Professional standards of practice for psychologists, social workers, and counselors in SCI rehabilitation

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Statement of purpose

These professional standards were originally created to promote improved outcomes for people with spinal cord injury (SCI). Having standards of care for psychosocial interventions is especially important because psychological, social and environmental factors are more predictive of quality of life than biomedical variables such as level or severity of injury in people with SCI.¹ In addition, many challenges facing people with SCI are behavioral or psychological in nature, including the challenge of making significant lifestyle changes and

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adhering to complex medical or self-care regimens. People with SCI have to learn to care for their medical needs, overcome attitudinal barriers toward disability, learn to manage caregivers, cope with changes in social support, and adapt to sexual dysfunction. Therefore, in order to attain optimal outcomes for people with SCI it is essential to have well-trained experts in social and psychological interventions as part of any comprehensive rehabilitation team. Standards of care for psychologists, social workers and counselors in SCI rehabilitation (The Standards) were written as a general clinical guide for psychologists, social workers, certified rehabilitation counselors, and licensed professional counselors (the latter two hereafter referred to as “counselors”) that work in the field of SCI rehabilitation. The Standards were also written for managers and policymakers who want to address the psychosocial factors considered to be important within comprehensive SCI rehabilitation, and what types of clinical activities are typically needed.

Acknowledgments

In September 1990 the Board of Directors of The American Association of Spinal Cord Injury Psychologists and Social Workers (AASCIPSW) appointed a ten-member Standards of Care Task Force and charged that Task Force with responsibility for developing professional standards. The contributions of the members of the original Standards of Care Task Force are gratefully acknowledged. The ten members of the Task Force included: Craig Alexander, PhD; Stephen C. Beer, MSW; Helen Bosshart, ACSW, LCSW; Mary Bozeman, MSW; Dawn Cooke, MSW; Bruce Ellsworth, MSW; Paul B. Johnson, PhD; Jayne Kleinman, MS, CRC; Charles Merbitz, PhD; and Ralph Snodgrass, PhD.

In 1995 the Clinical Practice Committee was given the charge of revising the Standards to include appropriate services provided in an outpatient setting. The work of the Clinical Practice Committee in support of this second edition is also commended. Clinical Practice Committee members included: Helen Bosshart, ACSW, LCSW; Lester Butt, PhD; Laura Cushman, PhD; Marguerite David, MSW; Lise Deguire, PsyD; Jayne Kleinman, MS, CRC; and Charles Merbitz, PhD, CRC. Members of the Professional Issues Committee also provided consultation on the development of the Standards.

The Clinical Practice Committee began a review of the Standards in 2001 with subsequent revision in 2005. Committee members reviewing and revising the

Standards included; Rebecca Adcock, PhD; Carol Bishop, Ph.D.; Charles Bombardier, PhD; Helen Bosshart, MSSW, LCSW, ACSW; James Burge, MSW, LCSW; Samuel Gontkovsky, PsyD; Sigmund Hough, PhD, ABPP; Sinclair Jackson, MSW, ACSW; Jayne Kleinman, MS, CRC; Bernie Mermis, PhD; Terrie Price, PhD; J. Scott Richards, Ph.D., ABPP; Hugh Taylor, MSW, LCSW; and Gail Wright, MSW, LCSW.

In 2009, the AASCIPSW was subsumed by the Academy of Spinal Cord Injury Professionals (ASCIP) as the Psychologists and Social Workers section (PSW). Starting in 2013, the ASCIP PSW Clinical Practice Committee was once again charged with review and revision of the Standards. Committee members involved in the revision of the current edition of the Standards include: Charles Bombardier, PhD; Thomas Dixon, Ph.D.; Elizabeth Richardson, PhD; Jon Rose, Ph.D.; Heather Russell, Ph.D.; Dawn Sheaffer, MSW; Shaun Smith, CRC; and Phil Ullrich, PhD. The Committee would also like to acknowledge Jackie Bultman, LMSW, Sara Klaas, MSW, C-ASWCM, and members of the Pediatric Committee of the American Spinal Injury Association (ASIA) for their assistance with the Pediatric SCI section.

The Committee recognized that input from other organizations involved in SCI rehabilitation not only reflects the collegial process that our field represents, but also serves to advance the document. Therefore, this version of the Standards was shared with the following organizations for their review: Academy of Spinal Cord Injury Professionals** members at-large; American Congress of Rehabilitation Medicine**; American Psychological Association Board of Professional Affairs; American Psychological Association-Division 22, Rehabilitation Psychology; American Spinal Injury Association**; CARF International; Council on Rehabilitation Education; International Spinal Cord Society**; National Association of Social Workers; Paralyzed Veterans of America; The Joint Commission; United Spinal Association; and Veterans Administration. All feedback and comments were carefully reviewed and incorporated where appropriate for a final, comprehensive vetting of the Standards during this revision.

The contributions and support of James J. Peters, Past Executive Director, Eastern Paralyzed Veterans Association (EPVA), Vivian Beyda, DrPH, Director of Research and Education, and Stephen Sofer, PhD, Program Manager, of United Spinal Association are sincerely acknowledged and appreciated.

