

# TRANSITIONAL SUPPORT INITIATIVE REPORT

Transitional Support  
Initiative and Brain Injury  
*Program Findings*  
*January 2018-January 2021*



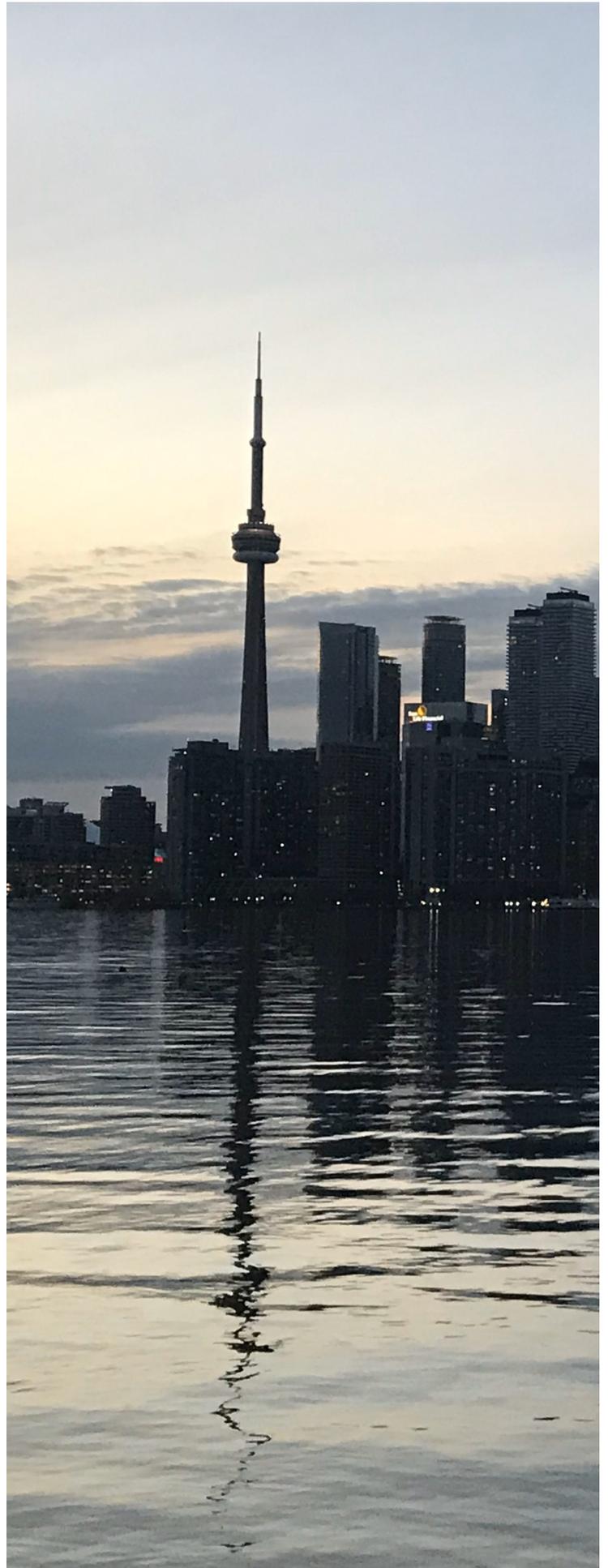
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***All names and initials have been changed in this report to protect the identities of the service users.***

# GLOSSARY OF TERMS

**ABI (Acquired Brain Injury)**

Acquired Brain Injury refers to injury to the brain that has occurred after birth that is not related to a congenital or a degenerative disease.

**TBI (Traumatic Brain Injury)**

Traumatic Brain Injury refers to an injury resulting from a jolt to the head or body or a violent blow such as from a fall, bullet, a sports injury, or a car accident.

**ABI Network (Acquired Brain Injury Network)**

The ABI Network is a Toronto based network that connects people with acquired brain injuries with hospitals or community-based services.

**OW (Ontario Works)**

Ontario Works refers to a government funded program that provides individuals with financial assistance for food, shelter, and other costs such as transportation or medical coverage.

**ODSP (Ontario Disability Support Program)**

Ontario Disability Support Program refers to a government funded program that provides income and employment support for individuals with disabilities.

**MHA (Mental Health And / Or Substance Use)**

Mental Health and/or Substance Use issues refer to a variety of disorders that impacts an individual's mood, thinking and behaviour. They can be associated with distress or functioning impairment. Symptoms of mental health and/or substance use issues can range from mild to severe in nature. Mental health and/or substance use issues can include diagnoses of schizophrenia, depression, anxiety disorders and/or substance use issues such as alcoholism.

**TSI (Transitional Support Initiative)**

The Transitional Support Initiative at the Brain Injury Society of Toronto.

**TSC (Transitional Support Coordinator)**

The TSC Transitional Support Coordinator at the Brain Injury Society of Toronto.

**HF (Housing First)**

Housing First is an approach that prioritizes finding suitable housing for individuals experiencing homelessness.

**DAU (Disability Adjudication Unit)**

The DAU is responsible for determining that an individual meets the legislative definition of having a "disability" under the Ontario Disability and Support Program.

# REPORT PURPOSE

This report summarizes the experiences of financially marginalized people with brain injuries/cognitive challenges who were serviced by the Transitional Support Coordinator to access appropriate financial support.

It also showcases important findings from the program and concrete outcomes.

The Transitional Support Initiative was an Ontario Trillium Foundation funded program, that aimed to reduce the impact of poverty on persons with disabilities.

This report summarizes the results of the three-year project and makes a set of clear recommendations for ensuring that individuals in Ontario can access the financial benefits they are entitled to.

It also highlights gaps in the overall disability benefits system along with barriers in health and social services. It identifies key obstacles and delays in the Ontario Disability Support Program (ODSP) and makes a number of recommendations to improve the process.

## OVERVIEW OF BRAIN INJURY SOCIETY OF TORONTO (BIST)

The Brain Injury Society of Toronto (BIST) is a not-for-profit organization that supports individuals living with the effects of brain injury. BIST is committed to providing safe and open spaces for individuals with brain injuries and their families, to connect, socialize, learn, and engage. Membership is open to anyone.

***Please note that all names and initials have been changed in this report to protect the identities of the service users.***

# WHAT IS BRAIN INJURY?

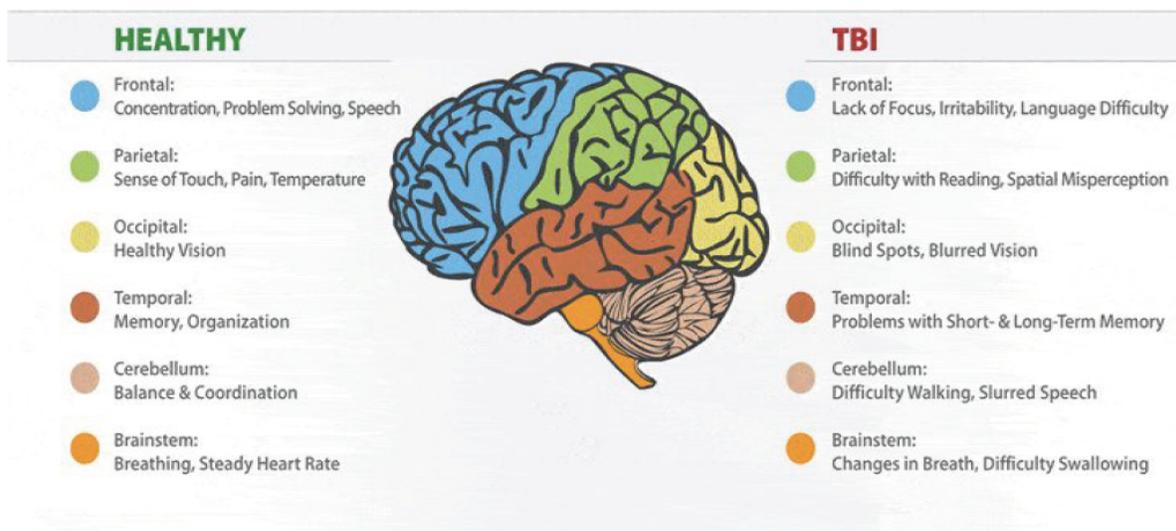
A Brain Injury is damage to the brain that can be acquired after birth due to factors such as: stroke, brain tumor, suffocation, substance abuse or poisoning. A Brain Injury can also be traumatic in nature and may be caused by incidents such as a car accident, fall, assault, domestic abuse, or sports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

There are currently half a million Ontarians living with Acquired Brain Injury (ABI) and over 45,000 new cases are added every year. Many Brain Injuries, especially amongst victims of intimate partner violence, are underreported or not diagnosed, leading to the conclusion that the actual incident rate is much higher.

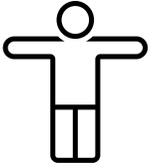
Brain Injuries can be mild, moderate, or severe. Any Brain Injury can have devastating effects on a person's quality of life including their ability to participate in a social network, employment, and day-to-day activities.

Often invisible in nature, Brain Injuries can impact one's cognitive functioning, emotional regulation, sleep, pain levels, fatigue and mental health. Brain Injury related impairments in communication can include difficulties with information processing, new learning, memory, language, literacy, hearing, regulation of emotion, reasoning and problem-solving. Brain injury symptoms may show themselves immediately or increase or decrease over time. Having a Brain Injury creates a unique set of challenges for individuals which range from physical, cognitive, emotional, and behavioural changes.

## HOW TRAUMATIC BRAIN INJURY (TBI) AFFECTS DAILY LIFE



# CHANGES AFTER BRAIN INJURY



## **Physical changes can include:**

Fatigue, chronic pain, seizures, sensory changes, trouble with hand-eye coordination, and changes in vision.



## **Cognitive changes can include:**

Vision problems, difficulty understanding information or making plans/organizing, difficulty writing, concentrating, memory loss, difficulty reasoning and using judgment.



## **Emotional changes can include:**

Depression, anxiety, anger, extreme emotions, limited emotional response, and loss of identity.



## **Behavioural change can include:**

Engaging in risky or impulsive behavior, poor decision making, aggression, challenges in social and work relationships, inconsistent sleep patterns, lack of independence and isolating oneself.

(Brain Injury Canada, 2020)



# BRAIN INJURY & HOMELESSNESS

Traumatic Brain Injuries among the homeless population are very prevalent. It was determined through a systematic review and large study of approximately 11,417 homeless and marginally housed individuals in Toronto that 53.4% had experienced a TBI during their lifetime (Mejia-Lancheros et al., 2020, p. 2).

As mentioned above, brain injuries can be invisible, as damage is not always visible to the naked eye and can go without treatment or awareness by both the individual themselves and health care or social service workers.

This makes it increasingly challenging to ensure that individuals with brain injuries who are experiencing homelessness are receiving proper care and support. These individuals are also exposed to an increased risk of violence and victimization which places them at a higher risk of continually experiencing TBI's.

A housing first model seeks to mitigate the risk of individual's not having a safe and secure place to reside. Mejia-Lancheros et al. (2020) stated that, 'By providing immediate access to permanent housing without preconditions, Housing First (HF) can reduce chronic exposure to street and shelter environments where individuals have a higher interpersonal violence. Thus, promoting comprehensive mental health services and enhancing access to appropriate treatment for mental and substance use disorders can contribute to violence reduction" (p. 7).

However, housing alone is not a sole factor in reducing challenges for persons with brain injuries amongst the homeless population as there are a multitude of needs that individuals might face such as mental health, substance use, limited income etc. Therefore, housing-first based initiatives work best alongside other programs such as the Transitional Support Initiative that helps to ensure homeless individuals with brain injuries are provided with support that meets all their self-identified goals and needs.

Mejia-Lancheros et al. (2020) stated that, "HF-based programmes and other programmes (ie, outreach services, shelter services, social services) serving homeless populations offer the opportunity to access additional health services and social supports to further enhance housing stability and violence-related victimisation and behaviour mitigation, and therefore reduce prevalent adverse health outcomes such as TBI" (p. 7).

For more information on Brain Injury and Homelessness and the work BIST has done to address it, see our Homelessness and Brain Injury Program Findings

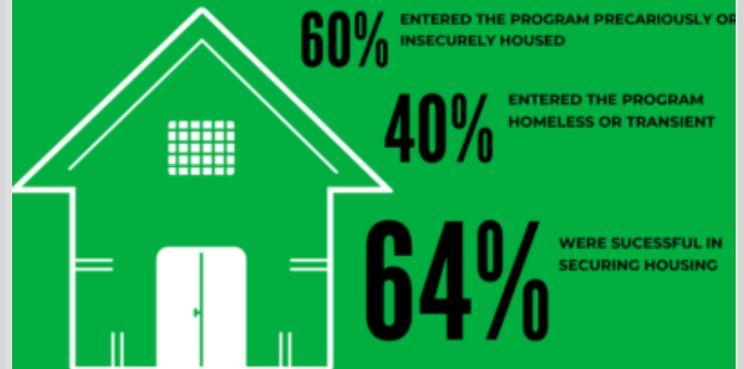


<https://bist.ca/homeless-prevention-coordinator-report/>

# HOMELESSNESS & BRAIN INJURY



In the fall of 2018, BIST received an Ontario Trillium Foundation Seed Grant for a Homeless Prevention Coordinator (HPC), who assisted 32 individuals living with brain injury over a 1-year period in securing housing. Here are the results.



