Toronto abi Network

June 18, 2025

Webinar II: Practical Application of ABI Behavioural Services: Case Studies and Discussion

Land Acknowledgment

Agenda

Welcome, Webinar Logistics, Audience Poll **Overview of Toronto ABI Network**			Charissa Levy Julie Osbelt Toronto ABI Network
Behaviour Services Case Study Presentations	Brigitte MacKay Coordinator York Simcoe Brain Injury Services	Megan Davies Community Health and Support Service Manager SCHC	Dena Sadeghipour Registered Behaviour Analyst, ABI Behaviour Services West Park/UHN
Q & A Session			Charissa Levy Moderator
Concluding Poll, **Summary & Next Steps**			Charissa Levy

Objectives

1. Provide a brief overview of the Toronto ABI Network's role as a central point of referral coordination and navigation
2. Outline various case studies to illustrate how ABI behaviour services can assist clients and other service providers in the ABI community.
3. Provide time for discussion to answer questions.

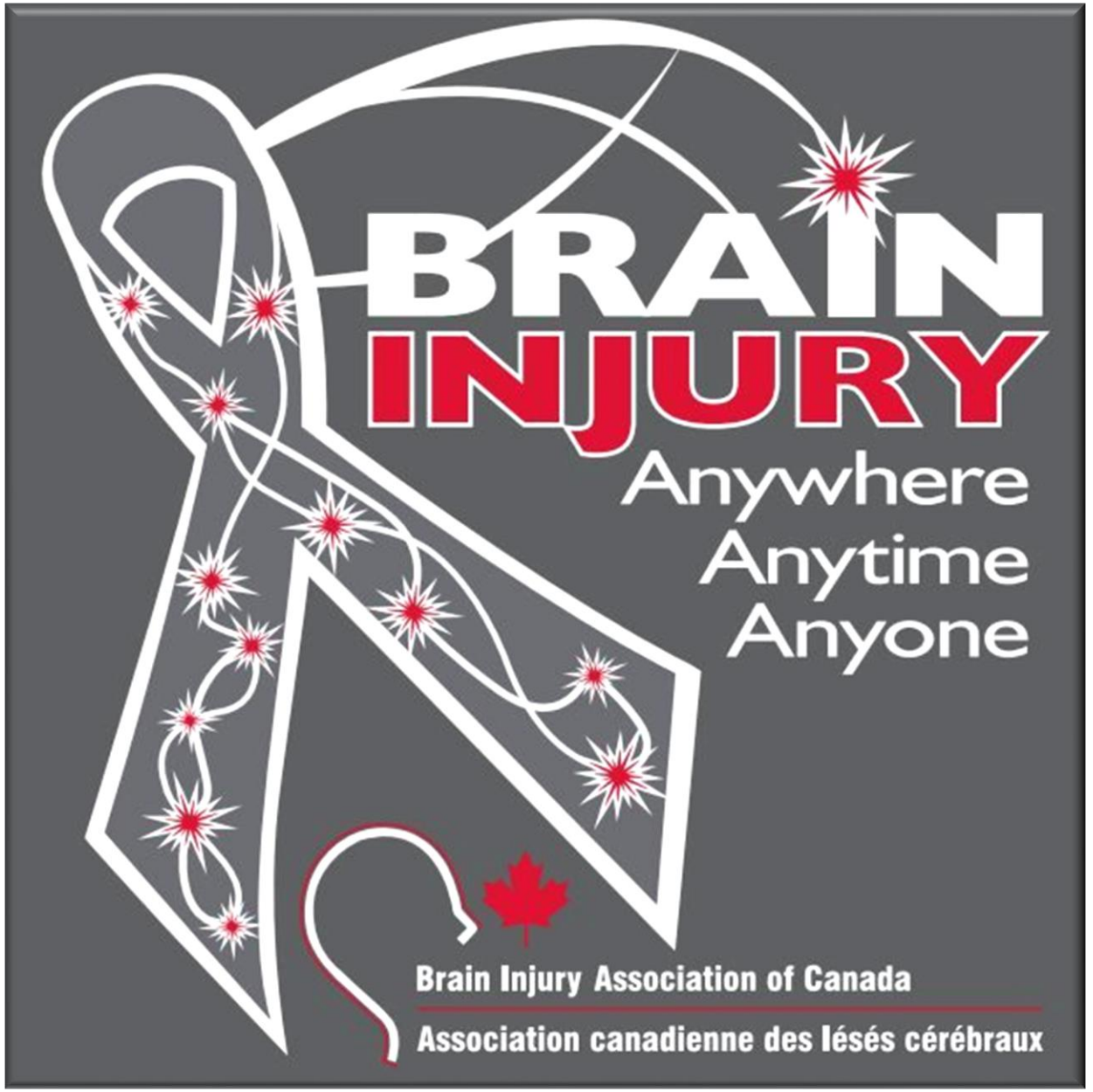
Note: Webinar on background on ABI behaviour services from November 2024 is available at: https://abinetwork.ca/events/webinars/

How to participate in this webinar

- All attendees will be muted during the presentations.
- To send a question for the presenters, use the **Q&A button**.
- If you see a question that is of interest to you, you can "up vote" the question by clicking on the icon beside the question to give it a higher priority in the list of questions.

