

A partnership between

Acquired Brain Injury Ireland
 2 Racecourt Manor, Tonaphubble, sligo
 Tel (071) 915 3472

Health Service Executive – North West
Physical & Sensory Disability Service, Sligo, Leitrim, & West Cavan
 JFK House, Kennedy Parade, Sligo
 Tel (071) 913 5001

The Community Acquired Brain Injury Team

The team is a HSE - Acquired Brain Injury Ireland Partnership and includes

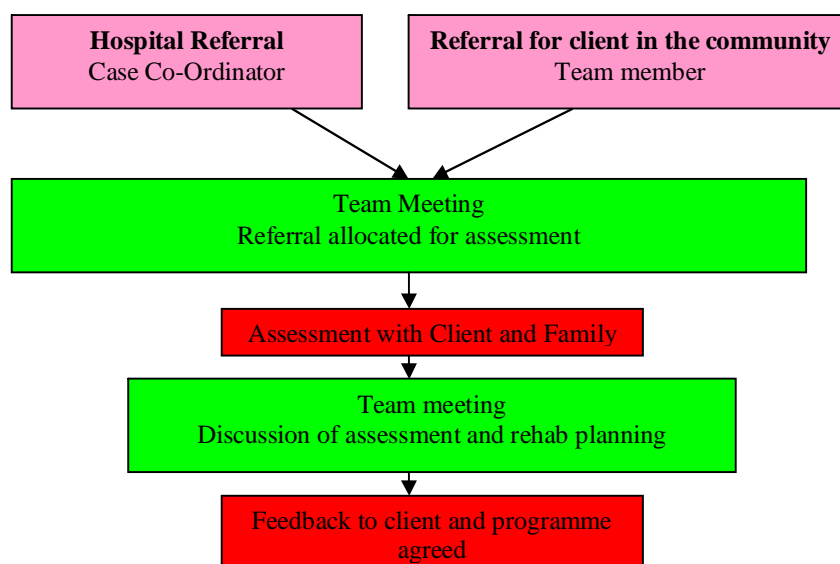
Senior Clinical Neuropsychologist:	To be appointed
Local Services Manager:	Teresa O’Boyle
Brain Injury Case Manager:	Phil McGoldrick (HSE)
Senior Occupational Therapist:	Rosemary Dillon (HSE)

Referral Process:

While referrals are accepted by all members of the team they are processed through the ABI Case Manager. All referrals are discussed by the ABI team and appropriate assessments arranged. **Referrals forms are available from the ABI team, JFK House, JFK Parade, Sligo or 2 Race Court Manor Tonnaphubble, Sligo.**

Assessment:

People with an ABI and a relative are seen for a comprehensive initial assessment covering background history and presenting problems. Neuropsychological, Occupational Therapy, and family needs assessments are arranged as appropriate following initial assessment. External referral to Speech and Language Therapy, Physiotherapy, Community Occupational Therapy, Psychiatry, etc. are made by the team as appropriate.



SPECIALIST SERVICES:

CONCUSSION/MILD HEAD INJURY CLINIC

This service provides information and advice to people following mild head injury, and treatment for people with persisting post concussion symptoms.

ACQUIRED BRAIN INJURY SERVICES:

REHABILITATION SERVICES

- **Case Management**

This service is provided by the ABI Case Coordinator. Referrals come to the CBIS primarily through the Case Coordinator, however, anyone can receive a referral on the Team and it will be processed in the same manner. All referrals to the CBIS are brought to the Team meeting weekly. The referral is discussed by the ABI team, and appropriate assessments arranged. The Case Coordinators responsibilities involve establishing a working Relationship with the Client and significant others. It may include recommending support workers, Social Welfare entitlements information, Care Packages, Rehabilitation Facilities, Education or Employment Services. They act as a link person with other agencies, to provide practical support, brain Injury awareness education and to assist with disability adjustments.

- **Post Acute Monitoring:**

In the early stages following injury people are screened by the ABI Case Co-ordinator. Neuropsychological screening assessments and occupational therapy assessments are carried out as necessary. Advice and support is provided on management of early difficulties. Referral is made to the rehabilitation programme when appropriate.