## 100% OF PARTICIPANTS

- Demonstrated cognitive impairments
- Required assistance initiating searches
- Needed help with housing providers, medical professionals & other service providers.

69%

Were experiencing a mental health issue

25%

Were determined to be illiterate

56%

Were socially disconnected

### IMPORTANT FACTS

Almost **half of participants were disconnected from primary health care services**, partly because they felt they could not articulate their concerns effectively to their doctor.



**20% of participants did not have a valid health card** or know where to get one



Over half of participants only had the HPC to come with them to attend appointments etc. **Relationships with family /friends had deteriorated to being non-existent.**



### RECOMMENDATIONS

- Advocate to reinstate the Toronto Housing Allowance Program (THAP) & increase social assistance rates to align with the Toronto Housing Market standard.
- Secure funding to support participants with the difference in rental payments for what they afford and what the actual cost is.
- Ensure income taxes are filled so participants receive all the benefits they are entitled to.
- Apply for all entitlements (diet, transportation, criminal injury, Trillium Drug Benefit etc.)
- Assist participants on ODSP to secure a transit pass

Funding for this project provided by:

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# BRAIN INJURY AND MENTAL HEALTH AND/OR SUBSTANCE USE ISSUES

The World Health Organization estimates that 10 million individuals per year are affected by brain injuries. It is more common than breast cancer, HIV/AIDS, spinal cord injury and multiple sclerosis combined. In Ontario, Canada, 39% of Canadians (one in six adults and one in five students) reported a history of traumatic brain injury (Chan et al, 2019, p.1). Chan et al (2019) stated that “These individuals were also at least 52% more likely to have elevated psychological distress, 100% more likely to use cannabis, 93% more likely to experience suicidal ideation, and 239% more likely to have attempted suicide compared with those without a history of TBI” (p. 1). The relationship between TBI and mental health and/or substance use (MHA) issues are widespread after TBI throughout one’s lifespan, most prevalent is the diagnoses of schizophrenia, depression and post-traumatic stress disorders (Chan et al, 2019, p. 2).

Despite these concerning statistics, research has determined a lack of appropriate services and community support for individuals with TBI and MHA in Ontario. March and Ford (2020) found that, “Although there are systems and services in place to manage the care of individuals with ABI and concurrent mental health conditions and/or substance use disorders in Canada, there is limited integration between those services. In many cases, the mental health and/or substance use care is a stand-alone program that is offered in addition to the ABI programming” (p. 17).

Survey results from participants also highlighted the need for integrated services between agencies, systems, funding etc. given the specific needs of individuals with brain injuries and/or MHA. Globally, it has been recognized that creating integrated care is a societal necessity to best support individuals with TBI and MHA. Chan et al (2019) stated that, “Most recently, the World Health Assembly adopted the ‘Framework on Integrated People-Centred Health Services’ with the vision that ‘all people have equal access to quality health services that are co-produced in a way that meets their life course needs and respects social preferences, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient, and acceptable; and all carers are motivated, skilled and operate in a supportive environment” (p. 2).

Creating integrated health care systems are ideal as they can provide a continuum of care that can improve an individual's experiences in transitions as well as prioritize the needs of individuals with lived experience. This in turn will positively impact their quality of life as a whole.

In addition, the March and Ford (2020) survey found that participants stated unmet needs and identified areas of improvement included: timeliness of treatment, access to treatment and limited resources as well as funding. It was also determined that there is a lack of brain injury awareness, and prevention programs among the general population as well as other health care providers.

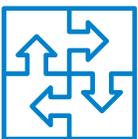
*The **Transitional Support Initiative** at BIST was able to fill the void in services to individuals with brain injuries and/or MHA that has been identified in the survey and literature review referenced above for the following reasons:*

### **Removing Barriers**



The program was able to remove barriers to treatment by offering support to any individual who identified as having brain injury and/or cognitive impairment without requiring a medical diagnosis.

### **Integration of Services**



The program was able to integrate services by supporting individuals with a multitude of needs such as income support, housing, mental health and/or addiction, medical, etc.

### **Goal Oriented**



The program supported individuals to achieve their self-identified goals and needs without imposing any rules around cancellations, time-frames to complete goals, etc.

# LANGUAGE, CULTURE & BRAIN INJURY

Toronto is one of the most culturally diverse places in the world with over 250 ethnicities and 170 languages represented in the Toronto Region and over half the population identifying as a visible minority (Ryan, 2018).

More specifically, there are 16 countries that have over 50,000 represented within the Toronto region which includes 337,000 from India, 300,000 from China and 200,000 from the Philippines (Ryan, 2018).

There is very little research about how different cultures experience and understand brain injuries. However, we are aware that brain injuries disproportionately impact individuals in poverty and subsequently individuals of minority cultures (Diaz, 2013, p. 1).

Diaz (2013) stated that its important to note that, “People from different cultures have unique expectations of what it means to be ill or to have a disability” (p. 1). Diaz went on to say that, “Different minorities and their cultures also have different expectations of how they should be treated for their illness and what they expect from the professionals treating them. Becoming aware of the differences in minorities and cultures will allow for a better rehabilitation process in the long term” (p. 2). This information further reaffirms the necessity of programs such as the TSI to ensure that individuals are receiving personalized support and that they are the drivers of the support they are receiving.

10% of the client supported in this TCI had a language barrier that impacted communication between them and the TSC. As this program is not offered in other languages, the TSC used family members and translators as needed to provide functional support.

Country of Birth	Number of People in the Toronto Region
India	336,835
China	303,900
Philippines	205,365
Pakistan	125,685
United Kingdom	124,615
Italy	107,575
Jamaica	107,280
Sri Lanka	105,015
Hong Kong	103,220
Iran	76,860
Portugal	73,430
Guyana	72,305
United States	66,250
Poland	62,005
Vietnam	61,435
South Korea	53,230

(Adapted from StatsCan, 2016 as cited in Toronto Global, 2021)

## SEX AND BRAIN INJURY

Research has discovered that traumatic brain injuries are highly gendered with men demonstrating moderate to severe brain injuries because of more high-risk activities or behaviours, while women are more likely to experience brain injuries because of intimate partner violence or occupations in health care (Colantonio, 2016, p 1).

It is also interesting to note the way in sex impacts the support that is provided and reported after experiencing a brain injury. Casper & O'Donnell (2020) stated, "In the matter of traumatic head injury, as this study suggests, women were expected to experience assault as an acute episode followed by chronic emotional disturbance. Boxers, usually men and in contrast, were denied chronic emotional disturbance and permitted brain injury as a consequence" (p. 8). Additionally, Colantonio (2016) stated that although depression is a common comorbidity after a brain injury in men it is underreported and treated with support (p. 3). Understanding how different sexes can experience brain injuries is imperative to ensuring that support is tailored specifically to every service users' goals and needs.

# BARRIERS TO ACCESSING SUPPORTS IN ONTARIO

A continued area of interest for research and health-care decision-makers is accessing health care and its related concerns such as equity, health outcomes and institutional structures (Ho et al., 2017, p.1312).

Access is considered an indicator of quality of care, and a recent review on the concept of access suggests a patient centred view defined as, “the opportunity to reach and obtain appropriate health care services in situations of perceived need for care” (Levesque et al. 2017, p. 4 as cited in Ho et al., 2017, p. 1312).

It is evident through research that patients, particularly those with multi health concerns, must navigate a health care system that is filled with programs that have their own entry criteria, long wait lists and assessment tools. Individuals have little choice but to negotiate these complexities while also managing their own personal health conditions.

For an individual with a Brain Injury, navigating our health and support system can seem daunting to the point where individuals feel a sense of helplessness, and they might retreat or “give up” on accessing support. Symptoms of Brain Injuries can include difficulty thinking clearly, challenges remembering or processing new information as well as forgetfulness.

This can create a vicious cycle where the barriers to accessing services become too challenging and individuals forgo support which can further deplete their physical, mental, or emotional health.

**A study by Ho et. al in Toronto consisting of 116 individuals with multiple health concerns (cognitive impairments, mental health issues as well as physical impairments) found that there were a multitude of concerns that they identified with accessing and receiving support within our community. Some of these challenges included:**



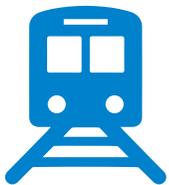
### **Inaccessible Services**

*Failing to qualify, long wait times, unmet needs, and inflexible care.*



### **Eligibility Criteria**

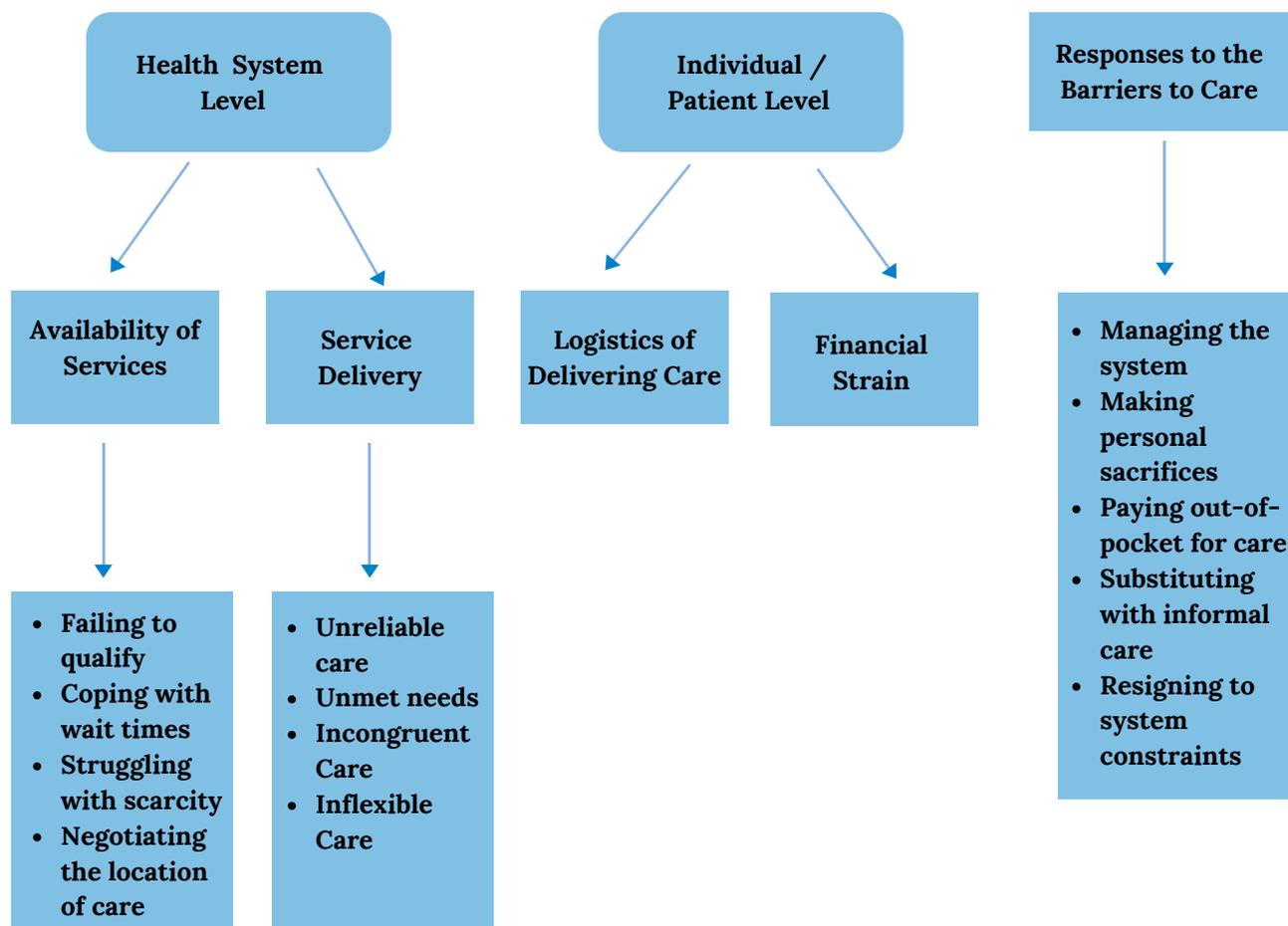
*Ho et al. (2017) stated, “Eligibility criteria that place the burden on the patient to demonstrate a threshold level of incapacity (often assessed at one point in time) may mean that principles such as ensuring that the “right” patient gets the “right” care may not be upheld. For instance, patients who fall just outside of thresholds such as income level, functional ability, age groups, may automatically be excluded for eligibility” (p. 1317).*



### **Ability to Physically Access Services**

*Individuals with multiple health concerns may have issues travelling, or have trouble paying for the cost of transit or parking, they may also have concerns with navigating a large city. Ho et al (2017) stated “In short, community services may be available but whether they are accessible depends on the complex dynamics between the personal circumstances of the patient, and their physical and social environment” (p.1317).*

For individuals with brain injuries, accessing services can be challenging without a support person such as the TSC to remind and accompany them to appointments, relay information, reiterate, retain and follow through on important tasks post appointment. All of these points of access require multi-level planning and organization. In addition, the TSC was aware of the physical and mental challenges that participants face when accessing services such as anxiety when taking transit, mobility issues, or the income necessary to commute. The TSC met individuals at locations that worked best for them such as in their home, or at a convenient location of their choice to ensure that they received support no matter where they were located.