Preface

ASCIP** is a not-for-profit professional membership association. Membership primarily consists of professionals who comprise the interdisciplinary team. Members of ASCIP include psychologists, social workers, counselors, physicians, nurses, occupational therapists, physical therapists, and other professionals who specialize in one of the many facets of rehabilitation and treatment for individuals with spinal cord injury. The organization's primary goal is to improve the quality of care for individuals with SCI. This goal is achieved by developing and promoting education and research related to their psychosocial needs. The PSW section of ASCIP advocates for the critical role played by psychologists, social workers, and counselors in SCI rehabilitation.

Since 1990, AASCIPSW, and now the ASCIP PSW, has pursued the development of Standards of Care to enhance the quality of care and outcomes in spinal cord injury rehabilitation provided by psychologists and social workers. Professionals currently working in this field drafted the Standards for psychologists, social workers, and counselors in SCI rehabilitation.

The need for a set of psychosocial program standards is derived from the basic right of individuals with SCI to comprehensive and effective treatment by competent professionals. The purpose of these Standards is to maintain and improve the quality and consistency of psychosocial services provided by psychologists, social workers, and counselors.

The Task Force, comprised of ten AASCIPSW members with expertise in psychosocial aspects of SCI rehabilitation, developed the first edition of the Standards. The Task Force surveyed major SCI organizations and consumers about the importance of different psychosocial services received during rehabilitation and their recommendations for current programs. The Task Force also surveyed the membership of AASCIPSW concerning essential psychosocial services in the treatment environment. Finally, a thorough review of existing standards, which address psychosocial care issues in SCI rehabilitation, was conducted. Utilizing this information, these Standards were developed through a consensus process. The first edition of the Standards for psychologists, and social workers in SCI rehabilitation was approved by the AASCIPSW Board of Directors and endorsed by the AASCIPSW membership in September 1992. Furthermore, it was agreed that the Standards would be reviewed periodically and modified as needed to be consistent with advances in professional practice.

In 1995, the Board of Directors recognized the importance of expanding the Standards to include those services provided by psychologists and social workers in the outpatient setting as health care had undergone numerous changes during the 1990s. The trend toward shorter inpatient rehabilitation and reductions in ongoing psychosocial care was concerning as it was felt to be neither cost-effective nor in the best interest of the individual and the community in the long term. As a result, the second edition of the Standards was written at that time.

The third revision of the Standards, completed in 2005, includes a focus on three major areas: an even broader definition of psychosocial services of SCI rehabilitation that occurs across the lifespan to include comprehensive review of literature, existing standards, and current practices relevant to the lifetime psychosocial issues of persons with SCI; inclusion of cultural and diversity issues; and citation of relevant literature directly in the document. Certified rehabilitation counselors and licensed professional counselors were incorporated following their admission as full members to AASCIPSW in September 2004. The third edition of the Standards for psychologists, and social workers in SCI rehabilitation was approved by the Board of Directors at the annual conference in September 2005.

The current document contains the fourth revision of the Standards which was completed in 2014, under the direction of the PSW Clinical Practice Committee of ASCIP (formerly AASCIPSW Clinical Practice Committee). This current revision reflects an increasing need for psychosocial care providers to have a better understanding of the physical and psychosocial changes that are to be expected in SCI across the developmental lifespan. To address this need, the current revision added two major sections: (1) A pediatric addendum; and (2) A geriatric addendum. In 2009, AASCIPSW was subsumed by ASCIP as the PSW section, and this change is reflected in the revision, in addition to citation of more recent literature. The fourth edition of the Standards for psychologists, social workers, and counselors in SCI rehabilitation was approved by the ASCIP PSW Board of Directors and then by the Governance Board in November 2014. Shortly afterward, the PSW section was renamed Psychologists, Social Workers and Counselors to reflect its expanded membership and these current standards.

These Standards are intended to define the scope of services and function provided by psychologists, social workers, and counselors throughout the continuum of SCI rehabilitation. The terms "**MUST**" and "**SHALL**"

Table 1 Definitions of terminology used in the *Practice Standards for Psychologists, Social Workers and Counselors in SCI Rehabilitation*, marked with (*) in the document

