

**SELKIRK MENTAL HEALTH CENTRE**  
**ACQUIRED BRAIN INJURY PROGRAM MODEL**  
**OCTOBER 2008**



*Striving for Excellence in Rehabilitation, Recovery, and Reintegration.*

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**Introduction**

In recent years, a number of reports have documented the need for a broader spectrum of services for persons with acquired brain injuries in Manitoba. On June 29, 2004 Health Minister Dave Chomiak announced approval for an active long-term Acquired Brain Injury (ABI) rehabilitation program at Selkirk Mental Health Centre (SMHC) and a five-bed transitional, community-based residence to be located in the City of Selkirk.

The decision to locate an inpatient ABI Program at SMHC was based on a number of factors, including SMHC's stable staffing complement, the existing administrative and physical infrastructure, and SMHC's considerable experience in serving persons with ABI who are currently accommodated on various units at SMHC. Nationally, there is no consistent approach to ABI programming. In some jurisdictions ABI services are grouped with those for the mentally disabled, while in other jurisdictions they are part of the mental health system. However, it is known that individuals with an ABI have unique needs and require specialized programming.

In the planning process it was determined that the ABI Program at SMHC will focus on individuals with severe brain injuries and challenging behaviours whose complex active treatment and rehabilitation needs cannot be met through other existing services. Emphasis will be placed on longer-term ABI rehabilitation (six months to two years).

Within the health system in Manitoba, current ABI services consist primarily of acute medical services that focus on immediate physical recovery from the brain injury. In addition, there are many for-profit organizations that provide rehabilitation post-injury, and these are accessed primarily by clients of Manitoba Public Insurance Corporation (MPIC) and Workers Compensation Board (WCB).

The following is a list of current ABI resources within the Manitoba health system:

- The Health Science Center A-5 is a 28-bed acute medical ward. This ward serves individuals who have recently sustained a brain injury.
- The Post Acute Neurosurgery Unit (PANSU) at Seven Oaks General Hospital is a 14-bed post surgery unit for individuals with brain or spinal cord injuries. The Unit provides short-term rehabilitation services. The average length of stay (ALOS) is six to eight weeks, although ALOS for complex cases can be as high as nine months or more. Admissions come from Health Science Center A-5 only.
- Riverview Health Centre has a 10-bed Sub-Acute, Short-Term Comprehensive Rehabilitation Unit. The ALOS is six to eight weeks.
- The Winnipeg Regional Health Authority (WRHA) Health Coordination Program serves individuals with complex discharge challenges and establishes community-based rehabilitation programs through Home Care and Mental Health. This program is not available outside Winnipeg.
- The Burntwood Regional Health Authority opened a five-bed transitional residence for individuals with an acquired brain injury in February 2008.

## Program Description

The new ABI Program at SMHC is intended to address some of the gaps within the ABI continuum of services in Manitoba. The primary goal of the Program is to provide longer-term rehabilitation to assist patients to return to as independent a life as possible, preferably to a non-institutionalized setting. ABI is an injury - it is not an illness and not a progressive condition. Current research in neuroplasticity (ability of the brain to generate neuronal changes), even in those with “chronic” brain injury, heavily supports the concept that rehabilitation focused on full recovery, rather than compensation, should be the initial goal. Therefore, with appropriate individualized rehabilitation, all persons with an acquired brain injury have the potential to improve their functioning for the rest of their lives.

Although SMHC has admitted individuals with ABI in the past, they have been inappropriately located and served within programs tailored for persons with mental illness. SMHC has not previously been able to provide rehabilitation services targeted to the unique needs of persons with ABI.

The newly developed ABI Program is located in a state of the art facility and has the benefit of enhanced staffing levels and a greater variety of specialized professional staff. These features support the Program’s ability to achieve its intended outcomes, in particular the successful rehabilitation and discharge of patients.

SMHC’s ABI Program will have a number of components:

30-Bed (Inpatient) Program: The Program provides an active rehabilitation and discharge focus. The interdisciplinary team works toward patient-driven goals using a psychosocial rehabilitation approach. Team members establish and maintain strong linkages with community resources in order to develop viable discharge options. The Program partners with family and caregivers in planning and addresses the medical, psychological, vocational, social, emotional, psychiatric, recreational and spiritual needs of patients.