*Adapted from Ho et al., 2017*

# INCOME SUPPORT IN ONTARIO

## **Ontario Works**

Ontario Works (OW) provides essential financial and employment support for people seeking long-term employment. The overall objective of Ontario Works is to aid participants on social assistance to prepare for, achieve and maintain employment and to make the transition to long term self-reliance (Hyland & Mossa, 2018).

## **Ontario Disability Support Program (ODSP)**

The Ontario Disability Support Program (ODSP) offers financial assistance to individuals and their families living with a disability that is expected to last one year or more. Individuals must complete an application to be eligible for these benefits and the benefits paid to participants must exceed the maximum allowance provided through the Ontario Works program (Hyland & Mossa, 2018).

### **A Person/Family Unit Applying to ODSP Must:**

-  *Have a substantial physical or mental impairment that is expected to last more than one year.*
-  *Have restrictions in their daily activities (personal care, functioning in the community or workplace.)*
-  *Demonstrate financial need within their budgetary costs.*

### **To qualify for ODSP applicants must:**

-  *Confirm financial necessity through a financial intake assessment at their local ODSP office.*
-  *Complete the “Disability Determination Package” (DDP). This information needs to be completed by a designated Health Professional and is then evaluated by the Disability Adjudication Unit (Hyland & Mossa, 2018).*

Qualifying for ODSP relies on the ability of the applicant to prove two critical factors:

1. That they meet the definition of disability created by ODSP and
2. That they are financially eligible.

Establishing entitlement for the program is a challenging and time-consuming process that entails applications, dates, forms, and meetings. Those with difficulties in areas such as memory, literacy, organization, scheduling, and mood typically struggle to remain focused through the long process and often abandon their application (Hyland & Mossa, 2018).

If the application is completed, the applicant is either awarded or denied ODSP Income Support. If an applicant receives a denial, an internal review can be requested, failing that, an appeal can be made before the Social Benefits Tribunal.

***About half of people who apply for Ontario Disability Support Program benefits get refused the first time (CBC/Radio-Canada, 2021) and have the right to appeal.***

Following an appeal, a large number of individuals are then granted the benefits through the Social Benefits Tribunal, however many applicants are unaware or unable to follow through with this process.

## STEPS IN THE PROCESS

People with disabilities who have no income when applying for ODSP are directed to apply for financial assistance under Ontario Works (OW) first. They must go through a two-step process:

1. A telephone assessment, reviewing basic eligibility information regarding their income and assets with an OW intake worker.
2. A income verification interview at the local OW office that requires submission and review of documentation.

## **During the COVID-19 Pandemic in Toronto:**

All OW Offices were closed to persons unless a scheduled appointment was made. Most income documentation verification processes were done virtually. After completing this process, clients were requested to complete the Disability Determination Package (DDP) to establish if they qualified medically.

The Disability Determination Package contains the following items:

### **Health Status Report (HSR):**

This is the key form that must be completed by a doctor, psychologist, or medical specialist. HSR asks for a) the principal impairment; b) duration of disability; c) what medications and treatments the applicant is or was on and d) medical/specialists reports.

### **Activities of Daily Living (ADL)**

It is required that the person report on their ability to complete basic daily living activities.

### **Consent to Release of Health Information:**

A form signed by the client allowing the DAU to communicate with their health care professionals.

### **Self-Report:**

The applicant has an opportunity to explain their disability and its impact from their point of view and experience.

These forms are filled out and must be sent to the Disability Adjudication Unit (DAU) within 120 days. A request for an extension can be made. If the due date for the forms has expired and no request for an extension is made, a new referral must be created by the local office. (Hyland & Mossa, 2018).

## ADJUDICATION OF APPLICATION

The DAU takes 90 business days (roughly four and a half months) after receiving the forms to decide if an applicant meets the requirements of the program. If an applicant is granted ODSP benefits, they are sent a written letter and an electronic confirmation is sent to the applicant's local ODSP office.

The DAU also sends an electronic confirmation to their local OW office. The OW office then transfers the person's file to the local ODSP office, where an ODSP caseworker then sets up an interview with the applicant to go over their financial information (Hyland & Mossa, 2018).

If the Disability Adjudication Unit (DAU) denies the applicant, they will inform the applicant by form letter stating that they do not meet the requirements of the program.

The individual then has 10 days to write a letter to the DAU to request an internal review (Hyland & Mossa, 2018). An internal review means that a different person in the DAU office will review the documents and reassess the application

If the DAU declines the applicant a second time, the DAU must inform the applicant by letter within 15 business days. An applicant will have 30 days to appeal to the Social Benefits Tribunal.

***This process can take 9 to 12 months before a tribunal date is assigned. Decisions from the tribunal take 60 days after the hearing. The overall process can take up to 18 months (Hyland & Mossa, 2018).***

# TRANSITIONAL SUPPORT INITIATIVE

## *Program Overview*

The Transitional Support Initiative in Toronto was modeled after a program developed at the Brain Injury Association of Durham (BIAD). To date the program has also successfully launched in Nipissing and Peterborough.

The purpose of this program was to assist these individuals in completing the application for ODSP as well as assisting them in stabilizing their lives through to the point of being granted appropriate income support.

This involved referring individuals to several formal service agencies as well as connecting them to essential medical services. The needs of these individuals often involved an array of vast issues (health, transportation, recreation, education, legal, family, and housing) and were extraordinarily complex.

## *The Role of Transitional Support Coordinator*

The Transitional Support Coordinator Initiative:

- Made the process of applying for Income Support as accessible as possible for individuals with cognitive challenges.
- Supported individuals in obtaining necessary medical information, including securing a family doctor.
- Ensured necessary referrals to support services and medical specialists were made and attended by the individual.
- Assisted the individual in following a schedule and organizing appointments.
- Created solutions in all areas relating to earning a limited income during the application process
- Assisted with food security, housing, legal issues and educational supports.
- Provided additional and modified support during the Covid-19 pandemic, assisting clients with navigating new technology, accessing groceries, medications and medical support.
- Created a best practices process for applying for disability supports in Ontario.

## Service Model

The Northern Brain Injury Association (2021) stated that, “In Ontario, 92% of men, and 100% of women who sustain brain injury, NEVER return to full-time employment”.

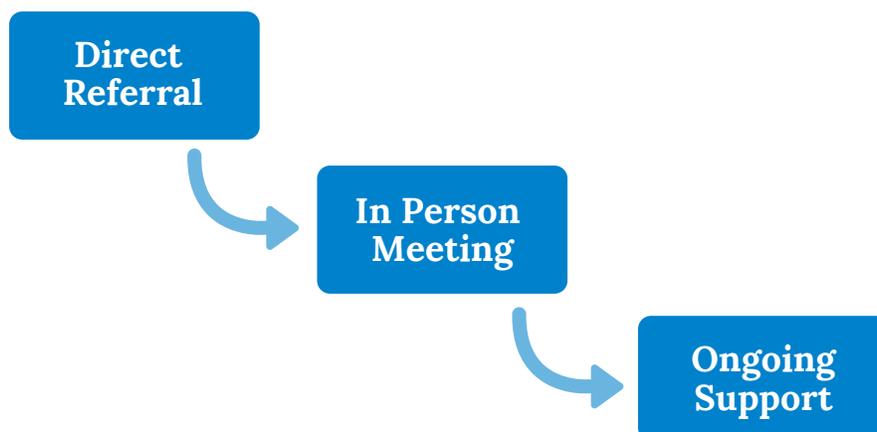
These are staggering statistics and show the crucial nature of programs such as the Transitional Support Initiative is to ensure that individuals with brain injuries receive the income support they are entitled to.

This project provided services to individuals with disabilities, serious mental health issues, cognitive impairments, and other complex issues. The Transitional Support Coordinator (TSC) coordinated and provided support services for individuals with disabilities who needed to access appropriate income support (ODSP/Canada Pensions Plan-Disability-CPP-D).

The TSC worked not only to complete the application, but also to improve and stabilize the person’s life. Often the lengthy application process further complicated their life. The program aimed to minimize barriers to accessing services.

To obtain support from the program, the individual had to:

- Contact the service directly (no third-party referrals were taken) and feel they required support applying for ODSP/CPP.
- Identify themselves as an individual with a disability, that impacted their ability to obtain and retain employment.



The majority of referrals were received from Ontario Works following an initial presentation on brain injury and this initiative to their offices. Other referral sources included current BIST members and other social service agencies. The referring staff requested that the service recipient contact the program and an appointment was then arranged.

A meeting then took place as soon as possible and the meeting location was set up close to or at the individual's home to minimize transportation and scheduling barriers. Staff then worked to establish self-identified goals, needs and supports.

The Transitional Support Coordinator worked with individuals to secure required identification, obtain medical services and assessments, access social service supports, complete income support applications and navigate the process of appeals and hearings, if necessary.

Staff would also support people in applying for additional income through Ontario Works as well and completing income tax returns, to provide them with income refunds and tax credits.

The TSC arranged services and accompanied individuals to medical, and income support appointments. In addition, staff supported the person in maintaining Ontario Works funding, assisted when responding to requests from case workers and suspension letters.

Often the TSC staff would keep notes and reminders for the person to ensure that they followed instructions given to them at appointments. Reminder phone calls and texts would take place to ensure necessary follow through.

Individuals were supported in locating previous medical documents to establish a medical history. This ensured a continuum of care with their family doctor and provided guidance on the information being submitted to ODSP/CPP. They were also supported in collecting their documents to confirm income eligibility.

The TSC ensured individuals received the ODSP application package at the appropriate time and would make certain that the application completed and received on time by the Disability Adjudication Unit (DAU).

The staff supported individuals through the internal review process (IR) and Social Benefits Tribunal (SBT), if necessary. Efforts were made to assist when people felt unfairly treated and staff would support them in contacting provincial regulators to ensure their rights were being respected.

Additional work was done to ensure individuals were supported to pursue other goals including employment and education. On several occasions, once supported, people were able to apply for school or return to part-time work despite their disability. One of the program participants was hired by BIST as a part-time staff.

The role of the Transitional Support Coordinator was to be a support worker, an advocate, and a coordinator with the person throughout the process to reduce and remove the numerous barriers they would otherwise experience.

Staff played a critical role of community-based support and a guided clients through the ODSP application process, making a complex system more accessible. The program operated with a single full-time staff responsible for all related services and administration.

### **Community Awareness and Education**

The TSI looked to service users to speak to their experiences and to express any barriers or oppressions that they faced. In collaboration, the TSC and service users sought to bring their experiences to the larger society to make service providers as well as the larger community aware of these issues.

The TSC gave presentations at several OW offices on the program as well as education on brain injury and the challenges that accompany it. The TSC also spoke at Provincial conferences about the TSI, and the barriers that individuals with brain injuries continue to face within the community.

More specifically, the TSC identified through engagement with service users, that there was an intersection between brain injury and the criminal justice system. Many service users expressed being unjustly treated by law enforcement and were involved in legal matters that they had difficulty comprehending. To further bring awareness of brain injury to law enforcement, BIST staff engaged in several presentations at different police stations across Toronto.

As we are aware, COVID-19 has brought on additional challenges and barriers to grant participants. Firstly, many services have closed their doors or limited in-person contact, making it extremely challenging for individuals without knowledge or access to technology to connect with supports. Grant participants expressed to TSC their challenges with affordable technology to be able to access important services within their community. The TSC brought forth this challenge to BIST and together they were able to gain a Community Connections grant that allows them to provide technology to service users as well as provide support with navigating and using these pieces of technology such as phones or computers.

### ***How Does the Program Fit within the Service Model of BIST?***

In Canada, there are approximately 165,000 serious brain injuries reported per year. Of those individuals', tens of thousands become partially or permanently disabled. Over 11,000 Canadians die each year from a brain injury (NBIA, 2021).

Brain injury is a silent epidemic as brain injuries often go unnoticed or untreated by both individuals, as well as health care or community workers. The Brain Injury Society of Toronto (BIST) has a great understanding of the hidden nature of brain injuries, and how they can impact an individual's life, sometimes without their knowledge.

The Transitional Support Initiative sought to bring awareness not only to the larger medical and social service community, but also to individuals to ensure that they were receiving adequate support.

BIST has always taken a client centred approach to ensure that service users govern their own care. The Transitional Support Initiative made certain that grant participants were involved in all aspects of their support plan, and determined what areas of support they deemed most important. Although receiving adequate income was of high priority to individuals, there were other needs to be addressed such as food security, housing and medical support.

BIST comes from an anti-oppressive approach, and provides a non-judgemental and open environment for individuals to feel safe. Completing an ODSP package can be extremely invasive and sensitive in nature as individuals are required to provide detailed information about their medical, emotional, and psychological history.

The Transitional Support Initiative utilized BIST's open and confidential environment, and ensured that individuals felt safe to disclose information without fear of judgment.

### ***Transitional Support Coordinator Program Statistics***

As described in the role of the Transitional Support Coordinator Program (TSC) section, the TSC's aim was to help individuals gain financial stability by applying for appropriate income support.

In the process, the program also helped to establish stability in their lives by addressing multiple access needs such as: medical support for application completion, physician and specialist referrals to diagnose and treat medical conditions; alternative income supports; completing appropriate community referrals for mental health supports, housing, transportation, and food security.

As this program followed a client centred approach, information was collected over the course of multiple interactions. The following sections are a breakdown of the information that was collected to help address participant needs and inform appropriate referrals for care.

As stated by the World Health Organization (WHO), social determinants such as the individuals social, economic and physical environment, as well as personal characteristics and behaviours, outline and often further complicate a person's income stability.

