Chapter 13

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Introducction

The increase in the survival rate of polyinjured patients who represent the majority of admissions to critical care centers, and the magnitude of the costs of trauma for medical, psychosocial and vocational readjustment, presents a new medical problem. Because of the youthfulness of the trauma population, whose average age is the mid-twenties, in a society where life expectancy is 70 plus years, means of aleviating the financial burden, over time, must be considered.

To provide cost-effective services to polyinjured persons it is incumbent upon trauma systems to develop networks and linkages between medical, rehabilitation and nonmedical community based programs. To facilitate early referral for physical rehabilitation, psychosocial reintegration and job re-entry, and an organized continuim of services is needed to provide adequate, appropriate care to trauma patients and their families.

Case Example

A med-evac helicopter landed on the Interstate between Washington, DC and Baltimore, Maryland; in response to a single care, personal injury accident. The driver, traveling at a high rate of speed, lost control of the vehicle which rolled over, spun off the road and hit a cement barrier. The impact ejected his passenger from the car and into a ditch where he was pronounced dead. The driver was extricated from the vehicle, stablized by the paramedics, and flown to the designated adult trauma center.

Bill Smith (ficticious name) the 24 year old driver is an electrician by trade. He and his buddy stopped at their favorite bar after working the evening shift at their jobs. Tests determined both had high blood alcohol at the time of the accident.

The State police notified Bill's family of the accident. Within an hour his mother, father and 19 year old sister were discussing the impact of this

of this tragic event with a family counselor at the trauma center. The counselor was helping the family cope with the sudden, devestating news that Bill had a severe closed head injury, a crushed chest, multiple extremity fractures, lacerations, and a ruptured spleen. The family also had to deal with the news that Bill's best friend is dead.

The trauma center believes that families, who are also victims of trauma, need psychosocial treatment for their emotional stress just as the patient needs good medical intervention. Early psychosocial intervention is necessary if family members, such as Bills', are to resolve the sudden crisis, regain coping strategies and readjust their lives to successfully deal with lengthy hospitalization and/or chronic disability secondary to injury.

During Bill's nine week course of recovery in the trauma center the family counselor scheduled regular family/team conferences for clinical information updates, and functioned as family advocate in helping resolve such concerns as communication problems with medical staff, adjustments to visiting times, facilitating family education sessions and planning for Bill's transfer to the rehabilitation center.

The patient/family support provided in the acute setting continued with individual, family and group counseling sessions in the rehabilitation center as Bill and his family try to cope with the impact of disability on their lives. His physical rehabilitation, including intensive physical, occupational and speech therapies as well as individual and family therapy, ~~is~~ was completed in fifteen weeks and the family counselor referred Bill, and his family, to a psychosocial reintegration program that will prepare him for successful re-entry into family/community/job functioning.

Bill's story is repeated daily in trauma centers and rehabilitation facilities across the Nation. However, what is unique for Bill and his family is that his trauma care was provided by a

single team in a comprehensive, continum of care system which provides an ongoing psychosocial treatment component.

A coordinated system of medical/psychosocial care that follows the patient from the time of his accident, through his acute medical phase, into intensive physical rehabilitation and finally into a social reorientation program is, in the minds of the authors, the best way to provide efficient, cost-effective ~~care~~ services to polyinjured persons.

Much has been written about acute trauma ~~care~~ management and the need for, and benefits of timely physical rehabilitation. What has been neglected in the development of ~~trauma~~ emergency systems is the psychosocial component of trauma care.

This chapter deals with this much overlooked component and offers a program design to meet the psycholosial reintegration needs of the polyinjured popultation.

REVIEW OF THE LITERATURE

The advanced technology of trauma centers, coupled with sophisticated communication systems allowing for rapid evacuation of dying trauma patients from their accident scenes, has created a new population which ten years ago did not survive its injuries. (Cowley et al, 1973[1]; Jordan, 1976[2]) The majority of these patients are single, working men under the age of 30 years, recently emancipated from families of origin. Most have been involved in life threatening motor vehicle, industrial or recreational accidents resulting in head injury.