Note: A recording of the webinar and slides will be available on the Toronto ABI Network website within one week of the presentation.

June is Brain Injury Awareness Month!



Introductory Poll

Where do you work?

- ❑ Acute care
- ❑ Inpatient/Outpatient Rehab Hospital
- ❑ Community-Based ABI Provider
- ❑ Shelter System
- ❑ Ontario Health atHome
- ❑ Long-Term Care
- ❑ Other Community-Based Non-ABI Provider

About the Toronto ABI Network

Established in 1995, The Toronto Acquired Brain Injury (ABI) Network is a recognized leader and collective voice in ABI.

We connect people to services by:

- Simplifying access, as a single point of entry to hospital and community-based services, for persons with ABI, their families, and service providers.
- Problem solving to help individuals with complex needs access the services they require.
- Serving as a central point of information and support to individuals with ABI and their families to help them navigate and access services.

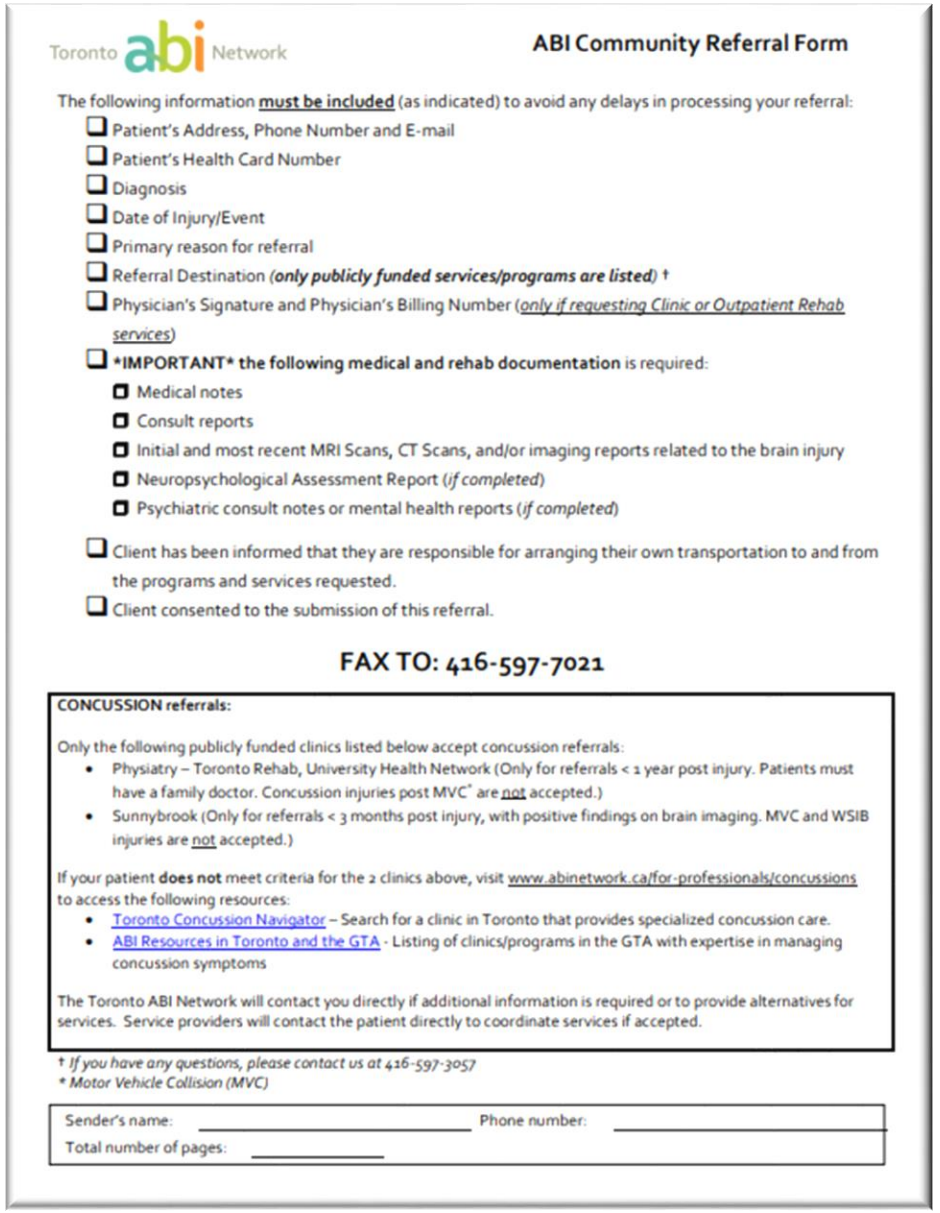
ABI Navigation

The Toronto ABI Network manages referrals to outpatient rehabilitation and community-based services such as behavioural outreach, recreational, case management and supportive housing programs.

