Evidence Based Practice to Support Successful Community Re-Entry

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Course Objectives

- Participants will define community re-entry
- Participants will be able to identify barriers to successful community re-entry for Brain Injured patients
- Participants will understand relevant research & best practices to support the role of community re-entry in rehabilitation programs

What is community re-entry?

Community Re-Entry ⇔ Community Integration ⇔ Community Reintegration

- Community reintegration is achieved in the form of functional independence in environments outside of institutions. (Yasui & Bervin, 2009)
Community integration refers to re-establishing, to the degree possible, previously existing roles and relationships, creating substitute new ones, and assisting people in making these changes. (Egbert, Koch, Coeling and Ayers, 2006)

The concept of community integration extends beyond self-care and physical function to include engagement in expected vocational, social, and community roles. (Salter, Foley, Jutai, Bayley & Teasell, 2008)

It’s Multi-dimensional

- Community Reintegration is a Multidimensional Concept
- Community – physical, emotional
- Roles and relationships – pre-injury, new roles / relationships
- Functional Independence – mobility, ADL’s, IADL’s,
- Employment status – volunteer work, retirement, home maker

Yasui, 2009
How do you know if it's successful?

- Community integration has no clear definition.....how do you know when it is successful?

- How is it measured?
Community Integration Questionnaire (CIQ)

- **Pros:**
  - Strong psychometric properties
  - Easy administration (Yasui, 2009)

- **Cons:**
  - Skewed results for sex, age, level of education
  - Favors those who engage in many different activities (Ritchie, 2014)

Other Outcome Measures

- Community Integration Measure (CIM)
- Craig Handicap Assessment and Reporting Technique (CHART)
- Reintegration to Normal Living Index (RNLI)
- Sidney Psychosocial Reintegration Scale (SPRS)
  
  Salter, 2008

In Summary...

- Community Re-Entry
  - Commonly used terminology without a clear definition
  - Multidimensional
  - Client-specific
  - Measurable
Barriers

- Executive dysfunction
- Memory deficits
- Self regulation difficulty
- Impaired self awareness
- Impaired attention & concentration
- Aggression & irritability
- Impulsivity
- Disinhibition
- Depression & anxiety
- Personality changes
- Lack of motivation
- Alcohol & drug misuse
- Fatigue
- Impulsivity
- Fatigue

Mahar and Fraser, 2012

Evidence Based Research Review

- 208 patients 2–5 years post discharge from inpatient rehab
- Used CIQ to divide patients into 3 groups (working, balanced, poorly integrated)
- Poorly integrated group had a more severe injury characterized by longer periods of acute care, post-traumatic amnesia, and greater functional disability on discharge
- Balanced group had higher participation in home and social activities compared to working group
- Hypothesized that working part-time may allow more time for home and social activities and therefore higher level of community integration

Doig, Fleming, and Tooth, 2001
40 patients with severe TBI at average of 9 years post injury
Used CIQ, CIM, and SPRS
Same findings as Doig for predicting poor community re-entry
Authors noted that interventions that minimize challenging behavior and disability can make a significant difference in level of community integration

Winkler et al, 2006

605 subjects
Mean years since injury = 28.8
Respondents with longer time since injury were less likely to report any TBI-related problems
Authors noted importance of counseling patients and families in the acute phase that recovery can continue over the lifespan with progressive improvement

Brown et al, 2011

119 clients with severe TBI
Cognitive and motor ability at discharge can predict return to "work"
FIM (Functional Independence Measure) + FAM (Functional Assessment Measure) scores
"Work" includes volunteer work and full/part-time vocationally related education

Foy, 2014
141 patients admitted to inpatient rehab and followed up at 1–2 yrs post injury
- CIQ, CHART
- For patients with mild/moderate injury, better family functioning = greater home integration; and less caregiver distress = better social integration
- For patients with severe injury, greater caregiver perceived support = better outcomes in productivity and social integration
- Authors concluded early interventions targeted towards decreasing caregiver distress, increasing support, and improving family functioning can positively impact later outcomes

