Acquired Brain Injury Partnership Project

Program Fact Sheets: 2013-15

September 2015

The ABI Partnership Project

...A joint initiative of...

Government of Saskatchewan

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INTRODUCTION

The Acquired Brain Injury (ABI) Partnership Project is unique partnership established by SGI and the Ministry of Health that is "a comprehensive, integrated system of supports, resources and services that will enhance the rehabilitation outcomes and improve the quality of life for individuals with acquired brain injuries and their families" (Acquired Brain Injury Working Group, 1995). The ABI Partnership Project provides funding to 28 programs that provide direct client service to registered clients, and five programs that provide education and injury prevention work. For the purposes of this report, these programs can be grouped as follows[1]:

1. Case Management (8 Programs)
2. Day Programming (5 Programs)
3. Independent Living and Residential Programming (5 Programs)
4. Life Enrichment Programming (3 Programs)
5. Children's Programming (1 Program)
6. Vocational Programming (3 Programs)
7. Crisis Programming (2 Programs)
8. Rehabilitation Programming (1 Program)
9. Education and Injury Prevention (5 Programs)

One of the reporting expectations in the 2013-16 contracts was that each funded program carry out an individual evaluation of their program due March 1, 2015. This evaluation was an opportunity for each agency to demonstrate the unique way in which their program works with clients and its unique benefits.

Program fact sheets have been developed using information from these site level evaluations and from service statistics within the ABI Information System. Each Program is represented in one of nine program types: Case Management, Day Programming, Independent Living, Life Enrichment, Children's Programming, Vocational, Crisis, Rehabilitation, and Education and Prevention programming, and a general description of each with highlights from individual site level evaluations are presented in the ABI Partnership Project Review (2015).

[1] Program types were altered from previous reports based on program descriptions provided in the site level evaluations. This new grouping is designed to better align with the types of services currently offered by funded programs.

PROGRAM FACT SHEETS

Case Management (8 Programs)

Three Outreach Teams and Five ABI Regional Coordinators

Sask Central Acquired Brain Injury (ABI) Outreach Team

PROGRAM DESCRIPTION

Service Area: Serves three health regions: Saskatoon, Heartland and Prairie North

History: Has served 1,118 ABI survivors since 1996

Location and Hours: Saskatoon (Saskatoon City Hospital), Monday to Friday, 8:00 am - 4:30 pm

Staffing: 9.2 FTEs

Target Group: Survivors of ABI & their families, and other service providers in need of consultation

Partners: Referrals typically come from rehabilitation services, acute care, acute care pediatrics, as well as Kinsmen Children's Centre (KCC). The Outreach Team partners with a wide variety of services in the central service area depending on clients' needs and the needs of the community. Examples of partnerships include: the Speech and Language Centre, neuropsychologists, psychiatrists, Client Patient Access Service, various ABI programs, and various housing and funding programs/agencies.

Typical Goals and Services: Case managers engage in different activities depending on a client's goal areas. Some typical areas are:

- **Return to Work:** This could involve meeting with the employer to provide education about the nature and effects of brain injury and helping to develop a return to work plan. It may also involve working with community agencies such as Radius or the Saskatchewan Abilities Council for skills assessment and retraining.
- **Return to School:** As with work, ABI Outreach involvement may include brain injury education to teachers and staff as well as providing expertise when collaborating to develop an education plan that meets the unique needs of the brain injured client.
- **Support for Independent Living:** This may involve an assessment of independent living skills in the home and community with recommendations and various support options aimed at maximizing client independence. This may involve occupational therapy recommendations for structural modifications to the home, memory aids or other cognitive strategies, as well as elements of home care services. It could also involve advocacy and partnering with various agencies such as the Saskatoon Housing Coalition/Authority for affordable community housing for individuals with an ABI.

- **Support for Family:** This can occur within any of the other areas identified; however, may also occur on its own, as the client may not be interested in services themselves and/or the family may need additional services on their own. Services may include individual education, psychosocial support, resource referrals, environmental changes or compensatory strategies to support their loved one. Resource linkages may be to the Saskatchewan Brain Injury Association, caregiver support groups, counseling agencies, ABI neuropsychologist, and/or the Stroke Network.
- **Education:** This can occur at many different levels. Case managers themselves provide education to clients and their families about brain injury and its effects (cognitive, physical, emotional, relationships, etc.). They may directly provide informational resources or provide links or referrals to specialized information depending on client and family need. This may include a referral to the ABI Outreach Team Neuropsychologist for education and support around dealing with unique client and family difficulties. As previously mentioned, education can involve education to employers, schools, health care providers, and other individuals and community agencies that clients may become involved with.
- **Connecting with services in the community:** This activity varies greatly depending on client need. These community services can involve any of the aforementioned areas all which funnel back to supporting clients in achieving their specified goals.
- **Re-establishing previous roles and reintegrate into their former lives:** This outcome can be said to have occurred when clients have successfully achieved their goals. It should result in a perception that they have returned as much as possible to their previous roles with improved quality of life.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • MVC – All Causes • Falls
Living Situation - Top 3	• Independent in own or family home • Supported Requiring Assistance • Supervised
# of service events per client over the fiscal years/ average minutes per event	49 events / 39 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Consultation/Education/Training • Case Management • Administration
Recipients – Top 3 (based on number of events, not time)	• Individual Survivor • Other Service Provider • Family/Natural Supports
Community/E&P Topics - Top 3 (based on number of events, not time)	• PARTY • Camp/Retreat Event • Therapeutic Activities Group

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 99 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 76% were fully achieved and 20% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for a quarter of recorded goals) were: "Employment", "Leisure Activities" and "Transportation".

Evaluation: Information was obtained through pre and post Mayo Portland Adaptability Inventory - 4th edition (MPAI-4) scores on the Adjustment to Injury & Participation subscales (35 staff, 23 survivor, and 8 significant other respondents); Satisfaction survey (29 respondents), a six month follow-up survey (25 clients contacted via phone and mail out); and 28 respondents to a community partners survey (used by all three outreach teams). Overall, results were positive, and supported the effectiveness of the program.

Highlights from the **satisfaction survey** (29 respondents):

- Satisfaction has been above 88% for the past five years, and 93% of respondents indicated that the Outreach Team had been beneficial to them
- 72% of clients said they felt more knowledgeable about brain injury and its effects
- 72% of clients said they felt more supported and less alone as a result of their involvement with ABI Outreach
- 67% of clients recalled having ABI Outreach help with connecting them to community resources
- 93% of clients felt that the goal setting process was collaborative, reflecting both their needs and opinions
- 93% of clients indicated being successful or somewhat successful in achieving their goals

Highlights from the **follow-up survey** (25 respondents):

- 88% reported feeling better or the same as compared to how they felt at discharge
- 88% reported maintaining or somewhat maintaining goals achieved in the program
- 96% indicated that they had some form of support
- 88% reported having some form of meaningful activity

MPAI-4 also showed positive results, with 83% of the 35 case manager respondents and 78% of the 23 clients noting improvement (as indicated by total inventory score).

The **community partners survey** results were also very positive, with "were you satisfied with the quality of service received by your client(s)" being rated on a 5-point Likert scale as 4.1 (between "agree" and "strongly agree"). Another highlight was substantial improvements in the ratings compared to those obtained in 2006 for two questions:

- "To what degree do you think your client(s) benefited from his/her participation with the ABI Outreach Team" at 4.3 compared to 3.8 on a 5-point Likert scale
- "Were you satisfied with how you were kept informed about your client(s') progress?" at 4.0 compared to 3.6 on a 5-point Likert scale

SK North Acquired Brain Injury (ABI) Outreach Team

Program Description

Service Area: Services are provided to the following health regions: Prince Albert Parkland, Kelsey Trail, Athabasca, Mamawetan Churchill River and Keewatin Yatthé Health Regions.

History: Has served 620 ABI survivors since 1996, plus 114 clients served in Mamawetan Churchill River, and 46 clients served in Keewatin Yatthé through the Outreach Team's subcontract and through the previously funded rehabilitation assistants in each of those areas.

Location and Hours: Prince Albert, Monday to Friday, 8:00 am - 4:30 pm

Staffing: 8 FTEs (includes 2 temporary FTEs in the 2013-16 contract)

Target Group: Survivors of ABI and their families in the northern 5 health regions (see service area above)

Partners: Referrals typically come from acute care, inpatient and outpatient rehabilitation, other health care professionals, survivors or their family members. The Outreach Team partners with a wide variety of services in the northern service area depending on clients' needs, and the needs of the community. Examples of partnerships include: home care, mental health and addiction services (in some communities), and a variety of community based organizations (e.g., Gary Tinker Federation, Scattered Site, etc.). Services in urban centers are not as limited and typically clients are referred to funding resources (SAP, SAID, Public Trustee, SGI, etc.), other health region programming (rehabilitation, mental health and addictions), and residential programs (e.g., long term care/personal care homes, Riverbank Housing Corporation, PA Community Housing).

Need met by the Program:

- Individuals who have sustained an ABI along with their families often need help organizing and coordinating services and resources to maximize their functional recovery after an injury, which the Outreach Team provides through **case management**.
- Other service providers and community members outside of the partnership need information regarding both general and client specific brain injury information. The Outreach Team provides this through **consultations.**
- Clients and/or their family members require **education** about the specifics of their brain injury (e.g., area of brain that was damaged, expected impact of damage to that area of the brain) as well as general effects of brain injury and management strategies (e.g., fatigue, impact of alcohol on brain function, how to prevent subsequent injuries). Also, community partners/service providers who are also working with individuals with ABI (e.g., home care nursing, community health centers, personal care home staff) often require the same education as noted above and, in addition, education about how their services might be tailored to best meet the needs of individual clients.

Services / Activities: The Outreach Team utilizes a multidisciplinary approach that includes case management, consultation and education services. Clients are seen in their homes, in the community and in the office depending on which method best suites the client and situational circumstances. Ongoing contact

and support is provided to clients and their families through various means – telephone follow-up, email communication and/or face-to-face meetings.

- Direct services to individuals with ABI include: providing case management/service coordination by assisting individuals to access appropriate services/supports; acting as a link between medical facilities, other health, human service and community-based programs/services and the individual client/family; within their scope of professional practice, providing direct client services/supports when other services/supports are not available; providing ongoing follow-up, evaluation and education to clients.

- Direct services to families of ABI survivors include: assisting family members/caregivers to access appropriate service/supports to have their needs met; providing education to family members regarding ABI; providing ongoing support and follow-up.

- Services to communities and other service providers include: assisting other health and human service programs to adapt their programs to meet the needs of individuals with ABI; developing necessary partnerships with other health and human services for the benefit of individuals with ABI; providing education to communities and other health and human services on ABI; and providing ABI prevention and health promotion services to communities throughout the service area as time permits.

Intended Program Impact: The intended result is that services are coordinated, referrals are made, and individual goal/action plans are developed. Ultimately, ABI Survivors experience reintegration back into the community, increased productivity, increased socialization and participation levels, and improved quality of life.

For consultations, the intended impact is that other service professionals, family members, caregivers, survivors and community members have a better understanding of brain injury, a better understanding of the unique challenges faced by individuals who have sustained an ABI, and in turn can provide better service and/or care.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• MVC – All Causes • Stroke • Blow to head (assault)
Living Situation - Top 3	• Independent in own or family home • Supported with limited assistance • Tied for 3rd: Independent with difficulty, Child requiring extra support, and Personal care home
# of service events per client over the fiscal years/ average minutes per event	48 events / 61 minutes each

Client Activities - Top 3 (based on number of events, not time)	• Case Management • Psycho-Social Services • Residential Services
Recipients – Top 3 (based on number of events, not time)	• Individual (survivor) • Group (of survivors) • Other Service Provider
Community/E&P Topics - Top 3 (based on number of events, not time)	• All were education on ABI

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 43 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 84% were fully achieved and 11% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for 27% of goals) were: "Physical", "Understanding ABI", and tied for third were "Housing" and "Navigating the Medical System".

Evaluation: Two surveys were used: 1) a survey of family members/caregivers of active and recently inactivated clients in 2013-14 distributed via mail-out, at group activities, and with the *Caregiver's Corner* newsletter. Throughout the course of the evaluation period, only a small number (11) of family members completed the survey either in full or in part; and 2) a community partners survey (used by all three outreach teams) was sent out in October of 2014 via email or fax. Twenty-three community partners responded.

- The results for the **family satisfaction survey** were very positive, with all family members who responded (100%) indicating that they were satisfied with the services that they have received. Results that highlight areas for improvements include: only 55% of respondents were aware of the ABI resource library, and only 73% of respondents indicated that they had received information on community resources that would be of assistance to them and/or their family member.

- The **community partners survey** yielded positive results with 89% of respondents indicating staff were 4 "mostly" to 5 "very much" helpful (on a 5 point Likert scale) at understanding and attending to the needs of their clients, 77% indicating their clients "mostly" to "very much" benefited from the program, and 82% indicating that they were "mostly" to "very much" satisfied with the quality of the service. A slight reduction in satisfaction with communication was seen from the 2006 survey (.6 on a 5-point scale), and results highlighted this as an improvement area.

SK South ABI Outreach Team

Program Description

Service Area: Services are provided to the following health regions: Regina Qu'Appelle, Sunrise, Sun Country, Five Hills, and Cypress.

History: Has served 1,654 ABI survivors since 1996

Location and Hours: Regina (Wascana Rehabilitation Center), Monday to Friday, 8:00 am - 4:30 pm

Staffing: 11.35 FTEs

Target Group: ABI Survivors and their families, and also other service providers through education and consultations.

Partners: Referrals typically come from acute care, inpatient and outpatient rehabilitation, other health care professionals, survivors or their family members. The Outreach Team partners with a wide variety of services in the southern service area depending on clients' needs, and the needs of the community. Examples of partnerships include: multiple health professionals within Regina Qu'Appelle Health Region, Probation and Victims Services, Social Services including Saskatchewan Assistance Program (SAP), Saskatchewan Assured Income for Disability (SAID), and Cognitive Disability Service (CDS) programs), SGI, ABI programs in Regina (SARBI, Pearl Manor, Sask Abilities Life Enrichment and Partners in Employment, SBIA, Mobile Crisis), Neil Squire Foundation, Personal Care Homes, and Saskatchewan Aids to Independent Living (SAIL).

Need met by the Program:

- **Client-Centered Assessment & Planning:** Clients require a comprehensive assessment of their needs after sustaining an acquired brain injury. Often, information regarding injury and client information is gathered in acute care, sometimes even initiating contact with client and family in hospital.
- **Service Facilitation & Coordination:** Clients require access to certain services and supports after sustaining an acquired brain injury. The ABI Outreach Team supports physical, social, emotional and cognitive well-being with their discipline specific skill base: social work, nursing, physical therapy, occupational therapy, speech and language therapy, teacher and rehabilitation workers. This is accomplished through direct home visits, telephone consultation, in-office visits and in-community visits.
- **Education & Prevention:** To increase the knowledge and understanding of individuals within southern Saskatchewan on the effects of ABI.

Services / Activities: The South Outreach Team provides a wide variety of services including:

- **Client Case Management/Service Coordination** – assessment, reassessment, care planning, client reviews, case conferences, service coordination, discipline specific assessment and treatment and crisis management as required. This means facilitating referrals to funded, formal and informal partners in the community. This service also includes coordinating team meetings for communication, service coordination and problem solving (i.e., integrated case planning meetings and service navigation). For in-

school settings, this will mean Personal Program Planning meetings. For work settings, this can mean graduated return to work planning and monitoring meetings.

- **Client Consultation/Community Development** – activities related to networking with other service providers including education about brain injury, client advocacy, adapting existing programs to meet client needs and accessing existing programs. The team also liaises, refers, and provides education to local support groups. The team currently has at least 25 clients throughout southern Saskatchewan for whom they serve as case lead to facilitate CDS funding and service coordination. Most of these CDS funded services include support worker services, respite supports, job coaching and cleaning services.

- **Education** – this includes both formal and informal education to clients, family members, other service providers and the general public on brain injury and injury prevention. This helps create capacity within communities. This can involve working with communities to adapt their existing services to meet the needs of the person with an ABI. This can be accomplished in a variety of ways: team conferences with regional formal and informal support networks, case planning meetings and education sessions.

- **Life Skills Training** – this includes assisting clients in developing daily living, home making, social, interpersonal, communication and life skills.

- **Therapeutic Activities** – This includes all of the discipline specific assessment and treatment conducted by the professional staff. This includes nursing, speech therapy, physical therapy interventions and supportive counselling. It also includes the work done by the Outeach Team's occupational therapists, including: *Living Assistance Grid Assessments*; and wheelchair, vehicle, equipment, and home modification assessments. The team runs a weekly Art Group and Communication Group that is facilitated by team members and designed to meet the needs of their clients.

- **Vocational Services** – This includes all activities related to employment, vocational training and counselling. Specific activities include job site visits, return to work planning, vocational exploration, job coaching, vocational assessments, accessing community based vocational resources and supported employment opportunities.

- **Work with Children and Youth** – A number of the outreach team members have training and experience with pediatric clients and are able to support children in returning to school and age appropriate extra-curricular activities. This can mean everything from participating in Personal Program Planning meetings, running education sessions for teachers, and providing individualized skilled tutorial support from our Educator. Given the lifelong nature of ABI, the team actively participates in facilitating transition from elementary to high school, and then high school to post-secondary and vocational pursuits. The team also collaborates with the other two outreach teams and Radius to offer the ABI Youth Camp annually (see Radius fact sheet for a description of this camp). Currently, 22% of the South outreach team's caseload is under 24 years of age.

- **Work with Families** – This includes working with families and caregivers to maintain their own health and quality of life. This may mean providing individualized supports to family members/caregivers from more than one outreach team professional. The team is also available to family members for ongoing telephone support as needed.

Intended Program Impact:

1) To improve the daily living skills of individuals with ABI through increased participation, productivity and community integration.

2) To improve the system of supports and services for individuals with ABI and their families through education, adjustment and understanding of the effects of ABI.

3) To increase the knowledge and understanding of the effects of ABI and to prevent the (re)occurrence of brain injuries for individuals living in Saskatchewan through education and prevention initiatives.

The Final Outcome is to improve the quality of life for children, youth, adults and their families living with acquired brain injury in Saskatchewan.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • MVC – All Causes • Tumour
Living Situation - Top 3	• Supported with limited assistance • Independent in own or family home • Independent with difficulty
# of service events per client over the fiscal years/ average minutes per event	41 events / 39 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Case Management • Administration • Discipline Specific Therapy*
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Partnership Service Provider • Other Service Provider
Community/E&P Topics - Top 3 (based on number of events, not time)	• Education on ABI • Camp Events • Survivor/Family Support (not support group)

* Includes a combination of discipline specific therapies such as: Occupational Therapy Interventions, Speech Language Interventions, and Counselling.

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 187 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 65% were fully achieved and 25% were partially achieved. Including withdrawn goals, the top 3 goal areas (accounting for one third, or 34% of goals) were: “Physical”, “Transportation”, and tied for third were “Employment”, “Leisure Activities” and “Understanding ABI”.

Evaluation: In reviewing their most recent Goal Attainment Data regarding clients active in the 2014 fiscal year, 6% of the outreach team's goal summaries were directly related to employment. The ABIIS information for this same fiscal year indicates 4% of their service events were directly related to vocational services, which the team feels is under-reported.

A 10-year **retrospective case file review** was conducted that looked at factors associated with vocational success in clients. The sample consisted of 186 clients aged 18 – 55 that suffered a traumatic brain injury and were admitted to the outreach team from April 1, 2003 – March 31, 2012 (50% were SGI clients). The average length of time on program was 975 days (2.7 years) with an average of 63 service events and 38.6 hours of service provision.

The review revealed two areas that would seem to be predictive of successful vocational outcome:

- Well over half (58%) of clients with pre-injury competitive employment maintained or obtained some competitive employment, as well as almost a quarter (22%) of clients that were students at the time of their injury. However, only 5% of clients with no pre-injury employment history went on to obtain competitive employment (1 of the 55 clients). These numbers illustrate the importance of pre-injury employment status as a predictor of employment outcome.
- The case file review also indicated clients with a **severe brain injury** were two to three times more likely to have a reduction in their employment category.

The roles of the team were varied and numerous with education being the most common followed by referral to other service providers and then, specifically, employee meetings and work site visits. A lot of the initial work was focused on rehabilitation, education, promoting independence, and making sure that clients' basic needs were met before considering return to work. In order to have a successful return to work, the client must be able to meet the required job demands and work in a safe and productive manner. Having a supportive employer is beneficial and a positive pre-injury work history increases the success rate.

A **community partners survey** (used by all three outreach teams) was sent out in October of 2014 via email and/or fax. Forty-eight community partners responded. The **community partners survey** yielded very positive results with average ratings for all questions falling between 4 ("mostly") and 5 ("very much"). The highest average ratings occurred for, "Do you feel that the ABI Outreach Team was receptive to your requests for services" and, "Given your overall satisfaction, would you collaborate again with future clients", both at 4.6. The lowest average rating (4.0) occurred for the question, "Were you satisfied with how you were kept informed about your client's progress."

Cypress ABI Regional Coordinator

Program Description

Service Area: Based out of the Cypress Health Region, serving nearly 80 rural and urban municipalities in the southwest corner of Saskatchewan. The region stretches from the South Saskatchewan River (its northern boundary) to the U.S. (southern boundary) to Alberta (western boundary) and east until the Morse/Mankota area. The region covers approximately 45,000
sq. km. In 2014, the covered population was 45,394.

History: Has served 158 ABI survivors since April 1997

Location and Hours: Swift Current, Monday to Friday, 8:00 am - 5:00 pm

Staffing: 1 FTE

Target Group: Serving individuals with traumatic, pathological and chronic brain injury, their families and their communities. The program gives priority service to individuals injured less than three years ago and to individuals with moderate or severe brain injury. This program offers case coordination for care provision and care planning to individuals, their families and communities, as well as direct services for emotional and behavioural issues. Consultation for community agencies and education and prevention activities are provided as requested by the community partners within the Cypress Health Region.

Partners: The Coordinator partners with a number of health and other human service professionals accepting referrals from and linking clients to services to assist them in achieving their goals. The Coordinator is involved in educating service providers throughout the service area regarding ABI and its effects and also works to increase awareness in at-risk populations and around conditions that cause brain injury. Examples of referral/consultation partners include: ABI Outreach Teams, acute care, rehabilitation facilities, primary healthcare, long-term care, employment services, therapy staff, dieticians, Home Care, Public Guardian and Trustee, and the court system.

The Coordinator partners with community committees, schools, police and emergency services, and primary care providers for prevention services.