Term	Definition
Assistive technology	Devices or software designed to enable individuals with disability to perform tasks that they may have previously been unable to do (or to do so with significant difficulty) without the technology. Assistive technology maximizes independence by implementing adaptations to or changing the methods with which one interacts with the environment in order for individuals to successfully perform daily activities or tasks important to the individual.
Americans with Disabilities Act (ADA)	A wide-ranging civil rights law enacted by the U.S. Congress that prohibits discrimination based on disability.
Biopsychosocial	A term to reflect the interface between and among biological, behavioral, emotional, and social forces that influence health and well-being. As contrasted with the medical model, which emphasizes the physical domain, the biopsychosocial model pertains to the holistic vision of a person.
Clinically indicated	Those individualized case determined activities or decisions rendered by the psychologist, social worker, counselor, or treatment team to abet the attainment of specified treatment goals.
Collaborative activities	Professional functions that involve the cooperation and/or coordination of team members from a variety of professions.
Community reintegration	The process of returning to the community after rehabilitation and adopting a meaningful, satisfying lifestyle with consideration of personality, physical, socioeconomic and employment factors.
Discharge planning	An interdisciplinary process to assist the individual and family in the development of post-hospital plans which ensure continuity of care and services consistent with the maximal level of independence in the least restrictive environment.
Follow-up	The process of comprehensive re-evaluations of the medical, rehabilitative, and psychosocial status of the individual with SCI. Re-evaluations are scheduled on a routine basis, as well as when emergent needs arise.
Hospital privileges	A formal agreement between the clinician and the health care facility, which authorizes the clinician to deliver psychosocial assessment, treatment, and consultation services independently within established professional boundaries.
Independent living	The concept that persons with disabilities have the right to control their own lives and make decisions about their futures. This concept is the basis of the social and civil rights movement also known as independent living.
Interdisciplinary treatment	In the field of SCI rehabilitation, a treatment model in which the team collaborates to complete assessments, set goals, plan and implement treatment strategies, evaluate progress and determine the discharge plan. This process occurs in a holistic fashion acknowledging that problems and solutions cross discipline boundaries.
Overlapping activities	Professional functions, which may be performed by more than one profession with varying degrees of formality and thoroughness.
Personal assistance services	Assistance provided by another person to assist the person with SCI to perform activities of daily living, fulfill responsibilities, and reach personal goals. This may include personal, household, communication, and mobility services.
Psychosocial	Pertaining to the psychological, social and environmental aspects of human functioning.
Quality of life	A subjective concept by which one defines the degree of life satisfaction. It is based in the many dimensions of life experience and personal values. Critical factors include subjective health and well-being, emotional status, role functioning within the family and community, independence, social support, and control.
Rehabilitation	The process of providing a program of coordinated services, with the full participation of the individual with SCI to achieve physical, psychological, social, economic, and vocational potential. Rehabilitation is a dynamic process of learning to live with a disability in one's own environment beginning at the moment of injury and continuing for the duration of one's life.
Rehabilitation Act	Enacted in the U.S. in 1973, this act prohibits discrimination on the basis of disability in programs conducted by Federal agencies, in programs receiving Federal financial assistance, in Federal employment, and in the employment practices of Federal contractors. Section 504 of the Rehabilitation Act created and extended civil rights to people with disabilities.
Self-advocacy	Individual efforts to promote needs and forward goals.
Social skills training	A component of rehabilitation in which the individual with SCI learns effective communication techniques and adaptive behaviors for a variety of social situations.

are used throughout this document to indicate what is mandatory. The term “**SHOULD**” is used to reflect preferred practice. The term “**comprehensive**” is used to reflect the wide range of psychosocial services provided in any setting, including inpatient and outpatient services. To assist with the definitions of terms used throughout this document, the term is marked with an asterisk (*) when first found hereafter in the document. Please refer

to Table 1 for the definition. Referenced professional organizations of psychologists, social workers and counselors in SCI rehabilitation that are discussed are marked with a double asterisk (**). Descriptions for these organizations are listed in Table 2.

Consistent with previous revisions, the principle goal remains the same: to provide a document setting forth a consensus on the standards of care for the provision of

Table 2 Referenced professional organizations of psychologists, social workers and counselors in SCI rehabilitation, marked with a () in the document**

Organization	Description
<i>Academy of Spinal Cord Injury Professionals (ASCIP)</i>	A national professional association representing various disciplines involved in spinal cord injury rehabilitation. ASCIP is comprised of four professional sections: American Paraplegia Society (APS), Association of Spinal Cord Injury Nurses (ASCIN), Psychologists and Social Workers (PSW) and Therapy Leadership Council (TLC).
<i>American Board of Rehabilitation Psychology (ABRP)</i>	A member board of the American Board of Professional Psychology (ABPP), which oversees and authorizes the credentialing activities of all specialty boards within the profession of psychology. The ABRP is responsible for establishing criteria related to the definition and requirements for education, training, and competencies relevant to the field of rehabilitation leading to Board Certification in Rehabilitation Psychology.
<i>American Congress of Rehabilitation Medicine (ACRM)</i>	A professional organization that assists researchers in improving their investigations and dissemination of findings; educates providers to deliver best practices, and advocates for funding of future rehabilitation research.
<i>American Counseling Association (ACA)</i>	The largest association representing professional counselors in various practice settings. ACA's stated mission is to "use the profession and practice of counseling to promote respect for human dignity and diversity."
<i>American Psychological Association (APA)</i>	The national professional organization that represents the largest proportion of psychologists in the country. APA's stated purposes are the advancement of psychology as a "means of promoting human welfare" as well as its advancement as a profession and science. Division 22 is dedicated to rehabilitation psychology.
<i>American Spinal Injury Association(ASIA)</i>	An interdisciplinary professional organization established to promote and establish standards of excellence for all aspects of health care of individuals with SCI, to provide SCI education to members, other healthcare professionals, patients, families and the public, to foster research to prevent and treat SCI and facilitate communication among treatment providers, researchers and consumers.
<i>Commission on Rehabilitation Counselor Certification (CRCC)</i>	An independent, not-for-profit organization that offers certification for professionals in the U.S. and Canada to include 1) Certified Rehabilitation Counselor (CRC) and 2) Canadian Certified Rehabilitation Counselor (CCRC).
<i>Council on Rehabilitation Education (CORE)</i>	A specialized accreditation organization for graduate programs that provide academic preparation for various professional rehabilitation counseling positions in addition to undergraduate programs in Rehabilitation and Disability Studies.
<i>Council on Social Work Education (CSWE)</i>	The national organization recognized by the US Department of Education and the Council on Post-Secondary Accreditation as the sole accrediting agency for social work education in the United States.
<i>International Spinal Cord Society (ISCOS)</i>	Interdisciplinary professional organization based in the UK dedicated to SCI research, clinical practice, education, rehabilitation and social integration in collaboration with similar organizations.
<i>National Association of Social Workers (NASW)</i>	The largest organization of professional social workers, serving to enhance the professional growth and development of its members, create and maintain professional standards, and advance sound social policies.
<i>National Rehabilitation Counseling Association (NRCA)</i>	The national professional organization representing the largest proportion of certified rehabilitation counselors in the country. The stated purpose of NRCA is "to advance the role and function of rehabilitation counseling in the rehabilitation of all persons with physical, mental or other disabilities." All members of the Association are to adhere to the Code of Ethics as set forth by the Commission on Rehabilitation Counselor Certification.