It is estimated that 100,000 people die each year from severe head injury. An additional 600,000 are injured seriously enough to require hospitalization. Of these individuals, 30,000 to 50,000 each year are left with behavioral or intellectual dysfunction precluding return to normal life (National Head Injury Foundation, 1982[3]). Young people disabled from head injury may cost society upwards of $1 billion per year (Kraus, 1980[4]). To address these issues, the emphasis of the last few decades has shifted from the acute medical management of traumatic injury to concern that quality rehabilitation and reintegration services be available to the trauma recoveree and his family (Long et. al., 1984[5]; Diller & Gordon, 1981[6]; Benton, 1979[7]; Bond & Brooks, 1976[8]).

Traditionally, the trauma recoveree with severe injuries is discharged to an inpatient rehabilitation center for physical restorative services. After

reaching maximum benefit from these services, the patient may be discharged home with little follow-up or may be moved along to a Vocational Evaluation and Training Center. While this progression of services may have been effective in the past, it is inadequate to successfully reintegrate the head injured trauma recoveree into his family, community and job. The move today is toward a continuum of care for the treatment of traumatic injury beginning at the accident scene, flowing through the acute medical and rehabilitation settings and culminating in a community based center for reintegration services (Tate et. al., 1982; Matheson, 1982[15]; Oakeshoff, 1982). The community based center is designed to provide the comprehensive psychosocial, educational, vocational and residential services necessary to bridge the gap from physical restoration to productive, independent functioning.

The average head injured patient will be ready for discharge from the in-patient rehabilitation setting after a few months. He may have made tremendous gains considering his condition on arrival at the trauma center. His family, after spending agonizing days as he hovered between life and death, is eagerly anticipating his return home. If he is discharged from the highly structured rehabilitation center to his complex home environment without continuing support, the head injured patient may not make a successful recovery and his family may eventually fall apart (Brooks & McKinlay, 1983[12]; Romano, 1974[13]; McKinlay et. al., 1981[11]; Boll, 1982[15]).

Although the recovering head injured individual may be physically restored, he may have cognitive and emotional problems which will require extensive intervention. The cognitive deficits may include: impaired memory, learning and concentration; slower rate of information processing; inability to solve problems, think abstractly or flexibly (Marshall et. al., 1981[16]; Rosenthal et. al., 1983[17]). Emotional problems may include those characteristics of frontal lobe syndrome: aspontaneity; lethargy; flattened affect; adynamia or lowered drive; inappropriate responses; and irritability (Walsh, 1982[18]; Stuss & Benson, 1984[19]). They may also include impulsivity, dependency, selfishness and temper (Lezak, 1978[20]; Jennett & Teasdale, 1981[21]; Klein, 1982). The depression and anxiety which often seems pervasive in this population may be related to perplexity, distractibility and fatigue often present after head injury. (Lezak, 1978[22]). The trauma reooveree and his family may also develop post traumatic stress disorder associated with the life threatening traumatic experience (Horowitz, 1976[23]; Krystal[24]; Schnaper & Cowley, 1976[25]). Symptoms associated with this anxiety disorder resemble organic deficits and illustrate the need for effective diagnostics to assess the dynamics involved in each individual case.

The recovering individual upon returning home is confronted with a complicated environment requiring constant decisions with impaired coping strategies and adaptive abilities (Heaton et. al., 1978[26]; Warrington, 1981[27]). The more severe the neuropsychological impairment, the more likely there will be psychosocial problems interfering in successful reintegration (Dodrill[28]; Gardner, 1974[29];

Jennett, 1979[30]; Fahy et. al., 1967[31]). Denial of impairment may also be part of the sequelae to head trauma and may interfer in rehabilitation efforts and cause increasing friction between the individual and his family (Heaton & Pendleton, 1981)[32]. Alcoholism and drug abuse may stem from the traumatic experience or may be an unresolved premorbid problem (Lacoursiere et. al., 1980)[33].

Families are more resilient to physical disability than to the cognitive and emotional problems associated with head injury. Over time, families without education and support report increasingly negative responses to these problems and less hope for successful reintegration (Oddy, 1978[34]; Bond, 1975[35]). At greatest risk are families with a history of premorbid dysfunction, in excessive denial, or with a severely impaired member (Rosenthal, 1980)[36].