Consultation/Assessment Component: Program staff members are available for consultation to Regional Health Authorities and other service providers. Consultation is facilitated through Telehealth or in-person visits. In addition, two of the 30 beds are designated for 30-day inpatient assessments.

Respite Component: One of the 30 inpatient beds is designated for respite support. This is a valuable option in preventing formal admission to the inpatient program. Given that many individuals with ABI are discharged to family, many families become overwhelmed with the burden of care and require respite and support in order to maintain their brain-injured family member at home.

ABI 5-bed Transitional Residence in Selkirk (Summer 2009): This component of the program is specially designed to provide transitional accommodation and support for individuals with an ABI, in preparation for more independent community living. The residence will be staffed with a nurse and psychiatric nursing assistant during the day and psychiatric nursing assistants on afternoon and night shifts. Residents have access to all interdisciplinary resources available to the 30-bed inpatient component of the Program.

Education: SMHC staff members participate in the development of education and training opportunities for caregivers in the community. Program staff members help to develop ABI training programs relevant for both internal and external care providers and agencies.

## Program Philosophy

The ABI Program is committed to maximizing independence and quality of life for patients while promoting empowerment on the road to recovery. This is accomplished through an individualized person-centered approach and an interdisciplinary delivery of care. The goal is to return all patients diagnosed with an ABI to a community setting.

All ABI patients have the right:

- to be treated with respect and dignity in a non-judgmental, non-discriminating milieu;
- to access individualized treatment and rehabilitation in the least restrictive and positive environment;
- to fully participate in all aspects of treatment and rehabilitation planning, implementation and evaluation;
- to make informed choices and to learn by doing: “participate to learn”;
- to access current best practice treatment and rehabilitation interventions, facilitated by qualified staff, and enhanced by family involvement;
- to consistently receive support, encouragement and hope;
- to live a life of maximal independence with an acceptable “dignity of risk”;
- to have family and chosen caregivers involved during all aspects of treatment, rehabilitation and discharge;
- to focus on successful and safe discharge to the most appropriate, positive, and least restrictive community setting;
- to reach for their dreams; and
- to succeed!

The ABI Program Philosophy is based on the understanding that:

- The longer a person stays in an institutional environment, the more difficult it is to reintegrate into the community.
- Any long-term rehabilitation program must have an intensive, comprehensive discharge program that accesses a range of relevant services, and places community reintegration as its priority.
- People with ABI require daily structured programming. Unstructured time is not only detrimental to the person, but increases the incidence of challenging behaviours and further decline in level of functioning.

The specialized nature of this Program and the smaller unit sizes support the recovery of people with an ABI and promote patient and staff safety. The Program provides a high level of intensity of service. The ABI Program team includes numerous rehabilitation disciplines such as physiatry, neuropsychology, psychology, occupational therapy, physiotherapy, speech language therapy and recreation therapy. Behavioural challenges experienced by persons with ABI are addressed by consistent programming and follow-through on rehabilitation plans.

## **Person-Centered Approach**

Patients and their significant family members are the central focus of the rehabilitation effort in order to ensure effective outcomes.

- Patients collaborate in goal setting based on their dreams, preferences, skills and abilities.
- Family and/or natural supports will be encouraged to participate throughout the rehabilitation and planning processes (with appropriate consent) including on-site instruction for families and/or caregivers.
- Emphasis on discharge planning and return to community is the primary focus of all rehabilitation activities.
- Education and specific training in ABI rehabilitation is made available to family, community caregivers and natural supports.
- Information about local Brain Injury Association and Community Programs is offered.