In addition to the WHO health determinants, grant participants were further affected by aspects of Brain Injury and/or cognitive issues. These factors were important when trying to determine the best support for care, as well as understanding how future support in Ontario can be organized and implemented to better fit participant needs.

## ***The TSC had 87 participants during the three year Ontario Trillium Fund Grow-Grant.***

It should be noted that other individuals initiated a referral, however did not wish to continue with the program, moved, or lost contact and have therefore not been included in the service numbers. Unfortunately, the individuals who had lost contact, were often in most need of services to stabilize their financial income and other health determinants.

## **DEMOGRAPHICS FROM THE PROGRAM**

### ***Age of Service Users:***

Approximately one third of program participants were under the age of 30. This statistic is startling, given that at a young age they are already living below the poverty line. Living in poverty at such a young age, is more likely to have increased effects on mental health, social isolation, and physical health issues. This is further complicated by identified disability conditions. Wilson et al., (2017 ) stated, “Traumatic brain injury (TBI) can have lifelong and dynamic effects on health and wellbeing. Research on the long-term consequences emphasises that, for many patients, TBI should be conceptualised as a chronic health condition”. If factors of health and income are not stabilized, persons in this demographic are more likely to have issues with affordable housing and are at increased risk for homelessness in the future.

It is imperative that we provide support and connect individuals with vital community resources as soon as possible, to allow for better quality of life, to alleviate the financial burden on the emergency medical system, and to streamline access to care.

Of the 26% between the ages of 50-65, 17% of the participants were over the age of 60, soon to be requiring assistance with the transition to Old Age Security (OAS) and the Guaranteed Income Supplement (GIS) Federal assistance programs.

Additionally, ODSP recipients may also qualify for the Ontario Guaranteed Income Supplement (GAINS).

Individuals reaching the age of 65 are required to make the transition from the ODSP program to OAS and GIS program in a timely manner. This is problematic for a client with cognitive issues. As noted on the Government of Canada's website: "The Old Age Security (OAS) pension is a monthly payment you can get if you are 65 and older. In some cases, Service Canada will be able to automatically enroll you for the OAS pension. In other cases, you will have to apply for the Old Age Security pension. Service Canada will inform you if you have been automatically enrolled." (Government of Canada, 2021).

Additionally, the GIS requires participants to have up-to-date taxes filed in order to determine financial eligibility and receipt of payments. Two participants in the program had been notified of needing to transition from ODSP to OAS/GIC as they reached the ODSP cut off age of 65 during the operation of the grant. Due to their significant cognitive impairments, both required extensive support with this process.

## **Sex and Gender of Service Users**



**50% of individuals identified as women**



**47% of individuals identified as men**



**3% did not want to be identified by gender**

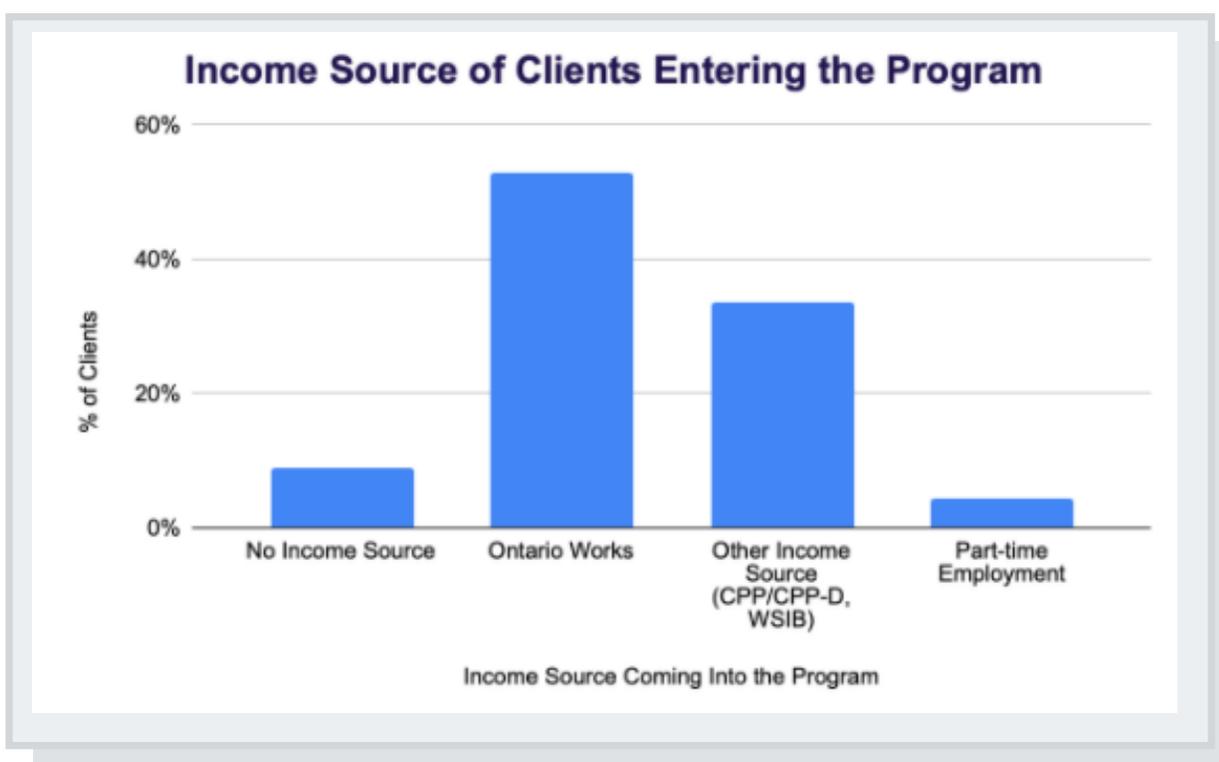
Although gender was not requested at intake as a question for statistical study, it is worthy to note that one participant informed BIST staff that they did not identify as male or female. Another grant participant identified as transgendered. Not much research is currently available for the LGBTQ2+ community in relation to Brain Injury. Programs and support that would help to educate, communicate and advocate for the Brain Injury LGBTQ2+ community is needed as a disability within a minority group is often further isolating and comes with its own set of challenges for the individual. BIST strives to support all members of its community as functionally as possible, to help them connect to resources and build capacity.

BIST is currently working to address this gap in service, by auditing the language used on our site and in programs, as well as working to start a support group for individuals with ABI within this community.

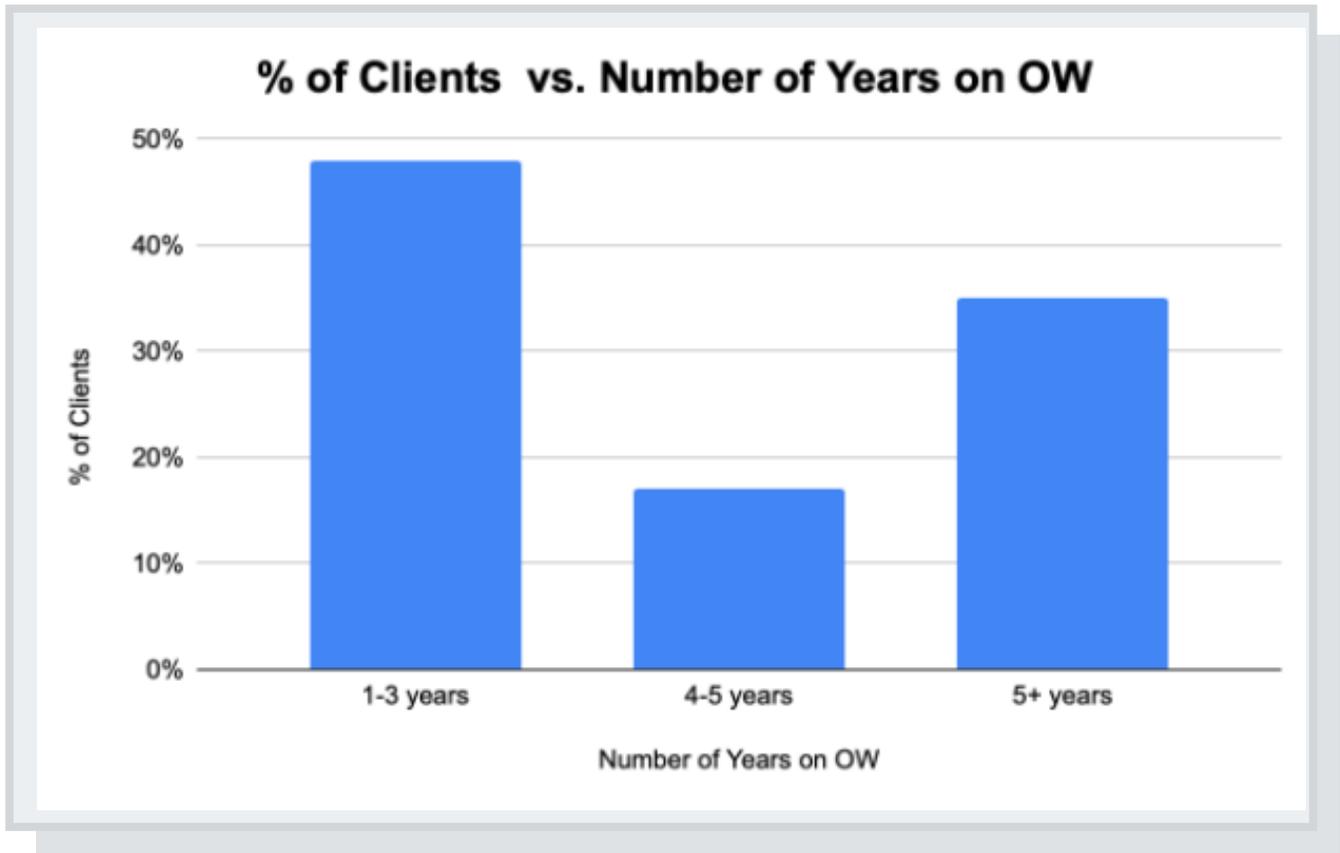
# PROGRAM OUTCOMES

## Income

Participants were referred to the program with the need to find appropriate financial income. Applications to multiple income supports were completed at Federal, Provincial and Municipal levels where appropriate and advised by government standards.



***100% of participants that had NO source of income, received support from BIST in obtaining Ontario Works***

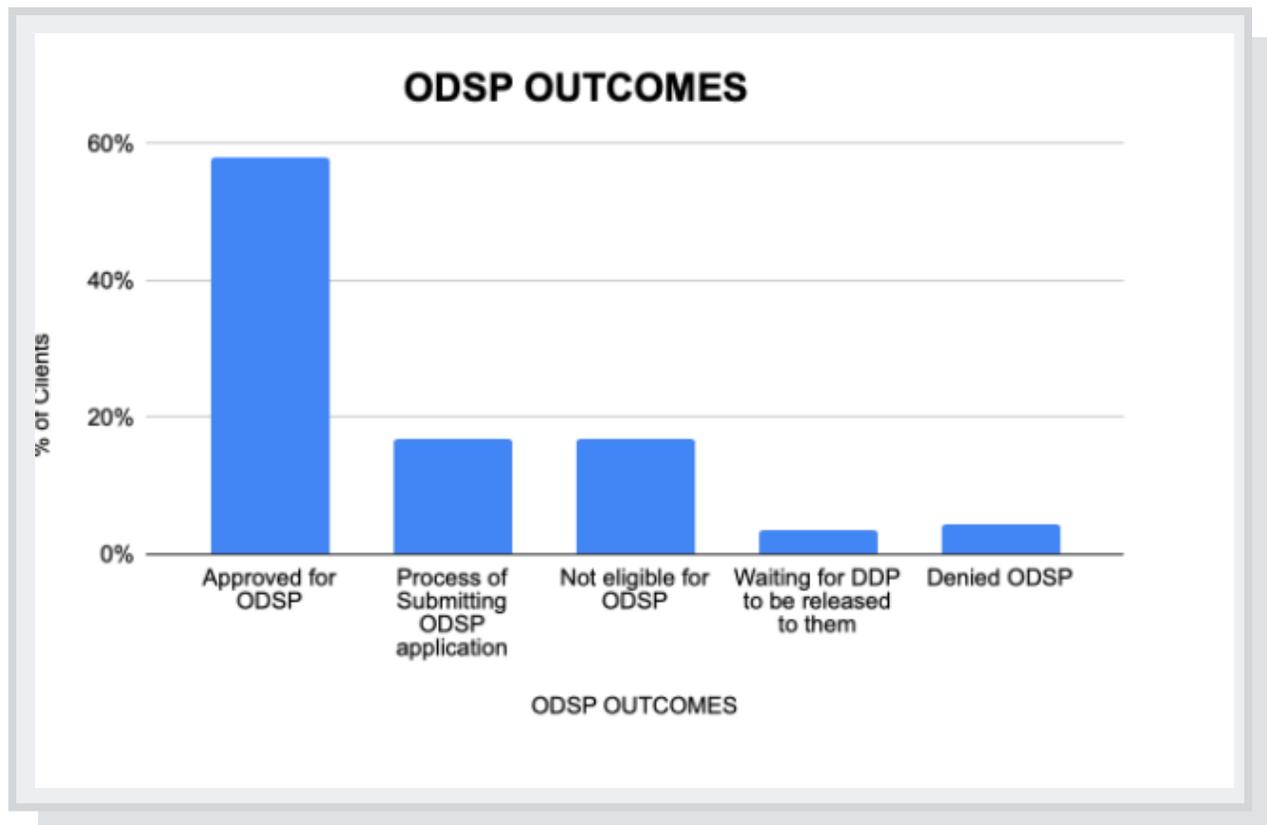


This graph informs the number of years grant participants were receiving Ontario Works, a program that is meant to be, a short-term initiative. Many of the participants had tried several times to apply to ODSP and had not succeeded in completing the Disability Determination Package (DDP), or had a DDP denied by the Disability Adjudication Unit (DAU). Often participants indicated that the process was too daunting and had given up trying to complete the DDP, future subjecting themselves to increased poverty and related health outcomes.