- **Rehabilitation Programme:**

The programme uses a combination of individual and group based services. These include education groups, a range of cognitive rehabilitation and therapy groups, supported clients and staff only and transitional group rehabilitation activities, individual cognitive rehabilitation, neuropsychotherapy, and community living skills. The appropriate input is recommended to the person and family based on the assessment and can range from occasional individual therapy sessions to an intensive 5 day programme, depending on need. This is a rolling programme and clients can join activities and individual rehabilitation programmes at any time.

Educational Groups	Supported Activity Groups	Transitional Activity Groups	Individual supports
Cognitive Rehabilitation Group Personal Issues Group Anxiety Management Leisure and Lifestyle	Cookery Woodwork Motorbike Renovation Project Robotics project Solar panel project Organic Gardening project Overseas aid project	Inland Waterways Boatyard Markree Castle Raptor Research Centre Social services project	Cognitive Rehabilitation Neuropsychotherapy Anxiety management Community living skills Vocational support Individual projects

Education Groups:

These provide education and advice about common difficulties, how they impact on the person's independence, relationships, occupation and leisure, and sense of self. The aim of the groups is to assist the person in increasing their awareness of their difficulties, assist them in managing these, and provide them with a forum where they can discuss their problems with others in a similar situation. They can share experiences, and learn from each other in a facilitated, safe environment. While a number of core groups are available as a rolling programme other groups are facilitated if a number of clients have been identified (e.g. anger management group, anxiety management group, etc). They are facilitated by the clinical neuropsychologist or occupational therapist.

High Support Group Activities

These are open groups which the person can join or move on from at any time depending on their progress. They are provided in the unit, or in the community but are exclusively for client with ABI working alongside staff. Through the activities people can learn about their difficulties and how to manage them in a safe and supported environment. Activities fall into two categories:

- a) the activity is carried out to help the person manage that specific activity e.g. cookery
- b) the activity is the vehicle through which the person learns how to manage their difficulties e.g. DIY group projects, gardening projects etc.

Transitional Group Activities

These are also open groups which the person can join or move from at any time if appropriate to their rehabilitation. They are sourced in the community and the clients work as 'volunteers' typically alongside other 'non-disabled volunteers' on mainstream community projects with the support of staff. Thus the activity serves as a stepping stone to integration into mainstream activity and has proved an effective model of vocational rehabilitation.

Activity groups are managed by the occupational therapist.

Individual Supports

Due to the nature of people's difficulties, group programmes are not always appropriate for people with brain injuries. Therefore, a number of specialist supports are also available on an individual basis. In addition, clients who have returned to work and mainstream activity may find individual supports more accessible.

- **Community Outreach**

These are tailored programmes provided by the Community Rehabilitation Assistants in liaison with the ABI team which focus on enabling the person to manage activities of daily living within their own community. A personal community reintegration programme is designed for each individual client. This is based on maximising their abilities and facilitates the regaining of independence where possible and the promotion of a better quality of life. Programmes are carried out by trained Community Rehabilitation Assistants under the supervision of the Services Manager.

- **Family Support Programme:**

The aim of the Family Support Programme is to increase awareness and understanding of the nature and effects of ABI, to provide information and advice about the management of ABI, and to facilitate and promote positive coping and adjustment in family and friends. Family members are included in the needs assessment process, programme planning, and review phases. In addition, specific family supports are made available to family members.

- **Leisure and Lifestyle Programme:**

This programme focuses on finding a work–leisure balance after ABI, exploring barriers to leisure, and identifying appropriate long term leisure activity. It includes an educational group and a social club.

- **Transitional Living Unit**

The Transitional Living Unit is a house in the community staffed by trained Rehabilitation Assistants. Three beds are available to clients who require assistance to return to independent living. A further rehabilitative respite bed is available to clients who require a period of assessment, a ‘refresher’ period of rehabilitation, or to enable those who live rurally to access rehabilitation. Residents are responsible for all the tasks required of a person living in this setting, with staff available to observe and assess performance in all areas of daily living. Clients also attend the rehabilitation programme or rehabilitative training. The Unit is run by the Acquired Brain Injury Ireland. Referral to the unit is through the ABI team.

- **Rehabilitative Training**

This is a 2 year programme run by the HSE and is tailored to clients requiring a protracted period of intensive rehabilitation. The course has core modules including personal effectiveness, personal development training, communications, drama, I.T. skills, brain injury awareness and management, career information, group projects, and social and leisure opportunities. Clients attending RT may also attend other programmes available from the ABI services and their overall programme is coordinated by the ABI Case Coordinator.