Typical Client Goals: Service is goal-directed and based on ongoing assessment information. Goals include: improvement to quality of life; access to rehabilitation; accomplishment of treatment and life transitions, understanding of injury and changed needs, self-advocating, gaining independence; assisting families with service navigation (re: finances, education, employment, health care, basic needs) and improving family functioning.

Most direct client service is delivered via home visits. The frequency of home visits is based on assessed needs and may occur weekly, bi-weekly, monthly, every two months or bi-annually. Service frequency depends on the relative risk the client/family is in, the amount of information needed, the amount of services available to support the client and family, the client/family's ability to access services, and what collaborative work is required with client/family and Coordinator together. As the client recovers, the assessment is updated to reflect new goals and recommendations.

Services / Activities:

- Direct Client Service activities include: Case management (assessing needs, goal-setting, linking, referring); Support Group facilitation; Case-specific support regarding behaviour, employment, etc.
- Family Work activities include: involvement in survivor goal-setting, assistance with service navigation and referrals (including counselling), problem-solving and coping strategies regarding family interactions, roles and communication; support group facilitation.
- Community support activities include: support to/education for community service partners, including employers, to assist them to adapt their service provision to account for issues like memory, reading, self-appraisal, physical ability, and emotional and behavioural challenges.
- Consultation activities include: assistance with problem-solving, information-sharing and care planning for clients who have 'slipped through the cracks' but who do not meet the ABI Coordinator's service mandate or whose immediate needs are better met by other services/providers.
- Education and prevention activities: are offered on request, tailored to audience needs with topics ranging from playground safety to sport safety to general brain health information. Examples include: behaviour management education in long-term care, targeted prevention programs of PARTY (15-17 year olds) and Brain Walk (5-12 year olds) in schools, bike safety initiatives with municipal governments and community committees.

Intended Program Impact: To increase the community integration and overall quality of life of ABI survivors and their natural supporters through support, education and linkage to community resources.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • MVC – All Causes • Tumour
Living Situation - Top 3	• Independent in own or family home • Supported with limited assistance • Supervised
# of service events per client over the fiscal years/ average minutes per event	27 events / 65 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Case Management • Support Group • To a much lesser extent, Behavioural Interventions
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Other Service Provider • Tied for 3rd: Family/Natural Supports, Survivor & Family

Community/E&P Topics - Top 3 (based on number of events, not time)	• Support Group • PARTY • Bicycle Safety

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 27 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 59% were fully achieved and 31% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for 20% of goals) were: "Memory", "Self-Awareness/Insight", and tied for third were "Planning/Problem Solving/Self Correction" and "Relationships with Others".

Outputs: In 2014:

- 7 survivor/family support groups were facilitated by Coordinator with a range of 8-25 participants per session.
- 36 education and prevention presentations were delivered to meet community general information requests such as the PARTY program, safety expos, bike safety days, event displays, intersectoral meetings, and radio interviews.
- 31 consultation events were delivered with average service time of 91 minutes per event
- 30% of client work includes family
- Referrals: 26 referrals to and 33 referrals from other community agencies and services

Evaluation:

Data was collected through a client experience survey, family experience survey and support group evaluations, and through an ABI program self-assessment with Accreditation Canada – ABI Program Standards.

The **Client Experience survey** utilized a 4-point Likert scale, using the ratings, "Usually", "Sometimes", "Seldom", "Never", asking 6 questions about the ABI Coordinator's role in relation to: amount of contact with them, consideration of their needs and opinions, making them aware of and linking them to necessary services, ability to educate other professionals about their ABI and service needs, and overall satisfaction with the service they provided them.

27 of 45 surveyed responded for a 60% response rate. Positive quantitative results were seen across all six questions. Open-ended responses further indicate the value clients see in the support provided from the ABI Coordinator. The Coordinator indicated that the client experience responses demonstrate that effective ABI service delivery "is all about engaging the client and building a supportive, encouraging relationship" (as referenced by Kreutzer).

The **Family Experience Survey** was administered in June 2014. Thirty current and former family members/supporters were mailed a 9-question survey asking them to rate their experience with the ABI Coordinator in relation to: amount of time spent, follow-up, help adapting to changes, involving them in treatment decisions, understanding, help with relationships, help with difficult communication with their loved one and recommending the service to others. They were asked to rate the Coordinator on a 4-point Likert scale with the ratings, "Usually", "Sometimes", "Seldom", and "Never".
Fifteen (50%) family members completed the survey.

Positive quantitative responses were received across all 9 questions. All 15 (100%) of respondents indicated that the Coordinator spent an adequate amount of time with them and provided follow up. 93% (14 people) responded "usually" across five questions, and 80% and 86%, respectively, responded "usually" on the other two questions.

In summarizing the open-ended responses, several of the families report that the ABI coordinator and/or the ABI support group are the only places that they feel they can speak openly and be understood even years after the injury.

Survivor/Family Support Group survey – Thirty-eight separate support groups in Swift Current were surveyed over four years (2010-2014). Average group attendance over the period was 8. Surveys revealed 85% satisfaction rating over the 5 questions asked over the 4 year period.

Through the **Accreditation Canada – ABI Program Standards – ABI Program Self-Assessment** process, ABI services are accredited on 16 standards, 131 sub standards, 6 required organizational practices, and 23 high priority practices. The process determined that the Cypress Health Region ABI Coordinator is meeting or exceeding 122/131 sub standards, 5/6 required organizational practices, and 22/23 high priority practices.

The accreditation process identified some (10) areas for improvement (many outside the program's direct control): targeted/standard prevention programming for middle-school aged children (ages 11-15), access to independent living support contracts, better (well-trained) respite, access to neuropsychological assessment, address isolation of ABI Coordinator, improved interdisciplinary communication, minimum standards for rural ABI services, improved public transportation in Swift Current, better exchange of information across referral points, better evaluation of how information is used to improve client care.

In summary, the evaluation results indicate that both survivors and their families report a high level of satisfaction with the ABI services that they are currently receiving. The Coordinator commented that having one knowledgeable, key contact is beneficial for the ABI community.

Five Hills ABI Regional Coordinator

Program Description

Service Area: Based out of the Five Hills Health Region, serving south-central Saskatchewan in a geographic area that extends from Lake Diefenbaker on the eastern boundary to the U.S. border on the southern boundary. In 2014, the covered population served was 56,517.

History: Has served 276 clients since January 1997

Location and Hours: Moose Jaw, Monday to Thursday, 8:00 am - 4:00 pm.
The position is designated 'Field' which allows for the flexibility of offering services outside of office hours, as required. Service is offered via a satellite office in Assiniboia the first Monday of each month.

Staffing: .8 FTE

Target Group: Individuals diagnosed with a moderate to severe brain injury with priority given to those within three years post injury. Clients must be willing to voluntarily participate in and benefit from services and be in need of specific supports and assistance to remain independent in their communities. Clients will not be excluded based on time since injury, age, or co-morbid/concurrent condition. Clients must be residents of Saskatchewan or eligible for Saskatchewan health coverage.

Partners: The Coordinator partners with a number of health and other human service professionals to link clients and assist them in achieving their goals. The Coordinator is involved in educating service providers throughout the service area regarding ABI and its effects and also works to increase awareness in at-risk populations around conditions that can cause brain injury.

Need met by the Program: The Coordinator acts as a link between survivors and services. The Coordinator works with individuals, families, caregivers, and other health care professionals in the Five Hills Health Region, to develop a realistic plan of support and rehabilitation for those impacted by ABI. The Coordinator provides follow-up, evaluation and education. The process is focused on assisting everyone to achieve their goals and optimal levels of functioning. Wherever possible, and in cooperation with the survivors and supporters, clients are connected with resources within their communities. The Coordinator cooperates with other agencies in the delivery of services for persons with ABI and their families throughout Saskatchewan.

Services / Activities:

- The ABI Coordinator works in partnership with clients, families, communities, and other health care professionals to enhance the rehabilitation and support services for persons with ABI and their caregivers
- One of the main roles of the ABI Coordinator is to assist clients and their support systems to identify, prioritize and plan client-driven, SMART goals.
- Acting primarily as a case manager / service navigator the ABI Coordinator provides:
    - **Direct-Client and Family Services:**
        - To provide support and education to survivors and families
        - To provide and direct persons to appropriate services

        - To assist the survivor to reintegrate into the community
    - **Support to Community/Education:**
        - To work with service providers to accommodate survivor's needs
        - To provide education to the community regarding ABI issues and prevention
        - To provide education and promote prevention of acquired brain injury

Intended Program Impact: Through support, education and linkage to community resources - to increase the community integration and overall quality of life of ABI survivors and their natural supporters.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • MVC – All Causes • Falls
Living Situation - Top 3	• Tied for 1st: Independent in own or family home, and Independent with difficulty • Supported requiring assistance
# of service events per client over the fiscal years/ average minutes per event	8 events / 70 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Case Management • Family Case Management • Administration
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Survivor & Family • Survivor & Other Service Provider
Community/E&P Topics - Top 3 (based on number of events, not time)	• Survivor/Family Support (Not Support Group) • Education on ABI • Support Group

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 43 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 71% were fully achieved and 20% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for one-third, or 33% of goals) were: "Employment", "Leisure Activities", and Transportation".

Outputs:

- Survivors/Natural Supporters - monthly newsletter, including calendar of events, regular group programming including monthly support groups in Moose Jaw and Assiniboia, consultations, 1:1 support
- Education to health and other human service professionals through various in-services (with topics such as general ABI education, seizures, behavior)

- Education to target groups (school-aged children) and the general public through: attendance at community events to increase ABI awareness and prevention on topics such as PARTY program, helmet use, Bike Rodeos, Scooter, ATV and farm safety; resource distribution on bike safety to libraries in several communities; ATV safety information packages to schools; and program promotion information to physicians' office and clinics

Evaluation: A combination of data collection methods were used between January 2014 and January 2015:

- **Client Chart Audit** - completed in February 2014 on each active client on caseload (44) – looked at the degree that goals guided service, where service referrals were indicated to assist with goal achievement and the outcome of the service referral.
    - Chart Audit revealed – 95% of charts (42 of 44) had goals listed; 90% had notes demonstrating a strong link between the goal and service and/or referrals of the ABI Coordinator; and 90% of charting (40 of 44) indicated referral follow-up by the Coordinator
- **Client experience survey** - completed in spring 2014 by mail-out (with pre-paid return) to 50 clients and their natural supporters, allowing eight weeks for survey return with reminders built in to that timeframe. Survey utilized a 4-point Likert scale, "Usually", "Sometimes", "Seldom", "Never", asking six questions about the ABI Coordinator's role in relation to: amount of contact with them, consideration of their needs and opinions, making them aware of and linking them to necessary services, ability to educate others professionals about their ABI and service needs and overall satisfaction with the service they provided them.
    - Client survey results, across all six questions, indicated that respondents had positive ratings about their relationship with the ABI Coordinator. The only question with a partial negative rating (2 of 26 or 8%) related to the Coordinator making client respondents aware of services that could help them.
- **Community partners survey** - mailed to 18 community partners who had worked with the Coordinator over the previous 24 months with 16 responses for an 89% response rate. Survey sought to determine partners' views of effectiveness of referrals and whether Coordinator follow-up was adequate.
    - Results indicated a high degree of satisfaction with the service coordination (referral, support and follow-up) received from the Coordinator.
- **Community education "ABI Behaviors" event survey** - 40 of 55 nurses (73%) who attended the workshop completed the survey providing very positive feedback about the content and delivery of the session. Qualitative responses indicated that the session enhanced participants' understanding of behavioural issues that individuals with brain injury face and provided helpful tips for working with ABI residents.
- **Client phone interviews** - Sixteen interviews were conducted (including one family member) to determine why individuals sought service, what aspects of the program have been helpful and ideas for program improvement.

Overall Results: The variety of data sources yielded positive quantitative and qualitative feedback regarding the program and its effect. In particular, phone interview results highlighted the benefits and enjoyment felt from group programming opportunities in addressing social isolation/loneliness, gaining from and supporting others, and helping to educate clients about their ABIs and, in turn, to better cope with the challenges that accompany their brain injuries.

Prairie North ABI Regional Coordinator

Program Description

Service Area: Based out of the Prairie North Health Region, serving an area of 29,951 sq. km. including the large centers of Lloydminster, North Battleford, and Meadow Lake. In 2014, the covered population served was 82,992.

History: Has served 199 ABI survivors since August 2005.
[Prior to 2005, ABI services to Prairie North Health Region were provided by the SK Central ABI Outreach Team (based out of Saskatoon Health Region). Originally based out of North Battleford, the position moved to Lloydminster in March 2013.]

Location and Hours: Lloydminster, Monday to Friday, 8:00 am - 4:30 pm

Staffing: 1 FTE

Target Group: The intended target groups for the ABI program are brain injury survivors with moderate to severe injury and their family / natural supports. Other groups who benefit from the ABI program include the community and other service providers via consultation or education services

Partners: The majority of partners are other health and human service professionals to which client referrals/linkages are made. The Coordinator also provides consultation support and education throughout the service area regarding ABI and its effects. Examples of referral partners include: therapists, physicians, rehabilitation facilities, NPs, social work, mental health, addictions, pharmacists, optometrists, dentists, SAID program, housing authorities, schools, other ABI funded agencies (LABIS, Pearl Manor).

Need met by the Program / Typical Client Goals:

Need for Client/Survivor Case Management: Through case management and service navigation the program offers **assistance and education** on how to access various services, including: the financial system, the medical system, housing, schooling, skills, employment, therapeutic activities **Impact:** The client or family will receive the supports that meet their needs and assist in achieving their goals.
Long Term Goal: The client achieves optimal level of functioning through connections with services and supports.

Need for Survivor/Family Support Groups: Survivors and families need to connect with others who have had experience with ABI, as well as learn about various brain injury topics through articles, video, discussion, or other methods. **Impact:** connecting with others who have suffered a brain injury, or with other caregivers of brain injury and by coming together to learn, share ideas and develop support networks leads to both improved knowledge and reduces isolation. **Long-term goal:** Survivors and families will feel less isolated by being part of a "community" of other survivors and caregivers. Those who no longer require the assistance of the ABI Coordinator will still feel like they have a support network to talk to and a safe place to continue their recovery.

Typical Client Goals: The target group has a variety of needs. For clients and families, it is often **assistance or education on how to access various services**. Some of these services may include:

- **The financial system** - Social assistance, Saskatchewan Assured Income for Disability (SAID), Canada Pension Plan for disabilities, Disability tax credit, the banking system, supplementary health prescription coverage, etc.

- **The medical system -** interpreting medical language, encouraging and/or assisting with booking appointments, placement on waitlists for services, correspondence on client's behalf, determining what services are available (e.g., addictions counselling in rural areas).

- **Housing** - accessing and/or applying for housing, rental income assistance, storage in the event of eviction, change of address, etc.

- **Schooling -** assisting in determining available schooling options, applications, accessing academic counsellors, retrieving high school transcripts, connecting with school services (e.g., Special education teachers)

- **Skills -** assisting with money management, (e.g., creating a budget and envelope for receipts), self care routine, family relationships, etc.

- **Employment** - linking clients with job postings, resume assistance, volunteering experience

- **Therapeutic Activities -** physical therapy intervention (e.g., balance exercises, strengthening, etc.)

Service Activities:

- **Goal setting:** Early on in the relationship, a discussion about goals occurs (as guided by the MPAI-4 version of the goal attainment form). This form is filled out and periodically reviewed to stay on track and is modified as needed.

- **Skills training:** based on an assessment of needs, some skill training occurs. An example would be money management. In subsequent visits this will be reviewed to determine the progress or success of the client. For example, were they able to retain receipts in an envelope, were they able to stick to their budget, what are the challenges, etc.

- **Information gathering:** For example, clients looking to return to school, information regarding what prerequisites are needed for various programs, comparing with the client's previous education, program options, etc. An example would be exploring Welding programs at college.

- **Service coordination**: Recognizing that some survivors aren't able to advocate for themselves in certain areas, it is at times necessary to advocate on behalf of the client. An example is ensuring other health services are sought, such as speech language pathology. This may involve getting the client on the appropriate waitlist and inquiring about follow up appointments.

- **Support groups:**

    - North Battleford: the "New Beginnings" Support Group (Survivor/Family) runs every 2 weeks from September to the end of June from 6:00 pm - 7:30 pm. The meeting starts with

introductions (for the benefit of new members) and people go around and tell however much of their "story" that they are comfortable with sharing. Ground rules emphasize confidentiality and work is done to build trust within the group. Early on in the gathering an article is read out or a video is shown that pertains to brain injury. Some examples are: Anxiety management, Getting overloaded, Problems getting organized, Anger and depression, Sleep disorders, Fatigue, etc. These are generally well received and generate great discussion following. Sometimes the topic and discussion fill the evening's agenda. Other times the topic and discussion wraps up and there is opportunity for a general visit which is just as beneficial to group members.

  - Meadow Lake: a support group was started in November 2013 jointly delivered with Multiworks staff. It runs one evening a month from 6:00 pm - 7:30 pm. Multiworks arranges the meeting room, does phone call reminders to clients and provides coffee and snacks at the meeting. The ABI Coordinator leads the group. The format runs the same as in North Battleford. Boundaries of confidentiality and respect are established, people introduce themselves and tell their stories, the facilitator leads a topic and the group discusses it and, if time permits, have an open visit. As in North Battleford, the atmosphere is welcoming, friendly and informal.

- **Education:** Clients or families are sometimes interested in the type of brain damage sustained, where it is in the brain, and what the expected effects may be. Often the behaviours exhibited by the survivor are more easily understood once they are attributed to the brain injury location.

- **Reassurance:** Often, it is welcomed relief for a client to be able to visit with someone who won't judge them, and who will listen to their concerns. It is sometimes a lonely adjustment to surviving a brain injury.

Intended Program Impact:

- Clients and families: education, links to further services, reassurance
- Helping clients meet their goals
- Empower clients to stay in community, take on previous role(s) if possible, e.g., parent, work, or school
- Maximize independence, function, happiness, and potential of brain injury survivors

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • MVC – All Causes • Falls
Living Situation - Top 3	• Independent with difficulty • Supported requiring assistance • Supported with limited assistance

# of service events per client over the fiscal years/ average minutes per event	17 events / 44 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Case Management • Family Case Management • Residential Services
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Tied for 2nd: Other Service Provider, and Survivor & Family
Community/E&P Topics - Top 3 (based on number of events, not time)	• Support Group • Therapeutic Activities Group • Survivor/Family Support (Not Support Group)

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 18 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 76% were fully achieved and 17% were partially achieved. Including withdrawn goals, the top 3 goal areas (accounting for 42% of goals) were: "Physical", "Community Involvement/Groups" and "Home Management".

Outputs: Two Support Groups are regularly facilitated by the program:

- North Battleford, survivor/family group, runs bi-weekly between September and June
- Meadow Lake, survivor/family group, runs monthly (jointly run by Multiworks and the Prairie North Coordinator).

Program Evaluation: Results were obtained through **client/survivor survey questionnaires** (n=13/14, 93% response rate), a **family survey** (n=8/10, 80% response rate), **support group survey** (one-time in both North Battleford and Meadow Lake), and a **case example**.

Quantitative results were tabulated and a summary was provided of client, family and support group surveys' qualitative responses.

Client and Family Survey questionnaires both used a 4-point Likert scale measuring agreement with six statements regarding the Coordinator with possible responses being: 'Usually', 'Sometimes', 'Seldom' and 'Never'. These statements sought to determine clients' views about the Coordinator's role in terms of: 1) accessibility (amount of contact they had with them); 2) making sure the client's needs were understood; 3) making client aware of other services to help them; 4) helping client connect to needed services; 5) helping other service providers in understanding ABI clients' needs; and
6) overall satisfaction with the Coordinator's services.

Quantitative responses were in the positive range across all six questions asked.

One client's qualitative response illustrates the positive impact of the Coordinator's role:

"(The ABI Coordinator) does an excellent job of promoting well-being and assisting a person in choosing a plan that supports their needs. She is knowledgeable and compassionate, she does a good job of keeping discussions relevant and timely and knows when its [sic] time to move on! Good work"

Family survey – while responses were also mostly positive for the sample of family surveyed, their quantitative responses indicated that family members might benefit from a more direct service approach. For example, 38% (3 of 8 respondents) indicated the Coordinator 'seldom' connected them to the services they needed, and also indicated that the Coordinator 'seldom' helped other service providers understand their personal needs.

The Regional Coordinator acknowledged this family feedback and viewed it as an opportunity to target some future program improvements in better addressing these family needs.

The **Case Example** provided was of a 53 year-old male, injured in a motor vehicle collision (MVC). This case example was provided to illustrate the types of services the program provides: 1) goal-setting, 2) SGI PIR liaison, 3) help with appointments for optometrist, dentist, physiotherapist, 4) direct physical therapy provided for balance, 5) help with moving (securing storage), 6) encourage housing applications, 6) help to find a family physician and provide background information to them, 7) provide CPP forms, and 8) offered client referral for mental health counselling (declined).

The **Support Group surveys** were handed out after one session at both the North Battleford (n=5) and Meadow Lake Support Group (n=4). An 11-point Likert scale measuring satisfaction with the support groups ranging from '0' being 'not happy at all' and '10' being 'very satisfied'. There were small sample sizes, but the responses were positive in terms of respondents' enjoyment of the group and the discussion topics, convenience of location and opportunity to meet with other survivors. Three open-ended questions ended the survey, asking: 1) Is there anything you would change?, 2) What is something positive about the group?, and 3) What topics would you like to see? Comments regarding support groups related to the benefit of meeting with other survivors and the topics addressed.

Overall, from all of the data sources, the survivor and family feedback was positive – supporting that the program is valued and meeting needs.

Sunrise ABI Regional Coordinator

Program Description

Service Area: Based out of the Sunrise Health Region, serving east-central Saskatchewan. The region covers approximately 25,000 sq. km. In 2014, the covered population served was 59,551.

History: Has served 298 ABI survivors since October 1996

Location and Hours: Yorkton, Monday to Friday, 8:00 am - 4:30 pm

Target Group: The Coordinator serves individuals with traumatic, pathological and chronic brain injuries. The program focuses on serving individuals injured less than 3 years ago, with moderate to severe injuries, and in need of specific supports and assistance to remain independent in their communities. Clients are not excluded based on time since injury, age, or co-morbid/concurrent condition.