# FINANCIAL OUTCOMES

## Ontario Disability Support Program (ODSP)

As the main purpose of the grant was to stabilize grant participants' income through access to the Ontario Disability Support Program, significant time was spent with individuals in acquiring the necessary documentation, support and signatures for the Disability Determination Package (DDP).



- Of the 17% of the participants who were determined not to be eligible for ODSP, support was given to find alternative income sources for financial stabilization.
- The clients who have recently had the DDP released to them have been transitioned to BIST's new Community Connections program to ensure application completion.

## Additional Income Secured

During the course of the grant, participants were supported with securing other sources of income. The following additional income sources were applied for or received during the course of this program:

Income Source	# of Clients Supported
Disability Tax Credit (DTC)	20
Discretionary Benefit (COVID-19 ODSP/OW)	46
Canadian Pension Plan (CPP)	6
OAS/GIS/GAINS	2
Survivor Benefits	3
Ontario Energy Savings Plan	5
Personal Income Tax	26
Housing Stabilization Fund	6
March of Dimes Equipment Funding	3
Long Term Disability	1
Jewish Family services - Family Loan (loan with no interest that clients could pay back monthly-this was applied for before they received social assistance)	3
Other	3

The Canadian Pension Plan-Disability (CPP-D) was reviewed with participants as an option if they met the criteria. Individuals who qualify for CPP-D do not have to complete the Disability Determination Package (DDP) for the ODSP process, and can access possible income before the age of retirement determined by the Federal government at the age of 65.

The Ministry of Children, Community and Social Services, requires that persons on the ODSP program make an effort to apply for CPP-D if they meet criteria, in order to have part of their funding come from the Federal Government. For those with cognitive issues and or mental health issues, that additional requirement is often met with the same challenges as completing the ODSP package.

Likewise, other income support applications like the DTC, require individuals to have a health professional complete forms, and are met with similar cognitive challenges and issues.

To complete these forms, Physicians cannot bill the government and often charge the patient. This fee is typically set between \$50.00 and \$100.00, as seen with grant participants. Individuals who receive OW and ODSP do not have additional income to spend on this process, and as such typically do not follow through with filling out the DTC.

As this was a need for many of our grant participants, BIST paid for some of the individuals DTC application fees so they could move past this step.

BIST also assisted when needed, with payment for completing and filing Personal Income Tax. This often allowed individuals to receive additional income throughout the year in the form of GST quarterly payments. This amount, although seemingly small, allowed for clients to purchase food and necessities they otherwise would not be able to afford. Several clients who were supported with personal income tax filing, required completion of five to ten years worth of back taxes.

### ***Additional Supports to Stabilize Grant Participants***

Grant participants were further assisted with referrals to health, housing and community supports in order to address additional barriers. As the grant length was three years, individuals needed to have help with securing long term case management and community access, as disability needs did not cease to exist after the completion of the ODSP application.

<b>Additional Supports</b>	<b># of Clients Supported</b>
Shelter (Assisting with securing housing, referring to subsidized housing)	32
Food Security	41
Legal Support	32
Referrals to Centre for Addiction and Mental Health (CAMH)	7
Other Mental Health/Addiction Supports	5
ABI Network Referrals	28
Other Social Service Referrals	49
Assistance with securing a Family Physician	23
Other medical referrals	36
Accessing Transportation (either via transportation allowance or securing accessible transportation)	48

## % OF CLIENTS REQUIRING ADDITIONAL SUPPORT

Support with either accessing transportation allowance and / or securing accessible transit

Other medical referrals

Assisted with securing a family physician

Other social service support referrals

ABI Network referrals

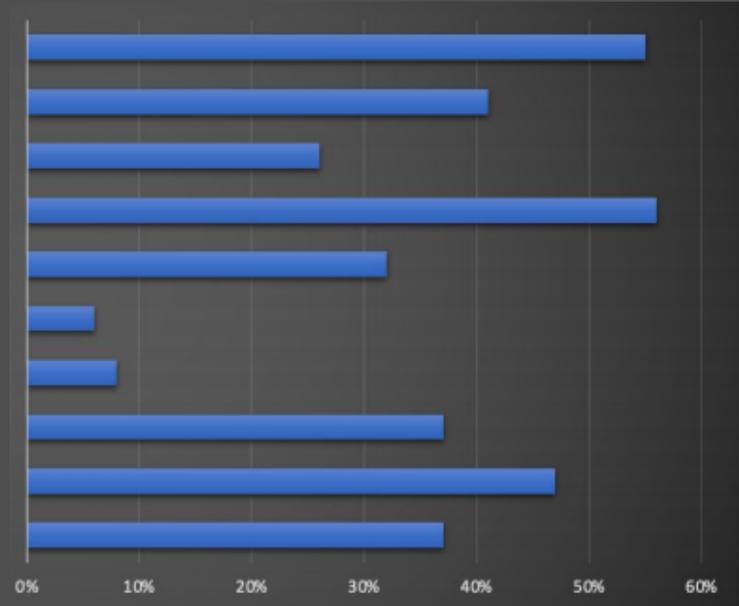
Other mental health / addiction support referrals

CAMH

Legal

Food Security

Shelter



# BARRIERS TO ACCESSING FINANCIAL SUPPORT:

## 1. *Cognitive Impairment or Brain Injury* - 100% OF CLIENTS

100% of clients experienced a cognitive challenge that impacted their ability to function independent of support. This lifelong disability is the number one barrier for participants to access appropriate financial stability. Participants often find the completion of the DDP difficult and confusing to complete. Several factors such as difficulty identifying conditions, issues with planning, organizing, memory, initiation, and difficulty with comprehension and understanding of questions, affected the majority of participants in completing the DDP. Many of the participants had been issued several DDP's during their time receiving OW, however had missed deadlines in submission because of the above listed issues.

The impact of this is devastating as participants went without appropriate income for several years increasing rates of poverty, and food insecurity.

## **2. Lack of Adequate Social and/or Community Network**

64% of individuals who were referred to the TSC program had limited social and community connections, or no circle of care, to help support the completion and submission of the documentation necessary for a successful application. This lack of a social network affected clients access to other resources like medical, food, and therapy support.

## **3. Lack of Access to Technology**

Lack of access to a phone, or finances to pay a monthly telephone bill, was a significant hurdle to securing access to appropriate income for 26% of grant participants. The TSC required creative solutions in order to ensure that communication with participants was maintained. Often participants missed appointments with Ontario Works staff, physicians, and community organizations, which impacted application completion and health diagnosis and treatment, and their monthly income support from social services. Lack of technology access greatly contributed to a client's inability to maintain independence, and stability.

## **4. Lack of Knowledge of Available Income**

Lack of knowledge of available income greatly contributed to a client's inability to maintain independence, and stability.

## **5. Lack of Family Physician - 26% OF CLIENTS**

Lack of Family Physician or other health professionals to sign for the Disability Determination Package (DDP) was a significant concern as 26% of clients did not have access to a Family Physician, General Practitioner, or health professional that could assess and treat their disability conditions.

Six types of licensed health professionals in the province of Ontario are listed as able to complete the Health Status report for the DDP, however 26% of grant participants lacked any connection to medical support when entering this program.

This impacted retrieving medical history, documenting conditions and delayed the completion of the DDP. Many participants needed time to find a Family Physician, establish a rapport, complete requisitioned tests, bloodwork etc., in order for the Physician to confirm an accurate diagnosis.

This process proved to be difficult given the inherent challenges posed by cognitive barriers. Attendance of an appointment alone involved multiple steps of initiation, planning, coordination and follow-through for multiple factors such as:

- **Transportation** - coordinating travel to and from appointment, identifying bus routes and times/booking Wheel-trans, calculating arrival and departure route times associated with date of travel.
- **Finances for travel** - calculating and memory to retrieve adequate funds for bus or taxi fare
- **Memory** - date and time, location, instructions and reason for appointment.
- **Follow through with recommendations** - completion of bloodwork, x-ray, ultrasound, referral to Specialist, prescription filling, dispensing and administration

Lack of adequate medical specialists also interfered with the DDP completion and submission, further delaying proper access to financial income. Due to the nature of some conditions, a medical specialist was needed in order to diagnose specific conditions.

Clients are often waiting several months for initial appointments and subsequent diagnosis with a specialist. Without proper diagnosis, Family Physicians are left without confirmed conditions often leading to lack of information on the DDP.

## 6. Missing Identification

18% of participants in the program with memory impairments or substance use issues, had ongoing concerns with lack of, lost or expired identification. This created a gap in ability to access care.

Replacing or acquiring missing identification came with several barriers similar to supports needed to attend medical appointments listed above, such as planning, organizing and follow-through. Sufficient information is needed to present to Service Ontario for a health card and this alone required several appointments and many hours of coordinated care. Participants often lacked a valid credit/debit card, drivers license or valid photo ID, proof of citizenship, proof of residency, or proof of a fixed address.

Without identification, health appointments were not completed, access to medical records could not be initiated, community referrals and completion of personal income tax was hindered. In some cases, missing identification meant that participants could not access a bank account or deposit financial cheques.

## 7. Mental Health and Substance Use

*Mental Health Issues - 74% OF CLIENTS*

*Addiction and Substance Use - 22% OF CLIENTS*

As many as 74% of participants had a mental health diagnosis by a treating Health Professional. Diagnosis included Anxiety, Depression, Post-Traumatic Stress disorder (PTSD), Obsessive Compulsive Disorder (OCD), Borderline Personality Disorder, Dissociative Identity Disorder (DID), and Psychosis.

When applying for support services, listing both Brain Injury and mental health factors on referrals meant that clients were denied for specific services as acceptance is often based on the exclusion of a Brain Injury or reversely, exclusion of a mental health diagnosis. This created an issue with referrals and intake interviews with participants with the diagnosis of a mental health condition and subsequent Brain Injury. Supports for individuals should strive to address all functional aspects of care.

## 8. Additional Comorbid Conditions

The Transitional Support Coordinator program looked at other comorbid conditions that participants faced when entering the program. These conditions were in conjunction with having a diagnosed or suspected Brain Injury.

Taken separately, individuals may be able to stay in the workforce earning an adequate income. Combinations of multiple health factors or conditions interfered with participants' ability to complete Activities of Daily Living, cope with daily stressors, apply for and maintain gainful employment. 100% of ODSP applicant's health professionals listed multiple conditions on the DDP, indicating two or more of the conditions as ongoing, remaining the same, or deteriorating over time. This meant that the participants likely will not improve to a significant point of transition off of the ODSP program in their lifetime, and most likely face increased challenges with age.

Below is a list of the additional conditions identified by grant participants and health professionals.

<b>Comorbid Condition</b>	<b>% of Clients Affected</b>
Mental Health	74%
Addiction	22%
Seizure Disorder	14%
Stroke	15%
Illness	10%
Loss of extremity/injury/mobility issue	47%
Developmental Disability	1%
Surgery	15%
Learning Disability	13%
Vision	16%
Hearing Loss	7%
Paralysis	9%
Literacy	8%
Speech	8%
Unsupported Medical	33%
Dental	15%

## 9. Transportation Support - 48% OF CLIENTS

In order for applicants to access medical care and/or therapy supports, transportation was needed. 48% of participants reported issues such as: lack of funds to pay for transit, a physical impairment limiting ability to use conventional travel, a mental health condition or cognitive barrier that prevented safe use.

Participants often avoided transportation due to physical impairments and required assistance with acquiring forms for accessible transit applications.

Barriers included having a health practitioner to complete forms, access to technology, cognitive or physical ability to complete self-report section, and funds to pay the health practitioner for the completion.

Ontario Works offices offered monetary support to clients to alleviate the financial barrier with transportation, a significant support given the already limited income received by participants.

However, OW recipients were required to provide documentation in the form of a letter, indicating the number of medical or treatment appointments per month to determine the amount of funds given. A participant's ability to produce and provide a letter is hindered when the client is diagnosed with a Brain Injury or cognitive disorder.

Participants faced additional barriers when transitioning to the ODSP program, as monetary assistance for transportation required use of the Mandatory Special Necessities form. Participants were required to request the document from the local ODSP office, coordinate bringing form to a health care professional, document visit locations, predict the number of visits per month and length of requirement.

A client was therefore required to be able to cognitively support this process, by initiating, planning, organizing, predicting, and following through. Those with cognitive or mental health disabilities are at a disadvantage with this process, and often go without these funds that they are entitled to.

Furthermore, the medical transportation benefit limits access to funding to travel to therapy and support groups as the treatment has to be provided by a physician, psychiatrist, or psychologist. This limits support groups overseen by Social Workers, Occupational Therapists, and community agencies, as well as needed travel funds for ID replacement, which is required for mental access in the first place.