https://abinetwork.ca/referral-forms/community-form/

Inpatient ABI Behavioural Services – West Park Healthcare Centre/ UHN

https://abinetwork.ca/referral-forms/inpatient-forms/



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ABI Community Referral Form

The following information **must be included** (as indicated) to avoid any delays in processing your referral:

- ☐ Patient's Address, Phone Number and E-mail
- ☐ Patient's Health Card Number
- ☐ Diagnosis
- ☐ Date of Injury/Event
- ☐ Primary reason for referral
- ☐ Referral Destination (***only publicly funded services/programs are listed***) †
- ☐ Physician's Signature and Physician's Billing Number (*only if requesting Clinic or Outpatient Rehab services*)
- ☐ ***IMPORTANT* the following medical and rehab documentation** is required:
  - ☐ Medical notes
  - ☐ Consult reports
  - ☐ Initial and most recent MRI Scans, CT Scans, and/or imaging reports related to the brain injury
  - ☐ Neuropsychological Assessment Report (*if completed*)
  - ☐ Psychiatric consult notes or mental health reports (*if completed*)
- ☐ Client has been informed that they are responsible for arranging their own transportation to and from the programs and services requested.
- ☐ Client consented to the submission of this referral.

FAX TO: 416-597-7021

CONCUSSION referrals:

Only the following publicly funded clinics listed below accept concussion referrals:

- Physiatry – Toronto Rehab, University Health Network (Only for referrals < 1 year post injury. Patients must have a family doctor. Concussion injuries post MVC* are not accepted.)
- Sunnybrook (Only for referrals < 3 months post injury, with positive findings on brain imaging. MVC and WSIB injuries are not accepted.)

If your patient **does not** meet criteria for the 2 clinics above, visit www.abinetwork.ca/for-professionals/concussions to access the following resources:

- Toronto Concussion Navigator – Search for a clinic in Toronto that provides specialized concussion care.
- ABI Resources in Toronto and the GTA - Listing of clinics/programs in the GTA with expertise in managing concussion symptoms

The Toronto ABI Network will contact you directly if additional information is required or to provide alternatives for services. Service providers will contact the patient directly to coordinate services if accepted.

† *If you have any questions, please contact us at 416-597-3057*
* *Motor Vehicle Collision (MVC)*

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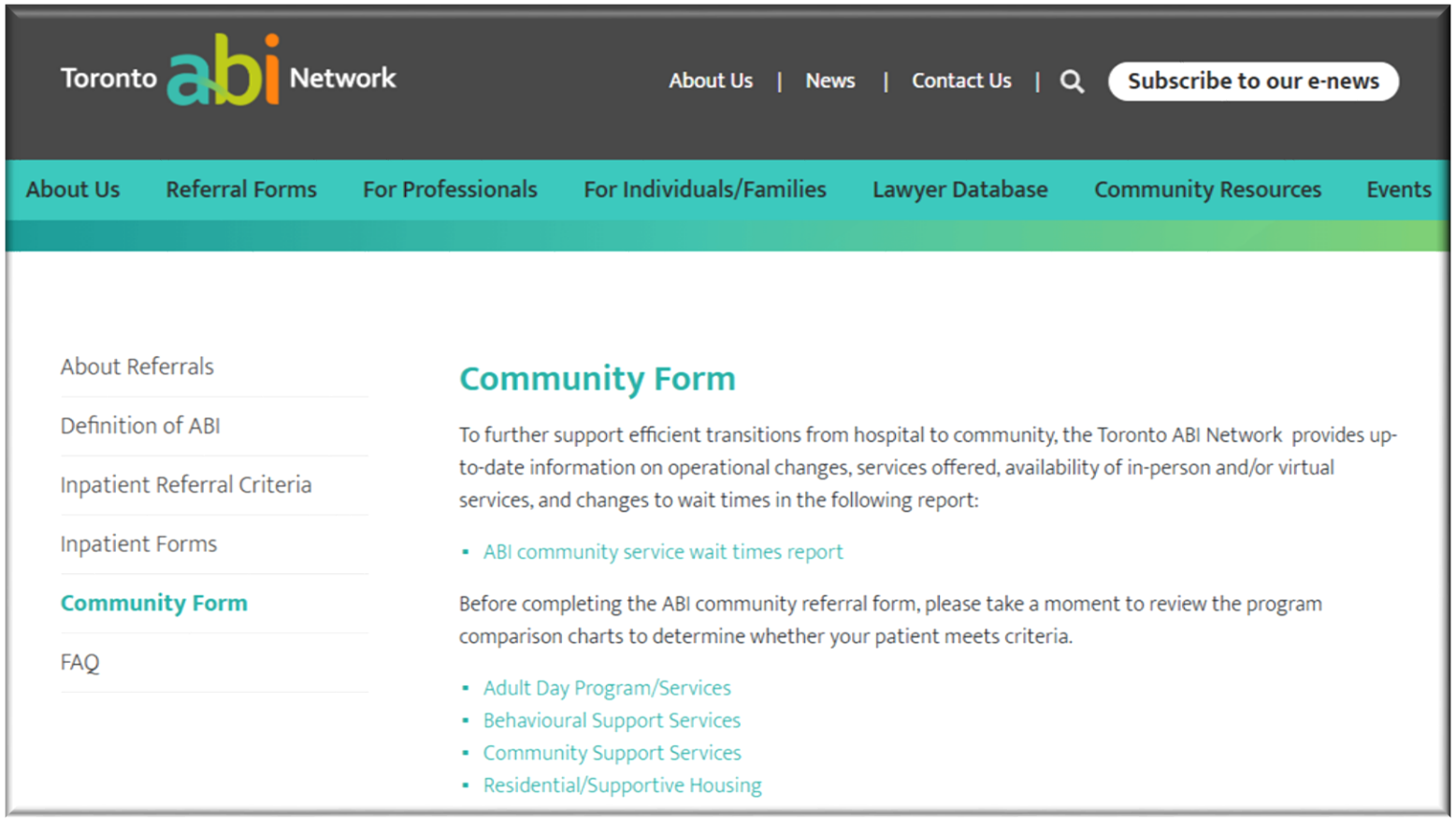
Key ABI Network Resources