psychosocial services to all individuals with spinal cord injury and dysfunction, across the lifespan and across treatment settings. The document framers, reviewers and Board of Directors recommend this document for dissemination and use in developing a comprehensive program of mental health treatment in spinal cord injury rehabilitation.

I. Introduction

A. Concept and goal of SCI rehabilitation

A foundation of this document is that rehabilitation* of persons with SCI necessarily involves multiple behavioral, psychological, social and environmental factors.

Therefore, experts in the area of psychosocial* factors are essential members of any comprehensive rehabilitation team.

In the literature, SCI is associated with numerous psychosocial complications such as major depression,²⁻⁴ post-traumatic stress disorder,⁵⁻⁷ anxiety disorders,^{8,9} loss of social support,¹⁰ and sexual dysfunction¹¹⁻¹⁴ as well as general difficulties with adjustment.¹⁵ SCI is frequently associated with co-occurring TBI and cognitive impairment in up to 40–50% of cases.¹⁶⁻¹⁸ Approximately 50–70% of people with SCI develop problems with chronic pain.¹⁹ There is a high incidence of pre-injury substance use disorders that may increase

risk of mental health problems and secondary medical complications.²⁰ Moreover, healthy adaptation to SCI often requires increased self-regulation and enormous behavior change. The person has to learn and maintain skin checks, pressure releases, vigilance to urinary tract infections and respiratory illnesses, exercise, dietary modifications and stress management. A large body of research shows that adherence to such behavior change is more difficult and complicated than typically assumed and is influenced by multiple behavioral and psychosocial variables.²¹

Psychosocial variables in SCI are not only inherently important, they significantly influence other core rehabilitation outcomes. For example, depression is associated with longer lengths of hospital stay and fewer functional improvements,²² as well as less functional independence and mobility at discharge.²³ Depression is related to the occurrence of pressure ulcers and urinary tract infections,²⁴ poorer self-appraised health,²⁵ less leisure activity,²⁶ poorer community mobility, poor social integration, and fewer meaningful social pursuits.^{27,28} Persons with SCI and significant depression spend more days in bed, fewer days outside the home, require greater use of paid personal care and incur greater medical expenses.²⁹ Moreover, symptoms consistent with depression, such as documented expressions of despondency, hopelessness, shame and apathy, are the variables most predictive of suicide 1–9 years after SCI.³⁰ Finally, attaining a good quality of life* after SCI has relatively little to do with biomedical variables such as type and severity of injury.¹ Rather, social and financial resources, transportation, access to the environment, freedom from depression and other psychological conditions, positive coping, and the chance to participate in meaningful activities are stronger determinants of life satisfaction.^{1,31–33} Since variables critical to these important outcomes are psychosocial in nature, it follows that specialized services to address these psychosocial factors are essential to the provision of effective rehabilitation, community reintegration,* and quality of life. Properly trained and experienced psychologists, social workers, and counselors have the knowledge, skills and expertise to positively assist both the individual and their support persons in the adaptation process. They facilitate learning, by assessing learning styles and barriers to learning, contribute to a psychologically helpful environment and provide the listening which helps individuals grieve and rework their lives.

B. The biopsychosocial rehabilitation process

The biopsychosocial* rehabilitation process should involve a continuum of services from the onset of a

spinal cord injury throughout the life span. The critical components in this rehabilitation process have many psychosocial implications. As soon as medically stable and capable of participation, the individual with a new spinal cord injury should enter a comprehensive SCI rehabilitation program. A comprehensive SCI Center should have sufficient numbers of persons with SCI treated annually to insure depth of staff experience and expertise. Such facilities ensure ongoing quality and competence by providing an effective ongoing continuing education program for its staff in the care of persons with SCI. Upon entrance to the program, the individual and family should be oriented to the general philosophy of comprehensive inpatient and outpatient SCI rehabilitation. Family in this sense refers to relatives by blood or marriage, significant others or the social support designee.

At this stage, the individual's unique cultural traditions and ethnicity should be acknowledged and addressed as treatment plans and goals are formulated. Additionally, the individual and family should be included in formulating the comprehensive, interdisciplinary treatment* plan. It should be noted that a portion of discharge planning* may occur through a case manager who may or may not be a trained social worker. The plan should include treatment goals for inpatient rehabilitation, integration into the community, and possible outpatient rehabilitation as warranted by the individual's clinical situation. The individual and family should participate when possible in a comprehensive education program throughout rehabilitation, commencing with the inpatient program. The educational program should focus on providing the knowledge and skills specific to SCI to insure optimal success of the individual and in managing all aspects of their care after discharge continuing this educational process throughout the life span.