Partners: The Coordinator partners with a number of health and other human service professionals to link clients and assist them in achieving their goals. The Coordinator is involved in educating service providers throughout the service area regarding ABI and its effects and also works to increase awareness in at-risk populations (children/youth, for example through PARTY) around conditions that can cause brain injury. Examples of partners include: for referrals - local ABI funded agencies (SIGN, Sask Abilities Yorkton), Partners in Employment, Therapy Services, Social Services (SAID, Cognitive Disability Strategy) , Home Care, Day Programs, and for prevention - PARTY partners: RCMP, EMS, Fire, volunteer services, funeral services, acute care staff, school divisions.

Need met by the Program / Typical Client Goals: Typical client goals include therapy (occupational therapy, physical therapy, and speech language pathology), financial, housing, and driving.

Program Activities: Direct client support via home visits, education and informal counseling services by the ABI Coordinator, programming planning to determine what type of activities/therapies would best assist the client's deficits and goal, service provision through consultation and education to community agencies and referrals, case conferencing on a monthly basis with local ABI service providers to assure the program developed is working.

- Consultation/coordination/collaboration/linkages
- Education - client, family, community, provider
- Social Programs
- Support Groups
- Life Skills/Enrichment
- Prevention and Community Awareness

Outputs:

- Support Groups – held monthly on a rotational basis between communities of Yorkton, Melville, Canora, Kamsack, Preeceville and Verigin
- PARTY – Regional Coordinator (Sunrise Health Region) holds the license, so is responsible for event administration - 7 events held; 248 Grade 10 students attended.

- Education Sessions – e.g., Linda Harrison Workshop "Promoting Independence Through Skills Teaching" - broadcast via telehealth on May 31, 2013 with good provincial uptake across health regions.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • MVC – All Causes • Tumour
Living Situation - Top 3	• Independent in own or family home • Independent with difficulty • Supported requiring assistance
# of service events per client over the fiscal years/ average minutes per event	26 events / 43 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Case Management • Support Group • Consultation/Education/Training
Recipients – Top 3 (based on number of events, not time)	• Partnership Service Provider • Individual (Survivor) • Other Service Provider
Community/E&P Topics - Top 3 (based on number of events, not time)	• PARTY • Support Group • Survivor/Family Support (Not Support Group)

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 27 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 74% were fully achieved, and 22% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for 22% of goals) were: "Attention/Concentration", "Memory" and "Physical".

Program Evaluation: A central evaluation question was, "Are clients connecting to the services they require to meet their goals?"

In addition to the administration of survey instruments to clients and their families as well as community service partners, client data utilized to evaluate services included: case examples, client file audits, goal attainment, MPAI-4, ABIIS-individual and group service event tracking, client monthly attendance, and ABI support group evaluations.

Three (3) case examples were provided to illustrate the role of the ABI Program Coordinator in facilitating improvement in quality of life for clients, present examples of individual client needs and the goals taken in addressing them. They portray a snapshot of clients' lives, the struggles they face and their successes. The

three case examples effectively demonstrated goal-setting and the overall process the ABI Coordinator takes in client work.

The **Client Satisfaction Survey** (administered to both survivors and families) had two samples – in January 2014, 36 of 51 active clients (response rate of 71%) were surveyed via phone by social work practicum students (to both survivors and family members), and in January 2015 another survey was conducted by phone by Cornerstone Therapies Administrative staff (n=30 with 23 being survivors and 7 being family members). Overall agreement was seen across all six questions asked, with slight improvement in agreement scores seen between January 2014 (Time 1) and January 2015 (Time 2) regarding frequency of contact with the Coordinator. At Time 1, 78% 'usually' felt the contact with the Coordinator was 'to their liking' compared to 91% of respondents at Time 2. **Note:** these are not the same respondents at these two time intervals. Overall satisfaction remained high between Time 1 and Time 2 at 94% satisfaction with the ABI Coordinator's services.

The **Family Satisfaction Survey** (sub-set of client survey in January 2015) had seven family respondents. There was overall agreement across the six questions asked. However, 14% responded negatively on two of the six questions. The first question related to being heard, understood and supported; and the second related to overall satisfaction with the Coordinator's services.

In order to improve the program, opinions were sought in relation to respective organizations' involvement with the ABI Coordinator. The **Community Partners Survey** was given to 18 partners, 9 of which responded for a 50% response rate in both January 2014 and January 2015. The survey utilized a 5-point Likert scale measuring agreement with 6 statements regarding their involvement with the ABI Coordinator re: living up to mandate (to achieve successful community re-integration and quality of life for ABI survivors, their families and communities), appropriateness of referral, follow-up communication, understanding of client needs, and future collaboration. The scale ranged from: "Not at All" to "Very Much". Improvement was seen between January 2014 and January 2015 survey timeframes.

For example, in January 2014, while there was general agreement with the statement, only 44.4% of respondents "***very much*** agreed" that they would collaborate with the ABI Coordinator again with future clients compared to 100% of respondents in January 2015.

PARTY evaluations were conducted after each of seven (7) PARTY sessions, yielding good qualitative information regarding the knowledge gained by participants. When asked, "what was the most effective part of the day?", the top two (most reported) themes related to listening to the survivor stories and viewing the mock crash scene.

Support Group surveys: 72 surveys/97 participants (74% response rate) over 7 events. Thirty-four of the 97 respondents (35%) were family/natural supporters. This survey had:

- Four closed questions asked using a 11-point Likert scale measuring satisfaction with the support groups with '0' being 'not happy at all' and '10' being 'very satisfied'
- Three open-ended questions: 1) Is there anything you would change?; 2) What is something positive about the group?; and 3) What topics would you like to see?

Quantitative results positively rated the support groups regarding participants' overall enjoyment, interaction with peer survivors, location and topic areas covered.

The chance to share stories and hear similar struggles and success was highlighted in qualitative responses as beneficial by several participants.

Summary: the various data reveal that the program is having a positive impact – it is meeting the needs of clients and their families and they are feeling respected and supported.

Sun Country ABI Regional Coordinator

Program Description

Service Area: Sun Country Health Region (SCHR) covers the southeast portion of Saskatchewan, from the Manitoba border in the east to the U.S. border in the south. The Region covers 33,239 square kilometers. SCHR operates 28 facilities and 40 community-based health programs, with 2,400 staff members. In 2014, the covered population served was 59,984.

History: Has served 281 ABI survivors since January 1997. [Note: total clients is additive based on 185 clients seen by this program and 96 registered with a previously funded Coordinator (Estevan) also responsible for service within Sun Country Health Region]

Location and Hours: Weyburn, Monday to Friday, 8:00 am - 4:30 pm

Staffing: 1 FTE

Target Group: The Coordinator serves individuals with traumatic, pathological and chronic brain injuries. The program will focus on serving individuals injured less than 3 years ago, with moderate to severe injuries, and in need of specific supports and assistance to remain independent in their communities. Clients will not be excluded based on time since injury, age, or co-morbid/concurrent condition. The Coordinator will additionally provide consultation and education services regarding ABI and related topics to other community members and health services as the need arises.

Partners: The Coordinator partners with a number of health and other human service professionals to link clients and assist them in achieving their goals. The Coordinator is involved in educating service providers throughout the service area regarding ABI and its effects and also works to increase awareness in at-risk populations and around conditions that can cause brain injury.

Referrals: clients are typically referred to the program from the South Sask ABI Outreach Team, survivors or their family members or other healthcare professional within Sun Country Health Region such as PT, OT, SLP, Home Care, local hospital Social Worker, Mental Health Services and Family Physicians.

Service Description: Most client services are provided in the client's home. Where safety is a concern the Coordinator meets with the client in an alternate, public location. Client visits average 60–90 minutes, once or twice a month, dependent on client needs. Family members may or may not be present during the home visit depending on what works best for the client. Support groups are another opportunity for the coordinator to "touch base" with clients monthly to see if additional visits are required to address any new concerns or issues that may have arisen in the client's life.

Intake Process: After an appropriate referral to the ABI Program is received, the Coordinator initiates contact with the client within one working week. The intake form is completed within 6-8 weeks after the first contact with the client. The client/caregiver is provided with educational information, and initial client-centred goals, and necessary actions to meet goals are determined.

When the coordinator first meets with a client, rapport building is the primary concern. The coordinator explains her role and that the program's services are voluntary.

During the first visit the Coordinator writes very little down, wanting the client to feel as comfortable as possible. Answers to questions on the intake assessment are written down after the appointment. At the second visit the Coordinator brings out the assessment form to complete with the client. This assessment helps the clients to build some goals if they are in need of suggestions/guidance.

Major Roles:

- Provide support and education to survivors and families and community to promote prevention of acquired brain injury within Sun Country Health Region.
- To assist the survivor to reintegrate into the community and promote successful community reintegration.
- To provide and direct persons to appropriate services and to be an ongoing contact for support, follow-up, evaluation, and education.
- Work with service providers to adapt services to accommodate survivor's needs
- Improve the quality of life for a person with an acquired brain injury;
- Work in partnership with clients, families, communities, and other health care professionals to enhance the rehabilitation and support services for persons with ABI and their caregivers.

Typical Goals: The Coordinator works with clients in a goal-directed way, setting up and measuring goals utilizing SMART principles. Examples of types of goals worked on include: assistance with return to driving or finding other means of transportation, memory/attention, communication, managing finances, social participation and support, navigating the medical system, physical recovery, and finding/maintaining independent living/housing.

Intended Program Impact: Works together with survivors to maximize their abilities, achieve their desired potential and to obtain the highest achievable level of independence and quality of life.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • MVC – All Causes • Aneurysm
Living Situation - Top 3	• Independent in own or family home • Independent with difficulty • Supported in own or family home
# of service events per client over the fiscal years/ average minutes per event	10 events / 66 minutes each

Client Activities - Top 3 (based on number of events, not time)	• Case Management • Support Groups • Psychosocial Services
Recipients – Top 3 (based on number of events, not time)	• Individual Survivor • Group of Survivors • Survivor and Family
Community/E&P Topics - Top 3 (based on number of events, not time)	• Brain Walk • Support Groups • Education on ABI

2013-15 PROGRAM EVALUATION RESULTS

Goal Attainment: Goals were submitted for 23 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 89% were fully achieved, and 11% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for one-third, or 34% of goals) were: "Understanding ABI", "Transportation" and "Leisure Activities".

Outputs: Support Groups and ABI in-services given to Long-term Care staff and Weyburn Primary Healthcare Centre staff.

Program Evaluation: Information used to evaluate the program included: goal attainment by case vignette, a client experience survey, and a Support Group survey

Goal Attainment – a description of the goal-setting steps and case examples of how the Coordinator works with clients to achieve goals was provided.

The **Client Experience Survey** was mailed out on Feb 14, 2014 to 30 Survivors, 11 of which were completed and returned by April 10, 2014 (37% response rate). The survey questionnaire used a 4-point Likert scale measuring agreement with six statements regarding the Coordinator with possible ratings being: 'Usually', 'Sometimes', 'Seldom' and 'Never'. These statements sought to determine clients' views about the Coordinator's role in terms of: 1) accessibility (amount of contact they had with them), 2) making sure the client's needs were understood; 3) making the client aware of other services to help them; 4) helping client connect to needed services; 5) helping other service providers in understanding ABI clients' needs; and 6) overall satisfaction with the Coordinator's services.

Responses to the Client Experience survey were positive with 91-100% of respondents giving maximum, positive ratings across all six questions asked.

Support Group Survey – was distributed at groups between January and March 2014 with 27 respondents (including both clients and families) over six sessions. 11-point Likert scale was used measuring satisfaction with the support groups with '0' being 'not happy at all' and '10' being 'very satisfied'. All responses were positive across four questions asked gauging enjoyment of…the group overall, meeting with other survivors, the topics presented and the convenience of location. Respectively, average responses (out of 11) were: 8.8, 9.3, 8.9 and 9.0.

The Coordinator summarized the Support Group questionnaire qualitative feedback as follows: *Clients enjoy the interaction with others and feel less isolated when attending support group. Clients have expressed that*

they are able to get ideas about how to deal with stresses related to their brain injury because of the professional, person and group experience. They appreciate being able to open up and share their feelings and learn to accept what is different in their lives and try to improve things that are in their own control.

The Coordinator continually evaluates support group locations based on client distance to them and their interest to attend.

Overall Results: Overall, the evaluation results were positive. In summary, the Coordinator stated that clients appreciate the Coordinator's services, in particular, education on available services and referrals to those services as needed. In working with the Coordinator, clients expressed that they felt heard, understood, supported, and respected.

Day Programming (5 Programs)

SARBI (Saskatoon, Regina, and Kelvington), LABIS (Lloydminster) and Sherbrooke Community Center "Moving On" (Saskatoon)

Lloydminster and Area Brain Injury Society (LABIS)

Program Description

Service Area: 100-mile radius of Lloydminster

History: Has served 65 ABI Survivors since 1996

Location and Hours: Lloydminster, Monday, Wednesday and Thursday, 10:00 am – 4:00 pm

Staffing: 4 paid and 10 volunteer staff – the ABI Partnership funds 1 FTE:

- 1 full-time Executive Director
- 1 part-time Program Coordinator
- 2 paid program staff (50 hours/week to deliver LEP program)
- 10 volunteers (working approximately 2,169 hours/year)

Target Group: ABI survivors who are unable to go back to work who need Life Enrichment programming.

Partners: LABIS accepts referrals from a variety of community agencies (e.g., Home Care, Lloydminster men's shelter, Strides), and works in partnership with a number of agencies in Lloydminster.

Need met by the Program: There is a community need for Life Enrichment programming for ABI survivors as many do not have a means of transportation to larger communities. Many people who have acquired a brain injury become isolated after their rehabilitation treatment. They are often unable to go back to work and lose contact with colleagues and friends. Compounding the problem, many survivors experience deficits to their communication abilities, memory, and their ability to manage their emotions and behaviors. LABIS programming addresses these deficits in a number of ways through individual and group programming. LABIS also provides respite to caregivers (18 hours/week of free respite).

Typical Client Goals:

- Memory
- Communication/Language Skills
- Social Skills
- Stress Management
- Independence

Services / Activities: The life enrichment program offers leisure, recreational and social activities for ABI survivors.

Monday & Wednesday Group: includes ABI survivors who are more physically and cognitively dependent. Activities are geared towards helping participants maintain their current level of function as improvement is

unlikely. Some of the participants from the higher cognitive level group (Thursday's group) attend this day to help out.

Thursday Group: This group is for higher cognitive and physical levels (determined using MPAI-4, and by intake interview with clients and their families). These individuals often form friendships and socialize outside of the program, and are the individuals most likely to become active again in the community. The Thursday group also volunteers at the Second Chance Clothing Store two hours a month (LABIS' used clothing store that began in 2011).

Example activities (applying to all program days) include: discussing current news and weather, mental activities such as word searches, Sudoku, and picture puzzles, sharing short stories, and regular exercise. During activities, program staff help clients work on communication skills, memory skills, anger management, and other emotional/behavioural/cognitive skills needed for community reintegration.

Intended Program Impact: LABIS expects that if clients attend their program regularly, they will: practice communicating and build relationships, increase their self-esteem and well-being, develop interpersonal and group skills, and eventually become more independent in their community interactions. This will lead clients to become less isolated.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • Anoxia • Encephalitis/Meningitis
Living Situation - Top 3	• Independent in own or family home • Long Term Care Facility • Personal Care Home
# of service events per client over the fiscal years/ average minutes per event	91 events / 273 minutes each
Client Activities - Top 3 (based on number of events, not time)	All Recreation Therapy Interventions
Recipients – Top 3 (based on number of events, not time)	• Group (of survivors) • Individual (Survivor)
Community/E&P Topics – Top 3 (based on number of events, not time)	None

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 7 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 36% were fully achieved, and 34% were partially achieved. LABIS recorded goals evenly across the goal areas where each accounted for 2-3% of the total. As such, there are no "top goal areas" to report.

Evaluation: LABIS tracked client work on goals for the 2013-15 site level evaluation for all of their active clients. High levels of full to partial achievement were seen in most areas. Levels of full to partial achievement for goal areas were: 74% for Effective Speaking, 70% for improved self-esteem, 56% for communication skills, 63% for interpersonal skills, 54% for listening skills, 67% for social skills, and 74% for fine motor skills.

Less success was seen in the areas of decision making (47% not achieved), problem solving (33% not achieved), and time management (35% not achieved).

Clients, families and caregivers (15 respondents) were also asked about goal achievement via a survey, and each rated goal areas on a 5-point scale (1 being poorest, and 5 being the best). The percentage of respondents indicating either a 4 or 5 per area were: 35% for memory recall, communication skills, and social skills, 40% for improved stress management, and 46% for good improvement of clients' independence.

SK Association for the Rehabilitation of the Brain Injured (SARBI) – Saskatoon & Regina

Program Description

Service Area: Saskatoon and area; Regina and Area

History: SARBI Saskatoon has served 97 ABI survivors since 1996; SARBI Regina has served 68 ABI survivors since 2003.

Location and Hours: SARBI Saskatoon runs Monday to Friday, 8:30 to 3:30pm. Regina SARBI runs five mornings and one afternoon per week in a scheduled, non-drop-in manner.

Staffing: The ABI Partnership funds 1.5 FTEs in Saskatoon; and 1.5 FTEs in Regina.

Target Group: ABI Survivors in need of psychosocial rehabilitation opportunities

Saskatoon Partners: SARBI Saskatoon shares some clients and programming with the Central Outreach Team and the Saskatoon Chapter of SBIA. Volunteers come from academic institutions (University of Saskatchewan's School of Nursing and School of Public Health and Public Policy; McKay School of Massage Therapy), and the Church of Jesus Christ of Latter Day Saints.

Regina Partners: SARBI Regina partners with St James United Church (which is the program's location), and the South Outreach Team (source of referrals and shared clients).

Need met by the Program / Typical Client Goals: Following brain injury, some ABI survivors need to relearn social and community skills. They are often isolated and require a program that will motivate them to leave home. SARBI meets the long-term rehabilitation needs of survivors of moderate to severe acquired brain injuries through individualized, client-centered programs within an encouraging, caring environment. The program objectives include establishing an association of volunteers and individuals interested in assisting people with brain injuries, to provide support for ABI clients and families, to support and facilitate the reintegration of brain injured individuals into the community or into other appropriate programs. The main goal areas are:

- **Psychosocial Rehabilitation**: providing social activities to aid in rehabilitation by providing opportunities to practice appropriate behaviours in public settings.
- **Recreational Work**: gives opportunities to clients to go out in public and take part in recreational activities.

Services / Activities: SARBI originally developed as a physical rehabilitation program, and in 2005 switched focus to psychosocial rehabilitation which promotes self-recovery, successful societal integration and satisfactory quality of life. Typical activities include: games, arts and crafts, yoga sessions, swimming, bowling, movies, festivals, and social outings. SARBI's main focus is on rehabilitation and includes life enrichment and day programming, which is conducted by volunteers.

Intended Program Impact: Anticipated short-term outcomes include: learning how to communicate and have an increased awareness of community events; increased motivation to perform neuromuscular movements and brain stimulating activities; and learning daily routines by having a scheduled day with other ABI survivors.

These short term outcomes are expected to lead to other improvements including: appropriate behaviours in social settings; more interaction and involvement with the community and the surrounding environment; engagement in physical activities and exercise; and increased self-sufficiency.

The ultimate intended program impact is better quality of life.

SASKATOON SARBI SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• MVC – All Causes • Stroke • Anoxia
Living Situation - Top 3	• Independent in own or family home • Personal Care Home • Long Term Care Facility
# of service events per client over the fiscal years/ average minutes per event	114 events / 223 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Psycho-Social Services • Case Management • Family Case Management
Recipients – Top 3 (based on number of events, not time)	• Group (of survivors) • Individual (survivor) • Family/Natural Supports
Community/E&P Topics -Top 3 (based on number of events, not time)	• Education on ABI • Support Group • Survivor/Family Support (Not Support Group)

REGINA SARBI SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• MVC – All Causes • Stroke • Tumour
Living Situation - Top 3	• Long Term Care Facility • Tied for 2nd: Supported requiring assistance, and Supported with limited assistance
# of service events per client over the fiscal years/ average minutes per event	102 events / 128 minutes
Client Activities - Top 3 (based on number of events, not time)	• Psycho-Social Services • Case Management • Family Case Management
Recipients – Top 3 (based on number of events, not time)	• Group (of survivors) • Individual (survivor) • Survivor & Family
Community/E&P Topics -Top 3 (based on number of events, not time)	• Support Group • Recreation/Leisure (not Camp/Retreat

2013-15 PROGRAM EVALUTION RESULTS

Saskatoon Goal Attainment: Goals were submitted for 4 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 0% were fully achieved, and 74% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for two-thirds, or 66% of goals) were: "Relationships with Others", "Behaviour Management" and "Anger Management".

Regina Goal Attainment: Goals were submitted for 9 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 48% were fully achieved, and 16% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for three quarters, or 76% of goals) were: "Community Involvement/Groups", "Relationships with Others" and "Behaviour Management".

Site Level Evaluation: From the fall of 2013 to 2014, SARBI Saskatoon had four different groups of students from the University of Saskatchewan's School of Public Health and Public Policy work on their site level evaluation. These students conducted a literature review, created an evaluation tool, and surveyed a sample of SARBI clients. SARBI staff (both Regina and Saskatoon) used the same tool to survey clients, families and caregivers in January 2015.

Saskatoon SARBI

- One of the student evaluations was completed in the Spring of 2014, and had 15 respondents and a 56% response rate. The study found that clients had a 93% satisfaction rating with SARBI based on four Likert questions (e.g., "I feel excited about coming to SARBI" and "I feel like I have made improvements/advancements since coming to SARBI"). All but one respondent considered SARBI and the SARBI team and members to be a family or second family. Many respondents indicated that SARBI had helped them develop relationships, allowed them to become more open with their feelings, improve their communication skills, and taught them to be more patient with others.

- Another student evaluation completed in 2014 surveyed caregivers (14 respondents). On a 6-point Likert scale (from least to most agreement), most respondents indicated (by indicating a rating of 4-6) that their loved one:
    - improved their attitude as a result of their attendance at SARBI – 79%
    - improved their behavior – 64%
    - improved in independence - 43%

- In the January 2015 survey, SARBI participants were surveyed in person (9 respondents).The questionnaire was qualitative in design. Highlights include:
    - 66% felt more comfortable in social settings than prior to SARBI attendance
    - 66% noticed an improvement in memory than prior to SARBI
    - 78% felt that the program helped improve their relationships with friends and family
    - 78% felt that SARBI participation increased their self-esteem

Site Level Evaluation - Regina: Highlights of the January 2015 in-person survey of 21 Regina SARBI participants (11 caregiver and 11 SARBI participants) include:

- 71% felt more comfortable in social settings than prior to SARBI attendance
- 42% of SARBI clients noticed an improvement in memory than prior to SARBI
- 79% felt the program helped improve their relationships with friends and family
- 86% felt that SARBI participation increased their self-esteem

Conclusion: Based on the results, it was concluded that SARBI's psychosocial rehabilitation and recreation programs for ABI survivors were effective and beneficial in terms of enabling and assisting ABI survivors with re-entry into the social world and providing support to their family members.