## **Programs and Services**

SMHC has adopted a model of care based on a Psychosocial Rehabilitation approach. Treatment is person-centered and person-directed, consistently including patient, family and/or significant others. Interventions include positive behavioural, cognitive, and communication supports and strategies based in everyday routines and meaningful activities. Individual choice and control is maximized, with supports gradually being removed as positive habits increase. The range of services available to patients with ABI may include the following:

- A full range of rehabilitation services including, but not limited to: occupational therapy, speech language therapy, recreation, physiotherapy, educational and vocational pursuits, social work, psychology, psychiatry, and general medicine.
- Rehabilitation activities may include daily living skills such as cooking, cleaning, laundry, shopping, and budgeting.
- Support to access community amenities including banks, grocery and other retail stores, theatres, restaurants and public transportation.
- Pre-admission and post-discharge outreach services.
- Education, training, and support of family members and/or caregivers.
- Education, training, and support of community-based providers.
- Spiritual care.

## **Program Eligibility Criteria**

In general, the target population includes the following criteria:

- Resident of Manitoba
- Ages 18-64
- Non-progressive condition
- Brain injury acquired as an adult
- Medical evidence of a moderate to severe acquired brain injury (ABI) that is not associated with a progressive neurological disorder or degenerative brain disease. ABI may include: trauma, vascular, one-time toxic events, anoxia, infection and tumor
- Medically stable
- Does not require mechanical ventilation
- Ability to actively participate in treatment and rehabilitation
- There are no other existing services that will meet the individual's rehabilitation needs

## Admission Criteria

Admission to the ABI Program requires referral from a health care professional such as psychiatrist, psychologist, or ABI service provider. Patients may be admitted to the Transitional Residence directly from the community or upon discharge from the ABI Inpatient Program as needed. An interdisciplinary Intake Team assesses referrals and oversees admissions to the program. Suitability for admission differs slightly for the two Program components as shown below, reflecting the nature and intensity of participants' needs.

ABI Inpatient Program	ABI Transitional Residence
<ul style="list-style-type: none"> <li>✓ diagnosis of non-progressive moderate to severe brain injury</li> <li>✓ 18 years or older, fully recovered from acute medical condition</li> <li>✓ assessment completed by neuropsychologist or post-acute ABI services, if available</li> <li>✓ requiring an extended admission to undergo complex rehabilitation and treatment in an inpatient setting</li> <li>✓ does not better suit admission criteria for alternate treatment program at SMHC</li> <li>✓ with a potential community placement identified</li> <li>✓ unable to benefit from the Transitional Residence or other community ABI treatment/rehabilitation services</li> <li>✓ those with a psychiatric or co-occurring psychiatric/substance use diagnosis will not be excluded</li> <li>✓ those with a diagnosis of developmental disability are not eligible</li> </ul>	<ul style="list-style-type: none"> <li>✓ diagnosis of non-progressive moderate to severe brain injury</li> <li>✓ 18 years or older, fully recovered from acute medical condition</li> <li>✓ assessment completed by neuropsychologist or post-acute ABI services</li> <li>✓ requiring intensive rehabilitation and support based on individualized functional goals</li> <li>✓ unable to live independently in community without rehabilitation</li> <li>✓ with an identified discharge environment</li> <li>✓ not requiring an extended admission to the ABI Inpatient Program</li> <li>✓ those with a psychiatric or co-occurring psychiatric/substance use diagnosis will not be excluded</li> <li>✓ those with a diagnosis of developmental disability are not eligible</li> </ul>

The Intake Team assesses each referral on an individual basis in order to determine eligibility, and to identify the potential for positive benefits from active rehabilitation.

## Discharge Criteria

Discharge criteria are individualized and are based on attainment of functional goals set for each program participant.

## Referral Process

Referrals and other program inquiries can be directed to: Linda Beaton, ABI Program Manager  
 Selkirk Mental Health Centre  
 825 Manitoba Avenue  
 Selkirk, MB R1A 2B5  
 Phone: 1-204-482-1683  
 E-mail: Linda.beaton@gov.mb.ca

## Appendix

### Team Profile

The ABI Program functions on the basis of an interdisciplinary team, with the patient/family as part of the team. Following the Program Management Model, the interdisciplinary treatment team collaborates with the patient and family, under the leadership of the Program Manager, to develop individualized functional goals that facilitate discharge to a community environment. All team members provide patient and family education and support. Ongoing education, training and support for the interdisciplinary team assist them in fulfilling their roles.

Patients in the ABI Program have access to the professionals and services listed below (alphabetical listing). Some professionals are assigned specifically to the ABI Program, while others are shared with other SMHC programs.