Discharge planning should begin at the time of hospital admission to insure that essential services for the individual's support are available during admission and after discharge from the facility. Discharge planning requires the participation of all team members, as well as the individual and family. Most often, primary discharge planning is coordinated through the team social worker. Discharge planning may require specific outpatient services to further rehabilitative gains, skills-acquisition, and constructive physical and psychosocial outcomes.

To optimize successful outcomes, the individual and family shall have access to psychosocial and physical rehabilitation services. Those services must be specific to the individual's needs, respect his or her cultural

preferences, and be directed toward the goal of optimal psychological, social, and physical functioning. These services may be provided in both the inpatient and outpatient programs and in individual, couple, group, and/or family formats. The body of psychosocial research emphasizes that the well-being of people with SCI is significantly influenced by the quality of social support, family support, caregivers and other social and environmental resources available to them.¹⁰

Involvement in community activities is a crucial component of the individual's accommodation to spinal cord injury. The individual should be involved in community reintegration activities on a regular basis to practice and develop those skills acquired in physical rehabilitation. To the extent possible, the community activities should be sensitive to the individual's culture, religion, and ethnic preferences. Social skills training* should teach the skills necessary to manage interpersonal relationships, individual attitudes, and societal barriers. Self-advocacy* training begins with participating in identifying crucial goals of the individual, related to community living and educational and vocational interests. The focus of training begins with SCI education and the person's critical role in preventative care, health maintenance, life care planning, and community reintegration.

Ideally, the medical rehabilitation goals specified in the SCI interdisciplinary treatment plan are achieved by the time the individual is discharged. Shortened hospital stays and authorized treatment requires team advocacy and education to funding sources as well as the individual and family. The team works to include the individual in resource management and resource identification. Trial home visits are recommended prior to discharge to maximize opportunities for successful community living. An aftercare plan should be developed to insure that necessary resources are available, in addition to follow-up* care. Outpatient services, coordinated with the inpatient treatment team, are essential in the long-term successful accommodation to spinal cord injury; particularly as the length of inpatient stays are reduced.

Regular outpatient follow-up visits are recommended for psychosocial (re)assessment and ongoing health care maintenance.^{4,34} Comprehensive (re)assessments should be completed by psychologists, social workers, and/or counselors to identify psychosocial needs and detect emergence of new problems. Focus on quality of life should be an integral part of these (re)assessments. This includes facilitating the development of self-efficacy and self-advocacy skills to increase confidence of the individual. Respite needs for care providers should

be recognized and facilitated. Lastly, the individual and family should be assisted in establishing linkages within the community to access specific resources and services.

C. Importance of the treatment team

The individual is the primary decision-maker for establishing their biopsychosocial rehabilitation goals in collaboration with the SCI Treatment Team. The team should include the family when feasible and clinically indicated,* and a representative of each discipline of the treatment team the individual considers essential to the attainment of the comprehensive treatment goals. As needed, the team may also include professionals from other agencies. The responsibilities of each team member should be clearly defined in the written policies and procedures of the facility. Team members complete individual assessments pertinent to their area of professional expertise and use the information to develop an integrated, comprehensive interdisciplinary treatment plan. There shall be regular, formal team meetings to review and document the individual's progress and to modify the treatment plan as goals are accomplished. During inpatient hospitalization, it is recommended that formal team meetings occur weekly. Formal team meetings in outpatient settings should occur on a regularly scheduled basis, dictated by the individual's needs.

Education about each team member's scope of practice should be provided to the individual. Each team member's treatment plan is collaborative with the individual and serves as a way to monitor and modify goals in accordance with the individual's treatment needs and life goals.

D. Role of the psychologist, social worker, and counselor team members

Psychologists, social workers, and counselors are core members of the interdisciplinary team. They contribute to the treatment team by providing specialized clinical skills and perspectives to help the patients and their families achieve optimal psychological, behavioral, social, vocational, and avocational functioning in addition to facilitating personal growth, resilience and wellbeing. The professional scope of practice of psychologists, social workers, and counselors working with individuals with SCI is predicated upon patient needs, regardless of the clinical setting. Clinical services may be provided in the acute care and rehabilitation setting, or a variety of follow-up settings, including but not limited to outpatient clinics, home health care and independent living* centers, assisted living and

long-term care facilities. In addition, psychologists, social workers and counselors utilize their specialized clinical skills and perspectives to enhance communication with and interactions between the patient/family and other interdisciplinary team members. Staffing levels in all clinical settings should be commensurate with facility guidelines and standards to ensure quality care, and maximize patient outcomes.

Psychologists, social workers, and counselors bring to the team a unique and complementary psychosocial treatment orientation. Their academic and clinical training prepares them to play particular roles in the rehabilitation process. As previously stated their functions are complementary; however, by no means are they interchangeable within the context of the interdisciplinary team. Their unique expertise should be utilized to conduct a thorough assessment upon which a treatment plan can be devised and appropriate interventions employed. Comprehensive assessments by psychologists, social workers, and counselors focus on the individual's current coping status and accommodation to the spinal cord injury in the context of person, family, and society. Psychologists, social workers, and counselors also bring to the team individual and professional expertise in assessment and intervention.

For the psychologist, the clinical diagnostic skills which allow the assessment of individual personality, intelligence, behavior, neuropsychological status, vocational skills and interests, and psychological functioning are unique contributions to the total psychosocial assessment. Additional unique skills (reflective of American Board of Rehabilitation Psychology**) include intervention and consultation with teams, agencies and professionals. Employed psychologists embedded within the rehabilitation facility are preferred to consultants as it allows for maximal team interaction.

