry process allowing service providers to call on behalf of individuals every six months to stay active on registry. *(Suggested lead: BC Housing, IH ABI Program, IH Privacy Department, IH Grant Funded position)*

6.4 Deliver BI-specific education to staff within housing programs, shelters, outreach and transitional housing to expand BI informed supports. *(Suggested lead: BC Housing, Community Service Providers, Operational Knowledge Coordinator: ABI & Concurrent Disorders, Local Brain Injury Organizations)*

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[13] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

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6.5 Establish shared housing response protocols with housing providers for roles, communication, and escalation pathways when clients disengage or are at risk of eviction, establishing a shared understanding formalized through an MOU with housing providers. *(Suggested lead: IH ABI Program, BC Housing, Community Service Providers, IH Population Health and Housing Team, MHSU Leadership)*

6.6 Explore and expand recovery-focused housing options beyond the current Housing First mandate, including safe placement protocols and pathways for individuals with brain injury and a history of substance use who are requesting recovery-supportive housing. *(Suggested lead: BC Housing and Associated Ministries, Community Service Providers, MHSU Leadership, Director of Toxic Drug Supply)*

6.7 Explore the applicability of interRAI Community Mental Health (CMH) and interRAI Rehabilitation/Post-Acute Care (PAC-Rehab) for individuals with brain injury, to ensure assessments capture Instrumental Activities of Daily Living, cognitive, and behavioral challenges in addition to personal care needs. *(Suggested lead: Home Health Leadership, Allied Health Leadership, Director of Long-Term Care Services)*

6.8 Develop young adult units in LTC that provide full long-term care supports but are tailored to younger individuals, including those living with brain injury who do not fit within traditional LTC. These should be pro-social care beds, not behavioral beds, and be community-integrated to support engagement and meet the needs of a younger demographic. *(Suggested lead[14]: CONNECT Lake Country, Directors of LTC)*

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[14] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

Recommendation #7: **Explore Opportunities to Improve Current Resource and Funding Models**

The CBISI Advisory Council recommends the essential examination of existing resource and funding models to ensure they align with the needs of both clients and service providers and strengthen and sustain brain injury services across the IH region.

Current structures often lack the reach to serve individuals in rural and remote communities and do not always support creative or cost-effective solutions that improve daily functioning and long-term recovery outcomes. Exploring alternative and upstream funding models will help ensure prevention, post-injury support, and recovery pathways are resourced in a way that meets demand across the region.

> "If you want to provide outreach in remote areas, you need to provide funding to get the outreach worker to the remote areas."
> **Service provider**

Recommended actions include:

7.1 Explore funding options for community service providers through the BC Brain Injury organizations to support community brain injury associations, including a potential shift away from temporary or targeted funding toward sustainable and flexible funding contracts. *(Suggested lead[15]: BC Brain Injury Organizations in partnership with Local Brain Injury organizations)*

7.2 Review and revise IH ABI Program contracts with brain injury organizations to seek opportunities for efficiencies within current BI funding. Contracts should be updated to eliminate age-based restrictions, such as limiting access to those over 65, and to address funding barriers that reduce flexibility in meeting client and provider needs. *(Suggested lead: IH ABI Program, IHA Contracts Department, Local Brain Injury Organizations)*

7.3 Enable brain injury societies to provide services for individuals without a formal diagnosis but who present with symptoms and support needs by reviewing funding and eligibility structures that currently restrict access for those without a formal diagnosis. *(Suggested Lead: BC Brain Injury Organizations, Local Brain Injury Organizations, IH ABI Program)*

7.4 Seek opportunities for increased funding for BI associations to cover outreach travel expenses (e.g. mileage) to surrounding communities by exploring options such as incorporating these costs into health authority contracts and pursuing other funding sources such as rural health organizations, ministries, and the BC BI Organizations. *(Suggested lead: BC Brain Injury Organizations, IH ABI Program)*

7.5 Explore academic partnerships to extend neuropsychological services into under-resourced regions such as the East and West Kootenays. *(Suggested lead: Neurology Department Leadership, Dr. Harry Miller, Associate Clinical Professor, Psychology, UBC Okanagan,)*

7.6 Evaluate BI funding return on investments and explore upstream funding models that strengthen prevention, improve post-injury supports, and enhance recovery outcomes *to reduce ongoing costs driven by delayed intervention, higher acute care utilization, justice involvement, and long-term support needs (Suggested lead: Ministry of Health in partnership with Ministry of Mental Health & Addictions, Ministry of Social Development & Poverty Reduction, and Ministry of Children & Family Development)*

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[15] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

Recommendation #8: **Improve Ability to Capture, Share and Use Brain Injury Related Data**

The CBISI Advisory Council recommends enhanced BI surveillance in the Interior region of BC by strengthening ICD-10-CA coding practices and implementing consistent data capture protocols within IH and provincial reporting pathways. This will address current under-representation of BI cases, support accurate provincial surveillance, and ensure health system decisions are based on complete, reliable data.

ICD-10-CA codes assigned to patient encounters are a primary data source for reporting through established provincial reporting structures to inform public health surveillance, research, and prevention efforts. However, research suggests that brain injuries including mild TBIs are likely under-represented in administrative datasets due to coding limitations and the exclusion of certain diagnostic codes. The Public Health Agency of Canada (PHAC) has identified significant surveillance gaps in TBI and concussion data, including inconsistencies across data sources, reinforcing the need for improved data linkage and coding procedures. Strengthening BI data capture within the IH–BCCDC reporting pathway will provide a more accurate and actionable picture of BI burden across the health care system, better informing prevention strategies, service planning, and policy development and in turn improving outcomes.

> "I was saying I have one client with, identified with a brain injury. Now I'm looking at my client list wondering how many other ones have had a brain injury."
> **Service provider**

Recommended actions include:

8.1 Request the addition of BI related conditions to CIHI's mandatory Type 3 ICD-10 diagnoses to all inpatient encounters to better understand various health metrics related to those with a BI when they are admitted to acute care. *(Suggested lead: BC Brain Injury Organization, Health Record Services, Lead Clinical Data Management, Lead Injury Prevention and Safety Promotion, Trauma Services BC)*

8.2 Explore data solutions to improve data collection for brain injuries across all E.Ds. **Solutions may include the use of National Ambulatory Care Reporting Systems (NACRS) Level 3 or other potential data capture and sharing solutions.** ICD-10-CA and CCI intervention codes would assist in capturing brain injury presentations and interventions, enabling better understanding of ED volumes and care needs *(Suggested lead: IH Business Solutions and Data and Analytics Team)*

8.3 Explore options to standardize collection and reporting of BI related workload data to the Ministry of Health, including confirming whether indirect time (e.g., non-direct care activities related to brain injury support) is currently reported to better reflect the true resource use associated with brain injury care (Suggested lead:[16] Health Record Services, IH ABI Program)

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[16] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

Recommendation #9: **Establish a Strategic Brain Injury Council**

The CBISI Advisory Council recommends establishment of a Strategic Brain Injury Council with membership across health and community sectors to strengthen partnerships and build a connected continuum of supports.

Building on the strength of the CBISI Advisory Council which successfully brought multiple partners together, a Strategic Brain Injury Council will ensure this collaboration continues. Brain injury intersects with nearly every department across health and community services, making it difficult for one area to hold dedicated ownership. By bringing diverse partners together, the council will foster alignment across sectors and advance a connected, collaborative approach to care, with lived experience remaining central in guiding decisions.