Before completing the ABI community referral form, please review the program comparison charts to determine if your patient meets criteria



Case Studies

Note: Details in the following case studies have been modified to protect patient confidentiality.

York-Simcoe Brain Injury Services

Brigitte MacKay, Coordinator

Mackenzie Health

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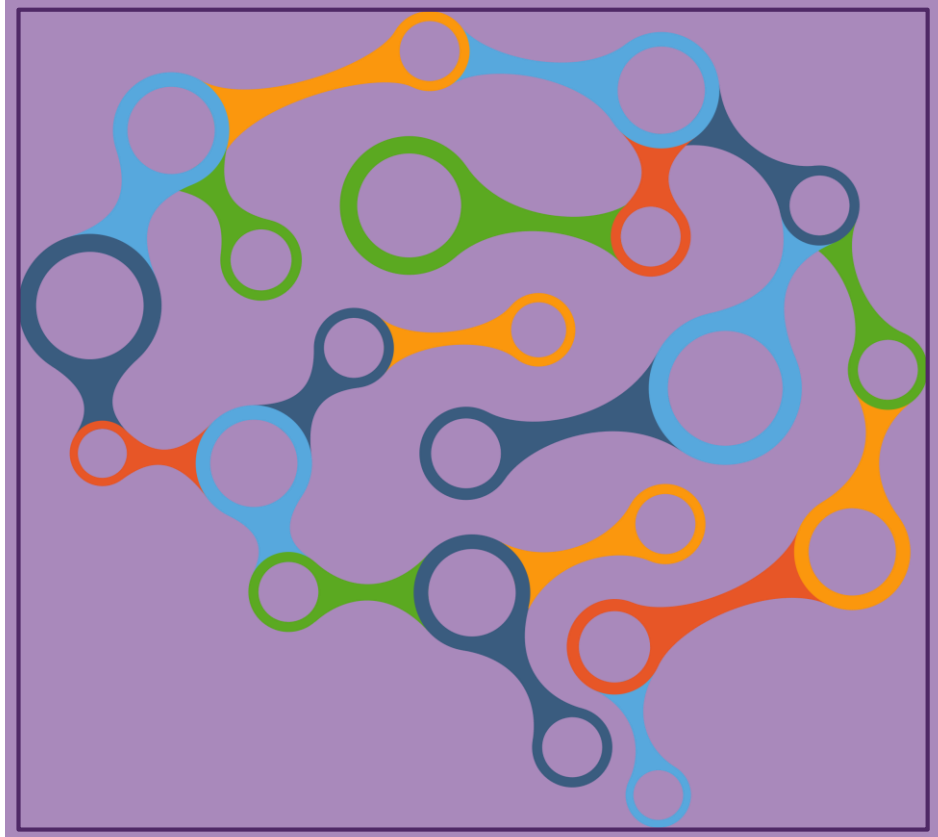
Client Profile

- Worked at the time of injury
- Pre & post history of substance abuse
- ABI - Meningitis and hydrocephalus
- Vision impairment due to ABI



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Reasons for Referral

- Connection to community resources, including substance use and low vision
- Housing – affordable, assistive living, supports with ADLs
- Increase socialization
- Rehabilitation support to promote maximum independence
- Peer and caregiver supports
- Problem-Solving Group

Overview of Behaviour Issues and implications

- Substance Use
- Low mood
- Social Isolation
- Low vision
- Increase independence in ADLs

Referrals for wrap around support

- OT, CNIB to increase ADLs; RSW to increase support and practice

Practical Strategies and Therapeutic Outcome

- Developing a Therapeutic Rapport and interests of the person (playing guitar, socialization, motivated). Complete assessments (MPAI-4, QOL, Beck Depression, Anxiety)
- Neuropsychiatry to address low mood and addiction
- Inpatient Addiction Rehab - Upon discharge, goal is to increase socialization
- Ongoing addiction support
  - resolve ambivalence about reducing alcohol intake, increase awareness of the negative consequences of drinking alcohol and the positive benefits of abstinence

Substance Use and Mood

- Pre-injury history of substance use
- On methadone upon initiation of YSBIS services
- Quit methadone without medical supervision; increased alcohol consumption to cope

Concerns

- Increase risk off falls, decrease ADL and services because of substance misuse.