For the social worker, the training and skills to assess the key components of the individual's overall support system, (i.e. family dynamics, finances, housing, living arrangements, and community resources) are equally important in the development of a comprehensive psychosocial intervention plan.

For the rehabilitation counselors and licensed professional counselors performing similar roles, there exists specialized knowledge of disabilities in their training as well as an understanding of the government statutes and laws, and the existence and availability of public and private services, benefits and resources, all significant components to support and meet immediate and long term needs.

Predicated on the specific needs of the clinical situation, these assessment and intervention skills may be

utilized in the inpatient and/or outpatient settings. As medical advances have made it possible for persons with SCI to live healthier and longer lives, return to work issues and age-related issues, such as navigating developmental life milestones or end-of-life planning, may need to be addressed. More specifically, rehabilitation and professional counselors should provide the practical resources to assist individuals with return to work goals; including vocational assessments, assistive technologies, and specialized counseling skills and techniques for addressing workplace adjustment. Psychologists, social workers, and counselors appreciate the importance of one's ethnicity and cultural diversity related to the healthcare of the individual with SCI and his/her support system.

In the conduct of therapeutic interventions, psychologists, social workers, and counselors have unique expertise in a variety of psychosocial treatment skills. Clinical expertise in specific psychosocial interventions is as important as the professional identities of the psychologist, social worker, and counselor. Therapeutic interventions employed by psychologists, social workers, and counselors may include but are not limited to education, counseling, crisis intervention, and advocacy. Therapeutic interventions focus on the individual, the family, social agencies, or other environmental and social systems. Psychologists, social workers, and counselors are obligated by their professional ethical codes to practice within their level of training, experience, and expertise.

Adding to their multiplicity of roles, the psychologist, social worker, or counselor may serve as a case manager for the individual with SCI. Crucial to this process is training the individual with SCI in the skills necessary to become their own case manager and effective self-advocate over time. In the case where there the individual with SCI is a minor, a major goal is to encourage the parents to teach their child or teen self-advocacy.³⁵ Furthermore, these professionals possess research skills, which are used to understand and improve clinical practice. Psychologists, social workers, and counselors also provide supervision to undergraduate and graduate students who are enrolled in psychology, social work, and counselor academic training.

Psychologists, social workers, and counselors serve as resources for the treatment team. Their specialized training in group processes, problem solving, communication skills, and interpersonal skills may help the treatment team function more effectively and efficiently. They facilitate communication, provide in-service education, serve as sources of support and supervision, and act as consultants on difficult, ethical or sensitive matters.

Knowledge of legislation that impacts individuals with disability including SCI (e.g. Americans with Disability Act* and Rehabilitation Act*) is beneficial in this regard. Psychologists, social workers, and counselors may also help members of the team understand the individual's psychosocial status and its influence upon accommodation to the spinal cord injury.

II. Patients' rights and responsibilities

ASCIP endorses Codes of Patients' Rights and Responsibilities that emphasize the autonomy of the individual: the right to be treated with dignity; the right to choice; the right to impartial access to appropriate, effective treatment; the right to informed participation in health care decisions; the right to refuse treatment; the right to grievance; and the right to personal and informational privacy. These rights are basic to quality health care and are central to the individual's role as a member of the rehabilitation team and consumer of health care services. The civil and legal rights of the individual must also be respected.

Individuals with SCI have specific patient responsibilities as a part of the treatment contract, regardless of the clinical setting. Psychologists, social workers, and counselors should be aware of these agreements and should address related issues as necessary. All individuals admitted to an SCI rehabilitation program must be provided a copy of the patient rights and responsibilities of that institution.

To the extent that it is clinically possible, individuals should be empowered and trained to manage and direct their own care. In the case of minors or cognitively compromised adults, the family and/or legal guardian should be involved and trained.

All referenced treatment components and processes of acute inpatient and outpatient rehabilitation are assumed to also be embraced by the voluntary agreement of the individual with SCI or their legally appointed guardian. If a minor child or incompetent individual refuses treatment, the psychosocial professional is guided by state regulations that govern such situations. If, however, the intact decision-making adult refuses rehabilitative treatment with the full benefit of informed consent, the health care system is bound to accept that decision.

III. Staffing

A. Definitions

1. Psychologists must have a Doctoral degree in psychology and be licensed and provide clinical services to individuals with spinal cord injuries, and/or be engaged in non-clinical activities related to

psychosocial aspects of spinal cord injury such as research, education, and training.

2. Social workers must have a Master's degree in social work from an institution accredited by the Council on Social Work Education** in the United States or its equivalent in Canada and be licensed.
3. Certified Rehabilitation Counselors must have a Master's degree from an accredited institution, approved by the Council on Rehabilitation Education,** or its equivalent in Canada and be certified through the Commission on Rehabilitation Counselor Certification (CRCC)** organization.
4. Licensed Professional Counselors must hold a Master's degree from an accredited institution and be licensed in the state(s) in which they practice, or its equivalent in Canada.