## **10. Food Security - 41% OF CLIENTS**

Participants indicated lack of funds to purchase food as a significant barrier and relied on food banks, community kitchens and grocery card donations to address food security. Many participants' food security was compounded by secondary challenges such as: access to technology to schedule appointments with food banks or agencies; challenges with transportation to and from grocery stores for weekly shopping; physical ability to shop, transport, and store items; cognitive/memory issues recalling food bank appointments, locations, and or grocery lists; overstimulating environments, headache/migraine inducing, and anxiety provoking.

## **11. Lack of Therapy Supports Accessible to Vulnerable People**

Accessible and affordable treatment for participants on income support is a systemic barrier. The majority of clients were identified as needing therapy such as, Psychological intervention, Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT), or other therapy to help stabilize and treat a diagnosed condition by health practitioners.

Those that do have referrals that are accepted, often wait months for initial assessment, due to limited publicly funded support, have limited access to treatment sessions, are challenged with accommodation and accessibility for comorbid factors.

Supports that are available online often involve intense reading and self-guided training which is not appropriate for individuals without technology access and/or have difficulties with reading, comprehension and motivation. Without finances to access supports, clients are left without treatment for serious conditions, and are often in a cyclical pattern of crisis management and intervention, with overuse of hospital emergency medical treatment.

# STRATEGIES EMPLOYED TO SUPPORT BARRIERS

**To address the 11 barriers outlined above, the TSC utilized a number of specific strategies to assist and advocate for her clients including:**

- Determined the current level of financial support, and whether other Federal, Provincial or Municipal benefits could be accessed in tandem with ODSP (CPP-D, LTD, Survivors benefit, DTC, municipal welcome policy for parks and recreation access).
- Assisted with the completion and submission of applications for these benefits.
- Determined if other income support initiatives could be accessed in future (OESP, RDSP, Rent Banks).
- Helped participants acquire identification necessary to attend doctors appointments in order to have the Disability Determination Package completed without additional expenses; arranged for documentation collection and storage through community programs; referred to the Partners for Access and Identification (PAID) program offices if necessary to help them with ID acquisition (PAID programs look at helping support individuals who are homeless acquire the following ID: Birth Registration, Canadian Birth Certificate, Verification of Status replacements, and Health Card).
- Provided support with finding a Community Health Clinic with access to Dental, Social Work/Psychotherapy and dietician/diabetes clinics for wrap around supports, or with finding a Family Physician accepting new patients.
- Provided clients with help with functional tasks in real time to alleviate stressors, ie support with locating resources, printing, scanning and mailing documents, arranging transportation.
- Assisted Primary Health Practitioners with finding available resources to address conditions; assisted with referrals for participants to appropriate specialists based on their health status report.
- Provided support with booking, attending and documenting appointment outcomes, providing reminders for appointments, completing follow up planning with clients for bloodwork, imaging and pharmacy prescription assistance; medication administration support such as requesting blister packing for better memory recall adherence, keeping medication history records.

- Researched community non-profits for treatment or care when OHIP services were non-existent.
- Relayed disclosed information to the primary health professional to help with navigating specialist referrals such as Psychiatrist, Psychologist, Neurologist, Mood disorder clinics, Seizure disorder clinics etc.
- Helped participants create questions and summarize information to relay to Health Professional(s); supported clients in learning new strategies to become more independent during health care appointments.
- Completed referrals for affordable/accessible transit for participants who identified with a physical impairment, mental health issue such as anxiety or PTSD, or memory/cognitive condition requiring accommodation.
- Provided travel training to and desensitization for clients with active therapy involvement, to therapy destinations, medical appointments and food banks.
- Supported clients in self-referral process for addiction support, and or mental health supports.
- Advocated for participant memory and cognitive issues to be identified and addressed with therapy providers and health practitioners to avoid missed scheduled appointments and subsequent charges.
- Provided resources for support groups in the client's area that could be attended, set up initial appointments and attended with clients so that they were familiar with workers, transit routes and meeting spaces.
- Completed community referrals to the ABI network to help clients access Brain Injury Supports, and Toronto Access Point for mental health and housing supports.

## RECOMMENDATIONS FOR FUTURE SUPPORT:

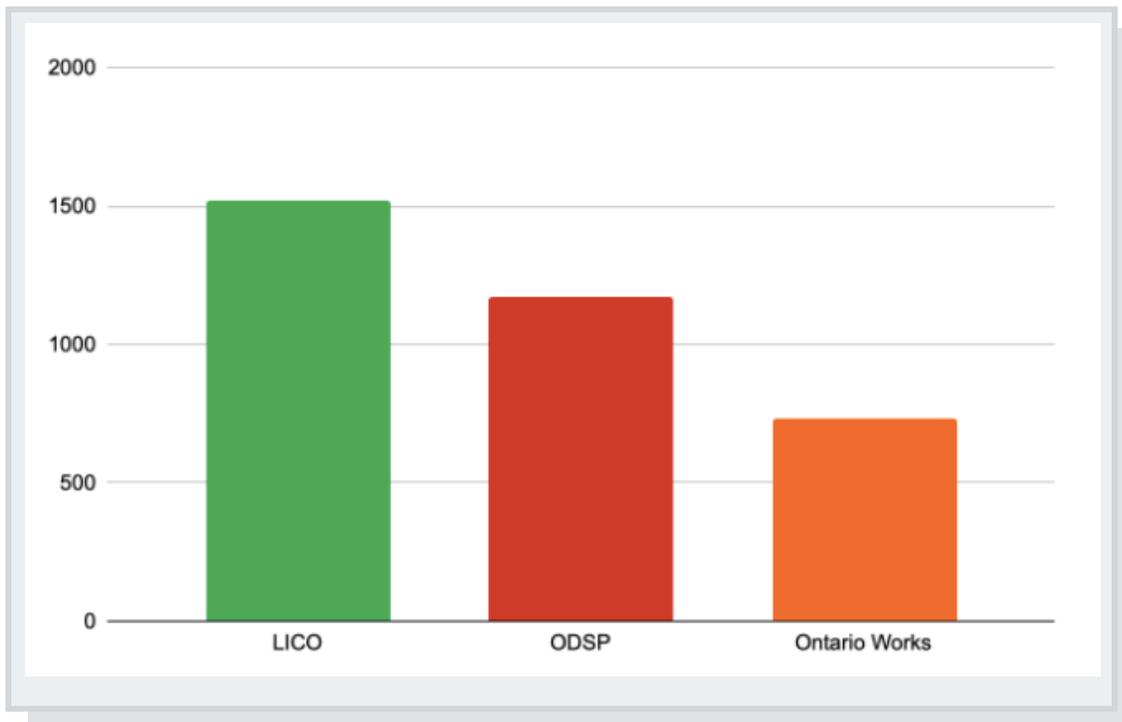
- Have workers in the Ontario Works and ODSP offices trained in brain injury/cognitive disabilities, and designate specific workers to help recipients with paperwork as application processes are the number one barrier for clients.
- Ensure basics for all participants are identified and a solution is put in place for housing security, food security, transportation, technology access, and referrals for mental health and addictions.
- Advocate for more accessible options for mental health access and affordable therapy related to diagnosis.
- Provision of training for community workers on the combination of effects for persons with concurrent brain injuries and mental health disorders.
- Advocacy for the inclusion of funds for therapy and support group in ODSP travel allowance.
- Advocate for the inclusion of Psychology, Psychotherapy and/or Social Work coverage for individuals with ongoing mental health conditions to alleviate stress on health care system and long term costs.

### **Barriers to Long Term Financial Stability:**

Statistics Canada defines Low Income Cut-Offs (LICO) as any individual who is receiving \$21,481 or less in yearly income (Government of Canada, 2021).

Individuals on OW receive on average \$733.00 per month for a yearly amount totaling \$8,796.00 and individuals on ODSP on average receive \$1,169.00 for a yearly amount of \$14,028 (CMHA, 2021). The yearly income received by individuals on OW and ODSP are significantly below the LICO standards and pushes individuals further into poverty, perpetuating the cycle of oppression, and increasing stressors and mental health issues.

It is systemically challenging for an individual receiving such an income to move out of poverty or work towards building savings. This is especially true when we consider that the cost of living in Canada, identified as \$2,730.00 per month, is substantially higher than the income received through social assistance. Those with lifelong disabilities are automatically set to fail.



Recognizing the discrepancy between social assistance income and the cost of living in Canada, the Federal government has created an opportunity for those who meet criteria to apply for the Disability Tax Credit (DTC). Once approved, the recipient can open a Registered Disability Savings Plan RDSP then apply for grants and bonds from the government.

This helps Canadians to potentially save, however the criteria for meeting the definition of disability for the DTC is very narrow and excludes many individuals from participating in a secure and safe future.

### **Recommendations:**

1. Advocate for an increase in maximum allowable income for ODSP recipients.
2. Create a streamlined application process for those participants with a reported memory or cognitive issue that renders the application process impossible without support.
3. Streamline the application process for participants with specific mental health diagnosis to allow for faster access to appropriate income.
4. Advocate for more resources that help support those individuals with cognitive disorders and/or a brain injury.
5. Advocate for more Community Health Clinics with wrap around supports.
6. Advocate for policy change that would allow for clients to have better access to technology so that information like ID and past medical records could be stored and maintained throughout their lifespan.

# CASE STUDIES

*All names and initials have been changed in this report to protect the identities of the service users.*

## CASE STUDY #1

### *Peter & Maria*

Peter and Maria are mother and son who immigrated to Canada from Chile.

Maria relied heavily on Peter to help her with most community related tasks as she primarily spoke and understood Spanish.

Peter was diagnosed with Obsessive Compulsive Disorder, Generalized Anxiety Disorder, Panic Disorder, Depression, Anger Issues, and Cognitive Issues.

Maria was diagnosed with Psychosis with hallucinations, Depression - secondary to Psychosis, Panic Disorder, Tinnitus, Brain Injury (MVA), High Cholesterol and Hypertension.

Both Peter and Maria had been on Ontario Works (OW) for more than 5 years.

Although several DDP packages for ODSP were released to the participants, they did not have the support they required to complete the application process.

Their OW worker referred them to the Transitional Support Coordinator to receive assistance in applying to ODSP, as well as to support them with other interconnected barriers, health related needs and Activities of Daily Living.

### **Barriers:**

- Cognitive challenges (Attention, memory, initiation, planning, organizing, sequencing, problem solving, follow through)
- Financial insecurity
- Access to appropriate medical support
- Difficulty taking and accessing transportation
- Lack of personal identification
- Isolation
- Food security
- Access to affordable technology devices
- Mental Health Issues

## **Support Provided**

### **Income Support**

The TSC assisted both Maria and Peter in the completion of their ODSP application by supporting them in drafting the DDP forms, as well as accompanying them to doctors appointments to ensure that the DDP Health Status Report and Activities of Daily Living forms were finished in a timely, efficient, and accurate manner.

Both Maria and Peter were approved for ODSP.

Maria and Peter were also assisted in setting up appointments with non-profit community organizations that help with filing Personal Income Taxes for persons on Social Assistance. Maria and Peter received support in gathering documents, reminders for appointments, and travel assistance to attend three separate appointments to complete 10 years of back taxes for each person.

As a result, both Maria and Peter were able to receive quarterly GST cheques for the 2019 tax year and are now up to date with tax filing. Peter was supported in having the DTC filled out by his Family Physician. He is still waiting for a decision regarding his eligibility.

Maria will require support in having the DTC completed now that she has a new Health Practitioner. Support was given to complete the process of transitioning over from OW to ODSP and completing the Authorization of to Make Payment Directly To Landlord. Communication between building management, subsidy and the ODSP worker, allowed for the completion of this direct payment making housing more secure, by avoiding missed rental payments.

### **Medical Support**

The TSC supported Maria in acquiring a Health Practitioner that spoke Spanish to ensure that she was able to clearly communicate her concerns as well as understand information recommendations. The TSC was able to connect Maria with a Health Practitioner at a Community Health Clinic with access to a Spanish speaking interpreter, Nurse Practitioner and Community Case Worker.

Both Maria and Peter also had challenges completing their self-assessment, due to language, cognitive and mental health barriers.

The TSC helped to ensure that the ODSP package had all necessary supporting documentation including reports from their respective Health Practitioners, past Psychiatrist and CAMH, St. Joseph's hospital records.

With this support being provided, both Maria and Peter were successful in acquiring ODSP.

### **Community Support**

The TSC connected Maria to a community centre that had Spanish speaking community groups which allowed her to join social drop-in, cooking and bingo programs.

Peter and Maria were referred to Progress Place, a community centre that supports individuals with food security, clothing and mental health support. The TSC also supported Peter and Maria with food security by providing them with food gift cards, and information on how to access food banks within their area, signed them up for draws for food baskets and during COVID-19, a food delivery service.

The TSC also completed a referral to Access Point to receive support for long term case management. Both Maria and Peter are on the waitlist for support.

### **Mental Health Support**

Within the first few months of the TSC program, Maria tried to commit suicide due to a psychotic episode. She was hospitalized and it was determined that she suffers from Psychosis with hallucinations.

The TSC supported Maria throughout her hospitalization and attended family meetings to help with discharge and outpatient support and follow-up recommendations.

Support was also provided with information retention from outcomes of hospital family meetings and discharge planning.

Maria and Peter were placed on the waitlist for the Community Health Centre, however due to Maria having an accessibility need based on her language barrier, Maria was able to complete an initial intake appointment after four months, where Peter continues to remain on the waitlist.

Once intake was completed, Maria was supported in follow-up with injection support at home for her antipsychotic medication as well as referral to an Ophthalmologist to address her diagnosis of cataracts and future surgery.