> "Even just being part of this advisory council has had an impact. This is the first time in my long career that I've been part of a collaborative committee that is so broad in its membership. The opportunity to learn from each other and connect has been so valuable, in addition to the work of drafting recommendations."
> **Service provider**

Recommended actions include:

9.1 Establish a Brain Injury Council to support ongoing collaboration across multiple portfolios and external partners. This council would serve as the central table for guiding service and support pathways, exploring implementation of CBISI recommendations, fostering alignment across health and community sectors, and ensuring that lived experience continues to inform decision-making. *(Suggested lead[17]: IH to lead with grant funded position, Individuals with lived experience, Local Brain Injury Organizations, Community Service Providers, IH ABI Program)*

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[17] **Individuals with lived experience are embedded as contributors and partners across all recommendations and action items, even where not explicitly listed as a lead**

Desired Future State for People, Providers and the Integrated System of Supports

Improved Patient and Caregiver Experience

- Knowing how and where to access care
- Improved access to services and supports
- One access point for BI services
- Improved trust of the system
- Improved resource navigation
- More patient centred and safe care experiences
- Enhanced patient care experience
- Less separation between teams and settings

Improved Population Health Outcomes

- Enhanced BI knowledge and competency across sectors
- Standardized clinical practice for BI care
- Stronger cross sector collaboration
- Improved coordination of services across the continuum
- Higher quality of care delivered earlier and more consistently

Improved Provider Experience

- Enhanced provider confidence and competency
- Improved decision-making tools
- Improved information and data sharing between service providers
- Improved provider efficiency
- Stronger communication and collaboration of care teams working together

Reduced Per Capita Costs of Care

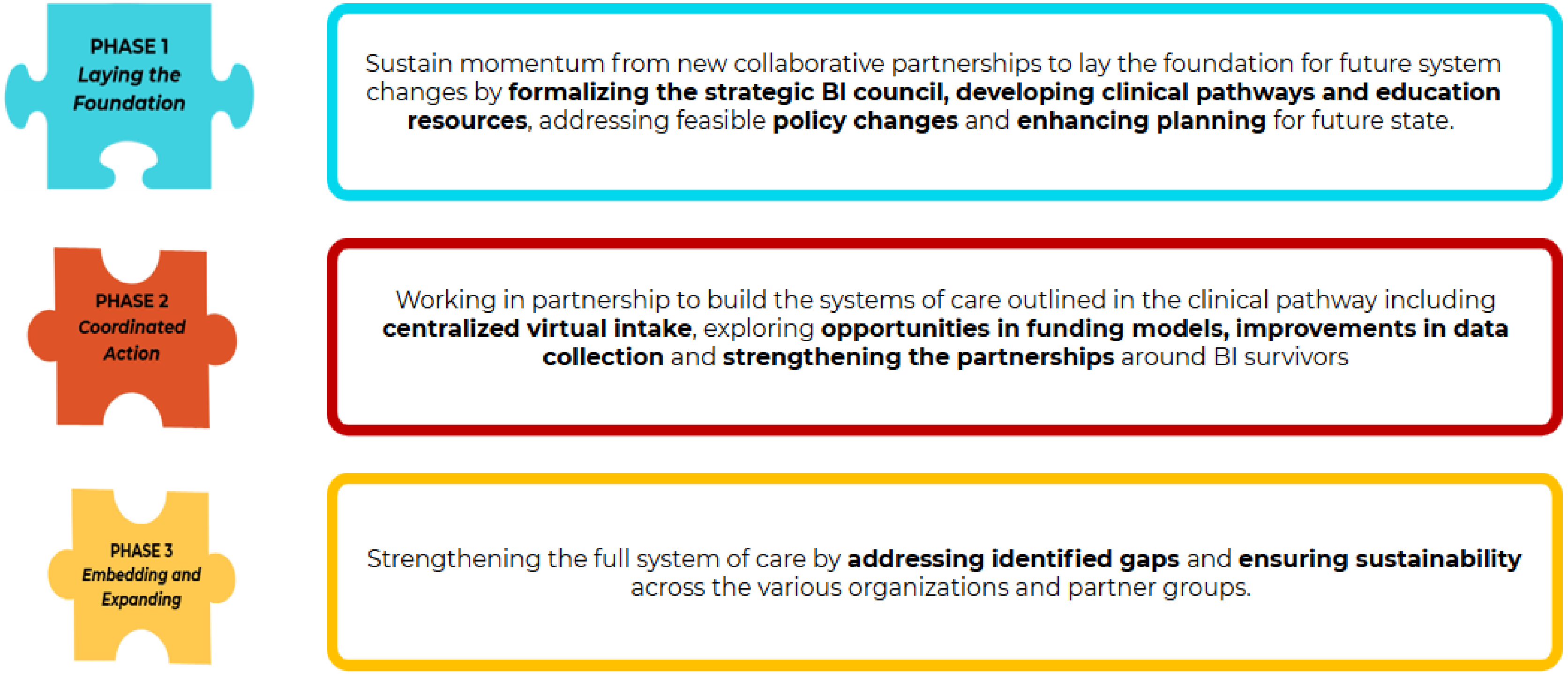
- Reduced downstream costs and ongoing care requirements
- Improved BI data collection to inform planning and resource allocation
- Improved efficiency of care delivery
- Improved information sharing to reduce duplication and service gaps

Shared Path Forward for Brain Injury Support

The CBISI recommendations are not intended as a directive for immediate implementation, but as an evidence informed framework intended to guide coordinated action as sectors and departments can draw from as they align with organizational priorities. Each partner may identify and adopt elements that best support their mandate, ensuring that system improvements unfold in a collaborative and sustainable way. The recommendations provide a foundation for future action by outlining a phased roadmap toward a coordinated, equitable, and person-centered system of BI support.

An important first step is establishing a Strategic Brain Injury Council to sustain momentum and build on collaborative relationships already established. The Council provides a cost-effective way to bring health, housing, community, justice, and academic partners together, leveraging existing expertise and resources to align efforts. By coordinating at one table, the Council offers a sustainable mechanism to carry CBISI's recommendations forward while ensuring lived experience remains central to decision-making. This collaborative forum provides a place for coordinated action well beyond the initial funding period and sets the foundation from which all other steps can follow.

Below is a high-level phased approach to working on the recommendation with project partners.



PHASE 1
Laying the Foundation

Sustain momentum from new collaborative partnerships to lay the foundation for future system changes by **formalizing the strategic BI council, developing clinical pathways and education resources**, addressing feasible **policy changes** and **enhancing planning** for future state.

PHASE 2
Coordinated Action

Working in partnership to build the systems of care outlined in the clinical pathway including **centralized virtual intake**, exploring **opportunities in funding models, improvements in data collection** and **strengthening the partnerships** around BI survivors

PHASE 3
Embedding and Expanding

Strengthening the full system of care by **addressing identified gaps** and **ensuring sustainability** across the various organizations and partner groups.

Learnings Through our Project

Hospital Resource Use and System Impact of Brain Injury in Interior Health

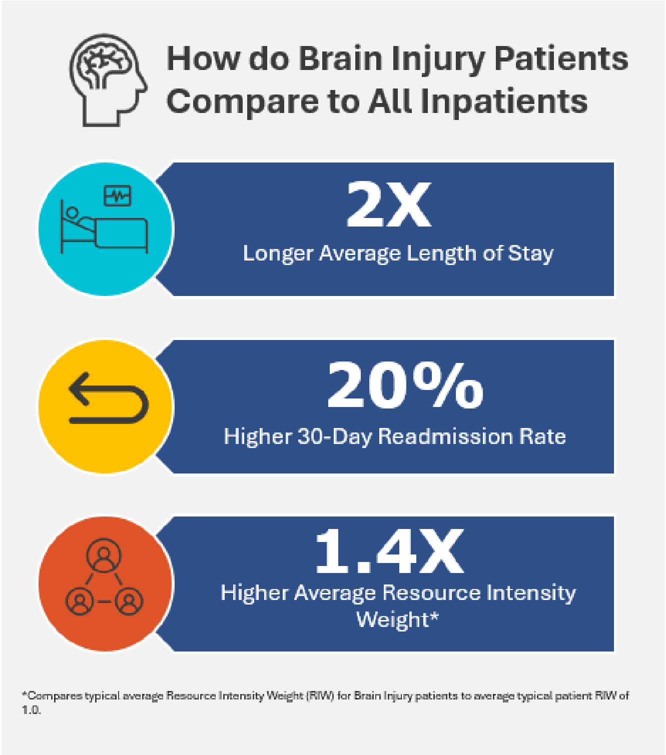
System Impact and Data Limitations

While data is available on resource allocation and length of stay for patients with BI, it is important to acknowledge a key limitation in our data sources: the reliance on ICD-10 codes. These codes are only assigned when BI is explicitly documented by the clinical provider in the patient's record. Patients whose BI significantly contributes to the complexity of their hospital stay but whose primary reason for admission is coded differently, such as for a wound or substance use would not be captured in BI-specific datasets.

Beyond coding limitations, BI may go unrecognized when individuals receive support in health or community setting. Many individuals with BI do not seek medical attention, do not present to hospital settings, or are not formally diagnosed despite a clear history, mechanism of injury, and symptomatology consistent with BI. This is particularly true for individuals with concurrent disorders such as substance use, mental health conditions, housing instability, or histories of repeated injury where BI may be less visible amid other presenting concerns. Survivors of IPV are also at increased risk of having BI go unrecognized, as injuries may be unreported, care may be avoided for safety or legal reasons, or individuals may choose not to pursue a formal diagnosis due to fear, stigma, or ongoing risk.