**Aboriginal Services** – Provides culturally appropriate social support 1 on 1, or in a group setting. Friendship Workers assist patients to strengthen skills in self-care and communication, and to explore social, cultural, recreational, vocational, and educational pursuits. Traditional cultural, social, and spiritual activities and events are available to all.

**Activity Instructor** - Assists therapists in the functional assessment of patients. Implements skill teaching in dressing, feeding, personal care, balance, mobility, social skills, endurance, sensory awareness, wayfinding, etc.

**Coordinator of Patient Services** - Directly coordinates the interdisciplinary team in providing assessment, treatment and rehabilitation to inpatients and those in the Transitional Residence.

**Dietitian** – Evaluates and monitors nutritional status and develops and implements individual diets to meet nutritional needs. Assists in evaluating and treating swallowing disorders.

**Information Services** – Coordinates and maintains patient records to ensure timely access and accurate integration of information.

#### **Medical Services:**

- **General Practitioner** – Evaluates physical status and leads the team in providing effective medical interventions.
- **Physiatrist** – Evaluates physical care and leads the team in implementing rehabilitative treatments to maximize functional ability and improve quality of life.
- **Psychiatrist** – Evaluates mental status and leads the team in developing and implementing psychiatric and behavioural interventions, including medication administration.

**Neuropsychologist** – Evaluates cognitive and behavioural status and leads the team in developing and implementing appropriate cognitive retraining strategies and behavioural interventions.

**Nurse (RPN/RN/LPN)** – Collaborates in the development and implementation of physical, cognitive, behavioural, psychiatric, vocational, recreational, spiritual retraining and social/life skills training.

**Occupational Therapist** – Evaluates functional skills used in daily life and develops and implements training in dressing, feeding, personal care, balance, mobility, social skills, endurance, and sensory awareness. Identifies any adaptive equipment required to maximize functional independence, assess vocational aptitude, and develops and implements cognitive and vocational retraining as appropriate.

**Patient Education Coordinator** – Provides assistance in developing educational goals and connecting with appropriate community resources. Literacy training and computer skill development is also provided.

**Patient Trust** – Provides a banking service environment for patients to deposit and access funds while at the Centre.

**Pharmacist** – Reviews medication profiles and consults on medications for inpatients and those in the Transitional Residence. Delivers medications to program areas, and provides medication education and input on drug information to patients, staff and families.

**Physiotherapist** – Evaluates physical status in the areas of balance, coordination, flexibility, strength and endurance; and leads the Team in developing and implementing individualized exercise regimes in order to maximize functional mobility.

**Program Manager** – Leads in the overall development, implementation, operational management, and evaluation of the treatment and rehabilitation services provided by the team to inpatients and those in the Transitional Residence.

**Psychiatric Nursing Assistant** – Under the supervision of nurses and therapists, assists patients in attaining their recovery goals through implementation of physical, cognitive, behavioural, social, vocational, recreational, and/ or spiritual skills training.

**Psychologist** – Evaluates general psychological functioning through group/individual therapy and conducts standardized testing. Collaborates with the team to develop and implement appropriate interventions.

**Recreation Therapist** – Evaluates recreational needs, leisure interests, and limitations and provides resources and alternatives to maximize individual recreation pursuits.

**Social Worker** – Evaluates and closely monitors financial, legal and family issues in the best interest of the patient; works collaboratively with community to establish supports in discharge environments. Advocates for the development of appropriate resources in the community.

**Speech Language Therapist** – Evaluates speech and language status and assesses underlying thinking skills, in order to develop and implement plans to maximize effective communication skills. Evaluates and treats swallowing difficulties.

**Spiritual Care Team** – Chaplain and Elder provide access to spiritual care resources according to preference, need and individual strengths.

**Support Service Team** – Provides support tasks including housekeeping, food service, provision of supplies and building maintenance.

**Vocational Resource Centre (VRC)** – Provides assessment and skill development related to goals for getting and keeping meaningful work; including completing resumes and coaching in preparation for job interviews. The Vocational Incentive Program (VIP) offers a number of jobs on site to enhance skill development in preparation for jobs in the community.