East Central SARBI

Program Description

Service Area: Serves ABI survivors living within 100 km of Kelvington

History: Has served 86 ABI survivors since 2003

Location and Hours: Located in Kelvington, the agency's general hours of operation are 8:45 am to 3:15 pm on Monday to Thursday, and on Friday from 8:45 am to 11:45 am.

Staffing: 2 FTEs

Target Group: Survivors of ABI who are 16 years or older who can arrange for travel to the EC SARBI facility.

Partners: East Central SARBI receives professional services and referrals from Kelsey Trail Health Region, SK North Outreach Team, and the Yorkton ABI Coordinator. East Central SARBI also receives mentorship and educational opportunities from the ABI Partnership, SARBI Saskatoon, and the SK Central Outreach Team. Fundraising and promotion assistance are received from East Central Co-op, the Kelvington interagency group, and Kelvington golf club.

Need met by the Program: Prior to 2003, there was a lack of services for ABI survivors in the area. East Central SARBI's mission is to improve the quality of life of individuals who have sustained an ABI through individually designed rehabilitation programs in a safe and caring environment.

Clients: Often, clients need to strengthen muscles, stamina, balance and small motor movements and coordination through carrying out physical therapy plans. They also need to improve functional ability, motivation, and enjoyment of life by engaging in cognitive and social activities.

Community: East Central SARBI also provides information to the community and surrounding areas. The intended outcome is to increase understanding of ABI leading to a greater acceptance of ABI survivors and their needs when out in community. In addition, community members will be more attentive to safety precautions to prevent injuries from occurring.

Families: East Central SARBI provides support to families. Each family member is provided information regarding client care and brain injury, information on expectations, tools, and methods of delivery of rehabilitative services, and encouraged to engage in self-care. The intended program impact is that families will be more comfortable with survivor needs, and that they'll be able to handle their interactions with the ABI survivor in a confident and knowledgeable way, and will have decreased levels of stress.

Services / Activities: East Central SARBI coordinates appointments with therapists from the clients' home health region or from visiting therapists (Kelsey Trail, North Outreach) who assess client needs and develop programs of rehabilitation activities. These programs are then carried out by East Central SARBI (staff and volunteers). Clients attend as frequently as they need or can (daily to once a week). Each client program is reviewed by an occupational therapist and speech language pathologist every three months on average. Clients work on:

- **Functional mobility** using the exercise area with various equipment (e.g., exercise beds, multi-gym work station, stationary cycles, weighted and passive pulley systems, parallel bars, treadmill and LiteGait harness, stairs, stability balls, thera-putty, therabands, weights and balance boards.
- **Cognitive Skills** through exercises to improve attention, memory, language, reasoning, problem solving and decision making. Example exercises include: memory games, puzzles, reading a short paragraph then answering questions, naming objects, reciting numbers, filling in blanks, and completing sentences.
- **Social Skills and Quality of Life** through recreational and leisure activities such as Wii gaming, coffee group outings, bowling, playing cards, doing jigsaw puzzles, crossword puzzles, reading, art and craft classes, musical entertainment, attending plays and cultural events, and learning new skills that the client is interested in.
- **Life skills** in the fully appointed kitchen when applicable.

Intended Program Impact: For the client to have improved physical abilities (strength and mobility), feel included/sense of belonging, decreased feelings of isolation/loneliness, and increased feelings of motivation to work towards their goals.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • MVC – All Causes • There are four additional causes each accounting for one client
Living Situation - Top 3	• Independent in own or family home • Independent with difficulty • There are six additional living situations each accounting for 1-2 clients.
# of service events per client over the fiscal years/ average minutes per event	141 events / 70 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Recreation & Leisure Activities • Physical Therapy Interventions • Administration
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Other Group (mixed) • Family/Natural Supports
Community/E&P Topics -Top 3 (based on number of events, not time)	• Recreation/Leisure (not Camp/Retreat) • Education on ABI • PARTY

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 6 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 47% were fully achieved and 43% were partially achieved. Including withdrawn goals, there were four top goal areas each accounting for the same percentage of total goals, and accounting for half of goals overall: “Community Involvement/Groups”, “Leisure Activities”, “Physical”, and “Understanding ABI”.

Evaluation: positive feedback was received via questionnaire (handed out to 10 clients, 7 responded), and informal interviews with families and staff (4 families, 5 staff and volunteers). Highlights include:

- All clients indicated that their goals were moving them in the right direction
- All clients indicated that East Central SARBI was beneficial to them
- The majority of respondents answered that the program was friendly, supportive, helpful, that staff were competent to address their needs, and that the format of their therapy program was very well suited to meet their needs
- Six of the seven clients indicated their ultimate goal remained the same
- Ratings from the four family members were all very positive, with families indicating:
    - East Central SARBI’s accessibility and supportiveness
    - 75% of families indicated they would not have been able to drive to the city for therapy, and greatly appreciated a program close to home
- An informal interview of five staff and volunteers highlighted some areas for improvement

Sherbrooke Community Centre "Moving On" Program

Program Description

Service Area: Within the Saskatoon Heath Region, the "Moving On" Program assists survivors of acquired brain injury (ABI) to develop psychosocial and independent living skills. These skills help provide life enrichment and enable access to community resources.

History: Has served 73 ABI survivors since 2000.

Location and Hours: The "**Moving On"** Program occurs twice a week, on Tuesdays and Thursdays from 4:00 - 8:00 pm in the Tawaw Centre at Sherbrooke Community Centre in Saskatoon.

Staffing: The partnership dollars are used for .7 FTE

Target Group: Clients who have previously undergone assessment and case management by the SK Central ABI Outreach Team and have a need to develop their life enrichment or activities of daily living.

Partners: The Central ABI Outreach Team is the main service partner for the "Moving On" program. They provide referrals for prospective clients, attend quarterly client reviews, and support/assistance for "Moving On" staff. The program commonly links clients with community agencies such as the City of Saskatoon's public libraries, leisure centers and other services. "Moving On" clients have opportunities to learn about and tour agencies such as Partners in Employment, SARBI, SBIA or Crocus Coop.

Need met by the Program / Typical Client Goals: The "Moving On" Program was funded to fill the gap in programming for ABI survivors who were unable to undertake competitive employment, but were perceived to have the capacity to reintegrate into their community with improvement in their independence and social skills. This program helps clients who are motivated to make changes and use self-directed goals to increase their independence.

The "Moving On" program uses a standard set of nine goals of which clients work on three to four. If achieved, these goals would facilitate community integration. The nine goals are: compensatory strategies to facilitate communication, social skills from onset of injury, basic money management, meal planning, preparation and clean-up skills, compensatory memory skills, organizational and decision making skills, knowledge of ABI, planning and participating in community leisure programs, and ability to participate in group situations by identifying self-management skills such as dealing with anger and sportsmanship.

Services / Activities: Clients participate in "Moving On" from 4-8 pm on Tuesdays and Thursdays for 12-18 months. "Moving On" uses a small group format and can accommodate up to eight clients. Programming staff facilitate clients to engage in activities that are selected to allow each client to work towards their individual goals. All scheduled activities are designed to be affordable, accessible and offer healthy lifestyle choices. Examples of some activities include walks at the Saskatoon Field House, aquatics at Sherbrooke, leisure education, and life skills such as meal planning and preparation, clean-up, shopping, and budgeting.

Intended Program Impact: The "Moving On" program is focused on rebuilding the skills necessary to access other community agencies or resources. The intended outcomes are to increase clients' skills in the

areas of communication, interpersonal relations, meal planning and preparation, money management, and interacting with the greater community. “Moving On” provides a safe, structured environment where survivors of ABI can work together to reach their goals.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• MVC – All Causes • Stroke • There were six additional causes each accounting for 1-2 clients
Living Situation - Top 3	• Independent in own or family home • Personal Care Home • Supervised
# of service events per client over the fiscal years/ average minutes per event	91 events / 139 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Recreation & Leisure Activities • Life Skills Training • Psycho-Social Services
Recipients – Top 3 (based on number of events, not time)	• Group (of survivors) • Survivor & Family
Community/E&P Topics -Top 3 (based on number of events, not time)	None

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for six clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 11% were fully achieved and 78% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for 77% of goals) were: ”Relationships with Others”, and tied for second “Nutrition/Meal Prep”, and “Community Involvement/Groups”.

Evaluation

Leisure Competency Measure: The “Moving On” Program completes regular assessments to track progress on goals using the Leisure Competence Measure (LCM). The LCM is a standardized instrument to measure outcomes related to therapeutic recreation. It is used to guide goal setting and to measure changes in leisure functioning over time.

A total of five clients were assessed with the LCM (between April 1, 2013 and December 31, 2014). Two clients are currently attending and three are graduates of the “Moving On” Program. All clients demonstrated an improvement in overall LCM score from admission when compared to reassessment. The lowest overall improvement was of two points, with the average being four points, and the highest being a seven point increase.

A **family questionnaire** was distributed at the spring and fall Alumni nights in April and November of 2014 (spring survey was handed out, fall survey was mailed out). A total of 22 surveys were completed (from a possible 23); three from current clients' families, and 19 from former clients' families.

The results of the family questionnaire were very positive and included many specific examples of how clients benefitted from attending "Moving On". Some highlights include:

- 100% of those surveyed stated that the program was an enjoyable experience for their family member, that their loved one experienced positive changes, and that the "Moving On" program helped their family member be more independent in the community
- 64% identified socialization/creating a new peer group/meeting new people as beneficial
- For "What changes did you notice?", 64% of families surveyed felt their loved one improved their communication and socialization skills, 27% observed improved confidence, positive interactions, and decreased anger, and 14% witnessed increased independence
- Other comments of note were that clients became more aware of their own abilities and they would not be where they are today without the "Moving On" program

Independent Living and Residential Programming (5 Programs)

Sask North Independent Living (Prince Albert), SMILE Services (Estevan), SIGN (Yorkton) and Thunder Creek Rehabilitation (Moose Jaw), and 1 Residential Program: Pearl Manor, Phoenix Residential Society (Regina)

SK North Independent Living

Program Description

Service Area: Direct services are provided within the boundaries of the Prince Albert Parkland Health region and consultation services are provided to the health regions in the broader northern service area (i.e., Keewatin Yatthé, Mamawetan Churchill River, Athabasca & Kelsey Trail Health Regions).

History: Has served 184 clients since August 1997

Location and Hours: Prince Albert, the Program's general hours of operation are 8:00 am - 4:30 pm, Monday to Friday.

Staffing: 3 FTEs

Target Group: Clients of any age residing within Prince Albert Parkland Health Region who have sustained an ABI. The Independent Living Program will provide consultative services as requested to other northern service areas.

Partners: Referrals typically come from acute care, inpatient and outpatient rehabilitation, other health care professionals and survivors or their family members. SK North Independent Living has a variety of partnerships within the health region (e.g., Mental Health & Addiction Services, Home Care), funding sources (Social Services, Public Guardian & Trustee, SGI Personal Injury Reps), and housing (personal care homes, Riverbank Housing Corporation/PA Community Housing).

Need met by the Program / Typical Client Goals: Many individuals who sustain a brain injury have decreased opportunities for recreation and leisure activities, require housing and placement options, and require independent living services (budgeting, cooking, Activities of Daily Living (ADLs), etc.) to assist them to live in their own homes. The SK North Independent Living program strives to meet these needs. This program also does some work similar to the ABI Outreach Team to meet needs for education/service coordination, etc.

Services / Activities: SK North Independent Living's services are delivered using a multidisciplinary approach that includes Case Management, Consultation and Education services similar to those provided by the Sask. North ABI Outreach Team. Unique to the Independent Living Program is the provision of Recreation Therapy and Independent Living Services.

Services include assistance in rehabilitation treatment plans, assessing and teaching independent living skills, health support, liaising with the public trustee, assisting clients in accessing social/recreational/leisure activities (within program and in community), case coordination to access services, compensatory strategy

training, psycho-educational groups (e.g., communication groups, anger management groups), and assisting clients when transitioning to a more independent living situation.

Intended Program Impact: Individuals have an opportunity to establish new and long term friendships and informal supports by participating in the recreation programs. Clients learn about healthy options for physical activity and leisure options in the community, and have improved independent living skills, improved self-esteem, and community integration. Additionally, independent housing and/or supportive housing options are found that individuals are satisfied with.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • Tied for 2nd: MVC – All Causes & Blow to head (assault)
Living Situation - Top 3	• Independent in own or family home • Personal Care Home • Supported with limited assistance
# of service events per client over the fiscal years/ average minutes per event	70 events / 70 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Psycho-Social Services • Recreation & Leisure Activities • Case Management
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Group (of Survivors) • Other Service Provider
Community/E&P Topics -Top 3 (based on number of events, not time)	• Recreation/Leisure (not Camp/Retreat) • Therapeutic Activities Group • Support Group

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 37 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 83% were fully achieved and 13% were partially achieved. The recorded goals were spread quite evenly across the goal areas. Including withdrawn goals, the three top goal areas that accounted for almost a quarter (24%) of all recorded goals were:
"Leisure Activities", "Advocacy" and "Understanding ABI".

Evaluation: One of the unique components of the Independent Living Program that sets it apart is the delivery of a variety of psychosocial programs for clients and families. As such, the major focus of the evaluation was determining the overall satisfaction and effectiveness of these programs/services. A "Client Program Evaluation" was developed by the Independent Living Recreation Therapist.

Fifty-one program evaluation forms were completed by clients attending programs, with the largest proportion of responses coming from participants in SK North Independent Living's longest standing programs – Drop-In (38%) and Coffee Talk (22%).

Overall, clients were very satisfied with these programs. Highlights include:

- A total of 82% of respondents agreed that the number of programs available to them was adequate
- The majority of respondents felt that the facilities and equipment used for the programs was adequate
- When asked whether they had the opportunity to offer suggestions regarding recreation programs, 53% of respondents indicated that they “strongly agreed” and 32% “agreed”
- The majority of respondents agreed that they enjoyed it when ABI staff participate in the programs with the clients
- Respondents indicated that they benefitted from the programs in a number of ways including improvement in self-esteem, physical benefits, having a place to practice social skills and express emotions

In total, 67 LiSAT (Life Satisfaction) questionnaires were also administered (52% from Post-Acute clients, 9% from Transitional clients, and 39% from Long-Term Clients) to measure life satisfaction. LiSAT results indicated that the majority of clients were “rather” to “very satisfied” in all life areas measured. Some areas to think about include: for post-acute clients, there was no significant difference between the initial score and their 3 month review score; there were more dissatisfied ratings in the "transitional client" group in financial situation, contact with friends, and ability to manage self-care; and more dissatisfied responses in "long-term clients" found for vocational and financial situation.

SMILE Services Inc.

Program Description

Service Area: The program provides services throughout the Sun Country Health Region

History: Has served 57 clients since January 2001

Location and Hours of Operation: Estevan, Monday to Friday, 8:00 am – 4:30 pm

Target Group: The SMILE-Independent Living Worker Program (ILWP) serves individuals with traumatic, pathological and chronic brain injuries (this does not include progressive disabilities such as Alzheimer's Disease, Multiple Sclerosis, or developmental disabilities such as Cerebral Palsy). The program focuses on serving individuals injured less than 3 years ago, with moderate to severe injuries, and in need of specific supports and assistance to remain independent in their communities. Clients will not be excluded based on time since injury, age, or co-morbid/concurrent condition.

Staffing: 1 FTE

Service Description: The SMILE ILWP provides intense and regular, hands-on assistance to clients. The purpose is to allow clients to live as independently as possible in their community. SMILE-ILWP will teach, support, and supervise clients in their residential setting. Overall program goals are to assist clients in maximizing their rehabilitation potential and to assist them in acquiring or relearning the skills necessary for successful independent living and to maximize the client's quality of life.

Program Objectives:

- In conjunction with the Sun Country Health Region ABI Regional Coordinator, assess and set goals in the area of independent living skills development and establish client routines in this regard.
- Teach and reinforce basic living skills. These skills include: money management, time management, medication management, personal hygiene, safety issues, meal planning and preparation, grocery shopping, home management, memory skills, and assistance in accessing other agencies.
- Under the direction of a licensed therapist, assist clients with physiotherapy exercises to help increase their mobility and independence.
- Under the direction of a licensed therapist, assist clients with their speech therapy program to help them regain as much speech as possible.
- Under the direction of a licensed therapist, assist clients with occupational therapy treatment to help them resume activities of daily living.
- Provide recreational opportunities to clients when possible.
- Assess clients' transportation needs, as required, and, in the absence of other options, provide time-limited/ad hoc transportation support with the goal of building client skills to establish an independent (i.e., not SMILE-ILWP-delivered) transportation plan.
- Provide residential options and assistance in finding safe, affordable, appropriate living accommodations.

Program Activities: Both one-on-one and group programming occurs. All therapy activities are delivered under the direction of a therapist in the respective disciplines listed below.

Examples of 1:1 activities include:

- Physical therapy – to improve flexibility and physical function exercises are done at the client's home, gym or pool such as stretching and strengthening
- Occupational therapy – playing cards to improve memory and digit dexterity; assist with obtaining adaptive devices and learning how to use them
- Speech therapy – exercises are done to improve speech and communication
- Life skills education – teaching clients how to use the computer
- Psychosocial support – taking clients on outings for coffee or lunch to socialize. These outing are often the only opportunity clients have to get out in the community.

Examples of Group activities include:

- Various community events – e.g., music concerts, theatre performances, hockey games, car races
- Various community activities – e.g., museum tours, mini-golf, bowling, card games, billiards, shuffleboard
- Dinners/Seasonal celebrations – e.g., pizza nights, BBQs, Christmas party

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • There were four other causes accounting for 1-2 clients each
Living Situation - Top 3	• Independent in own or family home • Independent with difficulty • Other 2 causes accounted for 1 client each
# of service events per client over the fiscal years/ average minutes per event	28 events / 90 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Occupational Therapy Interventions • Exercise • Speech Language Interventions
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Survivor & Family • Family/Natural Supports
Community/E&P Topics -Top 3 (based on number of events, not time)	• Support Group • Recreation/Leisure (not Camp/Retreat)

2013-15 Contract Review RESULTS

Goal Attainment: Reporting indicates the goal areas worked on in this contract reporting period include: Exercises to enhance physical mobility and to prevent falls; home management (including cleaning, organizing and de-cluttering); memory strategies; strategies to enhance speech and communication; and life skills such as computer use.

Society for the Involvement of Good Neighbours (SIGN)

Program Description

Service Area: The program provides services throughout the Sunrise Health Region

History: Has served 64 clients since July 2000

Service Description: The program assists and encourages independent living skills to enhance the quality of life of ABI survivors. The program is governed by a holistic approach, which takes into account all aspects of the person's life. This approach promotes client independence while providing respite for caregivers and families. The goal is to teach the client "how to" rather than "doing for". The services offered to the individuals in the program may be on a one-to-one basis, in a small group setting, in the community, in the client's home or as arranged at the SIGN building.

Location and Hours of Operation: Yorkton, Monday-Friday, 9:00 am – 5:00 pm

Staffing: 1 FTE

Target Group: The SIGN-ILWP serves individuals with traumatic, pathological and chronic brain injuries (this does not include progressive disabilities such as Alzheimer's Disease, Multiple Sclerosis, or developmental disabilities such as Cerebral Palsy). The program will focus on serving individuals injured less than three years ago, with moderate to severe injuries, and in need of specific supports and assistance to remain independent in their communities. Clients will not be excluded based on time since injury, age, or co-morbid/concurrent condition.

Program Objectives:

- In conjunction with the (Sunrise Health Region) ABI Regional Coordinator, assess and set goals in the area of independent living skills development and establish client routines in this regard.
- Through scheduled home visits, provide support through in-home supervision and Independent Living Skills Development. Teach and reinforce basic living skills. These skills include: money management, time management, medication management, personal hygiene, safety issues, meal planning and preparation, grocery shopping, home management, memory skills, and assistance in accessing other agencies.
- In conjunction with the ABI Life Enrichment Facilitator (Sask Abilities Council), assist clients in accessing recreational and social activities in the community.
- Assist clients in finding appropriate and affordable residential accommodations.
- Facilitate a monthly Life Skills group in Yorkton in collaboration with the ABI Life Enrichment facilitator.
- To raise awareness of the Independent Living Program (ILP), the ILP Coordinator will outreach in community to potential referral sources in order to provide information about and benefit of the services offered and to facilitate referrals to the ILP.
- In conjunction with the ABI Life Enrichment facilitator, provide rural group services, as necessary.

Program Activities: The program works in conjunction with the Sask Abilities Life Enrichment worker to plan and deliver a monthly Lunch N' Learn group providing education on a variety of topics. Examples of topics: What is a Brain Injury, budgeting, positive thinking/self-esteem, Veterans and TBI, healthy eating. The group also provides the opportunity for sharing meals and social support.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• MVC – All Causes • Stroke • There were nine other causes accounting for 1-2 clients each
Living Situation - Top 3	• Independent in own or family home • Independent with difficulty • There were five other living situations accounting for 1-2 clients each
# of service events per client over the fiscal years/ average minutes per event	50 events / 39 minutes each
Client Activities - Top 3 * **(based on number of events, not time)**	• Case Management • Administration • Life Skills Training
Recipients – Top 3 **(based on number of events, not time)**	• Individual (Survivor) • Partnership Service Provider • Other Service Provider
Community/E&P Topics -Top 3(based on number of events, not time)	Tied: • Support Group • Survivor/Family Support (Not Support Group)

***** The Top 3 client activities based on service time is a different list: Life Skills Training, Case Management, Residential Services

2013-15 CONTRACT REVIEW RESULTS

Goal Attainment: Goals were submitted for 14 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 73% were fully achieved and 19% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for 42% of goals) were:
"Home Management", "Community Involvement/Groups", and tied for third "Housing" and "Memory".

Contract Reporting: Information on client specific goal activities (16 clients) was provided to illustrate the type of goals and progress toward goals.

Goal setting is done utilizing Linda Harrison's Daily Living Worksheets (which programs were trained on in a telehealth session May 31, 2013) together with SMART principles. Examples of goal areas worked on include: assistance with finding housing and moving, memory, transportation, grocery shopping, mood management (including anxiety), home-making skills (cleaning, organization, assistance with de-cluttering, laundry), healthy meal planning and preparation, stress management/relaxation, exercise, and fatigue management.