Together, these factors result in systemic underrepresentation, as ICD coding systems have historically shown low sensitivity and positive predictive value for BI surveillance, particularly for complex or atypical presentations (Faul et al., 2010; Shore et al., 2005; Bazarian et al., 2006; Hedegaard et al., 2020).

This underrepresentation has real implications. ICD-coded data is widely used for public health surveillance, funding decisions, and system planning. When BI isn't documented or coded, those cases are effectively invisible in datasets that shape how services are designed and resourced. To support more standardized comparisons, our analysis excluded atypical cases when calculating the RIW; however, these cases often involve greater clinical complexity, more intensive hospital resource use, and longer lengths of stay, which increases the risk of underestimating overall system needs. Even among "typical" cases, average length of stay frequently exceeds what is expected, suggesting that the true care burden of BI is often underestimated. For these reasons, while the findings in this report highlight important trends in resource use and service demand, the numbers presented likely do not fully reflect the true scope of BI across the system.



How do Brain Injury Patients Compare to All Inpatients

2X
Longer Average Length of Stay

20%
Higher 30-Day Readmission Rate

1.4X
Higher Average Resource Intensity Weight*

*Compares typical average Resource Intensity Weight (RIW) for Brain Injury patients to average typical patient RIW of 1.0.

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Interior Health Data

Data related to BI patients in IH was pulled from the IH data warehouse[18] using ICD-10-CA codes inclusive of BI, selected based on Chen and Colantonio's definition of neurotrauma (2011). Selected diagnoses were identified as either most responsible diagnosis (MRDx) or pre-admit comorbidity (Type 1), as defined by CIHI coding standards (2022).

Across three fiscal years (2021/22 to 2023/24), 732 unique BI patients were identified. Their average length of stay (ALOS) was 12.7 days, approximately two-times longer than the ALOS for all inpatients. In comparison, a retrospective study by Phillips et al (2009) found a provincial average length of stay of 7.4 days for head injury admissions. Tertiary hospitals demonstrated a higher ALOS for BI patients compared to regional or community hospitals, likely reflecting the transfer of more acute cases requiring increased care needs. There were 219 (30%) BI patients identified as being readmitted within 30-days of previous visit discharge, with an average of 11.2 days between initial discharge and readmission. This is approximately 20% higher than the IH 30-day crude readmission rate for all hospitalizations (note crude readmission excludes MHSU patients).

For the same period, 78 patients (11%) were designated as Alternate Level of Care (ALC) during their admission. Resource Intensity Weight (RIW) analysis further highlighted system impact: the average RIW for typical BI patients was 1.4, which is almost one-and-a-half times higher than CIHI's typical average patient RIW benchmark of 1.0. Nearly half (47%) of BI patients were classified as atypical cases (which were excluded when comparing RIW), CIHI defines atypical patients as those who expired during admission, were transferred in or out, left against medical advice, or had long stays.

Canadian Comparison

Boutin et al. (2013) found that 7% of TBI patients were readmitted within 30 days, 12.7% by three months, and 17.6% within six months. In contrast, IH's 30-day readmission rate of 30% far exceeds 7%, underscoring the impact of limited coordinated community follow-up.

IH data show that BI patients face longer hospital stays, higher readmissions, and greater resource intensity utilization. These pressures highlight the need for coordinated pathways into community care, alongside the supports required in community to help individuals recover.

Disclaimer:

Direct comparisons between the Phillips et al. and Boutin et al. studies and IH data should be made with caution. The findings from these studies are contextually informative but not methodologically equivalent and differ in regard to time frame, data exclusions, and diagnosis definitions.

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[18] *IH Data Warehouse – Discharge Abstracts Universe, DAD*

Power BI Acute App, Discharged Inpatient Indicators, as of June 13, 2025,

Power BI Acute App, Indicators: 30 Day Overall Readmission Rate (IH Hospitals), as of June 13, 2025

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Note that the IH dataset resulted in a relatively small volume of BI patients for analysis therefore interpret trends with caution. Average length of stay values may be skewed by long stays which were not excluded from the data since they are an important fact of BI care.

Notes:

Average Length of Stay (ALOS): sum of all days between admission date and discharge date divided by total number of patients; includes alternate level of care (ALC) days.

Resource Intensity Weight (RIW): a relative cost weight value derived from case-cost data submitted to CIHI. All RIW cost weights are relative to the average typical inpatient case, such that the sum of typical cases is equal to the sum of the typical weighted cases.

Atypical Patient: includes patients who expired during admission, were considered a long stay per CIHI, were transferred in or out, or who signed out (includes did not return from pass or left against medical advice).

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Indigenous Engagement

In our project design, we aimed to include four communities: urban, regional, rural, and a remote Indigenous community to ensure diversity of perspectives and to reflect the full IH landscape. From the outset we have worked closely with Indigenous engagement leads, following all recommended steps and guidance to approach the engagement request respectfully. Despite these efforts, a partnership with an Indigenous community could not be established within the project timeline. Indigenous leaders acknowledged the importance of the work but due to the volume of engagement requests, combined with high staff turnover and burnout they expressed limited capacity to participate. To ensure Indigenous voices were still represented, the project pivoted to include perspectives from urban Indigenous individuals and Indigenous service providers across communities.

Remote Indigenous Communities & BI Care

- **BC (on-reserve remoteness): 55%** of on-reserve First Nations people in BC live **≥50 km from a service centre**
- In northwestern BC, patients often require **air travel and multiple nights in hotels** to access specialist care, with costs far exceeding the **~$700 provincial travel supplement cap** (BCMJ, 2020; Government of BC, 2024)
- In Ontario, rural residents with ABI had **25% lower odds** of discharge to inpatient rehabilitation compared to urban residents (Chen et al., 2012).

In response to our inability to secure a partnership with a remote Indigenous community, the advisory council selected the rural communities within the Thompson Cariboo Region (TCR) to represent rural and remote contexts with a high proportion of Indigenous residents. According to the 2021 Canadian Census, the TCR has the highest percentage of individuals who self-identify as First Nations, Métis, or Inuit, or who report Registered/Treaty Indian status or First Nation band membership within IH. It is important to recognize the broader systemic inequities that shape access to supports and to acknowledge that rural and remote realities disproportionately affect Indigenous populations. We recognize the demands on Indigenous partners and will work together to ensure Indigenous voices are included in future planning. The data in the box is included to provide context and highlight why rural and remote realities disproportionately affect Indigenous patients. Ensuring the meaningful inclusion of Indigenous voices will remain a priority in future phases of system planning.

Allied Health Constraints

Allied Health professionals are a critical part of the interdisciplinary team supporting brain injury rehabilitation. Across the project, Allied Health providers described how workload demands, and staffing shortages limit their ability to meet BI rehabilitation needs. This challenge was echoed in every region, with rural areas experiencing the greatest strain, where limited resources often mean longer wait times and cognitive rehab being placed lower on priority lists.

Many Allied Health providers expressed strong support for the project but highlighted that even a one-hour commitment to participation would directly reduce client care. In rural regions the local physiotherapist explained that taking time away for the CBISI project would result in clients waiting an additional two weeks to be seen due to full caseload and limited FTE. Similarly, some participants were unable to attend focus groups because these conflicted with scheduled rehabilitation sessions, and missed sessions meant delays of two weeks before being seen again.

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In some rural regions, providers also noted that cognitive rehab is often placed lower on service priority lists, with individuals more likely to be placed on waitlists due to the limited availability of Allied Health resources. This contributes to variability in access to rehabilitation and makes it especially challenging for clients outside of larger centers.

Future planning will need to consider how best to support Allied Health providers in balancing clinical responsibilities with the ongoing need for cognitive rehabilitation in community. To reduce variabilities in care, Allied Health must be consistently recognized as a core component of brain injury rehabilitation, ensuring continuity of rehab from acute care through to community. Brain injury should be prioritized within service guidelines, and rural providers supported with training that builds confidence in delivering cognitive rehabilitation.