B. Staffing patterns

While ASCIP recognizes that staffing patterns can vary widely by institution and are affected by evolving health care system changes, the Standards describe aspirational practices deemed essential to the provision of high quality psychosocial care. There should be at least one full-time psychologist and one full-time social worker for every twenty individuals in an inpatient SCI rehabilitation program. These psychologists and social workers should be core members of the interdisciplinary treatment team. Other health care professionals such as rehabilitation counselors, licensed professional counselors and case managers may also serve as core members of the interdisciplinary team.

Where outpatient services are rendered for ongoing medical/physical follow-up, there should be a psychologist or social worker available for at least an annual reassessment of psychosocial needs for each individual followed. Other health care professionals such as rehabilitation or licensed professional counselors may also serve to provide annual reassessments.

To facilitate continuity of care, it is recommended that these be designated staff, rather than rotating, to provide these services. For those individuals with identified psychosocial needs, a treatment plan will be developed and followed, predicated on specific individual needs, with appreciation and consideration of the individual's cultural and ethnic diversity.

Staffing levels need to be adequate to assess and address the individual psychosocial needs of the patient population served.

C. Education and orientation for staff

1. Limits of practice

Psychologists, social workers, and counselors must limit their practice to their areas of professional

competence as defined by training, experience and scope of practice.

2. Education

Psychologists should be trained in SCI care, rehabilitation, clinical and/or health psychology with direct involvement with SCI care. While ideal to have post-doctoral residency within rehabilitation, with significant exposure to individuals with SCI, the psychologist can possess skills obtained via on the job training.

Social workers need a background in clinical practice and training and experience in SCI care or a related area of rehabilitation.

Rehabilitation counselors require a background in disability/SCI care, rehabilitation and adherence to the criteria sent by the Commission on Rehabilitation Counselor Certification (CRCC).

Licensed professional counselors should be trained in SCI care, rehabilitation and meet the standards set by the American Counseling Association.**

For all professions, including psychologists, social workers, and counselors without SCI rehabilitation training and experience, educational and supervised experiences in SCI care are recommended. The program of education should include, but is not limited to, information on the following topics:

- acute and chronic pain
- advance directives
- advocacy
- aging/end-of-life planning
- anatomy and physiology of SCI
- architectural and attitudinal barriers
- assistive technology*
- bowel and bladder care
- community resources
- cognitive changes
- cultural diversity
- current SCI research
- disability legislation
- independent living
- medical complications
- medications
- nutrition
- pain management both chronic and acute
- parenting and childbirth
- personal assistance services*/attendant care
- psychological, social and vocational sequelae of SCI and factors related to treatment
- respiratory care
- safety precautions
- sepsis
- sexuality and fertility
- skin care
- social skills

- substance abuse
- team consultation skills
- treatment adherence and health promotion
- vocational issues
- wheelchair accessibility

Educational experiences pertaining to SCI topics can be arranged through local, regional, or national SCI conferences and professional meetings. Since many professionals may not be able to access formal education and/or supervision in all of these areas, resource bibliographies, such as the ASCIP's Suggested Reading List, can assist in self-instruction.

3. SCI orientation

Psychologists, social workers, and counselors should receive an orientation to the philosophy and goals of the SCI program, the administrative procedures governing the SCI program, the roles and responsibilities of the different team members and any SCI-specific accreditation standards.

D. Continuing education

Psychologists, social workers, and counselors must adhere to state guidelines for continuing education. Where no guidelines exist, there should be a minimum of 20 hours continuing education per year, of which ten hours should be SCI-specific. Appropriate education areas may include formally organized learning events, professional meetings, and individual professional activities. Institutions should be encouraged to support continuing education.

E. Supervision/consultation

During the first three months of SCI practice, one hour per week of individual supervision/consultation by a colleague with SCI experience is essential. Throughout clinical practice ongoing supervision/consultation is strongly recommended. Trainees, Psychological Assistants, Interns, Fellows, Students and Volunteers providing activities within the professions of Psychology, Social Work and Counseling must receive supervision as specified by their respective professional associations (i.e., American Psychological Association,** National Association of Social Workers,** American Counseling Association and Commission on Rehabilitation Counselor Certification), as well as state licensing boards and individual facility requirements.

F. Professional affiliations

Psychologists, social workers, and counselors are highly recommended to join and maintain membership in national professional organizations. In addition, psychologists, social workers, and counselors are

encouraged to obtain board certification/diplomate status in specialty areas of practice related to SCI care.

G. Hospital privileges*

Psychologists, social workers, and counselors are encouraged to apply for formal hospital privileges in accordance with their facility's bylaws, specifying their areas of professional competence and expertise.

H. Professional ethics

The PSW section of ASCIP endorses the ethical standards of the American Psychological Association (APA) and the National Association of Social Workers (NASW).** Psychologists, social workers, and counselors shall "act in accordance with the highest standards of professional integrity and impartiality (NASW)," and their behavior must be "guided by the principle of promoting human welfare (APA)." Professional principles of practice should always dictate professional behavior. Counselors should abide by the ethical standards of their own professional organization (e.g. National Rehabilitation Counseling Association**) or certification body (e.g. Commission on Rehabilitation Counselor Certification). Psychologists, social workers, and counselors will be diligent in recognizing and appreciating the diverse cultural and ethnic backgrounds of the SCI population.

Psychologists, social workers, and counselors shall assure confidentiality of patient information in accordance with professional ethics, federal/state law and policies of the health care facility. Individuals with SCI must be advised that confidentiality is not an absolute concept and that necessary sharing of information will occur in the context of treatment planning and legal mandates.