Thunder Creek Rehabilitation Association (TCRA)

Program Description

Service Area: The program serves the Five Hills Health Region

History: Has served 22 clients since April 2009

Location and Hours: Moose Jaw, general hours of operation are Monday, Tuesday and Wednesday from 8:30 am – 4:30 pm. The ABI Community Support Worker (CSW) may also work evenings or weekends, as required.

Staffing: .6 FTE

Target Group: The program serves individuals with moderate to severe brain injuries, who are in need of specific supports and assistance to remain independent in their communities.

Partners: various health services (mental health and addictions, Providence Place), employment services (Partners in Employment), Salvation Army, Yara Fitness Centre, Yara Community Garden

The program receives referrals, staff supervision and administrative support from the Five Hills Health Region ABI Coordinator. Client goal-setting and review is done in collaboration with the ABI Coordinator, the client and their family, as applicable. Group programming is delivered in partnership with the ABI Coordinator.

Program Description: This program was developed to encourage independence through skill building and connecting to community supports.

Program Activities: One-on-One referrals are to meet specific, time-limited needs and goals to help individuals remain independent.

Clients with primary needs for psychosocial support are referred to group programming options offered through the program.

Group programming offered weekly (Wednesday) includes: Walking Group, Breakfast Club, Coffee Support Group, Men's Pool and Women's Afternoon.

Need Met: Client needs are varied and unique. Independent living skill development is addressed on a 1:1 basis and psychosocial support is addressed through group programming.

CSW client time is roughly divided 80% to one-on-one and 20% to group programming.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • There were four other causes accounting for 1-2 clients each
Living Situation - Top 3	• Independent with difficulty • Long Term Care Facility • There were five other living situations accounting for 1-2 clients each
# of service events per client over the fiscal years/ average minutes per event	27 events / 226 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Recreation & Leisure Activities • Psycho-Social Services • Life Skills Training
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Survivor & Other Service Provider • Group (of survivors)
Community/E&P Topics -Top 3 (based on number of events, not time)	• Survivor/Family Support (Not Support Group) • Support Group • Recreation/Leisure (not Camp/Retreat)

2013-15 CONTRACT REVIEW RESULTS

Goal Attainment: Goals were submitted for four clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 73% were fully achieved and 20% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for 59% of goals) were: "Leisure Activities", "Employment" and "Handling Money".

Contract Reporting: An effective working relationship has been established between the CSW and ABI Coordinator with communication occurring regularly including at client reviews where progress toward goals is measured. Goals are considered 'achieved' when the client is able to accomplish the task they identified in the manner they feel meets their needs.

Information presented by case example illustrates the way the CSW works and the type of needs the program addresses. Client needs worked on are further outlined by demographic profiles of four clients (as of the February 2014 report).

The ABI Coordinator refers clients to the CSW to work on specific, time-limited goals. Examples of goal areas worked on include: assistance with finding and maintaining housing (including landlord liaison), finding volunteer opportunities, assistance with employment, budgeting, home-making skills (cleaning, organization, assistance with de-cluttering, laundry), healthy nutrition (grocery shopping, meals planning and preparation) and exercise.

A survey was conducted by a nursing student in October 2013 on the program's social programming. 90% of clients interviewed said that they had attended a social group and the same percentage indicated they enjoyed the group programs. Barriers to participation included transportation and cost.

PEARL Manor - Phoenix Residential Society

Program Description

Service Area: PEARL Manor is located in Regina but is a provincial program. PEARL's Supported Living Program is only available in Regina.

History: Residential program with capacity for seven clients since 1996. To date, PEARL has served 117 clients.

Location and Hours: Both the supported apartment and supported living program operate in Regina. The supported apartment has 24/7 staffing.

Target Group: ABI Survivors requiring residential support

Staffing: 8.85 FTEs

Partners: Referrals typically come from Outreach Teams, ABI Regional Coordinators, Wascana Rehab Center, and community based organizations such as the SK Abilities Council and the Metis Addictions Council of SK. A variety of referrals to community programs are made based on clients' needs. For example: Cognitive Disability Strategy, Social Services (SAP, SAID, Disability Rental Housing Supplement), vocational programs (Partners in Employment, South SK Independent Living Center), medical professionals (including family physicians, dentists, pharmacies), Regina Foodbank, Paratransit, Legal Aide, education centers, volunteer programs, and community based recreational programs.

Need met by the Program / Typical Client Goals: Individuals with acquired brain injuries living with families or still in hospital need to improve their skills in order to live in a more independent setting. Common goals for clients in both programs include: managing a budget, attaining and maintaining safe and affordable housing, pursuing education, coping with life changes, improving/maintaining physical health, engaging in meaningful daytime activities, and improving communication skills. As well, Supported Living Program clients set goals that focus on maintaining their current level of skills and abilities, and expanding their community integration. Goals are reviewed and revised on an ongoing basis, generally every three-six months, depending on the type of goal and the progress the resident makes toward accomplishing them.

Services / Activities: PEARL Manor is a residential program providing psycho-social and behavioral/cognitive rehabilitation services to seven individuals in a fully furnished apartment building staffed on a 24-hour basis.

The Supported Living Program provides rehabilitation and supported living services to 14 - 16 individuals living in a home of their choice in the community. Individuals in the Supported Living Program also receive ongoing support services (groups/classes, social/recreational), as well as crisis intervention through Pearl Manor.

PEARL Manor staff:

- complete and review pertinent assessments, including the Mayo Portland Adaptability Inventory (MPAI) and the Camberwell Assessment of Need for adults with Developmental and Intellectual Disabilities (CANDID)
- assist residents to set goals and develop plans to achieve their goals
- teach independent living skills individually and in group settings
- provide training in cognitive strategies

- provide trustee services and assistance with money management and budgeting
- assist in daily activity planning and time management

Intended Program Impact: As a result of participation in PEARL programs, the expected outcomes for residents may include: increased development and maintenance of independent living skills, increased community integration, increased quality of life, increased stability in terms of physical and mental health, and ultimately that residents are living more independently in the community with a higher quality of life.

For families and other service providers, the expected outcomes are that families have less caregiver burden and responsibility, and there will be less reliance on other service providers.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• MVC – All Causes • Blow to head (assault) • Stroke
Living Situation - Top 3	• Independent with difficulty • Independent in own or family home • Personal Care Home
# of service events per client over the fiscal years/ average minutes per event	638 events / 35 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Psycho-Social Services • Life Skills Training • Recreation & Leisure Activities
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Group (of survivors) • Other Group (mixed)
Community/E&P Topics -Top 3 (based on number of events, not time)	None

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 10 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 57% were fully achieved and 30% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for 22% of goals) were: “Handling Money”, “Nutrition/Meal Prep”, and tied for third were “Memory” and “Home Management”.

Evaluation: Data collection took place throughout 2014. Data was gathered from: ABIIS reports, client file reviews, agency documentation, client interviews, mail out surveys and case studies.

Of the 30 residents discharged from PEARL Manor and the Supported Living Program, 14 residents were identified as ‘successful’ discharges (i.e., clients moved to more independent settings). Of the 14 discharges that were not classed as successful: eight (8) individuals were discharged as a result of active addiction issues

or substance abuse issues which impacted their ability to participate in the program or their substance use was having a significant negative impact on the other residents in the program.

Results from client and family satisfaction surveys (28 clients, 8 family members) indicate a high level of satisfaction with services provided, with 23 of the 28 clients (82%) rating services as “very satisfied” or “excellent”. Results indicate that all families see that the services their family member received as ‘excellent’ (50%) or ‘very satisfactory ‘(also 50%). The feedback gathered from these surveys also provided invaluable information for improving PEARL programming.

Life Enrichment Programming (3 Programs)

Saskatoon, Regina and Yorkton

SK Abilities Council: Saskatoon Branch ABI Life Enrichment Program

Program Description

Service Area: Saskatoon

History: Has served 116 ABI survivors since 2000

Location and Hours: Coordinator works regular hours at Saskatoon Office. Community Service Worker (CSW) hours are causal and based on clients' needs. Typical CSW hours are late morning, afternoon or early evening, Monday to Friday. Some clients access service on the weekends. Overnight service is not provided.

Staffing: The Partnership funds .6 FTE

Target Group: ABI survivors whose needs are beyond the scope of vocational services, and caregivers in need of respite.

Partners: Referrals are often received from: CPAS, ABI Outreach, FIT, physiotherapy, social workers, SGI, WCB, Personal Care Homes & self-referrals. This program partners with a wide variety of ABI and other programs in Saskatoon. Other partnerships include the Cognitive Disability Strategy (CDS).

Need met by the Program / Typical Client Goals: Individuals with ABI need assistance in accessing their community and decreasing their social isolation. Common goals addressed by this program include: decreased social isolation through recreation and leisure based on individual interests, and increased independence through life skills training. Other benefits include: behaviour management, improved social skills, improved physical activities, and respite for family/caregivers.

Services / Activities: This program is coordinated by the ABI Community Support Services Supervisor, and service is provided by one-on-one community support workers (CSWs). Additionally, the Life Enrichment Enhancement program provides service to 10 survivors who cannot afford a fee-for-service CSW. Outings include bowling, walking, mini-golf, attending community/sporting events, tours of points of interest, etc. The ABI Community Support Services Supervisor provides service coordination when clients have no formal case manager.

Intended Program Impact: To improve the quality of life of adults with an ABI through facilitation of community activities based on individualized goals.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• MVC – All Causes • Stroke • Tied for 3rd: Aneurysm & TBI (Other)
Living Situation - Top 3	• Independent in own or family home • Personal Care Home • Long Term Care Facility
# of service events per client over the fiscal years/ average minutes per event	68 events / 216 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Recreation Therapy Interventions • Recreation & Leisure Activities • Administration
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Group (of survivors) • Other recipients account for less than .01% of total events
Community/E&P Topics -Top 3 (based on number of events, not time)	None

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 19 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 81% were fully achieved and 14% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for 41% of goals) were: "Relationships with Others", "Leisure Activities" and "Other Participation".

Evaluation: Information was gathered from client questionnaires on the community support program, client responses on the flourishing scale, questionnaires for client supports (e.g., family), client and service statistics, and case studies.

Results: Positive results were shown for all questionnaires and case studies. Results suggest that this program is client centered, increases clients' awareness of community, reintegration, and independence (shown in client and support/family questionnaire results). Positive results were also shown on the flourishing scale. All supports/family respondents indicated that the program provided them respite and benefited their loved one, and 62% of supports/family reported a reduction in stress levels. The flourishing scale results had the highest percentage of clients disagreeing with statements (5-11%) out of all of the questionnaires, which may indicate participants may wish to feel more engaged or independent.

SK Abilities Council: Regina Branch ABI Quality of Life Program

Program Description

Service Area: Regina

History: Has served 82 ABI survivors since 2001 (This program was a part-time position prior to 2007)

Location and Hours: The program's general hours of operation are from 8:30 am - 4:30 pm, Monday to Friday. The service headquarters is located in Regina. Community events and client goals determine the hours of this program. Approximately 60% of the hours are from 8:30 am - 4:30 pm and 40% are from 2:30 – 10:00 pm

Staffing: 1 FTE

Target Group: ABI survivors who indicated during assessment reduced quality of life satisfaction and barriers to enjoyment.

Partners: The Quality of Life coordinator has regular contact with program participants, but also partners with family members, approved service home providers, and group home staff as required.

Other partnerships include paratransit, a variety (a large number of) of community organizations, and the ABI Outreach Team.

Need met by the Program/Typical Client Goals: ABI Quality of Life Programming is needed to assist participants to develop, maintain, and improve functional skills required for participation in the community. The most common client goals are:

- Increasing social interaction
- Learning what's available in the community
- Increasing levels of engagement in community pursuits
- Learning new skills
- Increasing physical activity
- Learning and maintaining skills necessary for participation
- Having fun

Services/Activities: The evolving focus is to support individuals with an ABI in making purposeful/meaningful connections within their community.

A "Quality of Life Interview" guides participants in identifying what is important to them, and indicates how satisfied clients are with various aspects of their life. The personal information gathered from the interview corresponds with the Quality of Life template consisting of three domains, **Being**, who one is; **Belonging**, connections with one's environment; **Becoming**, achieving personal goals, hopes and aspirations. The Quality of Life Coordinator uses the results to develop and implement a realistic personalized quality of life action plan(s) with individuals to support achievement or attainment of quality of life goals.

The steps required and level of support needed depends on many variables including but not limited to: individual goals, starting point, the skill level and/or independence level of the participant as well as the skill building and preparation required to achieve the goal. The Quality of Life Coordinator supports clients with achieving steps required to reach their Quality of Life goals. This involves coordinating and facilitating a variety of individual or group activities for participants (day and evening). As well as working with natural and paid supports to create a consistent approach to the achievement of goal. It also involves researching community activities and opportunities regularly, and providing monthly calendars to clients with both program opportunities and community activities that align with the client's personalized quality of life action plan.

Intended Program Impact: The focus of the program is to support individuals with an ABI in making purposeful/meaningful connections within their community. Connections are made through a series of supported activities including: quality of life assessment, leisure education, individual skill building and participation in community based opportunities. Through increased awareness of self, participants are able to improve their overall quality of life.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• MVC – All Causes • Tied for 2nd: Stroke, and Other (not TBI)
Living Situation - Top 3	• Independent in own or family home • Supported with limited assistance • Long Term Care Facility
# of service events per client over the fiscal years/ average minutes per event	39 events / 57 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Case Management • Recreation & Leisure Activities • Administration
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Other Group (mixed) • Group (of survivors)
Community/E&P Topics -Top 3 (based on number of events, not time)	Camp/Retreat Event

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Due to the change in staff and changed program focus, goal attainment information for active clients (versus discharged clients) provides a more accurate assessment of typical goals and achievement in this program. Goals were submitted for 31 clients active in the 2014-15 fiscal year. Of the goals that were not withdrawn, 53% were fully achieved, 15% were partially achieved, and 31% were still in progress. Including withdrawn goals, the top three goal areas (accounting for 76% of recorded goals) were "Leisure Activities", "Community Involvement/Groups" and tied for third: "Physical Goals" and "Education".

Evaluation: Due to the recent change in programming, the evaluation focused on the new process for the five new active clients in 2013-14. All new clients were administered the new intake assessment and evaluation instruments. The results were positive, lending support for the new service model. New assessment and evaluation tools continue to provide the agency with records useful for review, managing, and tracking process and direction of services to clients. Assessments include:

- Pre and Post NYS IRRC QOL scale – This tool measures the perception of life quality in the core domains of emotional well-being: interpersonal relationships, material well-being, personal development, self-determination, social inclusion, rights, physical well-being, and overall assessment of satisfaction with life. This tool is completed post service period in order to measure increased life satisfaction as a result of participation in programming.
- Pre and Post "Barriers to Enjoyment" Survey – This tool is used to identify individuals' perceived barriers to enjoyment in recreation and leisure activities, and provides 17 examples of barriers. Clients are asked how they think the QOL coordinator can assist them in addressing identified behaviours, and ultimately "actions" for same. This tool was and is completed again post services in order to measure a potential reduction in barriers to participation.
- Calendars were amended to include individual client goals as well as global events. Coordinator wrote individual pursuits and appointments (in pen) and highlighted same specific to each individual. Several clients provided feedback re: change in calendars, and included statements like – "it is awesome, I can see everything I need to right there – I am no good at reading, so that helps me." This was evident by the increase in participation of those clients who provided feedback.

Result Highlights: All new participants (five clients) were administered the Quality of Life Assessment Interview "short version": 60% received a score indicating their quality of life to be "Adequate quality of life, but some areas need improvement" and 40% received a score indicating their quality of life to be "Problematic and needs improvement". All new clients also completed the post "Barriers to Your Enjoyment" survey. Highlights are that all new clients:

- saw a decrease in the number of barriers to their enjoyment
- saw an increase in their quality of life satisfaction
- stated that "because they participated in the Quality of Life Program…" they felt good while participating in programs, the activities were meaningful to them, they have people they can depend on, feel like they belong in their community, can manage everyday activities, have activities they are interested in, and feel like their quality of life has improved by being part of the Quality of Life Program
- 80% of new clients indicated that "because they participated in the QOL Program…" they participated in physical programs and had supports outside of the QOL program. This system of delivering programs and using measurement tools was implemented with existing clients also (19 clients). The results are that 40% of all active clients completed both the pre & post Barriers to Your Enjoyment Sheet, and 52% of all active clients completed both pre & post NYC IRRC Quality of Life Scale. Highlights are that:
    - 92% of those saw a decrease in the number of barriers to their enjoyment
    - 92% of those saw an increase in quality of life satisfaction

As a result of participating in the QOL Program, 100% (19 of 19) of clients stated that they felt good while participating, the activities were meaningful to them, they have people they can depend on, they feel like they belong in their community, they have activities that they are interested in, and most importantly that their quality of life has improved by being part of the QOL program.

Interpretation: Existing clients saw both a decrease in the number of barriers to their enjoyment, and increase in quality of life satisfaction.

"Yes, compared to the year before her quality of life has improved. It has given her more of a sense that she fits in. This program is more specialized and one to one".
- From a client's family member

SK Abilities Council: Yorkton Branch ABI Life Enrichment Program

Program Description

Service Area: Sunrise Health Region

History: Has served 69 ABI survivors since 1998

Location and Hours: The program's general hours of operation are from 8:00 am - 4:00 pm, Monday to Friday, with flexible hours offered outside of this based on client need. The service headquarters is located in Yorkton.

Staffing: .5 FTE

Target Group: ABI Survivors in the Sunrise Health Region

Partners: Referrals are received from the Sunrise Coordinator. Additionally, some programming is provided in partnership with SIGN Independent Living Program to improve personal and living skills.

Need met by the Program: The goal of SK Abilities Council Yorkton is to coordinate and facilitate individual and group avocational activities in the community, enhancing the quality of life for persons with ABI. The most common needs of survivors met by this program include: 1) Emotional support needed to attend recreational and leisure activities; 2) Transportation required to access recreational and leisure activities; 3) One on one quality time; and 4) Opportunity for peer interaction.

Typical client goals include:

- overcoming depression
- having someone to talk to who understands ABI
- managing memory loss
- getting back to everyday life
- building physical strength to get back to work
- having a clear direction
- getting out more
- re-engaging in hobbies
- gaining independence
- increasing ability to walk
- increasing ability to speak
- increasing physical strength
- meeting new people

Services / Activities: The service breakdown in SK Abilities Council's evaluation report indicated that 71% of activities delivered were one-on-one and 29% of activities delivered were in a group format. Individuals can choose between receiving one-on-one supports and/or group activities. One-on-one activities include life skills development, coffee, lunch, leisure walks, local concerts, and the Terry Fox run. Group activities include life skills sessions, bowling, museum tours, BBQs, seasonal get-togethers (e.g., Christmas party), and group community events (e.g., "The Illusionist").

Intended Program Impact: The program's main objective is to assist persons with an ABI to make social, recreational and leisure connections to the community thus enhancing their overall quality of life, increasing community integration, and reducing social isolation.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • MVC – All Causes • There were 10 other causes each accounting for one or two clients
Living Situation - Top 3	• Independent in own or family home • Independent with difficulty • There were four other living situations each accounting for one client
# of service events per client over the fiscal years/ average minutes per event	37 events / 38 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Case Management • Recreation & Leisure Activities • Administration (to a much lesser extent)
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Group (of survivors) • Other Group (mixed) – to a much lesser extent
Community/E&P Topics -Top 3 (based on number of events, not time)	None

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for four clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 31% were fully achieved and 58% were partially achieved. Including withdrawn goals, there were seven top goals reported in equal frequency (accounting for 54% of goals): "Anger Management", "Behaviour Management", "Handling Money", "Mood Management", "Planning/Problem Solving/Self Correction", "Self-Awareness/Insight" and "Understanding ABI".

Evaluation: Interview questions were based on clients' experiences over a twelve month timeframe (October 2013 - October 2014). All clients were given the survey, and 13 out of 18 individuals responded (72% response rate). In addition, five family members responded. Interviews were conducted in person, by phone and via mail delivery.

Results: Individuals were asked to identify the activities that they participated in throughout the twelve month period. Various community based activities were identified including life skills (time management, cooking, making decisions, coping strategies), walking, gardening, cooking, bowling, etc.

When asked "have you gained everything you wanted to from the services received…?" respondents reported overall high level of satisfaction, with 12 out of 13 individuals stating "yes," - a 92% satisfaction rate. Examples/themes from the interviews were very positive including: having a sounding board, someone to talk

to, feeling less alone, program facilitating friendships (old and new), and more exercise leading to better health. In addition, families appreciated support groups and positive changes in their loved ones.

The interviews revealed some negative responses as well which included a lack of services in the rural area and transportation barriers to accessing services.

Children's Programming (1 Program)

Radius: ABI Community Integration Services

Program Description

Service Area: Services are provided to clients within the rural and urban boundaries of the three Saskatoon School Divisions and the city of Saskatoon.

History: Has served 60 youth ABI survivors (age 6-22) since 1997.

Location and Hours: Based in Saskatoon. The Program Coordinator's normal hours are from 8:30 am - 4:00 pm, Monday to Friday. The part time Community Support Workers' (CSWs) hours of work vary as participant service is provided after school, evenings, and weekends and during the summer.

Staffing: The ABI Partnership funds 2 FTEs

Target Group: Children/youth 6-22 years of age with an ABI and attending school, and young adults 18-30 years of age with an ABI who are out of school transitioning to other community services.

Partners: Radius works together with local agencies and other ABI Partnership Project programs that assist with participant referrals, planning and service delivery. These valuable partnerships form a strong support team for the client and ensure that Radius does not duplicate existing services while enhancing the capacity of the community to support children and youth with an ABI.

Need met by the Program / Typical Client Goals: The needs of participants vary, but most often affected is appropriate social interaction, return to previous enjoyable activities and overall health and wellbeing. These affect the youth's ability to make friends, attend school or work, and ultimately their physical and emotional health. Radius seeks to facilitate positive recreation and leisure based activities that focus on promoting active living, appropriate social interactions and success.

Services / Activities: Participant goals are developed as part of a 12-week community integration plan that provides a framework for meeting program objectives and participant goals. The coordinator meets at least quarterly with those involved in the plan (family, youth participant, support team), and is a consistent point of contact to families. Input for goals and assessment of client strengths is garnered from the family and other agencies involved with the client (e.g., Central ABI Outreach Team, school). There is regular contact and meetings with the client's support team in order to stay up to date on client progress and areas of concern.