A community based psychosocial reintegration center must then include components to deal with the needs of recovering head injured individuals present at discharge from an inpatient rehabilitation setting. The primary needs include:

1. Effective diagnostics tailored to measure deficits and strengths and to design appropriate plans of action.
2. Psychosocial and cognitive therapies offered in a group setting with peer support and review (Diller & Gordon, 1981)
3. Family intervention
4. Networking with community resources in a team approach
5. Client advocacy

Continuation of the CASE EXAMPLE

Bill Smith, the 24 year old, single, high school graduate, is now ready for discharge home from the inpatient trauma rehabilitation setting after three months of intensive therapy. He and his family have arranged to visit the Center for a psychosocial evaluation prior to his discharge to avoid a gap between services. Bill and his family have known about the Center for some time having been advised of his need to continue treatment there by his team at the rehabilitation setting.

Psychosocial Evaluation:

Bill is seen alone to assess his level of functioning presently and premorbidly and to discuss goal setting. Because of Bill's alcohol usage, a Michigan Alcohol Screening Test (MAST) is administered and indicates that Bill is a problem drinker.

Following this interview, Bill is seen with his family to discuss Center programming and to develop a beginning plan of action. Family process is observed to assess roles and responsibilities. Bill gives permission to release records to the Center and to be referred to the Division of Vocational Rehabilitation. His counselor assigned by that agency will work with the Center as part of the team in an effort to determine Bill's vocational potential. Bill was an electrician for five years prior to his injury and wants to return to that line of work.

The evaluator recommends family counseling on a weekly basis to deal with problems anticipated from Bill's return to his family of origin. His parents, in their late fifties ~~sixties~~, were looking forward to retirement to Florida in the next few years and

are upset by their conflicting emotions toward their altered position. Bill is dealing with loss of funtion, independence, friends, self-esteem and is probably going to experience increased depression as he returns home. The evaluator also recommends involvement in Alcoholics Anonymous because of Bill's drinking which, if may continue upon ~~return home and~~ may result in a second accident. Education was also provided to inform Bill and his family that alcohol will interfer in his recovery from head injury.

Bill will soon be scheduled for a Speech, Language and Cognitive Skills Evaluation and for a Neuropsychological Evaluation to assess deficits and strengths and to develop individual programming tailored to meet his needs.

Finally, He will be referred to the next Psychosocial Day Program to give him the opportunity to deal with loss, practice emotional expression and rebuild self-esteem in an intensive group situation. In the interim, Bill and his family will receive weekly counseling and case management/client advocacy services.

Diagnostics:

A Speech, Language and Cognitive Skills Evaluation was performed three weeks after the psychosocial evaluation ~~Bill has been home one week and he and his family have attended one counseling session~~ from the rehabilitation center. Bill has problems with auditory comprehension and memory, abstract reasoning and judgment, expressive language, reading rate and comprehension, spelling, paragraph writing and mathematics. Speech and Language therapy was recommended three times per week.

A Neuropsychological Evaluation was performed two months after Bill's initial Center visit. He tested at a severe level of brain dysfunction of a diffuse nature, having problems with anomia, apelling apraxia, alexia, acalculia, construction apraxia and aphasia. Bill also has right cerebral damage, mild problems with perceptual motor skills and severe memory impairment. He sees himself as impaired and is feeling insecure, anxious and depressed. Recommendation was for the psychosocial day program followed by the cognitive day program depending upon his level of improvement. Counseling should continue until Bill is involved in the intensive programming.

Day Programs:

The Psychosocial Day Program began for Bill two and one half months after his initial visit. He participated in a group of six men and three women for twelve consecutive weeks. His goals were to increase short term memory, incease concentration, increase awareness of alcohol and drugs on his brain, and improve conversational skills. Bill made much progress during the twelve weeks in the area of concentration and memory. He became more sociable, initiated conversation, and increased his sense of humor. He is aware of his cognitive deficits (memory, visual motor, auditory comprehension, visual scanning, reading, dexterity, coordination and judgment) and is agreeable to participating in the cognitive day program.

Bill began the Cognitive Day Program one month after completing his psychosocial program. He worked on problem solving skills, reading, classification skills of verbal and non-verbal materials and memory skills. Bill continued to show

improvement in attention and concentration levels. The Neuropsychological Post-test completed six months after beginning the Cognitive Day Program showed improvement in all WAIS-R Subtests and in all Wechsler Memory Scales. On neuropsychological testing, current deficits are only mild to moderate with major gains in verbal reasoning and comprehension. Recommendation is for a vocational evaluation and training.

