



INSWABI Progress Report

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January - July 2012

1. Moving on from 5 years

It gives us great pleasure to provide the 11th Progress Report for the International Network for Social Workers in Acquired Brain Injury, as we move on from our first five years and look forwards to what we want to achieve over the next 5 years.

In this current issue, we feature a profile of INSWABI member Monica Lundenfelt from Sweden. Next, there is mention of two important issues raised by INSWABI members for peer consultation with the network by social workers at the Hampstead Rehabilitation Centre in South Australia and Susan David-Bailey from Parkwood Hospital in Canada. We then have an outline of the latest issue of Social Care and Neuro-disability. Nadia Elsayed and Jessica McCallum then inform us about their experience of using the Brain Injury Family Intervention program at the Toronto Rehabilitation Institute. In the research corner, Lenore Hawley from the Craig Hospital in Denver Colorado tells us about the latest developments in the Group Interactive Structured Treatment (GIST) for Social Competence, an intervention that she developed in collaboration with her co-worker, Speech Pathologist Jody Newman. Finally, Patti Simonson and Mark Holloway provide reports of recent conferences that they attended. We hope you find the report a useful and enjoyable read.

Dr Grahame Simpson
Co-convenor

Patti Simonson
Co-convenor

2. Membership Profile

Monica Lundenfelt



During this summer, I am going through a great change in my life: from work to retirement. I have been working in Health care as a social worker for nearly 40 years, mainly with ABI-patients in rehabilitation.

My place of work has been at the University Dept. of Rehabilitation in Stockholm, Sweden. The unit has the only in-patient ward for brain-injury rehab in Stockholm for patients in the age of 18 to 65. The out-patient teams are divided into two sites, north and south. For the last 16 years I have been working in such teams south of Stockholm.

Looking back, as part of my own current process, I think of many things that has changed over the years. For instance, that some 30 years ago patients and their families were told that improvement and progress were only possible during the first 6 months after injury. It is good to see that medical research and clinical experience have contradicted that, and that new methods for rehabilitation certainly have been important.

A major step forward for our group of patients in Sweden was the law that came in 1993, which permits people with severe BI to live in their own home with the amount of help they need for as much quality of life as possible.

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One of my core issues over the years has been the support, or rather the lack of it, to the children of our patients. I am so pleased to see that we now more and more address also the children in the rehabilitation-programs. This was also obvious in a recent INSWABI mail-conversation.

At this time when I am leaving my job, I feel worried about the development here, where the period for ABI-rehabilitation is getting shorter and more intensified. As we know, research in the field of rehabilitation stresses long-term planning and continuity. I see that our patients more often call us back some time after discharge from rehab, not knowing where to turn when they need more help than their GP can offer.

The economic climate has changed a bit also here in Sweden, and the number of unemployed has increased. Of course this has effects on our patients with mild or moderate BI who still have capacity for part time work. As our social-support systems also have become more restricted, it is a tough future ahead for many in this group.

Looking back, I also see that I never really have regretted my choice of work. Social work can be hard and disappointing but, as you know, also challenging and rewarding. It is not always easy to be the social worker in an ABI-team, where your role and methods of work are quite different from those of the other team members. For me, it has been very helpful to have a 2-year education in CBT 10 years ago. It has given me other tools to work with the patients, not only in psychotherapy, and it has sometime been useful in the teamwork itself.

Now when I leave my job, I am too wrapped up in this field to leave it entirely. I am going to work a bit with an organisation for patients with ABI. I hope to be able to use my experience for some activities with patients, also to take part in the

work of influencing politicians and other decision makers in matters important to rehabilitation.

Apart from this there are so many other things I want to do now: read a lot of books, spend more time with my family, travel, maybe learn to speak some Italian, sleep late in the mornings...

I will also stay as a member of INSWABI. During my years of membership I have taken part of so many interesting thoughts and ideas, and you must never stop learning!

3. Interchange

Two key issues were raised by INSWABI members for peer consultation and discussion during the last 6 months.

Our INSWABI members from the Hampstead Rehabilitation Centre in South Australia raised the following interesting query were in the process of updating our client welcome packs and wondered what other INSWABI members around provided clients and their families upon admission? A number of members were able to identify information resources

The other query was raised by INSWABI member Susan Davis – Bailey who is social worker on an inpatient ABI rehabilitation unit at Parkwood Hospital in London, Ontario Canada. Patients are typically admitted to Parkwood within days to weeks following their injuries (basically once they are medically stable) and are typically at a Ranchos Los Amigos IV - V level of recovery.