Participants meet weekly with their CSW after school hours, in the evenings, on weekends and during the summer. Participants are assisted in the areas of recreation and leisure, functional life skills (e.g., using the phone, money and time concepts, cooking, house cleaning, shopping for basic needs, using public transportation, and dressing properly for outings), social and vocational activity, and with access to existing individual or group activities in their community. In addition to linking participants to existing community resources in their home communities, Radius will advocate on behalf of participants to help reduce barriers and improve community participation.

Several program enhancements occurred in response to changing client and family needs. These enhancements are done in partnership with community agencies. These additional outputs include:

- **Summer Fun (1998):** Additional support staff was hired to guide and encourage the youth at the different summer activities including local day camps or drop in programming.
- **Education and Awareness Activities (2000):** Radius promotes activities through community presentations and programming to local agencies and post-secondary institutions. Presentations highlight Radius services and provide further understanding of brain injury which helps to recruit volunteers and community support workers, and to a lesser degree, these activities can aid in the identification of potential referrals.
- **ABI Youth Camp (2001):** This camp experience provides youth from around the province the opportunity to spend time at a real camp that provides overnight stays and fun activities during the day. It remains a highlight for campers who ask "when is camp next year". Campers are able to go boating, wall climbing, canoeing, fishing, cook over an open fire, learn about our natural environment and develop lasting friendships. Camp is offered in partnership with the three Outreach Teams.
- **Sports for Life (2007):** The program is inclusive in nature and brings together youth with and without an injury to experience recreational programming that is modified to foster safe, fun interactive experiences.
- **Parent Knowledge Exchange (2014):** This initiative is used to provide education opportunities for the parents or caregivers of the youth involved in Radius services and is open to others who are interested. Topics have included goal setting, stress management, laughter therapy, transition planning, guardianship, information about other services in the city that parents can access, and transition planning for youth ready to leave high school and beyond (work options).

Intended Program Impact: To assist community integration by linking participants to existing community resources in their home community and supporting families to help do the same.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Encephalitis/Meningitis • MVC – All Causes • There were six other causes each accounting for one or two clients
Living Situation - Top 3	• Child (under 18) no extra support • Child (under 18) requiring extra support • There were six other living situations each accounting for one or two clients
# of service events per client over the fiscal years/ average minutes per event	46 events / 149 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Recreation & Leisure Activities • Recreation Therapy Interventions • Case Management
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Group (of survivors) • Family/Natural Supports

Community/E&P Topics -Top 3(based on number of events, not time)	• Therapeutic Activities Group • Camp/Retreat Event • Survivor/Family Support (Not Support Group)

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for eight clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 83% were fully achieved and 3% were partially achieved. All goals were recorded in the area of "Leisure Activities".

Evaluation: The **40 Developmental Assets** are recognized as **"basic building blocks of healthy development - the positive characteristics and experiences that ALL children and youth need to grow up healthy, competent and caring** (*A Developmental Assets Profile of SK Youth ... A Chance to Listen*, 2008-2010). These assets are associated with immediate and future success for youth as they become adults. Radius piloted this measure in 2013-15 with six families with positive results.

The tool has initially provided a great platform to direct conversation and energy towards specific goals that help contribute to positive youth growth and development. When setting goals, many families pick very big goals to work on that seem right at the time but are hard to achieve or not specific enough. This tool helped narrow the focus to areas of need and success. The tool will be further implemented and used in conjunction with client and family education, and in the setting of SMART goals.

Highlights: Youth and family reported total assets that were higher than the SK average (27 and 24.5 versus 18.5). When asset ratings are combined with Significant Others' typically lower ratings (teachers and support workers), the average rating is **21.8** assets, which is closer to the SK average. This suggests that an average of youth, family and other significant adults that support the youth will tend to give a better indication of a youth's assets.

Survey results indicated Radius youth and families:

- **Have good connections to neighbors and families. Some highlights:**
  - 100% of the youth indicate they felt loved and supported by their family (reflected by 100% of families)
  - 83% of youth indicate they have at least three adults besides their parents they can go to (reflected by 83% of families)
  - 83% of the youth indicate that they feel valued and appreciated by adults in their community (reflected by 66% of families)
  - Four of the six responses indicated that they feel valued and encouraged by adults to do well but conversely they feel they don't have meaningful community roles nor participate in community activities. **This supports the need for the Radius program.**
- **Have good understanding of self/locus of control. Some highlights:**
  - Overall family and clients indicate that they feel good about themselves, feel positive about their future and that they have some control over things that may happen to them.
  - School/Academic life - School tends to be the primary outing and social experience for youth. Results from the surveys show that school can be a very "hot and cold" experience for most youth. They are often in the alternate or modified classes and feel this as a reflection of what they are capable of doing. Because of their disability, all reported having bullying experiences at school. It

should be noted that return rates of the school personnel were very low. Changing education assistant staff, changing grades, changing teachers all makes it difficult to gather feedback. **In light of this reflection – the value of a consistent support from Radius is important.**

Vocational Programming (3 Programs)

SK Abilities Council (Saskatoon and Regina), Multiworks (Meadow Lake)

SK Abilities Council Saskatoon Branch Supported Employment Program: Partners in Employment (PIE)

Program Description

Service Area: Saskatoon

History: Has served 276 ABI survivors since 1996

Location and Hours: The Program's general hours of operation are from 8:30 am - 4:30 pm, Monday to Friday. The service headquarters is located in Saskatoon.

Staffing: 2 FTEs

Target Group: ABI survivors with a desire for community employment

Partners: Referrals often come from the Central ABI Outreach Team, but have come from a variety of other sources (e.g., Canadian Paraplegic Association, Labour Market Services, SK Abilities Council ABI Community Support program, Sherbrooke Community Centre, Saskatoon Open Door Society, SIAST (now Saskpolytechnic), and Ministry of Social Services). This program makes referrals to a variety of agencies based on client need on an ad hoc basis.
Clients are employed with various businesses, and follow-up and contact with clients employed at these businesses would vary based on need, from weekly to quarterly. Follow-up with work placements typically occurs weekly.

Need met by the Program / Typical Client Goals: Some people with an ABI need individualized programming that assists them to develop their employability skills and eventually obtain and maintain employment. Typical work includes developing a vocational plan, providing vocational services based on identified goals, and these services reduce barriers and lead to community-based employment. Examples include: work readiness (skill development), individualized job search training, resource centre, pre-employment placing, job development, job match, employment, and job accommodation. Provision of employment supports are also provided that assist clients with maintaining their employment. Support includes the provision of: job coaching, regular follow-up meetings with client and/or their employer, sharing information regarding ABI with employers and their staff.

Services / Activities: PIE provides pre-employment supports including resume preparation and job search support to match participants with employment that values their skills and abilities; to provide on-site training to the worker and their employer including job coach support; and to provide ongoing follow-up support and consultation to the worker and employer as long as requested.

Intended Program Impact: To improve vocational options, minimize barriers to employment, and improve vocational supports. The ultimate goal of this program is to assist people with a moderate to severe ABI in Saskatoon to obtain and maintain employment.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • MVC – All Causes • Tied for 3rd: Other (not TBI) and Tumour
Living Situation - Top 3	• Independent in own or family home To a lesser extent: • Group Home • Six other living situations each accounting for one or two clients
# of service events per client over the fiscal years/ average minutes per event	34 events / 46 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Vocational Services • Administration
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Partnership Service Provider • Employer
Community/E&P Topics -Top 3 (based on number of events, not time)	None

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 36 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 71% were fully achieved and 10% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for 84% of goals) were: “Employment”, “Education” and to a much lesser extent, “Volunteering”.

Evaluation: Information was obtained from questionnaires (client and employer) that were administered in-person by a staff member to a random sample of 34 clients, 30 of whom completed the questionnaire (response rate of 88%). Out of 41 employers, 10 were randomly selected to take the survey and all responded (response rate of 100%). Additionally, three case studies were provided to illustrate the way in which the vocational program works with clients.

Results: Results from the evaluation were very positive and show that clients are being assisted to obtain and maintain employment. Service statistics showed that the program is engaging in services as planned. Additionally, provided case studies show the range of services provided by PIE.

Results suggest immediate outcomes were being met with 93% of clients engaged in their individualized plan showing that programming is client-centered, 73% of clients indicated they were more aware of services and

tools available to help them reach their goals since accessing service, and all employed clients received follow-up and support from the ABI employment specialist and/or mentor.

Results also suggested that intermediate outcomes were being met with 60% of respondents stating that they are closer to their employment goals since obtaining service, and 77% believing PIE helped them manage some of their barriers to employment.

During the review period, 21 jobs were found for 17 clients (and maintained). Twenty additional jobs were maintained for another 20 clients (for jobs obtained prior to the review period). Of clients seen during the review period, 40% of the entire caseload and 62% of clients in active job search were employed. All client respondents indicated that the ABI services they received made a difference in their lives, and a positive impact on their lives.

The Employer Questionnaire revealed very positive results with all respondents indicating that the supported employment service appears to benefit the client, that they believe there is a benefit to working with the program, and that the services do help address the client's barriers to employment. Eighty percent agreed that the ABI services made a positive impact in the client's life.

SK Abilities Council: Regina Branch Supported Employment Program - Partners in Employment (PIE)

Program Description

History: Has served 193 individuals with an ABI since January 1997

Location and Hours: Regina, office hours are from 8:30 am - 4:30 pm, Monday to Friday

Staffing: 1 FTE (Employment Specialist)

Target Group: Individuals are 16 years of age or older, and have an ABI that impacts their ability to prepare for, gain or maintain employment.

Partners: Partners in Employment offers a spectrum of supported employment services that assists individuals to prepare for, attach to, and maintain employment. These services include pre-employment skill-building, employment preparation, vocational counseling, job development, job coaching and maintenance services. In addition, Partners regularly networks/consults with other ABI programs, community based organizations, and government ministries.

Need met by the Program/Typical Client Goals: Some individuals with an ABI benefit from supports to assist them to understand and implement steps and or skills needed to successfully prepare for employment. The service responds to clients' needs by offering individualized supports that include skill building opportunities and strategies that garner vocational progress. Typical client goals include enhancing skills/knowledge related to areas of pre-employment, career direction, enhanced job search/ interview skills, development of a resume and/or portfolio, enhanced job search/interview skills, job match, and job accommodations/training support. All individuals accessing service will be supported to develop and implement a realistic Career Action Plans. Once developed, the Employment Specialist works with and encourages the participant to progress through the plan.

Services/Activities: The Partnership funds the Employment Specialist position. This person works with the client to determine what activities will prepare them for successful employment attachment, this information is captured within a Career Action Plan (CAP). Once the CAP is developed, the Employment Specialist works with, and encourages the participant to progress through the plan. The content of the career action plan is based on collected information discovered during intake and other routine meetings. Generally this information includes, individual job seeker's strengths, skills, abilities, and any barriers or skills which need supporting or strengthening. CAPs are often comprised of activities that fall under specific categories of employment support services. The Employment Specialist's role is to coach and mentor clients through these activities. The work that is undertaken by the Employment Specialist and the client may occur by: clarifying expectations, working through skill targeted worksheets, staff directed research, and/or practical application. The method of learning depends on the depth of skills to be acquired and the learning style of the individual.

Intended Program Impact: The goal of the program is to facilitate paid employment for individuals who have an ABI through placement training and individualized supports.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• MVC – All Causes • Stroke • Tied for 3rd: Other (not TBI) and Tumour
Living Situation - Top 3	• Independent in own or family home To a much lesser extent – and tied for 2nd: • Supported with limited assistance • Supported in own or family home
# of service events per client over the fiscal years/ average minutes per event	32 events / 30 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Vocational Services • Consultation/Education/Training • Administration
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Another six recipient types make up the other 2% of recorded recipients
Community/E&P Topics -Top 3 (based on number of events, not time)	None

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 27 clients discharged in 2014-15. Of the goals that were not withdrawn, 73% were fully achieved and 4% were partially achieved. All goals were recorded in the area of "Employment".

Evaluation: In 2014, 16 individuals participated in the evaluation. These participants were a mix of new and existing clients. Some components of the evaluation were focused on process.

Result Highlights: Approximately 30 individuals who were highly engaged in services were approached to participate in a questionnaire. Individuals who were not approached generally were employed and considered relatively stable in their jobs, and did not require support with any set routine or high degree of frequency. Of the 30 approached, 16 agreed to participate by completing appropriate sections of the Self-Assessment Questionnaire. Of the 16 who participated, nine were new clients to the service and would have begun service by developing a career action plan with the Employment Specialist. During the evaluation period, eight individuals moved into job search and began to access Job Development services. As these participants entered this service, they worked with the Employment Specialist to identify the focus of realistic employment and any accommodations that would need to occur to

ensure success. Individuals who either were employed, or became employed during the evaluation were included in the Job Maintenance focused portion of the evaluation which focused on clients building independence at work, employers satisfied with their new hire, and clients being satisfied with their jobs. Result highlights are as follows:

- In terms of the "Process evaluation" aspect of this report, 88% of clients had an updated Career Action Plan (CAP) on file
- Nine individuals who were both new to service, and progressed to job search phase, (completed pre-employment steps) gave the following ratings:
    - 55% clients with new CAPs indicated they were more confident in becoming employed after development of the CAP, indicating that clients gain knowledge of how to gain and maintain employment.
    - 100% of clients were more aware of their specific employment needs and accommodations.
    - All eight of the individuals who began employment had hours of support decreased by 80% between the first and fourth month of employment, indicating clients building independence at work.
    - All eight clients passed their three month probation period, and maintained employment for six months or more. These clients rate satisfaction as 3 or greater (out of 5) in their job satisfaction survey.
    - From information gathered from site visits, employers offered feedback indicating that their new employee's confidence had grown, and they were exhibiting appropriate work skills/ task completion over time. Employers became confident in the new employee and their skill in supervising/supporting them.

Multiworks

Program Description

Service Area: Residential – serves clients in Multiworks group homes in Meadow Lake.

History: Has served 20 ABI survivors since 2003, but has been serving persons with disabilities since 1978.

Location and Hours: Meadow Lake, delivers group homes and supported living, day program, supported employment, and the SARCC oil re-cycling centre programming.
Multiworks offers the Workshop and Day program: 8:30am-4:30pm for staff; 9am-4pm for clients.

Staffing: The ABI Partnership funds .32 FTEs

Target Group: Individuals with disabilities. ABI funding currently supports three clients with an ABI. Two clients attend the workshop and one client attends the day program.

Partners: Referrals come from Social Services' Community Living Division. Multiworks has many community partnerships including those that offer volunteer opportunities: outreach centre, hospital, churches, schools, RCMP-laundry services, second-hand store, care home, animal shelter; and clients work at various businesses including OCB mill-shop and newspaper depot. Multiworks also has many recreational linkages in the community including the bowling alley, swimming pool, library, and seasonal activities (e.g., Special Olympics). In partnership with the Prairie North Regional Coordinator, a support group is held once a month.

Need met by the Program / Typical Client Goals: Clients have varied goals. Common ones are for meaningful work, good friendships in the community and a good environment to live in. Goals include: showing up for work on time; having good hygiene; being dressed appropriately for weather, work or day's activities, being "part of the team", behaviour (e.g., being courteous, polite).

Services / Activities: Activities vary based on client goals and the program that a given client is in (group home, day program, workshop). Examples include work on life skills (meal prep/clean-up, taking medications, doing laundry, grocery shopping) where clients are assisted when needed, but encouraged to do the tasks themselves. Clients are also encouraged to go out into the community and visit friends and family, and staff also organize community and recreational outings.

Additionally, a support group is held once a month in partnership with the Prairie North Regional Coordinator.

Intended Program Impact: Vision Statement "Maximized opportunities, personal growth and happiness for people with disabilities."

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	Blow to head (not assault) Encephalitis/Meningitis
Living Situation - Top 3	Group Home
# of service events per client over the fiscal years/	469 events / 371 minutes each

average minutes per event	
Client Activities - Top 3 (based on number of events, not time)	• Life Skills Training
Recipients – Top 3 (based on number of events, not time)	• Other Group (mixed) • Individual (Survivor)
Community/E&P Topics -Top 3 (based on number of events, not time)	None

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: No clients were discharged in either 2013-14 or 2014-15. Goals were submitted for the three clients active in the 2014-15 fiscal year. Of the goals that were not withdrawn, 8% were fully achieved and 85% were still in progress. Including withdrawn goals, the top two goal areas (accounting for 54% of recorded goals) were "Understanding ABI" and "Pain Management". There were six other goal areas accounting for one goal each.

Evaluation: Multiworks' site level evaluation consisted of case studies of the three clients that the ABI Partnership funding supports. Case studies illustrated how staff's regular and consistent work with clients maintained and in some instances improved clients' independent living skills, and led to better anger management.

Crisis Programming (2 Programs)

Saskatoon Crisis Intervention Services (Saskatoon), Mobile Crisis (Regina)

Saskatoon Crisis Management Service (SCMS)

Program Description

Service Area: Saskatoon

History: Has served 44 ABI survivors since 1996, but the agency has been in operation since 1980. In 1983, SCMS established a second service for those with mental health and behavioural problems who manifested as "hard to serve, difficult to engage". The ABI Partnership contracted with SCMS to serve ABI survivors in crisis in 1996.

Location and Hours: Office is located in Saskatoon. SCMS operates ten hours daily, Monday through Saturday, and Mobile Crisis Service provides cover-off to all clients when the office is closed. Clients may call Crisis Management Workers at home as indicated.

Staffing: The ABI Partnership funds .5 FTE

Target Group: ABI survivors with mental health and behavioural problems and who manifest as "hard to serve, difficult to engage".

Partners: Referrals come from a variety of sources which include but are not limited to: ABI Partnership funded programs; agencies/services of the Saskatoon Health Region; Ministry of Social Services; Ministry of Justice; Ministry of Health; Salvation Army; Family or Second Parties.

SCMS partners with a variety of community services to help clients establish and maintain a support network and further plan for a safe and meaningful existence in community. Partnerships include: ABI Partnership funded agencies/services; Ministry of Social Services – SAID Program; medical services; psychiatric/psychological/therapy services; substance abuse programs; housing programs (The Lighthouse, Salvation Army, Saskatoon Housing Coalition, QUINT Housing, Mental Health Residential Services, personal care home services); Saskatoon Tribal Council programs; Ministry of Justice (Mental Health Court, Prosecutors Office, Legal Aid, Community Corrections); employment programs (Abilities Council, CMHA, Crocus Co-op); recreational/social programs (Crocus Co-op, Saskatoon Health Region Mental Health Services, City of Saskatoon); Public Trustee and Guardian's Office.

Need met by the Program / Typical Client Goals: Clients served have been marginalized/isolated by the stigma and fear of their behaviours which are usually no fault of their own. Individuals present as non-compliant and difficult to engage, possess complex needs and functioning impairments, and often their lives are chaotic, unsafe and endangered.

SCMS can stabilize ABI Clients' immediate condition (e.g., medical and/or psychiatric interventions, emergency housing, financial help). The primary goal is to help the individuals with compromised abilities to have a safe and comfortable existence. Through working with other services, SCMS identifies negative behaviour that is

the result of an injury or disorder and of that which is learned. SCMS can then pursue community treatment to modify/change those behaviours and ensure the client has a safe place in their community.

Services / Activities: SCMS Provides specialized service coordination and support to individuals with mental or behavioural impairments due to a major mental health diagnosis, acquired brain injury, congenital disorder and/or addiction problem. SCMS:

- Acts as case managers to individuals presenting with complex and chronic problems which affect their ability to function safely and comfortably in the community
- Provides financial trusteeship for those clients with difficulties managing money
- Advocates on the clients' behalf to build support networks and connect them with mainstream human services
- Collaborates with other mental health, addiction and social services to develop and maintain housing, sustenance, social and treatment needs.
- Works with Justice and Public Safety services to ensure clients' fair treatment when legal problems arise and help those services address safety issues the client may present

Intended Program Impact: Once the client has been stabilized and is in a safe environment, SCMS continues to provide intensive case management for however long it takes to establish and maintain their relationship with the client and partner services. The goal of this long-term case management is to enable the client to realize a comfortable existence in the community. Benefits to the community includes support to housing and treatment programs, reduced hospital visits, and reduced justice involvement including court, corrections and police time.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• MVC – All Causes • There were six other causes each accounting for one or two clients
Living Situation - Top 3	• Independent in own or family home • Approved Home • No fixed address
# of service events per client over the fiscal years/ average minutes per event	96 events / 35 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Case Management • Administration • Life Skills Training
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Other Service Provider • There were five other recipient types accounting for 1% of the total services

Community/E&P Topics -Top 3(based on number of events, not time)	None

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: No clients were discharged in 2013-14 or 2014-15. Goals were submitted for 13 clients active in the 2014-15 fiscal year. Of the goals that were not withdrawn, 5% were fully achieved, 55% were partially achieved and 23% were still in progress. Including withdrawn goals, the top three goal areas (accounting for 35% of recorded goals) were "Medication Management", "Behaviour Management" and "Handling money".

Evaluation: Saskatoon Crisis completed five case studies to highlight their work with clients including: clients' situations and need for crisis service, work done with clients by SCMS; gains made by clients, and benefits experienced as a result of their participation in service; and current goals areas.

Regina Mobile Crisis

Program Description

Service Area: Regina

History: Has served 186 ABI survivors through a specialized ABI Case Management Program since 2002. The agency was established in 1973.

Location and Hours: Flexible hours

Staffing: .5 FTE

Target Group: Mobile Crisis Services, Inc. ABI Case Management Program provides services for individuals and families experiencing intermittent, recurring or chronic crisis associated with ABI. This population is described as being non-compliant, hard to serve, or difficult to manage.

Partners: Partners include: CRT[Crisis Response Team – MHC], Rentalsman, MSS- Financial, ADS- Brief Detox and Social Detox, Kids First, Salvation Army, Landlords, Carmichael Outreach, SWADD, Regina City Police, Ministry of Social Services - SAID, Ministry of Social Services – Child Protection, Pearl Manor – Pheonix Residential, Public Trustee Office, Correctional Centre, Souls Harbour Rescue Mission, Regina General Hospital, Pasqua Hospital, Social Work: Emergency, Adult and Adolescent Psychiatry and Cancer Clinic, Marion Centre, Four Directions Community Health Centre, SGI, and Cognitive Disability.

Need met by the Program / Typical Client Goals: Mobile Crisis serves individuals and families experiencing intermittent, recurring or chronic crisis associated with ABI. This constant instability may result in unmet physical, mental, psychosocial or basic needs. These clients are often not receiving appropriate services as the services may be unavailable, inaccessible, inappropriate, or have been refused to the client. The ABI Case Management Program developed from the need to address these issues and take a proactive involvement with these clients to obtain and maintain required services.