Summary

One year after initiating services at the Center, Bill is ready for vocational services at the State Rehabilitation Center. He has made gains in all areas of functioning. Physically, he is stronger with greater stamina. Psychologically, Bill has mourned his losses, developed an adequate relationship with his family, and is abstaining from alcohol with AA support. Socially, he has made some new friends, is considering dating, and is confident about work.

Bill's family has remained intact and has a greater understanding of brain injury and the effects on behavior. His parents are optimistic that Bill will become an independently functioning member of society.

Bill knows that he is able to avail himself of Center reintegration services as the need arises. He may need transitional living or job reorientation services in his quest for independent living. He already attends the peer support group twice each month and is arranging to be a guest speaker at future day programs. Bill knows that his recovery will inspire others as he was motivated by those who came back to share with his group.

The program that was helpful to Bill and his family is the Center for Living. This psychosocial reintegration program was designed in 1979 with the help of TRAUMA RECOVERY; a self-help network of consumers joined together, in 1978, to offer support to one another and to advocate for much needed services for poly-injured persons. The ~~program~~ Center recieved its first clients in March 1981.

The program design allows for vocational services, respite care and transitional living in addition to the psychosocial and educational programs and diagnotic services currently available.

CENTER FOR LIVING

Rationale

The Center for Living is designed to address the psychosocial needs of the trauma recoveree and his family. It has taken its place in the continuum of care concept as the community based program offering lifetime psychosocial follow-up care to the trauma recoveree and his family, as mandated by the Maryland Emergency Medical Services System.

This flow through the system, emanating from the acute hospitalization stage at MIEMSS, or any of its satellites, feeding into the MIEMSS Rehabilitation Program at Montebello, culminates at the Center for Living, where the emphasis is on reintegration into activities of daily living.

In contrast to the Independent Living Centers, the Center for Living Program is primarily preventive in design. By providing adequate support services, social adjustment opportunities and job re-entry skills, the need to institutionalize patients in this multiple injured client population will be lessened. By providing services to families of physically restored trauma patients, the Center can maximimize the families' potential for acceptance and reintegration of the physically and emotionally damaged member into the family structure.

Mission Statement

Medical and rehabilitation personnel have often been puzzled by the trauma recoveree's resistance to efforts made in his behalf, directed toward education, vocational training and employment. Although body systems are healed and hospital rehabilitation has reached maximum benefit, the trauma recoveree may still be unready to assume his place in society.

The MIEMSS Family Services Division and the Counseling Department at the MIEMSS Rehabilitation Program at Montebello are cognizant of this phenomenon and direct their energies toward providing the necessary professional assistance.

As the trauma recoveree makes the transition from the acute phase to the rehabilitation phase, he and his family are offered professional counseling to aid in their adaptation to the trauma and the effect it has had on the family system.

The team approach adopted in the acute phase continues into the rehabilitation phase and includes the expectations that the trauma recoveree and his family will be an integral part of the treatment team.

Because the commitment toward the provision of professional counseling to the trauma recoveree and his family, and toward the utilization of a team approach involving recoveree and family is made at the point of entry into the system, the Center for Living enjoys the benefit of continuing this same philosophy.

The Center for Living is made known to this population as they enter the system and may be used to meet a multitude of psychosocial needs at a time when the supports of the acute and other rehabilitation personnel are no longer available.

The trauma recoveree and his family are able to feel secure in the knowledge that the continuum of care concept recognizes and provides for the treatment of the biological, psychological and social impacts of trauma.

The Center for Living will continue to be available for lifetime psychosocial follow up as the trauma recoveree and his family travel the long road toward reintegration into family and community systems.

Client Population

The Center for Living serves multiply-injured trauma clients from the Maryland Emergency Medical Services System whose physical rehabilitation needs are addressed by the MIEMSS rehabilitation program but who need structured psycho-social therapy in order to successfully return to the community. Types of clients who can derive benefit from the CFL include people with spinal cord injuries, i.e., quadriplegics, paraplegics; victims of closed head trauma which has caused organic brain dysfunction; people who have suffered multiple bone fractures causing residual limb dysfunction; burn patients who have restricted movement and/or physical disfigurement; or any combination of the above. MIEMMS' statistics show that most of these trauma victims are young males although the CFL is open to any trauma client who requires its service. The family of the client often needs psycho-social services as much as the trauma victim. Therefore, the CFL offers a family approach to treatment.