Pediatrics Population Needs

Although this project's scope centered on adult BI services, it is important to acknowledge the distinct needs and considerations within the pediatric population in future planning. In Canada, children and youth account for nearly 30% of all brain injuries, with concussions being the most commonly reported injury type (Neil Squire Society, 2024). Nationally, the Public Health Agency of Canada reports that among children and youth aged 5–19 years, concussions account for 74% of all TBI-related emergency visits (Public Health Agency of Canada, 2024). Children are at greater risk of concussion and more serious head injury than the general population, and they often take longer to recover compared to adults. Concussions can have lifelong impacts on a child or youth's functioning, influencing their ability to speak, walk, learn, work, and interact with others.

These realities point to the need for greater attention to pediatric concussion through improved recognition, management, research, and prevention strategies, alongside more accessible and publicly available care for children. While this project focused on adults, we consistently heard about the gap in concussion services, underscoring an important area for future consideration within IH and across British Columbia.

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Honouring the Voices We Lost

Throughout this project, we were profoundly impacted by the voices and experiences of people living with BI. Three individuals who generously shared their stories with us have passed away during the project, and another has returned to a precarious housing situation, and we have lost contact. Their journeys reflect both incredible resilience and the deep inequities that continue to exist across housing, health, and community systems.

We share their stories to honour their contributions, acknowledge their struggles, and carry their voices forward with the hope that this work will help drive meaningful change.

The first individual we wish to acknowledge had a history of substance use resulting in hypoxic BI, they had access to what could be considered the “best case” supports in the region. They had progressed through all rehabilitation streams and accessed specialized BI rehabilitation. Progressing to community living they were fortunate to secure stable subsidized housing, and with the support of a Life Skills Worker, they were actively working toward independence exploring employment opportunities and beginning an educational upgrading program. As they were reintegrating into community there was a break in their support system, which led to old coping mechanisms resurfacing. Unfortunately, on the day we were to connect they had passed away from an overdose. Their story is a reminder of the importance of building stronger, more integrated systems of care that address the intersecting realities of BI and substance use.

Another individual, who had experienced a BI two years earlier, spoke candidly about systemic barriers and frustrations. First contacted at the outset of the study, they were hesitant to contribute to a quality improvement initiative cautioning they would speak frankly about their sub-optimal experiences. They agreed to participate on the condition that their involvement serve as advocacy for change, stressing that improvement can only come from speaking candidly about lived experience. They shared about fragmented services and complex paperwork resulting in missing income supports, which created frustration and mistrust of the systems. Sadly, before the project ended, they passed away due to health complications. While their BI was not the cause of death, it compounded the challenges they faced in managing their overall health and navigating care. Although their acute medical needs were met, there were no BI-specific services or navigation supports available to address their longer-term needs. We are thankful for the strength they showed in sharing their experiences, and hopeful this project can bring some comfort to their loved ones in knowing their voice may help move change forward.

One participant described their rehabilitation journey, marked by both strong early supports and ongoing experiences of stigma and culturally unsafe care. This individual experienced a BI, received strong acute supports and went on to engage meaningfully in rehabilitation. Discharged at the beginning of the COVID-19 pandemic into a small rental that didn’t suit their needs but was all they could afford, they persevered and achieved significant gains in recovery. Although their speech was particularly impacted, they worked hard to improve despite limited access to speech therapy once discharged from the tertiary rehab site. Even with these barriers, they were able to return to employment, continue driving, and remain the primary care provider for the family. Their care journey, however, was not without challenges. They encountered culturally unsafe experiences within the healthcare system and faced stigma in their workplace following their BI. Over time, these pressures compounded. After years of abstinence, struggles with addiction resurfaced, accompanied by a deep loss of joy in daily life. Alcohol use increased, and suicidal thoughts emerged. These challenges were reflected in concerning behaviors, including erratic driving and periods of disappearing for days at a time. In the weeks before their death, police were made aware of these concerns through several encounters, after an assault in community they presented to hospital in significant pain. Despite being admitted, their condition deteriorated rapidly and, tragically, they passed away within 24 hours.

A fourth individual had been eager to engage with the project and remained connected until the final months. At the outset, they were re-entering the community after acute rehabilitation and had secured a placement in second-stage housing. This housing was temporary, designed to support individuals wishing to abstain from substances, with the expectation that they would eventually transition into more permanent housing. As they moved into low barrier housing, the reduction in life skills worker supports left

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their cognitive deficits unmet, while struggles with addiction resurfaced, and the need to focus on day-to-day survival left little room to stay engaged in the project. In the end, we lost contact highlighting how the absence of stable housing can derail recovery and break critical connections to supports and community.

These stories are not only tributes to the individuals we lost, but also reminders of the work still to be done. They highlight the importance of ensuring that BI supports are safe, equitable, and connected across systems. As we move forward, we carry these experiences with us to build a stronger, more supportive system of care.

Acknowledgements and Contributors

We gratefully acknowledge the many individuals, partners, and organizations whose voices, expertise, and collaboration shaped the development of this report. This includes people with lived and living experience of BI, their families, and community partners who generously shared their time and insights.

We thank the departments, teams, and community organizations across health, housing, social supports who will be instrumental in advancing the recommendations in the years ahead. Along with our academic partners Bradi Lorenz and Tori Stranges, whose collaboration was integral to this project and has helped pave the way for future partnerships.

Finally, we extend a heartfelt thank you to our gracious funders, the KGH Foundation, whose support made this work possible.

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Appendix A: Suggested Leads of Recommendations (External Partners)

Link to full document: Recommendations and Suggested Lead Matrix

	Suggested Lead	BC Brain Injury Association	BC Housing	Community Service Providers	CONNECT Lake Country	Divisions of Family Practice	Dr. Harry Miller, Associate Clinical Professor, Psychology, UBC Okanagan	Lead Injury Prevention and Safety Promotion	Local Brain Injury Organisations	Lived Experience	Ministry of Mental Health & Addictions	Ministry of Health	Ministry Social Development and Poverty Reduction	PAIR Program (Dr. Julia Schmidt)	Rural Transport Partners
Recommendations															
Service and Support Pathways															
1.1	Develop a transparent "service roadmap"	🟨		🟨	🟨				🟨	🟨					
1.2	Develop service and support pathways	🟨		🟨	🟨				🟨	🟨					
1.3	Support advocacy for a provincial brain injury strategy	🟨	🟨	🟨					🟨	🟨					
1.4	Expand peer support programs									🟨				🟨	
1.4	Develop direct pathways to income support agencies												🟨		
1.5	Expand transportation options to rural residents									🟨					🟨
Develop Centralized Virtual Intake and Coordination															
2.1	Establish a centralized virtual access	🟨							🟨	🟨					
2.2	Standardized tools, communication processes and privacy agreement		🟨	🟨					🟨	🟨					
2.3	Maintain an updated list of service providers	🟨							🟨						
2.4	Establish a brain injury stream within the Rapid Access to Consultative Expertise (RACE) program														
2.5	Create a care and service transition passport tool	🟨							🟨	🟨					

	Suggested Lead	BC Brain Injury Association	BC Housing	Community Service Providers	CONNECT Lake Country	Divisions of Family Practice	Dr. Harry Miller, Associate Clinical Professor, Psychology, UBC Okanagan	Lead Injury Prevention and Safety Promotion	Local Brain Injury Organisations	Lived Experience	Ministry of Mental Health & Addictions	Ministry of Health	Ministry Social Development and Poverty Reduction	PAIR Program (Dr. Julia Schmidt)	Rural Transport Partners
Recommendations															
Develop and Implement Brain Injury Specific Education															
3.1	Develop an interdisciplinary, foundational education module for IH and community organization staff	🟨							🟨	🟨					
3.2	Explore opportunities for IH staff providing neurorehabilitation to access BI specific education														
3.3	Provide concussion care and management training for teams such as allied health teams to improve competence and reduce variability in care as well as all ED clinical staff, and Primary Care Practitioners as part of orientation processes					🟨									
3.4	Ensure brain injury education for individuals with lived experience and caregivers is standardized, evidence-informed, and delivered consistently across settings	🟨			🟨				🟨	🟨					
3.5	Take a future-oriented approach to build long-term workforce expertise in brain injury by integrating BI-focused education into academic and residency training pathways														
3.6	Strengthen cross-training between ABI and MHSU staff										🟨				
Develop a Regional Concussion Management Strategy															
4.1	Develop and implement a concussion management strategy across the Interior Health region														
4.2	Develop and implement a standardized, comprehensive concussion clinic program														