Substance Use and Neuropsychiatry

- Connected with neuropsychiatrist for low mood and substance use.
- Support in connecting and attending inpatient substance use rehabilitation
  - CAMH
  - New Port

Substance Use and Mood

Fostering treatment compliance and increasing motivation and readiness to change

- Identified high-risk situations for relapse

  Environmental

  - Decrease negative emotional states (social isolation, boredom)
  - Decreased alcohol-related cues (ie. access to alcohol at home, no follow through with contingencies)
  - Referrals to supported housing (ABI, MH, Addictions, Assisted Living)

Substance Use, Mood and Coping Strategies

- **Psychoeducation:** on addiction/substance use and brain injury using the SUBI model
- **Harm Reduction:**
  -Behavioural contract to attend at least 1 virtual AA meeting per month
  -Attended with technology assistance from Rehabilitation Support Worker
- **Coping Strategies:**
  -teaching healthy coping strategies
  - ie. Anxiety reduction by listening to mindfulness meditation videos and comedy videos, or favourite music
- **Problem Solving**

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Problem-Solving and Coping Strategies

Steps:			
Situation:			
Development of Events	Triggers:	Feelings:	Body Signs:
Thoughts	My thoughts:		
	Negative Thinking:		
	Characteristics of Bad Communication:		
Preventative Strategies Used:			

Steps:	
Problem Solving Strategies	1.What is the concern? •What is bothering you? •Why is it a problem? •What do you want to happen?
	2. What could I do? •Write down all possible solutions (even if its silly or inappropriate)
	3. Think it over. •What could happen with each solution? •Consider the time required, cost involved, effects on you personally, effects on other people)
	4. Make a decision •Pick a solution that is best for you (consider the consequences)
	5. Now do it! •What do you need to carry out your solution and do it?
	6. How did it work? •Are you satisfied? •If you're not satisfied, what else could you do?

Increasing Independence

- CNIB referral to help with strategies for low vision

- Goal – increase independence in completing ADLs independently despite loss of vision due to ABI complications
  - increase confidence (felt hopeless and dependent)
  - in home (cooking, microwave use, make own coffee/tea) and community (training of white cane, crosswalks)
  - technology (use of apps on various devices, accessibility of devices)

Increase Socialization

Adult Day Program to increase motivation and socialization

- Must be sober to ride in community vehicle and attend program
- ADLs completed with clean clothing, no use of alcohol on site

Goal:

- Improving interpersonal functioning
- bolster social support

Outcomes:

- Attended 1 day and increased to 2 days (perfect attendance)
- Added additional community programs
- Sobriety after 2nd inpatient at CAMH
- Made friends whom continues to text and call
- Utilized accessible transportation (YRT Mobility Plus) to attend group independently (Increased his confidence)

Additional Community Support & Therapeutic Outcomes

Transition into Residential Brain Injury Program

Case Facilitator and Rehabilitation Counselors at St. Paul's

- Increasing ADLs (cooking, cleaning, showering)
- Increase physical health (abstain from smoking, drinking)
- Return to playing guitar
- Volunteering and vocation training

Ongoing Support for mood

- Neuropsychiatrist remains involved

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Thank You!

Brigitte MacKay

brigitte.mackay@mackenziehealth.ca

SCARBOROUGH CENTRE FOR HEALTHY COMMUNITIES

SCHC ABI Outreach team

SCHC is a multi-service organization with over 40 + programs from primary care to community support programs.

Intake line: 416 847 4134

www.schcontario.ca

SCARBOROUGH CENTRE FOR HEALTHY COMMUNITIES

Behavioural Therapist Case Manager role:

Our BT works to develop training based on individual client goals, for example

- **Cognitive Retraining**: Includes training in areas like vocabulary, numbers, and sequencing to enhance thinking and problem-solving skills.
- **Self-Management Skills**: Support service users manage daily life tasks independently, such as exercising, scheduling doctor appointments, and following up on treatments.
- **Self-Regulation and Emotional Control**: Trains service users to effectively regulate emotions, manage stress, and control reactions.
- **Social Skills Training**: Improves communication and social interaction skills, enabling service users to build positive relationships.
- **ADL Support**: Focuses on breaking down tasks into smaller steps and the skills training. This helps service users manage daily responsibilities with greater confidence.

As a case manager in our interdisciplinary team, the BT will also connect clients to other case managers/resources as needed; such as assistance with medication management, finding a family doctor, transportation services for example.