When a client's crises escalate or further impair his or his level of functioning, the unmet needs become evident or disruptive to the family, the community and/or other agencies. Often, it is one of these third parties who bring the client's needs to the attention of appropriate agencies. In many cases, the need is for crisis resolution (and prevention of further crisis), coordination of services or intensive case management. Many agencies have difficulty fulfilling these needs as time and resources are limited and intense involvement is often not possible although necessary. Presenting with chronic or serial crises, many clients have multiple deficits in social functioning:

- Mental health and severe behavioural problems
- Non-compliance to accepting help, treatment, etc.
- Conflict with others
- Self-harm issues, suicide prevention services
- Substance abuse and addictions issues
- Involvement with the criminal justice system
- Chronic Instability

Programming attempts to maintain stability of basic needs, reduce risk behaviors and identify areas of growth.

Services / Activities: Includes assessment, service coordination, crisis intervention/management and assertive outreach services through telephone, in-office visits and interviews, or a variety of meetings in the community. The worker works with the client to establish what their needs are, meets with the client, collaterals, and other agencies to obtain resources and services for client, develops appropriate plans with clients, regularly meets with clients to facilitate follow-through, and does more regular work to support day-to-day needs such as budgeting, paying bills, groceries, appointments, practicing social skills, and in the case of justice system involvement, working with the client and other agencies, such as Parole Officers, to ensure that the client follows conditions and does not compound current legal issues.

Intended Program Impact: to reduce crisis behavior and enhance client functioning, and movement towards service plan goals (e.g., clients will maintain housing, be able to budget, actively engage in appropriate treatments, reduce mental health risk behaviour, substance overuse, aggressive behaviour, justice system involvement, maintain stable basic needs (shelter, food, clothing, health care, etc.)

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Other (not Traumatic Brain Injury) • Blow to Head (Assault) • MVC – Driver or Passenger
Living Situation - Top 3	• Independent in own or family home • No fixed address • Tied for 3rd: Independent with difficulty, Supported with Limited Assistance
# of service events per client over the fiscal years/ average minutes per event	61 events / 47 minutes each
Client Activities - Top 3 (based on number of events, not time)	• All Case Management
Recipients – Top 3 (based on number of events, not time)	• All Individual (Survivor)
Community/E&P Topics -Top 3 (based on number of events, not time)	None

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 4 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 24% were fully achieved and 45% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for 41% of goals) were: "Relationships with Others", and tied for second "Addictions", "Behaviour Management", "Housing", and "Leisure Activities".

Evaluation: The complexity in evaluating the ABI Case Management Program lies in the amount of improvement achieved or that can be shown regarding each client. Data collection took place over a six month period, January 2014 to June 2014, and tracked number of contacts the ABI caseworker worker had in relation to eight service need areas. This data collection did not look at all needs (e.g., health) areas. Evaluation highlights include:

- Contacts directly with caseworker amounted to 70% of all contacts. Of the 114 client months of service, there were only 5 months that a client was not engaged by direct contact with the worker. There were 365 contacts with 19 clients over a six month period. Caseworker direct contacts with collaterals, community and client support system was 30% of the overall 1,224 contacts. This demonstrates that substantial proportion of caseworker time is addressing and coordinating services for "difficult to manage" persons with ABI.

- Data collection identified that all clients have needs that require service. Most frequent needs that need to be addressed are addictions; cognitive; food, clothing and personal; housing; and relationships. Over 75% of the 1,224 contacts that the case worker had directly or indirectly with client were in these five need areas.

- The Caseworker had 225 direct contacts that addressed issues with basic needs. That represented 42% of the clients. This need area is a service priority but medium risk to client. The program objective of ensuring clients are safe and have the basic necessities of life was met.

- ABI clients are always involved in an ongoing crisis. When caseworker addresses one ongoing crisis and it is no longer a priority, then the case worker needs to address another ongoing crisis in another needs area. The ability of the caseworker to reduce ongoing crisis is not realistic, unless the client is moved into supported housing that provides a response to service needs.

- Approximately 40% of ABI clients experienced a new crisis during the six months of data collection. Only 15% of clients experienced more than one new crisis, but 73% of clients were involved in an ongoing crisis in one of the need areas. This suggests that services need to be ongoing and part of clients' everyday life.

- ABI clients want services as they engage with caseworker. Data collection confirmed this as direct client contacts were consistent monthly and account for 70% all contacts.

- Mobile Crisis has had a positive impact on individuals with an ABI identified as "difficult-to-manage". This program has reduced incidents of crisis as well as assisted clients in meeting their basic needs. Clients are engaging with caseworker and collaterals. Due to the nature of their disability(s), most clients may only achieve incremental improvements in their abilities and ongoing case management will be essential for most "difficult-to-manage" ABI clients.

Rehabilitation Programming (1 Programs)

Kelsey Trail – Speech Language Pathologist (SLP)

Program Description

Service Area: Kelsey Trail Health Region

History: Has served 114 ABI survivors since 1997

Location and Hours: The program's general hours of operation are from 7:00 am to 5:00 pm on Monday and Thursday. The service headquarters is located in Melfort.

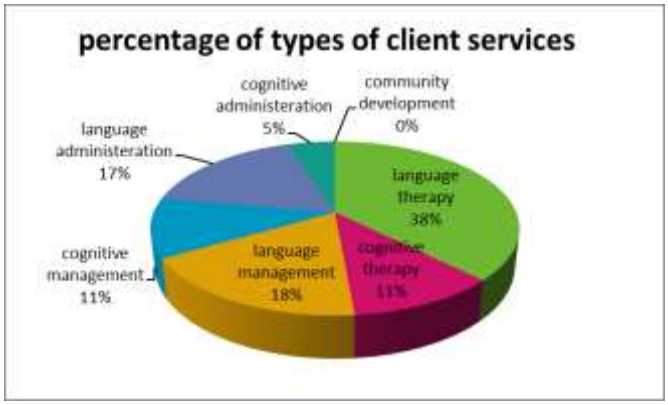
Staffing: .5 FTE

Target Group: Individuals of any age with a moderate to severe acquired brain injury

Partners: The main source of referrals for this program are received from medical staff, in particular, doctors and nurses in the LTC facilities and the rehabilitation program in Saskatoon. Referrals have also come from home care, East Central SARBI, from the therapy services in Prince Albert, through Kelsey Trail health region therapies, families and self-referrals. Schools have made referrals in the past as well.

Need met by the Program / Typical Client Goals: Prior to 1997, there was no adult SLP and no service for ABI survivors in Melfort or in the Kelsey Trail Health Region. This program works with ABI survivors (and their families) who have motor speech difficulties; language difficulties including auditory comprehension, reading comprehension, verbal expression and written language; swallowing difficulties, and/or cognitive issues.

Services / Activities: Once assessments are completed and scored, goals are selected to address difficulties in consultation with the individual survivor, and taking into account families', caregivers' and staff's concerns. Level of prior abilities is taken into account, especially with reading and writing. Goals are increased as they are met. Clients are seen directly with home programs and/or suggestions being given for them to do with their families. Reassessment is done based on progress, not on timeframe.



Intended Program Impact: The intended outcomes are that families are educated and consequently know how best to communicate with their family member. In addition, ABI survivors improve their:

- communication abilities, and are able to communicate their wants, needs, and dreams with others in their lives, as well as engage in conversation at the highest possible level they can;
- speech intelligibility so that others can understand what they are saying;
- cognitive and memory skills to the highest level possible and/or that they learn compensatory strategies, such as the use of external memory devices;
- oral motor skills as they pertain not just to their appearance, but to their speech and their swallowing abilities;
- their swallowing skills, so that they are safe oral eaters, and/or that they learn compensatory strategies to aid in their swallowing, or that the SLP provide the recommendation that the survivor is not a safe oral eater and provide non-oral feeding options.

SERVICE INFORMATION

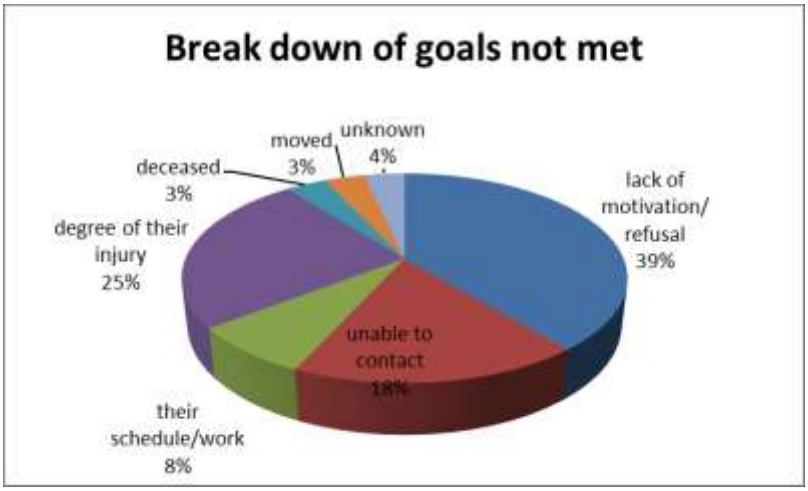
Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Causes of Injury - Top 3	• Stroke • Tied for 2nd: Aneurysm & Tumour
Living Situation - Top 3	• Long Term Care Facility • Independent in own or family home • Tied for 3rd: Supported requiring assistance and supported requiring limited assistance
# of service events per client over the fiscal years/ average minutes per event	10 events / 38 minutes each
Client Activities - Top 3 (based on number of events, not time)	• Speech Language Interventions • Case Management • Administration
Recipients – Top 3 (based on number of events, not time)	• Individual (Survivor) • Other Service Provider • Survivor & Family
Community/E&P Topics -Top 3 (based on number of events, not time)	None

2013-15 PROGRAM EVALUTION RESULTS

Goal Attainment: Goals were submitted for 30 clients discharged in 2013-14 and 2014-15. Of the goals that were not withdrawn, 45% were fully achieved and 33% were partially achieved. Including withdrawn goals, the top three goal areas (accounting for all recorded goals) were: "Memory", "Communication/Language" and "Eating/Swallowing Skills".

Evaluation: As part of the 2013-16 contract period, the Kelsey Trail SLP program conducted an evaluation using Time One (Baseline) Assessment and Follow-up Assessments. From the assessment results, specific areas were selected to work on through goals. There were a total of 91 goals for 27 clients, with an average of three goals per client. Those clients with language goals had the most goals, followed by those with cognitive goals,

then those with swallowing goals. Goal achievement was found to be influenced by the number of therapy sessions, client motivation, family support, the degree of their injury, number of strokes and other complicating medical conditions.



Assessment results showed that clients were making progress on their therapy goals and were improving their function in the areas of: memory (with facilitation tools), safe swallowing/eating and communication. Average score improvements from first to last assessment were as follows (bigger score equals greater ability):

- Language Abilities (n=5): 27% to 62%
- Repetition (n=2): 31% to 38%
- Naming (n=5): 16% to 58%
- Reading (n=1): 40% to 90%
- Cognitive Assessments (n=2): 58% to 63%
- Improvements were also shown for the five clients assessed for swallowing food, and fluids.

In addition to assessment and goal data, there was a general therapy survey that was done in 2013 which returned a satisfaction rating of 90%.

Education and Prevention Programming (5 Programs)

Central Education and Prevention Regional Coordinator

Program Description

Service Area: The Coordinator serves individuals and communities within the Saskatoon, Prairie North and Heartland Health Regions

History: The executive summary from the Program Evaluation Report titled "Acquired Brain Injury – A Strategy for Services" (December 1998) had several recommendations and action plans noted at the conclusion of the report. There were specific recommendations within this report that addressed the need for a coordinated education and prevention program. It stated that education and prevention activities and initiatives need to be developed and be a priority in each region. The position of Education and Prevention Coordinator was created on the Sask. Central Acquired Brain Injury (ABI) Outreach Team to meet these needs. A permanent full-time (1.0 FTE) position was filled on September 23, 2002. This position continues as 1 FTE to date.

Location and Hours: Saskatoon – full time

Target Group: Children/youth/students, adults, educators/teachers, health care professionals, community service providers, family/natural supports, general public, professionals and ABI survivors.

Partners: A network of professionals, services, contacts, volunteers in the Saskatoon Regional Health Region, Heartland Health Region and Prairie North Health Region, which include:

- Saskatchewan Prevention Institute – Brain Blast/Brain Awareness Week
- MS Society – Brain Blast/Brain Awareness Week
- University of Saskatchewan – Presentations to Kinesiology classes/Brain Awareness Week
- Alzheimer's Society – Brain Blast, Brain Awareness Week
- ThinkFirst/Parachute – Brain Day, Concussion Conference, No Regrets, and lead the ThinkFirst/Parachute Saskatoon Chapter committee as the program coordinator and liaison with the National Parachute office.
- SHR Media Relations – Promotion for PARTY program, Seniors Falls Prevention, Brain Awareness Week
- Forever In Motion and Older Adult Wellness – Teaching the Canadian Falls Prevention Curriculum Training
- Humboldt and Area Safe Community Coalition – Partnered with ThinkFirst/Parachute and PARTY program
- PARTY National Office – reporting in regards to the PARTY program
- NeuroDevNet – Brain Awareness Week
- Saskatoon Community Foundation – funding support for the PARTY program 2013-2014
- Saskatoon Tribal Council – PARTY program, Brain Walk and General Injury Prevention Initiatives

- Saskatoon Catholic and Public School Boards/Divisions, Sun West, Prairie Spirit, and Horizon School Divisions – ThinkFirst/Parachute presentations, Brain Walk and PARTY programs, Safety Superheroes - *Preventing Grandparents from Falling* book, General Injury Prevention Information
- Saskatchewan Teacher's Federation – currently houses our resource kits
- Saskatchewan Brain Injury Association – Brain Awareness Week
- SGI – SGI/ABI Community Grants, ABI Partnership Project
- Falls Prevent Consortium – Keep up to date on various falls prevention initiatives
- Safe Sask. – Look to as a resource in regards to Injury prevention information
- Brain Tumor Foundation – Brain Awareness Week
- Saskatchewan Neuroscience Network - Brain Awareness Week, ThinkFirst/Parachute Brain Day
- Let's talk Science – Volunteer Resource
- University of Saskatchewan – Continuing Physical Therapy Education and Huskie Athletics – Concussion Conference, Concussion Management cards
- SHR- 7th floor Rehab, Volunteer Services, Mental Health and Addictions – PARTY program
- RCMP "F" Division – Forensic Collision Reconstruction – PARTY program
- MD Ambulance – PARTY program
- Saskatoon Police Services – Drug Awareness and Health Lifestyles Day

Need met by the Program: Awareness and education is needed to reduce injury and develop healthy lifestyles within individuals, groups, and communities.

- Saskatchewan had the second highest economic burden of injury at $791 per capita (*The Economic Burden of Injury in Canada Report*, 2009)
- Injury was the major cause of death in ages 10-34 (*Saskatchewan Comprehensive Injury Surveillance Report*, 1995-2005)
- In Canada, the per capita costs arising from transport related injuries are 2.25 times higher for males than females. Males aged 20-24 had the highest per capita cost of transport related injury - 3.43 times higher than the cost for Canadians in general. The per capita cost for injuries involving males aged 15-19 was almost as high at 3.35 times higher than that for Canadians overall (*The Economic Burden of Injury in Canada Report*, 2009)
- Motor vehicle incidents generated the greatest costs among transport related injuries – 52% of all transport related injury costs, cycling incidents accounted for 12% followed by ATV/Snowmobiling incidents which accounted for 10% of total costs (*The Economic Burden of Injury in Canada Report*, 2009)
- Falls was the second top related cause of injury related deaths in seniors 65+ (*Saskatchewan Comprehensive Injury Surveillance Report*, 1995-2005)
- In Canada, brain injury is the number one killer and disabler of people under the age of 44
- Falls and motor vehicle/traffic incidences are the top two causes of these injuries
- Statistics further indicate that incidences are two times greater within the male population (*Brain Injury Association of Canada*, 2013)

The promotion of injury prevention practices will be achieved by providing resources, education, activities, research, consultation and community development initiatives to:

- Develop awareness and understanding within individuals, groups, and communities of the existing trends, patterns and lifestyles that lead to injury.
- Help individuals, groups and communities create awareness and injury prevention practices.
- Increase awareness and education of ABI within communities, service providers and families of injury.
- Provide one-on-one education to individuals that have sustained a mild brain injury. Studies (i.e., Mittenberg, Canyock, Condit et al., 2001) show that individuals who receive information about their injury recover faster and feel better during their recovery than patients who do not get such information.

Services / Activities:

- PARTY Program
- Brain Walk
- No Regrets
- Act as program coordinator for the ThinkFirst Chapter
- Identify resource need/gaps, research, develop, provide, and maintain resources related to PARTY program, Brain Walk, and other ABI Service/programs such as ABI Education & Prevention program, brain injury, bicycle safety, child passenger safety, fall prevention, general injury prevention, helmet use, home safety, playground safety and the brain
- Consult, advise, support and act as a resource to communities and professionals regarding brain injury and injury prevention resources
- Provide brain injury and injury prevention education and resources
- Maintain liaisons and participate with ABI Outreach Team, health care, health region, professional and community agencies to coordinate education and prevention services
- Research, develop, disseminate and deliver injury prevention programs, services, education, information and partnerships
- Assist in coordinating community-based injury prevention education, services and initiatives
- Maintain registry of appropriate local, provincial and national injury prevention resources
- Assist to identify community needs and risk groups/behaviors
- Assist in resourcing, planning, organizing and implementing injury prevention education, services and initiatives
- Research, develop, disseminate and deliver brain & brain injury programs, services, education, information and partnerships
- Assist in coordinating community-based brain & brain injury education, services and initiatives
- Maintain registry of appropriate local, provincial and national brain & brain injury resources
- Assist to identify community needs and risk groups/behaviors
- Assist in resourcing, planning, organizing and implementing brain & brain injury education, services and initiatives
- Actively participate in regional Seniors' Fall Prevention Consortium
- Provide resources, information and education to committees and professionals
- Assist in the planning and delivery of falls prevention initiatives
- Research and development of resources
- Teach the Canadian Falls Prevention Curriculum to professionals

Intended Program Impact: The ABI Education & Prevention Coordinator will support community based injury prevention initiatives and provide education on ABI. The ABI Education & Prevention Coordinator will support community based injury prevention initiatives and provide education on acquired brain injury.

- **Prevention:** To assist communities to develop effective injury prevention initiatives.
- **Education:** To raise awareness of acquired brain injury and its effects on individuals and their families and to impart specific knowledge to individuals with acquired brain injury, their families, and care givers.
- **Community Development:** To assist communities to develop, coordinate, facilitate and evaluate education and injury prevention initiatives.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Type of Group – Top 3 -based on attendee numbers	• Children/Youth/Students • Professionals • Educators/Teachers
Activities – Top 3 -based on service hours	• Community Development • Administration & Evaluation • Program Preparation & Follow-up
Topics – Top 3 -based on attendee numbers	• PARTY • Helmet Use • General Injury Prevention

2013-15 PROGRAM EVALUTION RESULTS

The Central ABI Education and Prevention Coordinator evaluated PARTY programming. Students were given a pre-program questionnaire, one week post-program questionnaire, and finally a six month post-program questionnaire. Each student's pre, one week post-program and six month post-program were matched so the same students' responses could be matched. The results were analyzed in two different categories.

1. Pre-program questionnaire and six month post-program questionnaire
2. One week post-program questionnaire and six month post-program questionnaire
3. Pre-program questionnaire and one week post-program questionnaire

The total number of students (sample) was 116. The number of students for all urban schools was 99 and the number for rural school was 17.

Results: Descriptive statistics were computed on each attitudinal question for urban, rural and all schools combined. The percent of ideal answers was calculated by taking the ideal, or non-risk taking answer to each question. Ideal answers were based on yes/no responses. For example, the ideal response to question one,

"would you operate a motorized vehicle after drinking alcohol", would be no. (Gerwing J, 2010). Some ideal answers were yes, such as "do you wear a seatbelt." For all schools combined, all of the one week post-test ideal percentage scores were higher compared to the pre-test time period.

In order to compare the pre-test and post-test scores statistically, paired sample t-tests were conducted on all attitudinal questions combined. There was a statistically significant (at the 95% level) increase in the percentage of ideal answers between the pre-program questionnaire and the one week post questionnaire for all schools combined. The same statistically significant results were found for all urban schools combined and for all rural schools combined.

However, when comparing the six month post questionnaire to the one week post questionnaire, attitudes were not maintained. However, these attitudes were still positively changed as compared to the pre-program questionnaire except regarding reckless skiing and snowboarding.

Sample of Evaluation Questions with Evaluation Results:

Is there a positive change in attitude from the pretest before the program in comparison to the post-program questionnaire one week after the program? There was a statistically significant positive change in attitude from the pre-program questionnaire filled out before the program in comparison to the post-program questionnaire filled out one week after the program.

Is there a change in knowledge from the pre-program questionnaire before the program in comparison to the post-program questionnaire one week after the program? There was a statistically significant increase in knowledge between the pre-program questionnaire and one week post-program questionnaire.

Is a positive change in attitude maintained six months following the program? Yes a positive change in attitude was maintained in all attitudinal questions as compared to the pre-program questionnaire except regarding the question about reckless skiing and snowboarding.

Is there an increase in knowledge maintained six months following the program? Yes. When compared to the pre-program questionnaire, students maintained an increase in knowledge six months post-program. However, this increase was not apparent when compared to the post-program questionnaire given one week following the program.

North Education and Prevention Regional Coordinator

Program Description

Service Area: Communities within Prince Albert Parkland, Kelsey Trail, Mamawetan Churchill River (MCRHR), Keewatin Yatthé (KYHR) health regions and the Athabasca Health Authority (AHA)

History: In 1996, under the original *Call for Proposals* from the Acquired Brain Injury (ABI) Strategy, the Parkland Health District submitted a proposal for a Prevention Worker position as part of the submission from the Northern Service Area Working Group. The objective of this position was "to plan for public education and prevention of accidents with other community partners". This request stemmed from the results of the Parkland Health District Youth Needs Assessment and information from the Saskatchewan Institute on Prevention of Handicaps' Child Injury in Saskatchewan report. This data demonstrated a high incidence of risk taking behaviours in children and youth that led to a greater number of injuries, hospitalizations, and deaths. The request for a Prevention Worker was deferred until the Provincial ABI Education & Prevention Coordinator was in place. At this time, funding was granted to hire an ABI Rehabilitation Assistant for Parkland Health District.