	Suggested Lead	BC Brain Injury Association	BC Housing	Community Service Providers	CONNECT Lake Country	Divisions of Family Practice	Dr. Harry Miller, Associate Clinical Professor, Psychology, UBC Okanagan	Lead Injury Prevention and Safety Promotion	Local Brain Injury Organisations	Lived Experience	Ministry of Mental Health & Addictions	Ministry of Health	Ministry Social Development and Poverty Reduction	PAIR Program (Dr. Julia Schmidt)	Rural Transport Partners
Recommendations															
Implement a Team Based Care Model for Moderate to Severe and Complex Brain Injury															
5.1	Establish a team-based care approach for individuals with moderate to severe BI's														
5.2	Revise eligibility criteria for IH ABI services to remove age-based exclusions and include individuals without formal diagnosis														
5.3	Establish a small, dedicated team focused on long-term, community-based case management for individuals with BI whose rehabilitation goals have plateaued									🟨					
5.4	Establish clear transition pathways into and out of the IH ABI program														
5.5	Develop an integrated care program between IH MHSU and IH ABI Program									🟨					
5.6	Embed psychiatry within IH ABI team for consultation and 1:1 psychiatry support														
5.7	Ensure substance use is not a barrier to accessing services									🟨					
5.8	Explore opportunities to expand and adapt the CONNECT-Lake Country model across the Interior region				🟨										
Integrate Stable Housing as a Foundational Element of Brain Injury Rehabilitation															
6.1	Create a diverse range of community housing options		🟨	🟨	🟨					🟨					
6.2	IH Health and Housing team to lead development of a housing strategy									🟨					
6.3	Explore standardization of BC Housing's registry requirements		🟨												
6.4	Deliver BI-specific education to staff within housing programs, shelters, outreach and transitional housing to expand BI informed supports.	🟨	🟨	🟨					🟨						

	Suggested Lead	BC Brain Injury Association	BC Housing	Community Service Providers	CONNECT Lake Country	Divisions of Family Practice	Dr. Harry Miller, Associate Clinical Professor, Psychology, UBC Okanagan	Lead Injury Prevention and Safety Promotion	Local Brain Injury Organisations	Lived Experience	Ministry of Mental Health & Addictions	Ministry of Health	Ministry Social Development and Poverty Reduction	PAIR Program (Dr. Julia Schmidt)	Rural Transport Partners
Recommendations															
6.5	Establish shared housing response protocols with housing providers		■	■											
6.6	Explore and expand recovery-focused housing options		■	■							■	■	■		
6.7	Explore the applicability of interRAI Assessments														
6.8	Develop young adult units in LTC				■										
Explore Opportunities to Improve Current Resources and Funding Models															
7.1	Explore funding options for community service providers	■							■						
7.2	Review and revise IH ABI Program contracts								■						
7.3	Enable brain injury societies to provide services for individuals without a formal diagnosis	■							■						
7.4	Seek opportunities for increased funding for BI associations	■													
7.5	Explore academic partnerships to extend neuropsychological services into under-resourced regions						■								
7.6	Evaluate BI funding return on investments and explore upstream funding models										■	■	■		
Improve Ability to Capture, Share and Use Brain Injury Related Data															
8.1	Request the addition of BI related conditions to CIHI's mandatory Type 3 ICD-10 diagnoses to all inpatient encounters	■						■							
8.2	Explore data solutions to improve data collection for brain injuries across all Emergency Departments														
8.3	Explore options to standardize collection and reporting of BI related data to the Ministry of Health														

	Suggested Lead	BC Brain Injury Association	BC Housing	Community Service Providers	CONNECT Lake Country	Divisions of Family Practice	Dr. Harry Miller, Associate Clinical Professor, Psychology, UBC Okanagan	Lead Injury Prevention and Safety Promotion	Local Brain Injury Organisations	Lived Experience	Ministry of Mental Health & Addictions	Ministry of Health	Ministry Social Development and Poverty Reduction	PAIR Program (Dr. Julia Schmidt)	Rural Transport Partners
Recommendations															
Establish a Strategic Brain Injury Council															
9.1	Establish a Brain Injury Council to support ongoing collaboration across multiple portfolios and external partners	🟨	🟨	🟨	🟨				🟨	🟨					

Appendix B: Suggested Leads of Recommendations (IH)

Link to full document: Recommendations and Suggested Lead Matrix

	Suggested Lead	ABI Special Populations	Allied Health Leadership	Long-Term Care Services	Stroke Network and Neurology	Home and Community Care Leadership	IH Health Technology (Data Analytics and Health Information)	IH Contracts Department	IH Grant Funded Position	IH Privacy Department	MHSU Network	Population Health	Primary Care Clinical Network	Professional Practice Office of Allied Health	Race Initiative Liaison	Trauma Service Network
Recommendations																
Service and Support Pathways																
1.1	Develop a transparent "service roadmap								🟨							
1.2	Develop service and support pathways								🟨							
1.3	Support advocacy for a provincial brain injury strategy								🟨							
1.4	Expand peer support programs								🟨							
1.4	Develop direct pathways to income support agencies								🟨							
1.5	Expand transportation options to rural residents															
Develop Centralized Virtual Intake and Coordination																
2.1	Establish a centralized virtual access								🟨							
2.2	Standardized tools, communication processes and privacy agreement	🟨			🟨				🟨							
2.3	Maintain an updated list of service providers															
2.4	Establish a brain injury stream within the Rapid Access to Consultative Expertise (RACE) program														🟨	
2.5	Create a care and service transition passport tool								🟨							
Develop and Implement Brain Injury Specific Education																
3.1	Develop an interdisciplinary, foundational education module for IH and community organization staff	🟨														
3.2	Explore opportunities for IH staff providing neurorehabilitation to access BI specific education	🟨												🟨		🟨
3.3	Provide concussion care and management training for teams such as allied health teams to improve competence and reduce variability in care as well as all ED clinical staff, and Primary Care Practitioners as part of orientation processes	🟨											🟨	🟨		🟨

	Suggested Lead	ABI Special Populations	Allied Health Leadership	Long-Term Care Services	Stroke Network and Neurology	Home and Community Care Leadership	IH Health Technology (Data Analytics and Health Information)	IH Contracts Department	IH Grant Funded Position	IH Privacy Department	MHSU Network	Population Health	Primary Care Clinical Network	Professional Practice Office of Allied Health	Race Initiative Liaison	Trauma Service Network
Recommendations																
3.4	Ensure brain injury education for individuals with lived experience and caregivers is standardized, evidence-informed, and delivered consistently across settings															
3.5	Take a future-oriented approach to build long-term workforce expertise in brain injury by integrating BI-focused education into academic and residency training pathways										🟨					
3.6	Strengthen cross-training between ABI and MHSU staff	🟨									🟨					
Develop a Regional Concussion Management Strategy																
4.1	Develop and implement a concussion management strategy across the Interior Health region	🟨	🟨										🟨			🟨
4.2	Develop and implement a standardized, comprehensive concussion clinic program	🟨	🟨													🟨
Implement a Team Based Care Model for Moderate to Severe and Complex Brain Injury																
5.1	Establish a team-based care approach for individuals with moderate to severe BI's	🟨	🟨								🟨					
5.2	Revise eligibility criteria for IH ABI services to remove age-based exclusions and include individuals without formal diagnosis	🟨			🟨						🟨					
5.3	Establish a small, dedicated team focused on long-term, community-based case management for individuals with BI whose rehabilitation goals have plateaued	🟨				🟨					🟨	🟨				
5.4	Establish clear transition pathways into and out of the IH ABI program	🟨	🟨			🟨										
5.5	Develop an integrated care program between IH MHSU and IH ABI Program	🟨									🟨					
5.6	Embed psychiatry within IH ABI team for consultation and 1:1 psychiatry support	🟨									🟨					
5.7	Ensure substance use is not a barrier to accessing services	🟨				🟨					🟨	🟨				
5.8	Explore opportunities to expand and adapt the CONNECT-Lake Country model across the Interior region	🟨										🟨				