Sady et al, 2010

136 persons with TBI with follow up at 1 month post discharge from acute rehab
- CIQ, CHART
- Better emotional functioning in caregivers = greater occupation and social integration outcomes within 6 months post injury
- Authors suggest screening caregivers early during post acute rehabilitation to target those who need assistance to improve their support of the person with TBI

Sander et al, 2012
8 tiered approach to deliver caregiver support

- Early engagement
- Meeting cultural needs
- Keeping families together
- Actively listening
- Active involvement
- Education
- Skills training
- Support for community re-integration

Practical Examples:
- Family meetings scheduled within 5 days of admission
- Caregivers are included in community outings

Foster et al, 2012

2 different studies:

- Peer Mentoring programs improve community reintegration and increased satisfaction with social life respectively
- Hanks et al showed peer mentoring significantly improved
  - Behavioral control
  - Lower alcohol use
  - Less emotion-focused and avoidance coping
  - Physical quality of life


- RCT (Randomized Control Trial) with 52 TBI patients
- Group treatment program for social communication skills training (90 min sessions, 1x per week, for 12 weeks)
- Subjects demonstrated improved communication skills that were maintained at 6 month follow up and overall life satisfaction scores significantly improved

Dahlberg et al, 2007
- 46 subjects with moderate to severe TBI 1 year or greater post injury
- High level of happiness and QOL associated with high satisfaction with activities and high proportion of those activities performed with others
- Increasing variety and frequency of social and leisure activities may not influence QOL
- Instead, increasing opportunities to participate with others and enhancing subjective experience of activities positively influences QOL (individualized approach is essential)

McLean et al, 2014

- Good psychological adjustment to TBI was related to low levels of emotional distress and small discrepancy between current and aspired functional status
- Poor functional status did not significantly impact psychological adjustment in individuals with poor self-awareness
- Authors offer the opinion: Rehabilitation outcomes may be improved "if brain–injured individuals are supported in their process of coming to grips with the consequences of their brain injury, not only at a functional level, but also in terms of revision of one’s self-concept and person growth."

Schonberger et al, 2014

Overall progress in resuming or maintaining a premorbid lifestyle shapes self-understanding of limitations which in turn contributes to the level of depressive symptoms during early community reintegration
Driving

- “Occupation Enabler” according to AOTA
- Allows greater participation in IADL’s, work, education and other activities
- Classen et al conducted a literature review of assessment tools predicting driving performance in individuals with TBI
  - Strong evidence for combination of self report, significant others’ report, and functional status
  - Good evidence for Comprehensive Driving Evaluation

- Liddle et al collected information from clients with TBI, family members, and health care practitioners
  - Rehab approaches need to provide clear, consistent information about safe return to driving and the process for doing so
    - Patients and family members do not know the process and healthcare workers either don’t talk about it or explain it well enough
  - Alternative transportation should be encouraged to support continued involvement in the community to reduce frustration experienced by people “on hold” from driving

Differences in Approach?

- A systematic review by Brasure et al on participation after multidisciplinary rehabilitation for moderate to severe traumatic brain injury showed no difference in one approach versus another.
- Examples:
  - Increased inpatient rehab intensity (adding Sat therapy versus therapy only on weekdays)
  - Intense cog rehab plus standard neuro-rehab versus standard neuro-rehab alone
  - Participation as measured by productivity (return to work) and scales measuring community integration
Best Practices

- Comprehensive, holistic, multidisciplinary, individualized approach
- Includes family/caregivers and addresses their functional and emotional needs
- Addresses driving
- Peer mentoring for patients and families
- Communication skills practice
- Opportunities to practice and/or develop interests/activities that are enjoyable and involve interaction with others
- Psychological adjustment
- Use of predictive tools to guide interventions

Questions?

References