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- **Name:** Mr. D
- **Age:** 19
- **Gender:** Male
- **Background information and Cause of Injury :** (we worked with the client for just over a year as he was referred in 2024)
  - The client was referred due to a traumatic brain injury in 2023 caused by a cerebrovascular malformation and a history of spontaneous intracranial hemorrhage, he has been experiencing significant emotional regulation difficulties and cognitive decline. These challenges have made it difficult for him to adapt to the academic and social demands of high school, leading to prolonged school absenteeism.
  - In terms of family dynamics, the client's anger management issues have strained his relationships with family members, particularly with his siblings, contributing to conflicts and the emergence of negative or violent behaviors at home. His mother stated that even though she was an RN she felt "helpless"

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Reason for referral – Client's Challenges

Physical Challenges	Cognitive Challenges	Emotional & Social Challenges
• Left-sided weakness affecting mobility and coordination • Requires a cane for safety and balance • Increased effort and time required for fine motor tasks (e.g., typing, playing chess)	• Memory deficits: frequently forgets recent actions and schedules • Needs external prompts for recalling routine tasks • Difficulty with divided attention and multitasking • Impaired executive functioning, affecting task planning and organization	• Poor emotional regulation, frequent anger outbursts • Easily triggered by minor frustrations • Uses avoidance or anger as coping mechanisms • Strained family relationships due to emotional dysregulation • Led to quitting high school in the final year

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Goal: Improve daily functioning and social competence through improved cognitive strategies, emotional regulation, coping skills and social integration.

Objective 1: Enhance different strategies to support memory and attention

Objective 2: Improve emotional regulation and reduce frequency of emotional outbursts

Objective 3: Develop effective coping strategies for frustration and stress management

Objective 4: Facilitate return to school and maintain active social interactions

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Interventions

Objective 1: Enhance different strategies to support memory and attention

Memory Aids:

Using Calendar, reminders, written schedules, and visual supports

Executive Function Coaching:

Breaking down daily tasks into step-by-step instructions

Attention Training:

Provided attention training to improve divided and alternating attention

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Intervention plans continued

Objective 2: Improve emotional regulation and reduce frequency of emotional outbursts

Emotional Recognition:

Enhancing awareness of emotions through labeling feelings, facial expression training, and reflection.

Self-Monitoring:

Journaling emotions, recognizing triggers, and tracking mood patterns

Emotional Regulation Techniques:

Teaching deep breathing, cognitive reframing, and grounding exercises to manage emotion.

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Intervention plans continued

Objective 3: Develop effective coping strategies for frustration and stress management

ABC Analysis:

Identifying antecedents, behaviors, and consequences to understand triggers and implement appropriate interventions.

Anger Management:

Recognizing anger patterns, identifying early warning signs, and using de-escalation techniques such as controlled breathing and problem-solving skills.

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Intervention plans continued

Objective 4: Facilitate return to school and maintain active social interactions

Social Skills Training:

Practicing appropriate responses in social situations through role-playing and real-life scenarios.

School Reintegration Planning:

Collaborating with family and school to create a supportive academic and social environment.

Reinforcement System:

Implementing a reward-based system to encourage school attendance.

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Factors of Success

- **Client Willingness and Motivation:** Active participation and engagement in treatment are essential for achieving progress and sustaining improvements.
- **Family Support:** Encouragement and reinforcement from family members play a vital role in maintaining consistency and motivation in therapy.
- **Interdisciplinary Support – Comprehensive Care:**
  - **Behavioral Therapy (BT):** Addressing memory, attention, emotional regulation, impulse control, coping strategies, and social integration.
  - **Occupational Therapy (OT):** Enhancing mobility, balance, and hand function to improve independence.
  - **Independent Support Worker (ISW):** Assisting with fine motor training.

SCARBOROUGH CENTRE FOR HEALTHY COMMUNITIES

HOW TO APPLY FOR SERVICE?

In order to apply for the service, please complete a referral form through the Toronto ABI Network by calling 416-597-3057 or by using their website: www.abinetwork.ca

WHERE CAN I GET MORE INFORMATION?

Send us an email at abioutreach@schcontario.ca

West Park Healthcare Centre

ABI Behaviour Services

Two comprehensive case studies and rehabilitation journey following ABI for two patients

By Dena Sadeghipour

(Registered Behaviour Analyst)

UHN | Canada's #1 Hospital

West Park Healthcare Centre

Case Study: A

Patient Background:

- Male, in his late 20's, single, homeless and living in shelters.
- Found unconscious, was diagnosed with streptococcus pneumonia leading to respiratory failure requiring intubation.
- Alcohol withdrawal seizures, leading to brain injury with significant cognitive deficits.
- Hospitalized for medical treatment and once stable, started in-patient rehabilitation.
- Discharged back home with his family.
- Ten months following discharge, admitted to acute care for severe behaviours of concern (BoC) towards family members.