Although the CFL will eventually offer job reorientation/ education and respite/residential care, the most immediate need of our clients are for psycho-social services.

Counseling Services

Evaluation

Prior to acceptance in a Center for Living program area, the trauma recoveree and his family participate in an evaluative process designed to gather information to determine appropriateness of referral. The evaluation begins with a psychosocial interview with the trauma recoveree with a view toward assessing level of functioning. Attention is paid to historian capabilities, premorbid history, appropriateness of response, attention span, attitude toward referral and stated goals.

Following this one to one interview, the family is invited to share in the process thereby adding a critical dimension to Center programming. The expectation is explicit from the first contact that the family will play an important role in the rehabilitative process. Additionally, important elements in the psychosocial functioning of the recoveree are observed by encouraging family interaction during the evaluation period. By offering information relating to program areas during the family interview miscommunication is avoided. The family leaves the Center after the evaluation with a clear understanding of the program and of the responsibility expected to them if they are to become active. The recoveree is relieved of the burden of pursuing his rehabilitation on his own without system support.

Clinical Counseling

After the initial psychosocial assessment, the evaluator has the opportunity to recommend individual, group and family modalities in clinical counseling. These counseling sessions are an important element in reintegrating productive trauma clients into the community. Therapy is structured to re-establish and strengthen the individual and social support resources which will sustain the trauma recoveree and his family as readjustment progresses.

Neuropsychological Testing

The majority of Center clients (92%) have experienced head trauma and benefit from a diagnostic tool to assess organic deficits. Neuropsychological testing, especially with head trauma, has proven to be effective in designing a comprehensive plan for trauma recoverees.

As a result of extensive testing followed by a sensitive interpretation session with clients and family, realistic goals may be set and appropriate therapies.

LIFE ENHANCEMENT AND EDUCATION PROGRAM (LEEP)

In many cases of closed head trauma, physical problems decrease over time during rehabilitation, but psychological and social problems that directly affect return to employment increase (80% of our clients are young men between 18–30 years).

The LEEP program objective is to serve the multiply-injured young adult with cognitive and neurological complications resulting in behavioral adjustment problems. The mental/psychological deficits include: depression, loss of judgement, memory loss, lowered self-esteem, impulsiveness and lowered frustration tolerance.

The 12 week structured day program is designed to afford the trauma recoveree an opportunity to relearn those skills and behaviors that will be necessary to reintegrate into society and specifically into the existing rehabilitation process, i.e. (vocational evaluation, training and employment).

In order to be ready for this group situation, the recoveree may need to be at least six months post trauma and ready to deal with sensitive psychosocial issues. To assist in this process, the Center contracts with a psychodramatist and a dance and movement therapist. Group therapy is offered to encourage ventilation following psychodrama and to faster understanding of psychosocial functioning.

In addition to emotive therapies, the recoverees are exposed to didactic sessions covering such areas as assertiveness training, decision making, sexuality and substance abuse. Guest speakers are invited to participate in the program where appropriate.

A team approach is utilized in LEEP with recoveree and family members and significant rehabilitation professionals as an integral part of the team. Team meetings are scheduled twice during the twelve weeks for each client. A rehabilitation plan is developed by the trauma recoveree with the assistance of the program manager which is used to focus on goals and provide direction for future planning.

STRUCTURE AND GOALS OF LEEP

The LEEP Program is held five days a week, Monday through Friday, from 9:00 a.m. to 2:30 p.m. for twelve consecutive weeks. The primary goal of the program is to help each client readjust, both psychologically and socially, to his environment.

This program focuses on helping the clients deal with their new identity, relearn social skills, maximize communication abilities, explore new roles, and new vocational opportunities.

LEEP emphasizes the client's functional capacity in the areas of communication, cognition, mobility and psychological awareness. Certain identified problem areas for the trauma recoveree are low frustration tolerance, mood swings, cognitive deficiency, (memory) deficits, poor social judgements, low self-esteem and impulsive decision making.