Her query related to whether any INSWABI members had experience with screening measures for depression in the acute ABI population. Susan wanted to understand more about the implications of a proposed initiative that was being considered for introduction to her unit for early screening of depression, given that

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the vast majority of the patients were not oriented, had no awareness of their injury or deficits, couldn't even recall what they did 2 hours ago let alone how they've felt over the past 2 weeks. She was interested in any views/experience from INSWABI members working in similar settings regarding their processes and any screening tools which members have found to be effective for this population. Once again a number of INSWABI members were able to provide some thoughts/suggestions on this issue.

4. New resources

Brain Injury Family Intervention Program



In March of 2012 Nadia Elsayed and Jessica McCallum (social workers at Toronto Rehabilitation Institute inpatient ABI program)

started an ABI support/education group for caregivers. The group is based on the Brain Injury Family Intervention (or BIFI) materials created by the National Resource Centre for Traumatic Brain Injury at the Virginia Commonwealth University. Nadia and Jessica both attended BIFI training in 2011, and felt that the material could be used for an inpatient caregiver group. This kind of group was not available at Toronto Rehab, but the provision of counselling and education on an individual basis is a significant part of the social work role on the inpatient setting.

The goal of the group is to offer both ABI education and peer support. Some of the educational topics covered include an overview of ABI (causes, symptoms), how ABIs can impact on families and also developing strategies for coping, problem-solving, goal setting, managing stress, and self care. The peer support element was designed to develop

naturally as participants discuss their concerns and experiences, and provide mutual support and problem solving ideas to one another.

The group runs for four weeks (once a week, for 1.5 hours each session) with different topics covered during each session and BIFI materials are provided to the participants. It is an open group, so members are invited to join all or any of the sessions. The group has been facilitated by Jessica, Nadia, and their social work colleague Cathie Percival (two facilitators per session). Participants are asked to complete a feedback form at the end of each session, and feedback has indicated that participants enjoy talking to others with a shared experience and that people feel a sense of togetherness. Overall, participants have reported that the meetings are very helpful and should continue to be an integral part of the services that Toronto Rehab offers.

Nadia Elsayed and Jessica McCallum.

5. Research corner

Group Interactive Structured Treatment (GIST) for Social Competence



Group Interactive Structured Treatment (GIST) for Social Competence, is a holistic, dual-disciplinary

intervention aimed at improving interpersonal skills and social communication for individuals with TBI. GIST is a dual-disciplinary program developed collaboratively by myself and my colleague, Jody Newman, MA, CCC-SLP, through our private practice. Over the past 20 years, we have used the GIST program to assist civilians and military personnel post-TBI as they cope with the cognitive, communicative and emotional obstacles which interfere with successful social interaction.

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Jody and I have presented several therapist workshops on the GIST intervention and the GIST workbook is now used by therapists in over ten countries.



Impairments in social competence after TBI can result in an individual being isolated, in conflict with others, and denied access to social and vocational opportunities. The GIST model blends a structured curriculum with a group therapy process, addressing both the psycho-social and speech-language components of social competence. Self-awareness, individual goal setting, group interaction and support, the development of residual strengths and family involvement are emphasized. GIST was shown to be efficacious in improving social skills for individuals with TBI in a randomized controlled trial completed as part of a TBI Model Systems grant at Craig Hospital in Englewood, Colorado. This project was funded by the United States



National Institute for Disability Research and Rehabilitation. Currently, we are involved in a multi-site study investigating the effectiveness of the GIST program with both military and civilian participants. This study will allow us to train

other therapists in the GIST intervention and to test the intervention against an alternative intervention. The Principle Investigator for this multi-site study is Cynthia Harrison-Felix, Ph.D, Assistant Director of Research at Craig Hospital. Five other centers across the U.S. will collaborate on this project: The Rehabilitation Hospital of Indiana,

Indianapolis, Indiana; The Rehabilitation Institute of Michigan, Detroit, Michigan; The University of Washington, Seattle, Washington; Hunter Holmes McGuire VA Medical Center, Richmond, Virginia; and the VA Palo Alto Health Care System, Palo Alto, California.

Lenore Hawley, MSSW, LCSW, CBIST

References related to GIST:

- ♦ Hawley LA, Newman JK. Group interactive structured treatment (GIST): a social competence intervention for individuals with brain injury. *Brain injury* 2010;24:1292-7.
- ♦ Hawley L, Newman J. Group Interactive Structured Treatment - GIST: For Social Competence; available online at: www.braininjurysocialcompetence.com (Previously titled Social Skills and Traumatic Brain Injury: A Workbook for Group Treatment, 2006; Social Problem Solving Group. 2003.) 2008, 2012.
- ♦ Dahlberg CA, Cusick CP, Hawley LA, Newman JK, Morey CE, Harrison-Felix CL, Whiteneck GG. Treatment efficacy of social communication skills training after traumatic brain injury: A randomized treatment and deferred treatment controlled trial. *Archives of Physical Medicine and Rehabilitation* 2007;88:1561–1573.