	Suggested Lead	ABI Special Populations	Allied Health Leadership	Long-Term Care Services	Stroke Network and Neurology	Home and Community Care Leadership	IH Health Technology (Data Analytics and Health Information)	IH Contracts Department	IH Grant Funded Position	IH Privacy Department	MHSU Network	Population Health	Primary Care Clinical Network	Professional Practice Office of Allied Health	Race Initiative Liaison	Trauma Service Network
Recommendations																
Integrate Stable Housing as a Foundational Element of Brain Injury Rehabilitation																
6.1	Create a diverse range of community housing options	🟨										🟨				
6.2	IH Health and Housing team to lead development of a housing strategy											🟨				
6.3	Explore standardization of BC Housing's registry requirements	🟨							🟨							
6.4	Deliver BI-specific education to staff within housing programs, shelters, outreach and transitional housing to expand BI informed supports.	🟨														
6.5	Establish shared housing response protocols with housing providers	🟨								🟨	🟨	🟨				
6.6	Explore and expand recovery-focused housing options										🟨	🟨				
6.7	Explore the applicability of interRAI Assessments		🟨	🟨		🟨										
6.8	Develop young adult units in LTC			🟨												
Explore Opportunities to Improve Current Resources and Funding Models																
7.1	Explore funding options for community service providers															
7.2	Review and revise IH ABI Program contracts	🟨						🟨								
7.3	Enable brain injury societies to provide services for individuals without a formal diagnosis	🟨														
7.4	Seek opportunities for increased funding for BI associations	🟨														
7.5	Explore academic partnerships to extend neuropsychological services into under-resourced regions				🟨											
7.6	Evaluate BI funding return on investments and explore upstream funding models															
Improve Ability to Capture, Share and Use Brain Injury Related Data																
8.1	Request the addition of BI related conditions to CIHI's mandatory Type 3 ICD-10 diagnoses to all inpatient encounters						🟨									🟨
8.2	Explore data solutions to improve data collection for brain injuries across all Emergency Departments						🟨									
8.3	Explore options to standardize collection and reporting of BI related data to the Ministry of Health	🟨					🟨									
Establish a Strategic Brain Injury Council																
9.1	Establish a Brain Injury Council to support ongoing collaboration across multiple portfolios and external partners	🟨							🟨		🟨	🟨				

Appendix C: Environmental Scan – ABI Services by Location

Link to full document Environmental Scan - BI Services by Location

Legend below. Please contact Tanya.Zeron@InteriorHealth.ca with questions.

Y	N	Y1
Services Available	Services Not Available	Services Limited

	Neurology	Neuropsychology	Psychology	Psychiatry within 20 kms	Physiatry	Inpatient Rehab Unit within 30 kms	Outpatient PT within 20 kms	Outpatient OT within 20kms	Outpatient SLP within 20kms	IH Community PT	IH Community OT	IH community SLP	Community SW, UPCC/ PCN SW	IH Brain Injury Case Manager in person	IH life Skills worker available in person	Brain Injury Society	Brain Injury society worker in person	Brain Injury Society Groups in person	Brain Injury Groups Online	Public Concussion Care Clinic	MHSU Case Management	MHSU Groups	Home Health Nursing	ABI Specialized Beds	ABI OT	Contracted ABI LSW not attached to BI Society	ABI SLP
Kelowna	Y	Y1	Y1	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	N	N
Cranbrook	Y	N	N	Y	N	N	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	N	N	N	Y	Y	Y	N	Y	N	N
Nakusp	N	N	N	N	N	N	Y1	Y	N	Y	Y	N	Y	Y	N	Y	Y	N	N	N	Y	Y	Y1	N	N	N	N
Remote Thompson Cariboo Region	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	Y	N	Y1	N	N	N	N	Y	N

	Neurology	Neuropsychology	Psychology	Psychiatry within 20 kms	Physiatry	Inpatient Rehab Unit within 30 kms	Outpatient PT within 20 kms	Outpatient OT within 20kms	Outpatient SLP within 20kms	IH Community PT	IH Community OT	IH community SLP	Community SW,UPCC/ PCN SW	IH Brain Injury Case Manager in person	IH life Skills worker available in person	Brain Injury Society	Brain Injury society worker in person	Brain Injury Society Groups in person	Brain Injury Groups Online	Public Concussion Care Clinic	MHSU Case Management	MHSU Groups	Home Health Nursing	ABI Specialized Beds	ABI OT	Contracted ABI LSW not attached to BI Society	ABI SLP
OK - Okanagan / IH Central																											
Armstrong	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	N	Y	N	Y	Y	Y	N	N	N	N
Enderby	N	N	N	N	N	N	Y	N	N	Y	Y	N	Y	Y	Y	N	N	N	Y	N	Y	Y	Y	N	N	N	N
Keremeos	N	N	N	N	N	N	N	N	N	Y	Y1	N	Y	Y	Y	N	Y	Y	Y	N	Y	Y1	Y	N	N	N	N
Oliver/Osoyoos	N	N	N	N	N	N	Y	N	N	Y1	Y	Y1	Y1	Y	Y	N	Y	N	Y1	N	Y	Y	Y	N	N	N	N
Penticton	N	N	N	Y	N	Y	Y	Y1	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	N	N
Princeton	N	N	N	N	N	N	Y1	N	N	Y1	Y1	N	Y1	Y	Y	N	N	N	Y	N	Y	Y	Y	N	N	N	N
Summerland	N	N	N	Y	N	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	N	N
Vernon	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y1	Y	N	Y	Y	Y	Y1	N	N	N
Lake Country	Y	Y	Y1	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y	N	N	N

	Neurology	Neuropsychology	Psychology	Psychiatry within 20 kms	Physiatry	Inpatient Rehab Unit within 30 kms	Outpatient PT within 20 kms	Outpatient OT within 20kms	Outpatient SLP within 20kms	IH Community PT	IH Community OT	IH community SLP	Community SW, UPCC/ PCN SW	IH Brain Injury Case Manager in person	IH life Skills worker available in person	Brain Injury Society	Brain Injury society worker in person	Brain Injury Society Groups in person	Brain Injury Groups Online	Public Concussion Care Clinic	MHSU Case Management	MHSU Groups	Home Health Nursing	ABI Specialized Beds	ABI OT	Contracted ABI LSW not attached to BI Society	ABI SLP
TCS - Thompson Cariboo Shuswap / IH West																											
100 Mile House	N	N	N	N	N	N	Y1	N	N	Y1	Y1	N	N	N	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	Y	N
Ashcroft	N	N	N	N	N	N	N	N	N	Y1	Y1	N	Y1	N	Y	Y	Y	N	Y	N	Y	Y1	Y	N	N	N	N
Barriere	N	N	N	N	N	N	N	N	N	Y1	Y1	N	N	N	Y	Y	Y	Y	Y	N	Y	N	Y	N	N	N	N
Chase	N	N	N	N	N	N	N	N	N	Y1	Y1	N	N	Y	Y	Y	Y	N	Y	N	Y	N	Y	N	N	N	N
Clearwater	N	N	N	N	N	N	Y1	N	N	Y1	N	N	Y	N	Y	Y	Y	N	Y	N	Y1	N	Y	N	N	N	N
Lillooet	N	N	N	Y1	N	N	Y	N	N	Y1	N	N	N	Y1	N	N	N	N	N	N	Y	Y1	Y	N	N	N	N
Logan Lake	N	N	N	N	N	N	N	N	N	Y1	Y1	N	N	Y	N	Y	Y	N	Y	N	Y	Y1	Y	N	N	N	N
Merritt	N	N	N	N	N	N	Y	Y	N	Y	Y	N	Y	N	N	Y	Y	N	Y	N	N	Y	Y	N	N	Y	N
Revelstoke	N	N	N	Y1	N	N	Y	Y1	N	Y1	Y1	N	Y	N	N	Y	Y	N	Y	N	Y	Y	Y	N	N	Y	N
Salmon Arm	N	N	N	Y	N	N	Y1	N	Y1	Y	Y1	N	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	N	N	N	N
Williams Lake	N	N	N	Y	N	N	Y1	Y	N	Y1	N	N	N	N	N	Y	Y	N	N	N	Y	Y	Y	N	N	Y	N
Kamloops	Y	Y	y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	N	N