In order to help the trauma client regain, readjust and attain emotional and social stability, certain emotive therapies, i.e., psychodrama, dance and movement and group therapy have been incorporated into the daily program schedule.

The LEEP Program also encourages a systematic, highly structured didactic and behavioral approach by incorporating decision making, assertiveness training, video-taping, role playing and behavior contracts.

The group setting and leisure time provides an informal atmosphere which promotes client socialization and communication. This spontaneous socialization and leisure time are key components in encouraging a sense of normalcy which enhances confidence.

Underlying this process is the role that staff and family play as part of the team which will participate in goal formation and agree to goal attainment as an affirmation of their commitment to help the traumatized person make a successful readjustment to a new life..

Psychodrama

The purpose of psychodrama is to create a safe environment in which clients can experiment with alternative behaviors. Psychodrama is a theatrical context in which integration occurs from the spontaneous joining of the real and ideal self.

Psychodrama engages all of the senses of the client group in the reconstruction of scenes from the clients' life story in dramatic action. The drama medium provides maximum flexibility for safety and the freedom to explore novel responses to old dilemmas or adequate solutions to new situatins in the here and now.

The healing process often occurs in taking the role that was never taken and in having the conversation that was never had in real life. Psychodrama evokes new cognitive patterns of thought which allow for new roles and new behaviors, thus creating more choices.

Perhaps the most important goal of psychodrama lies in its power to elicit hope, stimulate potential and renew one's sense of responsibility to themselves and others.

Live storytelling provides for framework for weaving together the concrete and abstract dimensions of the client's experience. New meaning emerges as clients reintegrate old thought patterns with new possibilities for role taking which helps to actualize their social and vocational potential.

Dance and Movement Therapy

The dance and movement sessions focus on the client becoming reacquainted with his body. The sessions emphasize sensory awareness, locomotive and expressive movement and a sense of self.

In order to increase his sensory self-awareness, each client goes through a series of sequences of movement and balance control. Music, imaging, props and movement help to integrate internal and external stimuli effectively.

The repetition of movement sequences helps the client with memory recall and provides social experiences that help the client develop a more positive self image and body posture. Relaxation therapy is an integral part of each session and focuses on anxiety reduction through muscle relaxation.

Group Therapy

Group therapy is scheduled as an adjunct to each psychodrama to give the client a chance to ventilate his feelings of the drama. It provides each client an opportunity to test his group image and role performances against those of peers and to convert inadequate, irrelevant, or inprecise perceptions.

Important factors implicit in the goals and treatment in the group are: 1) interpersonal learning, 2) imitating adequate models, 3) instilling hope, 4) developing socializing techniques, and 5) peer identification. A tool frequently available to the group is a video tape of the preceding psychodrama.

Transitional Skills - Assertiveness, Decision Making and Job Readiness

Assertiveness Training

Assertiveness training and decision making classes help promote a sense of independence, self-esteem and more rational decision making.

This is accomplished by role playing everyday situations helping the client gain insight. Many of the trauma recoverees have sustained brain injury, and through these classes are able to relearn how to think out multiple-step directions and more complex decisions. This in turn reduces their impulsivity.

The assertiveness training sessions lend themselves well to video-taped role playing in which everyday situations and problems are expressed. Brainstorming is an effective technique for stimulating conversations and coming up with effective solutions to problems.

Job Readiness

This course is designed to reorient the clients to the mental and social demands of returning to work. There are a number of areas to focus on, such as: 1) job applications, 2) interviews, 3) job expectations and 4) career information.

Video-taping of mock job interviews and career films are used to expand their knowledge of job etiquette. The goal is to help them become aware of their abilities, skills, values and interests so that they can get closer to making a realistic career choice.

Substance Abuse Education

Many trauma recoverees report that they often experience social isolation, depression, anger and guilt because of their mental and/or physical impairments, which may prevent them from returning to their pre-trauma level of functioning. This state of mind can make the trauma client more vulnerable to substance abuse.

Substance abuse education provides the client with accurate information and services related to alcohol and drugs. Guest speakers, lectures and films help dispell myths by replacing them with facts.

Didactic Speakers

The weekly didactic session includes guest speakers (Neurosurgeons, Nurses and former shock trauma recoverees) from MIEMSS and other health agencies. These speakers can accurately describe the functioning of the Central Nervous System and the ramifications of their injuries upon their capacities.