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6. Conferences

Head First Conference

MORE THAN MEETS THE EYE: Exploring overlooked issues in Brain Injury

The 5th annual Head First conference took place at the Headquarters of the British Medical Association on the 10th May 2012. The theme and focus of this year's conference was on those that confound and complicate presentation post injury. A total of 300 delegates came and contributed to lively discussions throughout the day.

The first talk was from Andrew Dart and Dr Sheppard, parent of a brain injured son and Consultant Clinical Neuropsychologist respectively. Mr Dart's son presents extremely well and has limited insight in to his complicated executive deficits. This has had significant consequences for his engagement with social workers, some of whom have taken the brain injured party at face value, failed to communicate with wider family and the clinical team and have failed to compare the brain injured person's actual functioning against his statements of intent. Mr Dart and Dr Sheppard made a plea for social workers to recognise the impact of poor insight into reduced executive functioning when making assessments.

Professor Chew spoke of the importance of testing endocrine function post injury as, in the UK at least, this would appear to be significantly under-diagnosed and treated, even for brain injured people in specialist rehabilitation settings. Dr Savundra gave a lively presentation on the need to consider the likely impact of damage to the vestibular system post injury. Similar to endocrine difficulties post brain injury, this would appear to be outside of the sphere of knowledge for many social workers but an absence of diagnosis/treatment can lead to increased fatigue and reduced attention (for

example), factors that impact upon community integration, mood and functioning. As this is frequently not assessed for by our medical colleagues it is of note for us too.

Professor Sharp spoke of advances in neuro-imaging and how these help our understanding of presentation post injury, in particular looking at damage between different parts of the brain, interruptions to the connections that are normally present. Dr Dilley gave an overview of Neuropsychiatric sequelae following injury, using research data to indicate likely difficulties and effective treatments. Dr Rado spoke of the need to maintain hope and to look at what factors support a brain injured person to adapt, to accept the changes that have occurred in their life and to develop a new narrative, a sense of self worth post injury

Dr Scheepers spoke of the need to understand just how complex the world can be for brain injured people post injury and the need for environmental management to support the brain injured party to maximise their recovery and minimise the negative impact of difficulties with behavioural control. Professor Oddy spoke of the importance of recognising that most of the hidden difficulties that occur post injury are hard to identify and that families, the brain injured and professionals need support and information to ensure cognitive, executive, emotional and behavioural difficulties are not wrongly attributed as this will affect recovery and insight development.

What I took away from the conference, as a Social Work trained Case Manager was the need to look beyond what is said by our clients and their families, to actually look at what is happening for a person and their family and to recognise that not everything we need to address is obvious or visible.

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I also am reinforced in my belief that there is firstly no one party or profession with all the answers, that advances in understanding are being made as we speak and that we must expand our thinking beyond that of a simplistic “social” model of disability to incorporate wider notions of neuro-functioning and poor insight. Doing so does not push us to be “medical” model social workers, far from it, but perhaps it makes us “neuro-psycho-social” model adherents?

Mark Holloway

7. INSWABI Committee news



The INSWABI Committee had its third Skype meeting in April 2012. The meeting was conducted with great difficulty due to the poor audio quality. As a result, a decision was made to transfer to Adobe Connect technology for following committee meetings, hosted by Dr Thomas Strandberg at Orebro University Sweden. The June 2012 INSWABI Committee was conducted with the new Adobe Connect technology and the audio quality was substantially improved and the committee will aim to continue with the new technology for future meetings.

Arising from the committee meeting, the following actions/decisions were undertaken:

- ♦ The domain name www.inswabi.org has now been purchased
- ♦ Commenced planning for INSWABI activities at the 2013 International Social Work Conference in Health and Mental Health (see above)

- ♦ Use the Orebro University Adobe Connect technology to host some pilot webinars for INSWABI members

Our final committee meeting for 2012 will be held in September.

8. INSWABI membership update

INSWABI currently has a membership of 129 social workers from around the world. We would like to welcome the following new members who joined between January – June 2012.

Candice Burt	Australia
Kate Dawes	Australia
Bob Lomax	Canada
Lenore Hawley	United States
Carmel Martin	Ireland
Declan McNicholl	United Kingdom

9. Pass this on.

Please circulate the progress report to any of your colleagues who might be interested.

10. Interested in joining INSWABI?

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