	Neurology	Neuropsychology	Psychology	Psychiatry within 20 kms	Physiatry	Inpatient Rehab Unit within 30 kms	Outpatient PT within 20 kms	Outpatient OT within 20kms	Outpatient SLP within 20kms	IH Community PT	IH Community OT	IH community SLP	Community SW, UPCC/ PCN SW	IH Brain Injury Case Manager in person	IH life Skills worker available in person	Brain Injury Society	Brain Injury society worker in person	Brain Injury Society Groups in person	Brain Injury Groups Online	Public Concussion Care Clinic	MHSU Case Management	MHSU Groups	Home Health Nursing	ABI Specialized Beds	ABI OT	Contracted ABI LSW not attached to BI Society	ABI SLP
KB - Kootenay Boundary / IH East																											
Castlegar	N	Y1	N	Y	N	N	Y	N	N	Y1	Y1	N	N	Y	Y	Y	Y	Y	N	N	Y	Y	Y	N	Y	N	N
Grandforks	N	N	N	N	N	N	Y1	Y	N	Y	Y	N	Y	Y	Y	N	N	N	N	N	Y	Y	Y	N	Y	N	N
Kaslo	N	N	N	N	N	N	Y1	Y1	N	Y1	Y1	N	Y	Y	N	N	N	N	N	N	Y	Y	Y	N	Y	N	N
Nakusp	N	N	N	N	N	N	Y	Y1	N	Y1	Y	N	Y1	Y	N	N	N	N	N	N	Y	Y	Y1	N	Y	N	N
Nelson	N	N	N	Y	N	N	Y	Y1	Y1	Y	Y	N	Y	Y	Y	N	Y	Y	N	N	Y	Y	Y	N	Y	N	N
New Denver	N	N	N	N	N	N	Y1	Y1	N	Y1	Y1	N	Y1	Y	N	N	N	N	N	N	N	N	Y	N	Y	N	Y1
Salmo	N	N	N	N	N	N	N	N	N	Y1	Y1	N	Y1	Y	N	N	Y	N	N	N	Y	Y1	Y	N	Y	N	N
Trail	N	N	N	Y	N	N	Y	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y	N	N	Y	Y	Y	N	Y	N	N
EK - East Kootenay / IH East																											
Cranbrook	N	Y1	N	Y	N	N	Y	Y	N	Y	Y	N	Y	Y	Y	N	N	N	N	N	Y	Y	Y	N	Y	N	N
Creston	N	N	N	N	N	N	Y	Y1	N	Y	Y	N	Y	Y	N	N	N	N	N	N	Y	Y1	Y	N	Y	Y	N
Elkford	N	N	N	N	N	N	N	Y1	N	Y1	Y1	N	Y	N	N	N	N	N	N	N	Y	Y1	Y	N	Y	Y	N
Fernie	N	N	N	N	N	N	Y	Y	N	Y	Y1	N	Y	Y1	N	N	N	N	N	N	Y	Y1	Y	N	Y	Y	N
Golden	N	N	N	N	N	N	Y	Y1	N	Y	Y	N	Y	N	N	N	N	N	N	N	Y1	Y1	Y	N	Y	Y	N
Invermere	N	N	N	Y1	N	N	Y	Y	N	Y	Y	N	Y	Y1	N	N	N	N	N	N	Y	Y1	Y	N	Y	Y	N
Sparwood	N	N	N	Y1	N	N	N	Y	N	Y	Y	N	Y	Y1	N	N	N	N	N	N	Y1	Y1	Y	N	Y	Y	N
Kimberley	N	N	N	Y	N	N	Y	Y1	N	Y	Y	N	Y	Y	Y	N	N	N	N	N	Y	Y	Y	N	Y	N	N

Appendix D: Codebook for Thematic Analysis

Name	Description	Sources	Refs.	Direct Quote	Who Said it
Theme #1: Pathways Toward Improved Services	Participants highlighted both constructive recommendations for system change and examples of positive service experiences. These insights demonstrate not only what is working well but also provide direction for how services and systems could be strengthened to better meet needs.		149		
Participant Recommendations	Suggestions from participants on how to improve the system or services.	20	118	[We need] wrap around care, integrated care. If we're able to set up a model where people aren't going from somebody's care to another person's care to another person's care. Families [need] more support. Patients [need] more support, [that then] reduces hospitalizations.	Service Provider
Positive Service Example	A particularly effective or supportive experience with an organization, provider, or service.	12	31	There's always somebody available to you for questions if you need directions, anything you need help with, they make you set goals and they help you reach them in your life, which is really important to keep people on the right path, I believe.	Individual with Lived Experience
Theme #2: Housing Options	Limited availability of housing that accommodates the unique cognitive, behavioral, and physical needs of individuals living with BI		80	Some of the individuals that we've seen come through with brain injury have been unhoused or precariously housed, and so the brain injury has impacted their ability to function independently. So leaving them to go back to the streets or go back to a precarious housing situation where they're put in unsafe situations on a daily basis, it creates a lot more distress.	Service Provider
Theme #3: Gaps in Knowledge and Understanding of BI	Both service providers and individuals affected by BI experience significant gaps in awareness and understanding. For providers, insufficient training limits their ability to recognize and respond to BI, particularly when it intersects with other complex needs such as substance use, mental health, or intimate partner violence For survivors, a lack of clear information, diagnosis, or recognition of symptoms leaves them and their support networks struggling to understand the injury and its impacts on daily life. These knowledge gaps contribute to miscommunication, stigma, and unmet needs across the system.		116		

Knowledge, Training, and Education	**Insufficient education, training, or awareness among service providers about BI, its signs and symptoms, and how it interacts with other complex needs (e.g., substance use, mental health, IPV).**	**15**	**74**	**“I was a social worker… before I came here, and then I've been in a couple different roles… and in none of those roles I've never had any training offered to me. I realized I've never sort of had anything like that… I can't think of any core training or anything that I've had that specifically to brain injury.”**	**Service Provider**
Lack of Knowledge or Understanding	Experiences where individuals with BI feel that service providers, employers, community members, or even family do not understand BI or its impacts on daily life. This also includes situations where survivors themselves have limited understanding of their injury due to lack of diagnosis, inadequate explanation, or the invisible nature of BI symptoms.	13	42	I tried to get some education for myself and for my son too, so he could better understand it. But nothing ever happened. That's always been my problem with the services	Individual with Lived Experience
Theme #4: Systemic Constraints Limiting Service Delivery	Service providers face structural barriers that restrict their ability to deliver comprehensive and sustainable care. Limited resources contribute to burnout and capacity issues, rigid organizational mandates constrain flexibility, and partnership barriers hinder collaboration across sectors, jurisdictions, and with community-based or holistic care providers. Together, these systemic constraints reduce the effectiveness and accessibility of services.		105		
Burnout and Capacity	Overwork or stress due to limited resources.	9	23	Yeah, I think TJ is supposed to be providing life skills, support, and rehab but I I think she's just so overwhelmed just trying to help Edward survive that really, she hasn't been able to address those things.	Spouse of person with lived experience
Mandate Limitations	Constraints due to organizations’ mission or funding policies.	8	39	You know they have a brain injury. They have behaviors which [certain organizations] will not work with them, so nobody's working with them and they get they don't get supported [because] we can't support them within ABI really.	Service Provider
Partnership Barriers	Challenges collaborating across sectors or jurisdictions, both within and outside of IH, including community partners and holistic care providers.	9	43	My experience primarily with brain injury within the hospital has been in the context of substance use, and so the substance use in combination with the acquired brain injury is the that's the barrier that's the sticking point. They're not able to participate in rehab because of the brain injury or because of the substance use… it seems like mental health and substance use programs will kind of pin everything on the brain injury and then brain injury will talk about the substance use piece as being the barrier to participation, and so there's just no cohesion and no integration in the supports that are available.	Service Provider

Theme #5: Care Experiences Shaped by Stigma of Bias	**Participants described encounters with services that were re-traumatizing, unsafe, or dismissive. These included care interactions that re-triggered trauma, reinforced marginalization based on identity (e.g., sex, gender, sexual orientation, ethnicity, substance use), or reflected poor practice that felt harmful, stigmatizing, or unhelpful. Such negative experiences undermine trust in providers and create additional barriers to seeking or continuing care.**		**56**		
Re-Traumatization	Care interactions that re-trigger trauma. Instances where care was triggering, invalidating, or emotionally harmful.	9	17	It's quite degrading at times, when you have to ask for help, and if the person sitting behind the desk or on the other side of the room is judgmental, which is one of the biggest gaps is lack of training for staff in the services. There's a lot of judgment and there's a lot of entitlements and a lot of assumptions made when there shouldn't be.	Individual with Lived Experience
Unsafe Care	Experiences of marginalization due to identity in care interactions. (ex. sex, gender, sexual orientation, ethnicity, drug use)	5	14	As any form of trans person, I don't feel the care here is appropriate that way. I'm not 100% comfortable with giving them my medical records and moving my care here because they asked questions that are not even gender aware whatsoever. So, I already have problems with like feeling safe to get care here.	Individual with Lived Experience
Negative Service Example	Descriptions of specific encounters with services or providers that were experienced as harmful, dismissive, stigmatizing, or unhelpful by survivors of BI, or that providers themselves identify as poor practice within the system.	11	25	I never heard back from her again. And basically, after six months with no communication my reaction was fuck you. Obviously, there's no help for me. There's no services [for] me. My doctor didn't offer me services.	Service Provider
Theme #6: Navigating the Complex Realities of BI	Survivors of BI often face multiple, intersecting challenges that complicate both daily life and access to care. Service providers describe clients as “complex” due to co-occurring needs such as mental health concerns, substance use, housing instability, or histories of violence, which can also make recognizing BI more difficult. Survivors encounter barriers when strict eligibility criteria or bureaucratic rules exclude them from services, and the invisible nature of BI can lead to disbelief, stigma, or dismissal. These challenges contribute to a profound impact on identity and quality of life, while survivors also develop coping strategies to manage symptoms, stigma, and service gaps.		172		