Reason for Referral

- Aggression and severe behaviours of concerns
- Cognitive impairments
- Significant memory deficits and attention difficulties
- Physical limitations
- Recurrent agitation
- Barriers for rehabilitation goals and interventions
- Functional goals:

  Reduce BoC, restore independence, reduce isolation and safe community reintegration

Assessment Findings

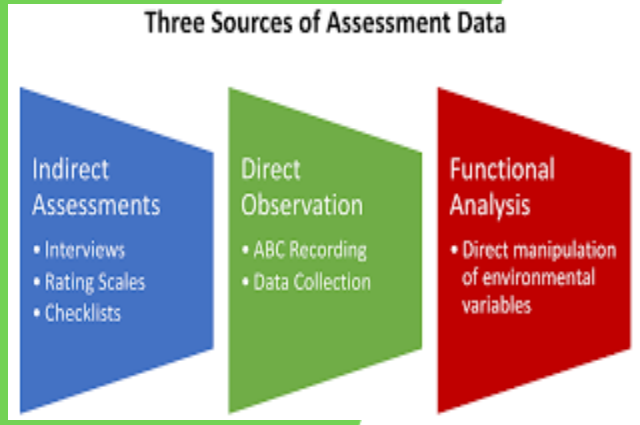
Functional Behaviour Assessments (Direct and indirect ass, Functional analysis, etc.)

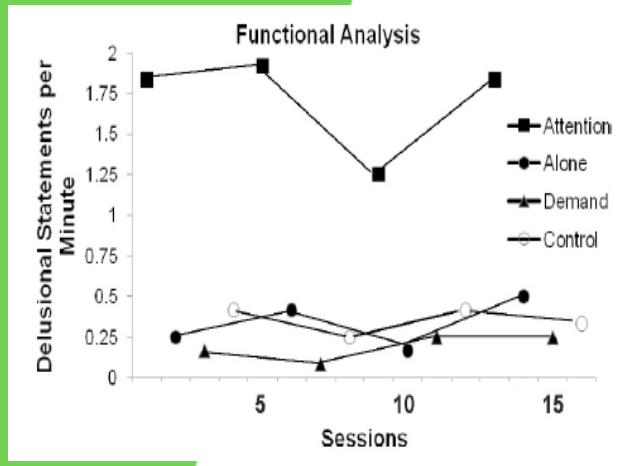
Behaviours of Concerns:

- Physical and verbal aggression towards others
- Impulse control
- Property destruction
- Wandering
- Sexual disinhibition

Triggers:

- Hearing “NO”, Boredom, Support in close distance, Co-patient’s discharge, Goodbyes, Locked spaces





Practical Strategies Employed

- Behavioural scripts and Routine Managements
  - Visual step by step guides for new skills (e.g., shower routine)
  - Social stories (e.g., navigating social interactions)
  - Planned outings (e.g., regular visits to hospital coffee shops and rebuilding social confidence)
  - Boredom Busters (e.g., personal activity lists to provide structure during downtime)
  - Crisis Management (e.g., clear action plans and reduce anxiety during difficult situations).

Staff and Family Engagement Techniques

Calm Interactions

- Approach A with consistent, measured and positive communication.
- Maintain even tone and relaxed body language

Recreation Therapy

- Implement structured therapeutic activities.
- Focus on both enjoyment and skills development.

Activity Setup

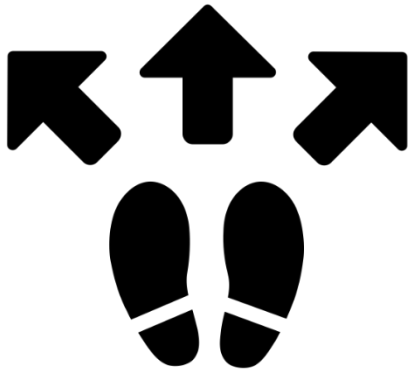
- Assist with initiating tasks without completing them.
- Provide just enough support to enable success.

Family Education and training on how to support and interact with A.

Redirection and Priming Strategies

Alternative Activities

- Guide to different tasks when agitated. Offer choices that match interests.
- Change wording of requests to prevent resistance. Use positive phrasing.



First/Then Approach

- Clearly structure expectations with visual supports. Show what happens now, then next.
- Break activities into manageable sequences. Reward completion of first step.

Precursor Support

- Identify early signs of distress. Intervene before escalation occurs.
- Document triggers to develop personalised strategies. Share observations with team.

Memory and Attention Enhancement

Memory Compensation

- Implement alarm systems and visual reminders. Create consistent placement for important items.

Attention Exercises

- Practise basic maths and word searches. Gradually increase complexity as skills improve.

Task-Specific Training

- Use discrete trial training for medication routines. Practise until habits form.

Problem-Solving Development

- Teach simple step-by-step instructions. Practise calling support people when needed.