The topics are chosen by the clients and are varied. They can range in interest from cognitive abilities to sexual functioning, as well as transportation and independent living.

Cosmotology and Leisure Skills

The physical and emotional damage which a trauma recoveree often suffers may elevate the need to maximize their remaining resources, such as hygiene, hair, facial care, cosmetic use, and dress. The LEEP Program has included a beautician who volunteers her time and expertise to cut and style hair, and address other grooming needs.

Since these clients often have some residual brain injury, they have difficulty organizing unstructured leisure time. The staff helps them relearn how to structure their time by keeping a log of daily events, using a calendar to schedule extracurricular activities, and learning or relearning crafts in the hopes that these new skills will carry into the home.

COGNITIVE RELEARNING PROGRAM (CORE)

This twelve week structured educational day program is designed to offer students with deficits caused by head trauma the opportunity to focus on problems in communication, daily living activities, academics, and social skills. The CORE team includes a special educator as coordinator, a speech pathologist, social worker and psychologist.

Through differential diagnosis and specifically designed exercises, the students abilities can be increased or alternate modes of functioning can be developed.

Social Center

A major element in the program is the Social Center at the CFL. This part of the program addresses the social needs of the physically restored trauma client in a semi-structured setting. An identified problem area for the trauma client is adjusting to a new body image which recognizes the damage and loss of ability caused by traumatic injury and requiring enormous personal adjustment. The Social Center offers an opportunity to redevelop social skills and test social acceptability in a setting where the fear of being repulsed or ridiculed is fully recognized and addressed.

There will be two activity levels at the CFL: individual and group. Individual activities include daily living adjustment, communication skills development, and personal interaction skills. Personal adjustment activities are designed to meet each individual's needs according to physical disability and level of functioning. The underlying philosophy is that the physical damage which a trauma victim suffers may be irreversible, and this fact elevates efforts to maximize remaining resources of the person to the highest priority.

Group activities include transportation for field trips, organization of team sports, family activities, and community days organized by Center members and the Social Center Coordinator. These activities will provide opportunities for clients to practice their developing social skills and their families will be able to interact with each other sharing experiences and support.

Computer Learning Center

The Computer Learning Center is another innovative element of Phase I. The CFL will use learning modules for instruction in the following areas: personal hygiene, simple educational exercises, personal finances, and electronic games. The Modules are dual purpose programs: first, the content of the modules is valuable, and second, these activities will familiarize clients with computer operation.

Related Programs

Important resources for the Social Center are two volunteer groups which will utilize the CFL for their programs: Trauma Recovery Group and Families United for Trauma Rehabilitation (See appendices E and F). The Trauma Recovery Group is an incorporated volunteer self-help network of multiply-injured trauma recoverees who were patients at the Shock Trauma Center at MIEMSS and have returned to the community. They meet bi-weekly to discuss and exchange their experiences. The Trauma Recovery Group currently meets at the Shock Trauma Center, but will move part of their program to the CFL.

Families United for Trauma Rehabilitation (FUTR) is a family support network/consumer advocate group.

FUTR is comprised of trauma recoverees and family members. It meets several times a month so that members can meet with others who feel the same stress. FUTR is predicated on strengthening the social support system which will sustain the trauma victim once he has returned to the community. TRG and FUTR envision expansion of their programs once they move to the CFL.

CONCLUSION

Traditional rehabilitation services are inadequate to meet the cognitive and emotional problems associated with head injury. Without the intermediate step between the inpatient rehabilitation setting and the vocational evaluation and training, the ~~head~~ poly injured individual and his family is at risk to "fall through the cracks". Since return to work is most often the primary goal of this population, emphasis needs to be on providing services to best assure goal attainment. Referral for vocational services before the individual has dealt with his losses; developed appropriate behavioral responses, decision-making, communication and assertiveness skills; and retreived or compensated for cognitive deficits, is bound to result in failure. An already fragile ego needs successes upon which to build self-esteem.

An effective reintegration program, such as the Center for [illegible], must provide comprehensive programming dealing with psychosocial, educational, vocational and residential needs. Each client and family must be assessed with a plan of action developed to meet their needs. A network of caregivers is must be organized as part of the team to provide continuity of services.

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