Complex Clients	Service providers' descriptions of clients with BI as presenting with multiple, intersecting needs (e.g., mental health challenges, substance use, housing instability, or experiences of violence) that make support and care coordination more difficult.	6	55	For these concurrent disorders and these poor individuals who need that model of care, that doesn't yet exist.	Service Provider
Recognizing BI	Difficulty identifying BI in clients with mild or complex needs.	11	27	I have one client with, identified with a brain injury. Now I'm looking at my client list wondering how many other ones have had a brain injury, but I just didn't [know].	Service Provider
Eligibility Barriers	Inability to access services due to rules, criteria, or bureaucracy.	12	36	I feel like we don't fit that narrow referral criteria... I don't know if that's who BI programs are offering services [to] or wanting to even connect with. It just seems like everyone I've had in mind just doesn't really fit the check boxes.	Service Provider
Inclusion Exclusion Criteria	Instances where survivors of BI are unable to access services because they do not meet strict program eligibility rules or criteria for inclusion.	2	5	[We have multiple] ABI individuals who we're having difficulty getting into other resources because they don't meet the inclusion or exclusion criteria.	Service Provider
Coping Strategies	Tactics to manage symptoms, stigma, or service gaps.	2	2	We need to find a place where they can have that heavy wrap around support for the rest of their lives, because that's what they need exactly. Without the stigma, [helping you with] mental health and the fact you got a brain injury.	Individual with Lived Experience
Invisible Disability	Not being believed or validated due to non-obvious symptoms.	10	22	I am losing my long term as well as well as my short-term memory, but there's been no diagnosis yet, so I've been trying to find out avenues to get to the bottom of it. You go somewhere and you reach for help and the door is closed on your face, there isn't another one that's open. It's not like 'OK, sorry, we can't, we can't help you, but this person can.' It's like 'we can't help you.' That's that.	Individual with Lived Experience
Loss of Identity	BI changed sense of self or social role.	6	11	What I found is that immediately [after brain injury] you're either like isolated into poverty, homelessness or social isolation somehow. You lose your job, you lose all your old friends. If you're one of the people that turns into a monster, you lose [all of your] connections.	Individual with Lived Experience
Quality of Life	How brain injury has affected their overall well-being, daily functioning, independence, relationships, and sense of purpose.	4	14	You can't expect them to be contributing members of society because their basic needs are not met and our current structure is contributing to that. So I think if you provide an individual with the support and structure that they require and caring for their basic human needs and basic human rights, that they're more likely to be able to have that kind of return back into community.	Service Provider

Theme #7: Service Gaps and Accessibility Challenges	**Survivors of BI face major barriers in accessing appropriate supports due to both the absence of needed services and the inaccessibility of those that exist. In many communities, services for BI survivors are entirely lacking, while in other cases, existing programs are constrained by limited capacity, long waitlists, or restrictive funding. Geographic and transportation barriers, particularly in rural and remote regions, further compound inequities in access and contribute to unmet needs.**		**105**		
Lack of Existing Services	Situations where needed services or programs for BI survivors simply do not exist within the community or region.	7	41	Just simply, the availability of services is very slim here. There are no supports, no ongoing life skills work, there's no support in between [hospital discharge and independent living].	Service Provider
Remote Access and Transportation Challenges	Difficulties accessing services due to geographic or logistical barriers.	19	48	So really because I was on the bus services on a fixed scheduled timeline, I could never get into Nelson or Castlegar timing wise, I get there after they start and I [have to leave] before they end. Plus, I've also spent an hour to an hour and a half on the bus to get there. And so I've blown my executive functioning before I even start.	Individual with Lived Experience
Rural and Remote	Difficulties accessing services due to geographic or logistical barriers.	2	5	So we had a neuropsychologist in Nelson. They have since retired, and so Nelson's about 3-4 hours away, and that was the closest one. Now there may be somebody in Kelowna which is 7 hours away and then the rest are at the coast, which is upwards of like is about 10-12 hours away.	Service Provider
Lack of Available Services	Situations where services technically exist but are inaccessible to survivors due to limited capacity, long waitlists, funding restrictions, or geographical inaccessibility.	6	11	I think in theory we have access, but in practice we don't. We get declined. Maybe their needs don't align with what [that provider] typically provides and then the individual doesn't have access to private resources… especially if they're living somewhere precarious, shelter, tent city or kind of precarious apartments. Whatever the case may be the limitations are definitely there.	Service Provider
Theme #8: Fragmented Systems and the Need for Coordinated, Person-Centered Support	Participants described how siloed and poorly coordinated services create redundancy, service gaps, and inconsistent care pathways for BI survivors. Recovery is often interrupted by scattered supports, unclear next steps, and services that prioritize tasks over person-centered needs. Survivors and providers emphasized the potential value of dedicated care navigation, improved communication across sectors, and stronger integration of family and peer supports to ensure continuity and holistic recovery.		373		

Service Silos	Breakdowns or lack of coordination between service providers or sectors.	14	25	We always have the silo… you see it in every area and you see people working on the same things in different spaces	Service Provider
Service Coordination	Redundancy and/or service gaps caused by poor coordination and communication across programs.	14	78	There's just zero communication for anybody. Like, here's your binder… that's it. No phone calls, no nothing. She reached out to her counselors, but she'd had to do it.	Parent of Individual with Lived Experience
Consistency in Care	This code captures the systemic fragmentation in BI care and the potential benefits of having a dedicated navigator or hub to ensure continuity, reduce service duplication, and improve client outcomes.	16	53	If there [was] a case management model where everybody with a brain injury was held onto by one central person… that would just be safer and just better patient care.	Service Provider
Peers + Family	Value of non-professional support in recovery. Includes need for family support as well	13	34	We will see partners or parents leave, which sounds horrible, but then that forces the healthcare system to pick that up when they lose their partner… if we had done a better up front job, they wouldn't have lost their partner. But now they have and now they're completely vulnerable and now we do have to do more for them… the [family members] burn out and they completely back out.	Service Provider
Disconnect with Services	Support services are often task-focused rather than person-centered, leading to the provision of assistance that doesn’t reflect what clients actually need to move forward.	17	84	"[Service workers] can help me brush my hair, they can help me brush my teeth… I came up with this saying that if it's something I do not need help with, [they] can help me. If it was something I do need help with, they don't do that… like they wouldn't give me a ride to the college to check out a new course, because that's not what they do.”	Individual with Lived Experience
Fragmented Recovery Pathway	Scattered care or unclear next steps interrupting recovery.	23	99	I never realized how hard it is to actually… have somebody follow through with their job. That's a different story… I've applied for a lot of services, but I've never been… able to actually get through, and if I do get through to the service, [if] the referral goes through, there's really nothing they can help me with, so I find that I fall through the cracks all the time.	Individual with Lived Experience
Theme #9: Lack of Funding or Finances	Barriers related to insufficient financial resources, either at the individual or system level, that limit access to appropriate services and supports for BI survivors.	15	49	I have physical injuries that obviously can't be fixed. I can't afford physio. I can't afford things like that to work through them, so as far as like if there was free services I am unaware.	Individual with Lived Experience

Note: Theme #2 (Housing Options) and Theme #9 (Lack of Funding or Finances) were initially included as individual codes in the original codebook. Upon reviewing the data, we determined that the issues captured by these codes were sufficiently substantial and distinct from other themes to warrant being elevated to full thematic status. By recognizing these as standalone themes, we aim to highlight their critical role in shaping participants’ experiences and the structural obstacles they encounter.