Other Strategies Employed

Task Simplification Techniques

- Complex Task Analysis (i.e., breaking activities into smaller steps)
- Step Completion (i.e., Master one step before moving into next)
- Skill Mastery (i.e., Celebrate progress at each stage)

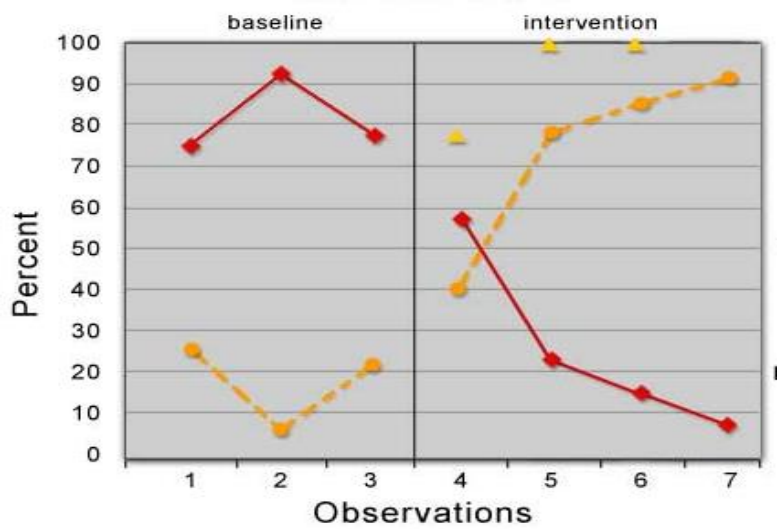
Independence Development

- Initial full support with clear instructions
- Skill maintenance with minimal intervention
- Gradual reduction in prompts and support
- Brief Separation (i.e., short periods alone with access to support)

Family Education and Support

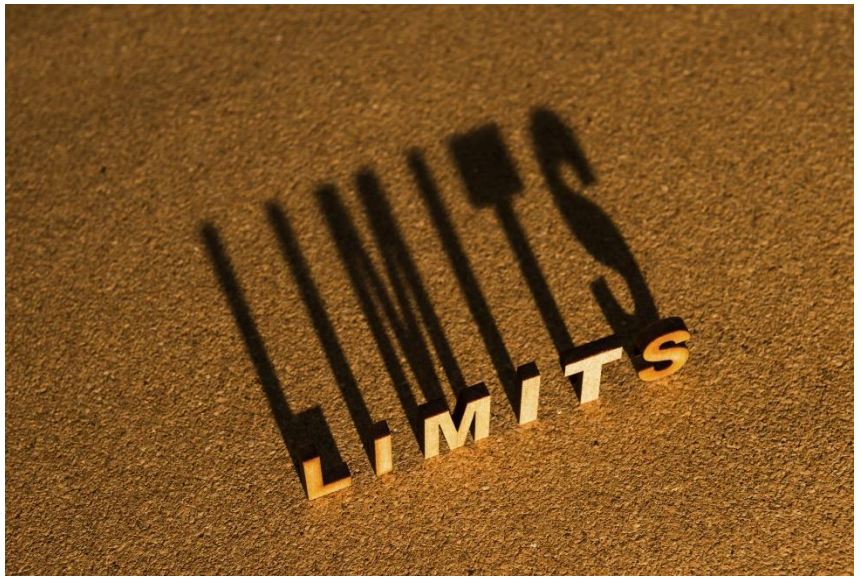
Therapeutic Outcome:

- Received 12 months of Outreach behaviour support from BT services.
- Moved back to his family home with continued outreach support from the BT.
- Behaviours stabilized, violent behaviours and exit seeking was significantly reduced. (no reports of Physical aggression, sexual disinhibition, no property destruction and no exit seeking)
- Joined the Day Program and re-integrated back to the community on social outings.
- Family education and support.
- Support with a long term goal of starting volunteer work.
- Increase in engagement in OT and PT rehab exercises and met Rehab goals.



Limitations:

- Poor Short Term and Long Term memory impacting patient's ability to start and maintain employment.
- Poor insight and awareness resulting in limitations in decision making capacity.
- Limitations to processing information and problem solving skills prevents patient to live fully independently.



“Thank you”

Let’s connect:

Dena.Sadeghipour@uhn.ca

West Park Healthcare Centre ABIBS Behaviour Services:

ABI-Outreach@uhn.ca

For Referrals please contact:

ABI.Network@uhn.ca

Q & A

Share your thoughts!

Let us know what other webinar topics would be of interest.

Please share your thoughts in the chat box.

Additional Resources

- **Contact your local ABI Navigator:** https://abinetwork.ca/for-professionals/abi-navigators/
- **Behavioural Supports Ontario** (BSO) https://behaviouralsupportsontario.ca/
- **Hamilton Health Sciences – Neurobehavioural Program –** Provincial program responding to needs of individuals with ABI who display challenging behavioural and/or mental health issues. Hamilton Health Sciences- Neurobehavioural Program (page 5-6)
- **St. Paul's, Transitional Living Program** – A partnership with Brain Injury Community Re-Entry (Niagara) Inc. and Canadian Mental Health St. Paul's Transitional Living Program (page 13)
- **Concussion Services** – Find a clinic in Toronto for individuals 18 years of age or older that provides specialized concussion care. Toronto Concussion Navigation Tool
- **Mental Health Services** – A number of resources can be found in The Central Link ABI Resources Library under Specialized Supports and Services https://www.neurotraumapathways.ca/central-link

Toronto abi Network

June 18, 2025

Thank you for attending!