Maria gained greater independence by communicating with her physician without the presence of her son. Peter lacked a supportive Health Practitioner. His current Physician had completed several refers to Cardiologists and Psychiatrists to help diagnose Peter based on his reports of heart palpitations and severe panic attacks.

Due to Peter's lack of follow-through related to his cognitive issues, Peter's Health Practitioner grew frustrated. In order to complete the DDP, the TSC attended Peter's Physician appointments.

His Physician agreed to complete new referrals knowing that Peter now had support in order to attend future appointments. Peter was supported during the three year grant in attending Cardiologist, Psychiatrist, Optometrist, and therapy appointments at CAMH. This support allowed his Health Practitioner to accurately complete Peter's DDP for the ODSP application.

The TSC also learned that both Peter and Maria had not been to the eye doctor or dentist. She referred them to a dentist and ensured that the hygienist spoke Spanish. The TSC supported Maria and Peter in finding and accompanying them to eye doctor appointments. Maria was then referred to a specialist as it was discovered that she had cataracts.

The TSC located and accompanied Peter and Maria to an eyeglass store so they could pick out new glasses and ensured that they store was able to accept income from ODSP. Support was given with follow-up and communication between Optometrist, ODSP worker and participants to ensure timely receipt of corrective eyewear.

Help was required to ensure Maria received her monthly injections for mental health stabilization, as well as the follow through with referrals to a Spanish speaking Psychiatrist and Psychotherapist in an outpatient program.

The TSC connected Peter with the Centre for Addiction and Mental Health where he now attends group supports and workshops as well as connected with a Psychiatrist that he continues to see regularly.

### ***Identification Support***

When Peter and Maria came to the TSC program, they both did not have any valid identification. The TSC supported them in applying for and receiving new health cards as well as connecting with their respective Consulates to acquire supporting documents to replace lost ID.

### ***Travel Support***

Peter suffers from debilitating anxiety and OCD which can make everyday tasks extremely challenging. Navigating the public transit system and being in large crowds, overwhelms Peter to the point of experiencing physical chest palpitations. The TSC supported Peter and Maria in learning how to comfortably take transit to the grocery store. Support was given to complete the Mandatory Special Necessities form for the ODP travel benefit to ensure that they could take a taxi to and from important medical appointments.

### ***Additional Supports***

The TSC supported Peter and Maria in ensuring that they have access to Technology for ongoing support. Communication with cell phone companies was made to address bill payments. Maria was also supported with receiving her own cell phone, providing her with greater independence.

The TSC also helped them to obtain a computer to support virtual appointments. Lastly, support was provided to Peter in signing up for free college courses at Ryerson University through their mental health program which connects individuals suffering from mental health with access to Post secondary education.

### ***Continued Support During COVID-19***

The TSC continued to support Peter and Maria during the COVID-19 pandemic through frequent phone or text message check-ins. The TSC supported both participants to prepare for appointments by writing questions for their health practitioner and texting them the information prior to the appointments.

The TSC would provide reminders of upcoming appointments, and would be present over the phone during appointments in a three-way communication with Peter, Maria and the Health Practitioner to support them with recalling prepared questions, retaining/documenting any important information.

The TSC also helped with the scheduling of Maria's injections to be at her home instead of at the hospital to minimize the risk of exposure. The TSC supported Peter and Maria in accessing the Discretionary Benefit through ODSP, where they were able to access \$100.00 per month to cover additional costs due to COVID-19 such as income to purchase Personal Protective Equipment (PPE), cleaning supplies, food and travel.

The TSC would support Peter and Maria by calling their ODSP worker every month to ensure that they received this additional fund. The TSC supported Peter and Maria in ensuring that they had an adequate supply of food. Accessing the food bank during the pandemic became a challenge during citywide lockdown and continues to be a challenge when individuals are trying to minimize risk and exposure.

The TSC had to find additional food sources such as People's Pantry, and Red Cross that were able to deliver food to Peter and Maria. In addition, she helped them to navigate and set up an account to access the nearest food bank online. Again, it is important to note here that these individuals could not have navigated any of these supports/services without direct assistance from the TSC.

# CASE STUDY #2

## Gurpreet

Gurpreet is a male client with a significant brain injury and involvement in the criminal justice system. He was referred to TSC from Ontario Works. He has a severe Brain Injury from an Arteriovenous Malformation (AVM), a tangle of abnormal blood vessels that connect arteries and veins within the brain, disrupting the proper flow of blood from the heart and lungs to the brain and back. As such he underwent treatment. Causes of AVM are unclear but are likely there from birth and are genetically related. Gurpreet also has a Seizure disorder, and was in a car accident which severely damaged his leg, causing mobility issues. He has been on OW for many years and had previously applied to ODSP. Gurpreet had previous support in taking his DDP to the Social Benefits Tribunal, however the package was denied after having the ODSP DDP process open for approximately three years.

## Barriers

- Brain Injury (Severe memory issues, Irritability, impulsivity, lack of filter, attention, initiation, planning, organizing, sequencing, problem solving, follow through)
- Financial insecurity
- Mental Health Issues
- Legal Issues
- Difficulty taking and accessing transportation
- Lack of personal identification
- Isolation
- Food security
- Access to affordable technology devices

## ***Income Support***

The TSC learned that Gurpreet had previously applied to ODSP but was unsuccessful. He has been referred at the time to Legal Aid, however they were unable to successfully support him and his DDP at the Social Benefits Tribunal Level and the application was denied.

The TSC supported Gurpreet in updating his application by having his Physician complete a new DDP with recommendations from the TSC, additional medical documentation providing support of the AVM as well as Seizure disorder, and mobility issues. Gurpreet was supported in completing the self-report and Activities of Daily Living section of his application.

Gurpreet's recent application was approved within two weeks of his submission to the Disability Adjudication Unit.

## ***Medical Support***

The TSC supported Gurpreet by accompanying him to his doctor's appointments to ensure that he was able to communicate his concerns, and retain information outcomes of the appointment. Support was given to Gurpreet at a Seizure Disorder clinic in Toronto, to support his diagnosis as well as to manage his seizures.

In addition, the metal rod that had been inserted in Gurpreet's leg following his MVA had been causing chronic pain issues, the TSC supported him in being referred to pain management specialists. During one support session, Gurpreet had a severe allergic reaction to a prescribed medication.

The TSC went to the hospital and stayed with Gurpreet to support him in properly relaying this information. It was discovered that Gurpreet has Steven Johnson Syndrome which is a rare but serious skin disorder that affects the skin and mucous membranes typically brought on by a reaction to medication.

The TSC ensured Gurpreet was referred to a Dermatologist and Rheumatologist and accompanied him to these appointments to relay information. TSC also ensured that Gurpreet's allergy was properly registered on his medical records and supported him in the registration for Medical Alert.

Gurpreet also had several significant seizures over the three years where he was hospitalized and required open reduction internal fixation (ORIF) as he fell on his shoulder. Support was given at the hospital and at fracture clinic follow ups for multiple appointments. A referral to the ABI network for brain injury supports, and an Access Point referral was completed. He is currently on wait lists for long-term case management.

### ***Transit Support***

The TSC supported Gurpreet in applying for Wheel-Trans due to his mobility issues. He is currently on the waitlist to receive an interview. Support was also given with the Mandatory Special Necessities form for the ODSP transit Benefit.

### ***Identification Support***

The TSC supported Gurpreet in applying for and securing a new Health Card, a Disability Parking Pass and a system to keep track of other ID as the client has severe memory issues.

Pictures of his SIN, passport and health card were taken and emailed to the client as a strategy to track important documents. A copy of his health card was kept with the TSC to ensure the number was ready to present at all medical appointments.

### ***Legal Support***

The TSC supported Gurpreet in addressing a bench warrant that had been issued. Gurpreet had received a letter to this effect, however he did not recall that he had a court date set for an offense that occurred on public transit.

Support was given to call the Ontario Court of Justice to determine when the next scheduled appearance was, to connect with Legal Aid to find a lawyer to help address the matter, attend court with the Gurpreet, connect with Duty Counsel to explain Marco's memory issues and brain injury and how he could not attend court without support to recall dates and times, plan transit and understand the proceedings and court etiquette.

The TSC advocated with Duty Counsel, relayed information to help with referral to the Mental Health Diversion Program as a way of intervention, and attended the court proceedings with Gurpreet.

Support was given to help document his participation in ongoing medical appointments to highlight to the court that he was agitated on public transit after having a significant medication change that had negative effects, in conjunction with a brain injury with issues with irritability and impulsivity.

The courts accepted his participation in the Mental Health Diversion program and the Crown Attorney later noted that she was satisfied with Gurpreet's participation with support. A secondary arrest was made at the client's house the following year, and he was arrested in his home. Gurpreet notified the TSC worker to help him navigate the court system for the second time. When attending court for the matter to be spoken to, the charges were dropped.

# CASE STUDY #3

## *Tisha*

Tisha is a female client who had sustained multiple concussions throughout her life from trauma and abuse. She was referred to the TSC by her OW worker. She has mental health and substance use issues without any connection to health support. Tisha had been on OW for two years, prior to this, she had worked as a sex trade worker. Tisha required intense support in addressing multiple conditions.

### **Barriers**

- Brain Injury (Memory issues, irritability, impulsivity, attention, initiation, planning, organizing, sequencing, problem solving, follow through)
- Financial insecurity
- Legal Issues
- Mental Health Issues
- Difficulty taking and accessing transportation
- Lack of personal identification
- Isolation
- Food security
- Access to affordable technology devices
- Substance use / trauma assault issues

### **Income Support**

The TSC supported Tisha in completing her ODSP package by finding her a Family Physician, and accompanying her to appointments to ensure that the medical portion of the application was completed in an accurate and efficient manner. She also helped Tisha obtain any supporting medical documentation. Tisha's application was approved by the DAU and she is currently receiving ODSP income. The client was also supported in the completion of the DTC. The DTC was submitted, however denied. Support was given to appeal the process. Due to COVID-19, the matter is being deferred to a later date. Tisha was also supported in completing 10 years worth of Personal Income Tax, allowing her to receive quarterly GST checks.

## ***Medical Support***

As indicated above, the TSC supported Tisha with finding a Family Physician, accompanied her to appointments, helped relay issues with tremors, memory, addictions, PTSD, depression, and anxiety. TSC supported Tisha in receiving referrals to and attending appointments to a Neurologist, Movement Disorder Clinic, Concurrent Disorders Program, Psychiatrist, Social Worker, Sleep Specialist and Dietician. The TSC also connected her with an Optometrist and Dental Surgeon, which resulted in a prescription for new glasses and dental surgery.

## ***Mental Health and Substance Abuse Support***

Tisha has a debilitating substance use issue that causes her to lose contact with support frequently. The TSC was able to offer support that met her where she was at, both in location and capability. She completed an application to Homewood to receive in patient substance use support as well as to Access Point for ongoing case management support. The TSC connected Tisha to a Social Worker through her family health team to support her with ongoing issues.

## ***Additional Supports***

The TSC helped support the completion of the Mandatory Special Necessities form for Transportation Benefit to ensure that Tisha would be able to travel to necessary medical appointments. She also set up food security such as providing grocery gift cards, booking appointments to local food banks. Tisha was provided with a City of Toronto ID so she could access community centres, and various activities throughout the city. The TSC also supported Tisha in obtaining several pieces of ID, such as replacing Health Card, debit card, and Social Insurance. The client was also supported in housing and communication with her Landlord to address ongoing issues with rent, building maintenance and mailbox access.

## ***Continued Support During COVID-19 Pandemic***

Tisha is now part of the Community Connections Program at BIST to ensure that she receives continued support. This program has supported her with obtaining a phone and setting up a system to have her monthly phone bill paid which has helped to stabilize her and ensure that supports are able to reach her and vice versa. Food services have been acquired through Peoples Pantry and Uplift Kitchen.

## **CASE STUDY #4**

### ***Luis & Iris***

Luis and Iris are mother and child who self-referred to the TSI when they relocated to Toronto from Sudbury, Ontario. Luis identifies as non-binary and their pronouns are, they/them. Iris was in a very bad car accident and suffered a debilitating Brain Injury. She was told about our services through a friend who knew about BIST. Luis has severe anxiety, paranoia and depression which impacts their ability to complete daily tasks without the support of their mom.

### ***Barriers:***

- Brain Injury (Memory issues, attention, initiation, planning, organizing, problem solving, follow through)
- Financial insecurity
- Mental Health Issues
- Isolation food security
- Access to affordable technology devices
- Substance Abuse / trauma assault issues

## ***Income Support***

Both Luis and Iris were without any source of income and were relying on employment savings and support from Iris' son. The TSC immediately supported Luis and Iris in securing OW income and set up meetings with their OW workers.

The TSC attended meetings with their OW worker and requested necessary documentation to complete ODSP applications as well as CPP and OAS applications. The TSC assisted Iris in completing her online CPP and OAS application and submitted it to the appropriate location through registered mail.

The TSC supported Luis in completing their ODSP application by accompanying them to their medical appointments and ensuring that their physician was aware of deadlines and had the requested the necessary supporting medical documentation.

The TSC also met with Luis on various occasions to complete their self-report and activities of daily living. Luis has great fear of taking the subway and being in large crowds so the TSC ensured that she met with them in a location that felt accessible and safe to them.