Through the years from 1996 to 2000, Parkland Health District still maintained an interest and a need for a Prevention Worker. The Prevention Institute released two further reports in 1997 and 1998 that further supported this need -- *Critical Issues in Health for Children* and *Critical Issues for Health in Youth*. During this time, the Parkland ABI Rehabilitation Assistant did some work in injury prevention as time permitted including bicycle safety, child passenger safety, water safety and snowmobile safety. The ABI Rehabilitation Assistant also recognized a need for education around the brain and brain injury and created the Brain Walk © program.

In May 2000, a designated ABI Education/Prevention Coordinator position was created with the position being located in Spiritwood and providing services for the people and communities within Parkland Health District. Original funding was for 0.6 FTE for this position.

In December 2002, the funding for the Education/Prevention Coordinator position was increased to 1.0 FTE. This led to the creation of the "North Central" ABI Education & Prevention program and service area was increased to include both Prince Albert Parkland and Kelsey Trail health regions. The position remained in Spiritwood until the spring of 2007 when the position became vacant and was relocated to Prince Albert to be co-located with the Sask North ABI Outreach & Independent Living programs (formerly Residential Options).

During the 2007-2010 contract period, this Prince Albert based Education/Prevention position began to provide service to the three northern health regions (Athabasca, Keewatin Yatthé & Mamawetan Churchill River) in addition to Prince Albert Parkland and Kelsey Trail health regions. This coverage began as a temporary arrangement when the northern regions were unable to maintain consistent staffing in their funded Education and Prevention position. This arrangement became permanent in the next contract period and became known as the "North" ABI Education/Prevention Program. This is the program that is currently in place today.

Location and Hours: Prince Albert – full time. 8:00 am - 4:30 pm, Monday to Friday.

Target Group: Children, youth, adults, educators/teachers, health care professionals, and the general public.

Partners:

- Prince Albert Safe Communities
- Red Cross
- PAPHR Health Promotion, Public Health, Therapies, ER , Volunteer Services, Addictions
- KTHR
- MCRHR
- AHA
- In Motion
- School Divisions
- Tribal Councils
- NITHA
- Saskatchewan Prevention Institute
- SK Snowmobile Association
- SK Safety Council – ATV Safety
- Parachute
- Kids First North
- SGI
- PA Cooperative Health Center
- Lakeland District for Sport, Rec & Culture
- RCMP, PA Police
- Fresh Air Experience
- Sask Provincial Parks
- Parkland Ambulance, Blaine Lake Ambulance, Spiritwood Ambulance, Big River Ambulance

Need met by the Program: The current need for injury prevention and education in the North is summarized in *The Northern Saskatchewan Health Indicators Report* (2011) by Dr. James Irvine and colleagues. The report provides a summary of health and living circumstances in northern Saskatchewan, and portrays many issues and challenges faced by northern residents.

In consideration of injury risk and prevalence, the following excerpts depict the need for injury prevention programs to enhance healthy habits and practices:

- Injuries and violence account for 23.4% of deaths in northern Saskatchewan compared to 6.4% of deaths among the total Saskatchewan population.
- In Saskatchewan, circulatory diseases and cancers are the most common causes of death with injuries being the fourth most common. In northern Saskatchewan however, injuries are the leading cause of death followed closely by circulatory disease and cancer.
- A child under 20 years of age in Mamawetan Churchill River Health Region is twice as likely to die from injury as is the average Saskatchewan child.

- Suicide was the leading cause of injury deaths in northern Saskatchewan between 1998 and 2007, accounting for 1 in 4 injury deaths. Motor vehicle traffic collisions and water transport/drowning and submersion, were the second and third leading causes of injury deaths respectively, followed by homicides and assaults. These four categories accounted for about 65% of all injury deaths in northern Saskatchewan.
- Greater proportions of both injuries and deaths from traffic collisions involve a drinking driver in the north compared to the province as a whole. In 2010, one in three injuries and two in three deaths from traffic collisions in the north involved a drinking driver.
- Between 1995/6 and 2006/7, the rate of injury hospitalization was higher in northern Saskatchewan than in the whole province, with Keewatin Yatthé Health Region at 1.2 times and Athabasca Health Authority at 1.6 times the provincial rate.
- Between 1995/6 and 2006/7, the major causes of injury-related hospitalization in northern Saskatchewan were: accidental falls, assault, land transport, intentional self-harm and accidental poisoning.
- The crude rate of deaths from traffic collisions remained relatively stable across the province between 2004 and 2008. In contrast, rates in northern Saskatchewan have been rising since 2005, and in 2008 were over 2.5 times the provincial rate. Ongoing surveillance will determine whether this increase in 2008 is a sign of an increasing trend or a one-year anomaly.

Services / Activities:

- **Administration & Evaluation:** Program related administration & documentation such as reports, grant applications, program questionnaire evaluations, etc. concerning PARTY, No Regrets, Brain Walk, Bicycle Safety, etc.
- **Community Development:** Networking with community resources for the identification of education and prevention priorities or needs in a community.
- **Education & Training:** Various events, activities or programs are delivered for the purpose of increasing knowledge, skills or awareness. The level of involvement of the worker may vary at each event e.g., presentations, organizing, facilitating. Examples would be Camp event, PARTY, Brain Walk, No Regrets, etc.
- **Program Preparation/Follow-up:** The preparation and consultation to stage events for Community Development activities and Education/Training as well as follow-up is ongoing.
- **Promotion:** Proactive efforts that offers or promotes services and resources is ongoing. For example: resource catalogue, media activities, newsletters, event posters.
- **Research:** Activities of research relevant to program delivery (e.g., locating resources or other organizations and audits) is ongoing.
- **Resource Development:** The creation or ongoing development of services/resources (e.g. resource kits, developing fact sheets/brochures, newsletters, etc.) is ongoing.

Intended Program Impact: The overall logic of this program is that promotion of safe lifestyle choices will be achieved by providing resources, education, activities, research, consultation and community development initiatives to:

1) Develop awareness and understanding within individuals, groups, and communities of the existing trends, patterns and lifestyles that create injury
2) Provide stimulus and incentive to individuals, groups and communities to adopt safe lifestyle practices

The expected effect of this work is that individuals, groups and communities recognize the dangerous patterns within themselves through education and information. With acceptance, change of attitude, and motivation, a shift to a positive life style will take place.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Type of Group – Top 3 -based on attendee numbers	• Children/Youth/Students • General Public • Adults
Activities – Top 3 -based on service hours	• Program Preparation & Follow-up • Event Delivery (Education & Training) • Administration & Evaluation
Topics – Top 3 -based on attendee numbers	• Brain Walk • The Brain • Mild Brain Injury

2013-15 PROGRAM EVALUTION RESULTS

For their site evaluation, the North Education and Prevention program chose to analyze one of the largest programs it delivers – Brain Walk. An analysis was completed of program evaluations that were collected from teachers, participants and volunteers for programs that ran between April 1, 2013 and March 31, 2014. Evaluation from a total of 401 students and 30 teachers/school staff were received representing completed programs in four of the five health regions within the North Education & Prevention program service area.

Results: During the time period included in the evaluation, the Brain Walk program was provided to students from Grades 1-7 with the largest proportion of students (28%) being in Grade 3. Overall student responses to the program were very favourable with:

- 87% choosing a “happy face” when asked what they thought about the Brain Walk program
- Demonstration of learning with respect to functions of the brain, ways to protect their brain (97% responded to wear a helmet), and the long term effects of brain injury

Teacher/support staff responses to the Brain Walk program were also very favourable with 100% of respondents indicating that they were happy with the program.

South Education and Prevention Regional Coordinator

Program Description

Service Area: Communities within the Regina Qu'Appelle, Five Hills, Sun Country, Sunrise, and Cypress Health Regions

History: The executive summary from the Program Evaluation Report titled *Acquired Brain Injury – A Strategy for Services* (December 1998) contains recommendations and action plans at the conclusion of the report. Recommendations 8, 9 and 10 address the need for a coordinated education and prevention program, and that activities and initiatives be prioritized and developed within each region. The Sask South ABI Outreach Team received initial funding from the ABI Partnership Project in September 2002 to operationalize the Southern ABI Education and Prevention Program. This allowed for the creation and hiring of a 1.0 FTE South ABI Education & Prevention Coordinator. The position was recruited for and filled in September 2002 and the original hire remains in the position.

Location and Hours: Regina full time

Target Group: Children/youth/students, adults, educators/teachers, health care professionals, community service providers, family/natural supports, general public, professionals, and ABI survivors.

Partners: Regular partners (in alphabetical order) include:

- ABI Education & Prevention Coordinators (Central and North)
- ABI Partnership Provincial Office
- ABI Regional Coordinators (Cypress, Five Hills, Sun Country and Sunrise Health Region)
- Parachute
- PARTY: Community Partners (participating schools and community services) and Program Headquarters
- Regina and Area Seniors Falls Prevention/Partners in Positive Aging committee
- Regina Qu'Appelle Health Region – urban and rural Health Promotion, urban and rural Population Public Health, Therapies
- Safe Communities in Assiniboia
- Safe Saskatchewan
- Sask Prevention Institute
- Sask South ABI Outreach Team
- Schools within the South Service Area
- SGI
- University of Regina – Faculty of Kinesiology, Nursing, and Centre on Aging & Health

Need met by Program: To provide ABI education and injury prevention support through creating awareness, providing education and resources and collaboration through the community development process.

Services / Activities:

- **Administration & Evaluation:** Program related administration & documentation such as reports, grant applications, program questionnaire evaluations, etc. concerning PARTY, No Regrets, Brain Walk, Bicycle Safety, Senior's Wellness Clinics, Resource Kit usage etc.
- **Community Development:** Networking with community resources for either the benefit of client service provision or the identification of education and prevention priorities or needs in a community. Examples would include attending Safe Communities Priority Setting day, and the Regina and Area Seniors' Falls Prevention Strategic Planning sessions etc.
- **Education & Training:** Various events, activities or programs are delivered for the purpose of increasing knowledge, skills or awareness. The level of involvement of the worker may vary at each event i.e., presentation, organizing, facilitating. Examples would include child passenger inspection appointments and clinics, PARTY program days, Brain Walk events, No Regrets initiatives, etc.
- **Program Preparation/ Follow-up:** The preparation and consultation to stage events for community development activities and education/training as well as follow-up is ongoing. Examples would include all efforts related to gathering resources, files and equipment as well as transportation for various community PARTY program days or Brain Walk events, coordinating resource kit utilization to and from various schools, professionals and communities, forwarding related or post follow-up information after attending an injury prevention initiative such as the Seniors Wellness Clinics or Health Fair.
- **Promotion:** A proactive effort that offers or promotes services and resources is ongoing. Examples would include resource catalogue, media activities, newsletters, event posters, web site etc.
- **Research:** Activities of research relevant to program delivery. Examples would include locating topic-specific resources or organizations, and audits, updated injury stats, current best practices etc.
- **Resource Development:** The creation or ongoing development of services/resources. Examples would include updating resource kits, developing fact sheets/brochures, newsletters, revising PARTY program templates and presentations etc.

Intended Program Impact: The ABI Education & Prevention Coordinator will support community-based injury prevention initiatives and provide education on ABI.

- **Prevention:** To assist communities to develop effective injury prevention initiatives.
- **Education:** To raise awareness of acquired brain injury and its effects on individuals and their families and to impart specific knowledge to individuals with acquired brain injury, their families, and caregivers.
- **Community Development:** To assist communities to develop, coordinate, facilitate and evaluate education and injury prevention initiatives.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Type of Group – Top 3 -based on attendee numbers	• Health Care Professionals • Children/Youth/Students • Other
Activities – Top 3 -based on service hours	• Community Development • Administration & Evaluation • Resource Development
Topics – Top 3 -based on attendee numbers	• ABI • PARTY • General Injury Prevention

2013-15 PROGRAM EVALUTION RESULTS

The South Education and Prevention Coordinator chose to do a survey of currently used **concussion resources and concussion management policies and procedures within schools**. Following distribution of the survey in the summer of 2014, 23 responses were received on behalf of 51 schools within 6 school divisions in southern Saskatchewan. Reponses were received from Regina Catholic School Division, Prairie Valley School Division, Good Spirit School Division, Regina Public School Division, Prairie South School Division and Holy Trinity School Division.

Survey Questions:

1. What concussion information are you currently using to assist injured students return to school?
2. What concussion information are you currently using to assist injured students return to play/gym/sports?
3. What policies and procedures does your school have in place to assist injured students return to school?
4. What policies and procedures does your school have in place to assist injured students return to play/gym/sports?
5. What concussion information would you like to see developed and/or provided to you?
6. What methods would be most effective in providing this concussion information to you?

Results: The general trend of the results indicates that there is a universal need for concussion management resources and accompanying policy and procedure for the management of concussions. Education to staff, coaches, administrators, parents and students will be an important aspect of any program development.

SK Prevention Institute

Program Description

Service Area: Province of Saskatchewan

History: The Saskatchewan Prevention Institute (SPI) was founded in 1980. The Institute is a non-profit, provincial organization that raises awareness and educates others about the prevention of disabling conditions in children. The Institute promotes primary prevention by focusing on education, information services, research and evaluation, special projects, community capacity exchange and communications. Their *Partners in Prevention* are the Government of Saskatchewan, the Kinsmen Foundation, the Saskatchewan Abilities Council, the University of Saskatchewan, and the Community-at-Large. Additional program funding is provided by the Ministries of Health and Social Services, Government of Saskatchewan, Public Health Agency of Canada, SGI, and SLGA. SPI is guided by a Board of Directors, a Medical Advisory Committee, and a Program Advisory Committee.

The Child Injury Prevention Program has been funded by the ABI Partnership Project since 1997.

Location and Hours: Saskatoon – full time

Target Group: Children, parents, teachers/educators, health professionals, general public

Partners: Law enforcement, fire departments, EMS, SGI, ABI Outreach Teams, tribal councils, community based organizations, local businesses, wellness coordinators, schools, universities, health region employees, Ministry of Health and the general public.

Need met by the Program: Unintentional injuries, which occur when no one is trying to inflict harm, are the leading cause of death and hospitalization among Saskatchewan children and youth aged 1 to 19 (Government of Saskatchewan, 2008). Every 4.5 days a child, between birth and 19 years of age, dies and 38 are hospitalized due to injury in Saskatchewan (Government of Saskatchewan, 2008). Injuries cause almost 50% of all deaths in Saskatchewan to children and youth who are between birth and 19 years of age (Government of Saskatchewan, 2008). The leading causes of unintentional injury-related death for children and youth in Saskatchewan are motor vehicle incidents, drowning, suffocation, poisoning, fire and flame, pedestrian-incidents, falls and bicycle-incidents (Government of Saskatchewan, 2008). The Child Injury Prevention Program works toward reducing the risk of injury-related disability and death to children in Saskatchewan.

Services / Activities: General child injury prevention, bicycle safety, child passenger safety, farm safety, helmet safety, home safety, pedestrian safety, playground safety, and abusive head trauma.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Type of Group – Top 3 -based on attendee numbers	• Children/Youth/Students • Professionals • Educators/Teachers
Activities – Top 3 -based on service hours	• Program Preparation & Follow-up • Resource Development • Community Development
Topics – Top 3 -based on attendee numbers	• Bicycle Safety • General Injury Prevention • Child Passenger Safety

2013-15 PROGRAM EVALUTION RESULTS

SPI regularly evaluates each of their program areas. Several program area evaluations were submitted to the Partnership as part of their site level evaluation. Below is the evaluation for Bicycle Safety Week 2014 and is just a sample of the information submitted.

Method: An evaluation was sent to every participant in Bicycle Safety week 2014.

Results: The Saskatchewan Prevention Institute supported a total of 70 registered participants, with an additional 38 participants who were not registered but ordered resources for Bicycle Safety Week, in 55 communities throughout Saskatchewan. These participants and their community partners reached over 6,000 children in Saskatchewan. Partner organizations included RCMP, city police, local EMS and fire departments, health regions, recreation centres, local convenience stores, gas stations and businesses, local libraries, local radio stations and newspapers, schools, RMs, town offices, SGI, interagency groups, and community associations.

An evaluation completed by participants of Bicycle Safety Week showed that 53% of respondents were not previously involved in Bicycle Safety Week in Saskatchewan, and 88% plan to be involved in Bicycle Safety Week 2015. Participants who stated they would not be participating next year also indicated that they are only able to host an event every two years due to limited funding.

Electronic invitations were sent out in the form of a postcard. Two versions of the postcard were created using the winning drawings from the Bicycle Safety Week 2013 drawing contest. The postcard contained the URL for the bike and wheel safety website and encouraged people to access the website to register. An evaluation completed by participants of Bicycle Safety Week showed that 100% of participants who received the postcard via email found it easy to use in accessing the website, and 94% of participants found the registration process on the website easy to complete and understand. A total of 31% of all registered participants who responded to the evaluation received the invitational postcard. 84% of participants found Bicycle Safety Week information on the Internet through email or on the Saskatchewan Prevention Institute website.

A provincial needs assessment and planning survey was sent out to previous and potential Bicycle Safety Week participants and organizers. The needs assessment allowed participants to provide suggestions on giveaways, themes, and specific bike and wheel safety issues that they felt needed to be addressed. An evaluation completed by the participants showed that 64% of participants who received the needs assessment and planning survey appreciated the opportunity to be able to provide input into the planning of Bicycle Safety Week 2014. A total of 73% of all registered participants who responded to the evaluation found that participation in the planning of Bicycle Safety Week was a positive experience.

The Saskatchewan Prevention Institute distributed 4,706 paper resources, 9,000 promotional wristbands, 550 bells, and 50 bike rodeo toolkits to registered participants for their communities and child participants during Bicycle Safety Week. An evaluation completed by participants of Bicycle Safety Week showed that 100% of registered participants found the resources on the website easy to access, and felt they received their requested resources in a timely manner.

Bicycle Safety Week 2014 was considered a great success by the Saskatchewan Prevention Institute. Below are a few additional comments that were included in the participant evaluations:

- *We always have a local business donate a bike and helmet for a grand prize draw for all participating students. This is a great way to get our business community involved and the kids shiver with excitement!*
- *The students in our school were very eager to work on the colouring contest and handouts that they were given. They are hoping we can organize a bike rodeo, obstacle course, and have RCMP and other officials here next year.*
- *Just a note to say thank you for the tool box for our bike rodeo. It was very successful and my Pre-K children and their parents enjoyed it. I overheard parents say how they had learned new information during the event.*
- *We had an RCMP Officer and a man from SGI from Meadow Lake plus 2 young ladies from The Safety Squad. The students had the opportunity to use hand signals plus ride their bike. Their helmets were checked which was an important part of it for me.*

SK Brain Injury Association (SBIA)

Service Area: Provincial

History: The Saskatchewan Brain Injury Association (SBIA) was founded in 1985 by families who were directly impacted by brain injury with the mission to improve the quality of lives for survivors of ABI and their family/caregivers. Over its history, it has expanded its mission to include education, awareness about and prevention of brain injuries. Since its inception, it has provided supportive programming and advocacy at no cost to ABI survivors and their caregivers. As a registered charity and a non-profit organization, SBIA has worked to create and maintain community partnerships, which have made providing its unique and valuable programming possible.

Location and Hours: SBIA has offices in Saskatoon and Moose Jaw.

Target Group: Brain injury survivors and their families.

Partners: ABI Partnership Project, Saskatchewan Government Insurance, Saskatchewan Health, SARBI (Saskatoon, Regina, Kelvington), Lloydminster and Area Brain Injury Society, Brain Injury Canada, BHP Billiton and WorkSafe Saskatchewan

Need met by the Program: The overall objective of SBIA's programs is to increase the quality of life of ABI survivors and their caregivers in Saskatchewan.

Services / Activities: SBIA holds three annual events for both ABI survivors and their caregivers. At each annual event, SBIA offers information workshops that provide tools to survivors and their families for coping with the injury and the challenges that come with ABIs. The goal of such workshops is to increase emotional fluency and improve the state of mind of survivors so that they may lead more independent and satisfying lives. At all annual events, SBIA also provides information about services offered outside of its program that can help survivors live more independently. An emphasis is placed on creating non-judgmental environments for sharing, and community building among survivors and caregivers. SBIA supports that survivors and caregivers have first-hand experience with injuries and the challenges that accompany them, thus they are a crucial component in the healing journeys of other SBIA members.

Intended Program Impact: To decrease social isolation, increase community connectedness, increased physicality of survivors, increase happiness and mental well-being, provide information sessions focused on increasing quality of life, and capacity building for caregivers.

SERVICE INFORMATION

Service Information:	2013-14 & 2014-15 (Last 2 Fiscal Years)
Type of Group – Top 3 -based on attendee numbers	• ABI Survivors & Family • General Public • ABI Survivors
Activities – Top 3 -based on service hours	• Program Preparation & Follow-up • Survivor/Family Support • Promotion
Topics – Top 3 -based on attendee numbers	• Survivor/Family Support (Not Support Group) • ABI Partnership Project • Camp/Retreat Event

2013-15 PROGRAM EVALUTION RESULTS

In order to assess awareness of SBIA as an organization, program effectiveness and program reach, SBIA elected to develop a series of surveys to disseminate to attendees of SBIA programs and community partners that work directly with ABI survivors and their families. Some of the variables it sought to explore among community partners were demographics of their clients, whether they were familiar with SBIA programming, whether they attended SBIA programming and reasons for not attending, where applicable.

Surveys were disseminated to SBIA chapter leaders as well, in order to assess member satisfaction with SBIA programming on local levels, and areas that SBIA could improve. This included a tally of average attendance to local chapter events and attendee opinions about the events.

Finally, SBIA ensured that evaluations were developed for each annual event. These evaluations went beyond the survey questions designed for local partners and chapter heads. Though these evaluations worked to assess satisfaction with annual programming, they were also designed to address the program goals and objectives that SBIA developed for the evaluations.

Results: It is evident from the survey responses and event evaluations that in general, individuals who participate in SBIA programming enjoy the programs offered and feel comfortable sharing their opinions about what future programming they would like to see. They also were very satisfied with SBIA's capability to create supportive spaces for caregivers and survivors to share and network. SBIA members also wanted to see more programming available with more community partners involved to share new and relevant information. Where possible, members also wanted to have more transportation options available to them to get to and from programs.

ABI Outreach and Partnership funded agency responses highlighted that SBIA priorities should focus on increasing transportation access, increasing programs, as well as finding ways to share and update SBIA program scheduling so events and programs are easy to find for those who wish to attend. Some ABI

Partnership respondents also expressed wanting to collaborate on some programming, particularly information sessions and prevention programs. This collaboration would aid in increasing awareness about SBIA programming, as some Partnership clients are unaware of SBIA events and services.