The TSC was also cognizant of the fact that completing a self-report and activities of daily living can be extremely stressful, so they scheduled shorter, more frequent meetings and Luis was continuously checked in throughout each meeting.

Luis' ODSP application and Iris' CPP and OAS applications were approved.

## ***Mental Health Support***

The TSC supported Luis in locating a counsellor at a community health clinic, and completing referral forms for the Family Physician to submit for Psychiatry.

## ***Continued Support during COVID-19***

The TSC continued to support Luis and Iris by checking in on a weekly basis and supporting them with any needs they might have identified such as being referred to a therapist or support with completing back taxes.

# IMPACTS OF COVID-19

As in most areas of society, the COVID-19 pandemic posed and continues to pose significant challenges for persons accessing the Transitional Support Coordinator program.

During the many months of quarantine, vital services within our community had to shut their doors, which left the Transitional Support Coordinator (TSC) without the ability to refer clients to necessary services as well as to engage with individuals in person.

Completing important paperwork pertaining to an ODSP application can be quite challenging at the best of times, but the challenges are only compounded over the phone or through video conferencing as the information is sensitive in nature as well as extremely detailed. In addition, it was challenging to maintain contact with medical personnel as many scaled back office hours or shut down their practices completely.

As we are aware, medical professionals are crucial to the completion of ODSP package, and referral supports. However, the TSC mitigated these challenges by sending important information through secured mail, continuously engaging with service users over the phone as well as maintaining contact with medical and ODSP personnel through the phone or email.

These approaches helped to ensure that clients were receiving income support in a timely and appropriate manner. The TSC supported service users in accessing the discretionary fund that was available through OW and ODSP, which provided \$100.00 per month to further protect individuals during the pandemic.

Funds were allocated to purchase Personal Protective Equipment (PPE), cleaning supplies, accessing transportation as well as food. In addition, the TSC supported individuals with food security access throughout the pandemic when food banks and other resources had to close their doors.

The TSC found food services online that delivered to clients such as the People's Pantry, Uplift Kitchen, and Redcross to ensure that service users had adequate food.

The TSC also supported individuals to navigate providers websites, set up accounts, place orders, and access the foodbank when it became available online. The TSC also continued to support individuals to ensure that they were first and foremost safe, and then addressed their self-identified goals and needs. The closure of many services through the pandemic increased the TSC's workload substantially as she inadvertently had to take on the role of many other service providers.

It was a challenging and time-consuming role, but it has continued to reaffirm the importance of programs such as the TSC in our community to ensure that individuals are receiving transitional and ongoing support.

## TSC INSPIRED INITIATIVES

The important and critical work of the Transitional Support Coordinator and the plethora of needs supported by this program, helped launch a variety of initiatives over the three-years. The outcomes will surely inform more projects to support the most marginalized in our community.

### ***BIST Initiatives inspired by the Transitional Support Program:***

- **Violence Impact Program** - a 1 year OTF Seed Grant initiative to support survivors of Intimate Partner Violence with poverty reduction and financial stability. Outcomes of this program can be seen here: [www.bist.ca/ipv](http://www.bist.ca/ipv)
- **Homeless Prevention Program** - a 1 year Seed Grant Initiative to support persons with brain injuries acquire safe and stable housing. Outcomes of this program can be found here: [www.bist.ca/brain-injury-and-homelessness/](http://www.bist.ca/brain-injury-and-homelessness/)
- **ABIJustice.org** - An online toolkit to provide support to persons with Brain Injury navigate the justice system: [www.abijustice.org](http://www.abijustice.org)
- **BIST Community Connections** - a program funded by the United Way until March 2021 to support persons with Brain Injury accessing technology during the pandemic

## FUTURE WORK

After completing this work, we learned and have reflected on hundreds of cases of people who struggle to access the necessities of life. As an agency, this project enabled our service, staff, and board to look deeper into our approach to ensure a more inclusive service model.

This development is ongoing and will undergo countless revisions as we continue to support those most vulnerable in our community.

***We acknowledge that while we operate as a Brain Injury Association, we must continue to grow our understanding of how individuals struggle and survive in the community without the awareness of the full impact of their disabilities. Inclusivity is a value not a place. It must be consistently adapted and changed to meet the needs of those we serve. Our agency is by no means finished in this pursuit and we must continue to work to remove barriers.***

Future work should involve continuing to have programs specific to those impacted by Brain Injuries and challenges accessing income support within Ontario. Through engagement in this program, it has become imperative that programs should be barrier free and collaborative in nature.

This means that anyone who identifies as having a brain injury, should be able to access services without having to obtain medical documentation first, therefore ensuring that individuals can receive the support that they need.

In addition, it would be beneficial if programs were collaborative in nature among various supports within the community to ensure that individuals are receiving all of the support that they need, and we are not neglecting an area of their self-identified needs.

As well, individuals who suffer from brain injuries can have symptoms that limit their capacity to effectively receive support such as emotional exhaustion, lack of follow through or forgetfulness, so it's important that there is a qualified team of individuals that can provide a holistic approach to their treatment plan.

It is also important that this support is long-term in nature and mobile to ensure that we are meeting individuals where they are at (both in location and personal situation), as well as ensuring that we have enough time to meet and help to achieve their self-identified goals and needs. As we have mentioned previously, brain injuries are often characterized as an “invisible” disability as their symptoms are often hard to recognize such as difficulty processing, forgetfulness, difficulty with social cues etc.

It can make it extremely challenging for service providers to identify a brain injury in clients as well as for service users themselves to identify whether they have suffered from one.

This can deeply impact the type of support that is provided to the individual as well as impact whether an individual seeks support in the first place. It is prudent that we continue to bring awareness to the signs and symptoms of brain injuries to members within our society. Due to the complexities of the extended crisis of the pandemic, we expect a growing population in need of access to income.

The true impact and/or trauma experienced by vulnerable populations is yet to be understood. It is expected that in the next year the needs of the individuals served by this project will intensify. This service model will become even more vital to supporting both communities and vulnerable individuals across the province in access income support and individual stabilization to address the complex needs faced in unparalleled times.

Lastly, the COVID-19 pandemic has created additional barriers to services such as the inability to physically go into services due to increased risk or service closure. The TSC has identified alongside service users that access to technology is a necessity when accessing services that are not always accessible due to increased cost and challenges with usage. BIST is participating in a provincial advocacy strategy to address this need.

# RESOURCES

## *Brain Injury Services*

### **BIST (Brain Injury Society of Toronto)**

[www.bist.ca](http://www.bist.ca)

### **ABI Network**

[www.abinetwork.ca](http://www.abinetwork.ca)

### **Ontario Brain injury Association**

[www.obia.ca](http://www.obia.ca)

## *Intimate Partner Violence Services*

### **Ontario 211**

<https://211ontario.ca/>

### **Talk for Healing**

<http://www.talk4healing.com>

### **Assaulted Women's Helpline**

<https://www.awhl.org/>

### **Mobile (#SAFE)**

#7233

## *ABI & Intimate Partner Violence*

### **ABI & IPV Toolkit**

[www.abitoolkit.ca](http://www.abitoolkit.ca)

## *Homelessness Research*

### **Canadian Observatory on Homelessness**

Homeless Hub

<https://homelesshub.ca/users/homelesshub>

**Insights on Canadian Hidden Homelessness in Canada**

[www150.statcan.gc.ca/n1/pub/75-006-x/2016001/article/14678-eng.htm](http://www150.statcan.gc.ca/n1/pub/75-006-x/2016001/article/14678-eng.htm)

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

[www.toronto.ca/wp-content/uploads/2018/11/981e-2018-SNAResults-Highlights-Slides.pdf](http://www.toronto.ca/wp-content/uploads/2018/11/981e-2018-SNAResults-Highlights-Slides.pdf)

**Housing First**

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

**Cost Analysis of Homelessness**

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

**Brain Injury & Homelessness Research****Traumatic Brain Injury & the Homeless Population: a Toronto Study**

<https://www.homelesshub.ca/resource/26-traumatic-brain-injury-homeless-population-toronto-study>

**The Disabilities Trust - Homeless and Brain Injury (UK)**

<https://www.thedtgroup.org/foundation/brain-injury-and-homelessness>

**The Effect of Traumatic Brain Injury on the Health of Homeless People**

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2553875/>

**Homelessness - Advocacy & Consulting Organizations****Toronto Alliance to End Homelessness**

<https://taeh.ca/>

**OrgCode Consulting**

<https://www.orgcode.com>

## Identification

### **Partners for Access and Identification Project (PAID)**

<http://neighbourhoodlink.org/partners-for-access-and-identification-paid/>

## Substance Use/Addictions & Brain Injury:

### **Substance Abuse and Brain Injury (SUBI)**

<https://www.subi.ca/Income>

## Income resources

### **Health Providers Against Poverty**

<https://healthprovidersagainstpoverity.ca/resources/clinical-tools/>

### **Income and Security Advocacy Center**

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

## Food Security

### **Quest Food Exchange**

<http://www.questoutreach.org/>

### **Toronto Community Garden Network**

<https://tcgn.ca/about/aboutcommunity-gardens/>

## Extreme Cold Weather

<https://www.toronto.ca/community-people/health-wellnesscare/information-for-healthcare-professionals/environmental-healthinformation-for-health-professionals/extreme-cold-weather-alertsinformation-for-health-professionals>

## Housing

### **Rent Smart Ontario**

Rent smart is an organization that provides education to tenants and landlords with the intention of teaching skills necessary for each group to be knowledgeable of their rights and responsibilities. A certificate is provided to those who participate; and in Vancouver, landlords have 'bought-in' to the program by using the certificate as a reference on housing applications.  
<http://www.rentsmartontario.ca>

### **Raising the Roof**

<https://www.raisingtheroof.org>

### **City of Toronto Emergency Housing Help**

<https://www.toronto.ca/community-people/employment-socialsupport/housing-support/financial-support-for-renters/housingstabilization-fund/>

<https://www.toronto.ca/community-people/community-partners/socialhousing-providers/affordable-housing-operators/current-city-of-torontoaverage-market-rents-and-utility-allowances/>

### **City of Toronto Rent Geared Income Housing**

<https://www.toronto.ca/community-people/employment-socialsupport/housing-support/rent-geared-to-income-subsidy/> 37 5.

## Shelters

<https://www.toronto.ca/community-people/housing-shelter/>

### **Pet Support for People Who Are Low Income:**

[https://www.torontohumanesociety.com/pdfs/Cannot\\_Afford\\_Care.pdf](https://www.torontohumanesociety.com/pdfs/Cannot_Afford_Care.pdf)

## Transportation

### **Fair Pass Transit Discount Program**

<https://www.toronto.ca/community-people/employment-socialsupport/support-for-people-in-financial-need/assistance-through-ontarioworks/transit-discount/>

### **Wheel Trans Accessible Transit**

[https://www.ttc.ca/WheelTrans/How\\_to\\_apply/index.jsp](https://www.ttc.ca/WheelTrans/How_to_apply/index.jsp)

### **Transit App**

<https://transitapp.com>

## Employment

### **STAR**

Program provides an environment for the homeless to rediscover activities that are meaningful to them. They provide opportunities for participants to develop skills (e.g., conflict resolution, interpersonal, financial basics, community engagement.)

<http://www.stmichaelshospital.com/programs/mentalhealth/star.php>

## Recreation

### **Access to Entertainment Card**

This is a collaborative partnership between Easter Seals and over 500 movie theatres, cultural attractions, entertainment venues, and recreation facilities across Canada. Designed for people of all ages who have a permanent disability and require the assistance of a support person, the goal of the Access 2 Program is to improve social inclusion and provide access to entertainment, cultural and recreation opportunities and experiences without any added financial burden.

<https://easterseals.ca/english/access-2-card-program>

### **City of Toronto - Free and Low Cost Recreation Options**

<https://www.toronto.ca/explore-enjoy/recreation/free-lower-cost-recreationoptions/> 38

## Legal Services

### **Tax Clinics**

<https://www.canada.ca/en/revenueagency/services/tax/individuals/community-volunteer-income-taxprogram.html>

### **ID Clinics:**

<https://neighbourhoodlink.org/partners-for-access-andidentification-paid/>

### **Community Legal Education Ontario (CLEO)**

<https://www.cleo.on.ca/en>

## Organizations

### **Google**

Creating Gmail accounts for individuals to send and receive communications, utilizing Google Drive to store important documents, copies of identification for individuals who may be transient or at risk of losing important information.

### **Google Calendar**

Use free app for organization of routine and daily appointment reminders. This can be shared with service providers to add appointments or track schedules with permission.

### **WhatsApp**

Free communication app for texting, video conference, and voice recording.

## Health/Social Service Connections

### **Health Care Connect**

Register for Health care connect and a nurse will search for a doctor or nurse practitioner who is accepting new patients in your area.

<https://www.ontario.ca/page/find-family-doctor-or-nurse-practitioner>

**211 Ontario**

Call, email or live chat on 211 to find social service programs in your community.  
211ontario.ca

**Big White Wall**

An online mental health and wellbeing service offering self help programs, creative outlets and a community that cares.

<https://www.bigwhitewall.ca/v2/Home.aspx?ReturnUrl=%2fDatacollection/HIFIS>

**National Homelessness Information Initiative****Homeless Individuals and Families Information System**

<https://www.canada.ca/en/employment-socialdevelopment/programs/homelessness/hifis.html>

**Accessibility in Toronto****AccessNow**

Using crowd-sourced information to show how mobility friendly buildings and public transit are across Canada.

<http://accessnow.me>

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