IV. Psychosocial components of rehabilitation

Psychosocial services in SCI rehabilitation enhance individual and family adaptation to living with a disability from behavioral, psychological and social perspectives. Continuity of care throughout the entire treatment process and community reintegration is emphasized. Health promotion, quality of life issues, and self-advocacy are critical in the rehabilitation process. All psychosocial programs will be sensitive to the unique cultural and ethnic background of the individual and family.

A. Basic components of psychosocial programs and general guidelines for implementation

1. Orientation

Each individual shall receive an orientation to the psychological and social work components of the rehabilitation program within the first week of

admission to the inpatient or outpatient SCI program, unless precluded by the individual's medical condition.

The individual's family shall be included in the orientation process when feasible and clinically indicated.

The orientation shall include a review of the individual's rights and responsibilities and a review of psychologist, social worker, and counselor team members' roles and responsibilities.

2. Assessment

Each individual entering an SCI rehabilitation program should have an assessment by a psychologist and a social worker in a timely manner commensurate with other interdisciplinary team initial assessments into the inpatient or outpatient program as needed, unless precluded by the individual's acute medical or psychological condition.

Records of previous psychosocial interventions and relevant medical treatments should be obtained when possible. If feasible, family or significant others should be included in the assessment process. Assessment is an ongoing and incremental process tailored to the individual needs of each patient. However, the assessment should include psychosocial factors known to be prevalent, clinically significant and related to more general rehabilitation outcomes. Whenever possible, clinicians should use measures that have been developed for people with SCI or have SCI-specific norms. Based on current knowledge, areas of assessment should include:

- chief concerns and individual preferences of the patient
- individual and/or family expectations of goals for treatment
- ethnic, cultural or spiritual factors of significance to the person
- family/social support and potential caregivers
- prior life challenges and coping
- financial and insurance status
- housing and living arrangements
- educational/vocational status and history
- hobbies or leisure interests
- legal issues
- behavioral and psychological adjustment to SCI
- spiritual beliefs
- past and current psychiatric status including mood and anxiety disorders
- recent substance use history including alcohol, other drugs and tobacco
- psychological and behavioral strengths and vulnerabilities
- mental status or neuropsychological functioning whenever concomitant brain dysfunction is suspected
- pain related concerns

- identification of any problems working with the rehabilitation team or adhering to therapies
- sexual dysfunction and related concerns
- other factors needed to develop appropriate goals and an effective treatment plan

3. Treatment plan

Each patient shall have a written treatment plan based upon an initial assessment. This information should be integrated into the comprehensive interdisciplinary treatment plan to promote both efficiency and quality outcomes. Each plan shall contain the following:

- summary of assessment, including diagnoses when indicated
- specific treatment goals
- methods for achieving each goal

Whenever feasible, the individual and/or their legal next of kin should be involved in the treatment planning process and consent to the proposed goals and methods. Progress toward treatment goals should be monitored systematically. The plan should be reviewed and revised as warranted by progress assessments. The treatment plan should be reviewed on an ongoing basis and revised as needed. Psychologists, social workers, and counselors will actively participate in inpatient family conferences as scheduled. Outpatient family conferences should be held when feasible and clinically indicated. Progress notes should document each therapeutic encounter, the goal(s) addressed, interventions attempted, progress made and revised plans. Other clinically significant events also should be documented.

4. Interventions

The individual should have access to psychosocial treatments for mental health and substance use disorders, symptom management, disability adjustment, and health behavior change in addition to wellness and health promotion. Emphasis should be placed on utilizing evidence-based therapies when they are available and evidence-informed treatments when efficacy studies on individuals with SCI are unavailable. For example, there is currently Level 1 evidence that supported employment significantly improves return to work rates for veterans with SCI.³⁶ There is Level 2 evidence that for people with SCI cognitive behavioral and coping effectiveness style therapies can be effective for depression and other forms of psychological distress;^{37,38} that cognitive-behavioral treatment of chronic neuropathic pain reduces anxiety and improves participation;³⁹ and that hypnosis reduces chronic pain intensity.⁴⁰ In the absence of SCI-specific treatment efficacy studies, clinicians should use the evidence-based treatments (EBTs) that have been designed for and

tested on the person's presenting problem. The National Registry of Evidence-based Programs and Practices (<http://www.nrepp.samhsa.gov>) and the National Institute for Health and Care Excellence (<http://www.nice.org.uk>) maintain vetted lists of EBTs. Clinicians should consult sources of expert opinion regarding how to adapt EBTs to people with SCI, for example in the areas of coping with disability,⁴¹ sexual dysfunction,⁴² substance use,²⁰ and psychotherapy in general.⁴³ Clinicians should practice within their area(s) of expertise and refer to other professionals with relevant expertise as needed. Other counseling resources that should be made available to people with SCI include peer counseling, financial counseling, discharge planning, and life care planning. More specific interventions include:

- individual psychotherapy
- group therapy
- couples counseling
- family therapy
- interventions for cognitive impairments
- behavior management
- pain management
- problem solving and coping skills training
- social skills and assertiveness training
- sexuality and sexual counseling
- stress management modalities such as relaxation exercises, biofeedback, or meditation techniques
- substance and/or alcohol abuse interventions and referrals
- recommendation to specialized services such as peer counseling, psychiatric consultations, psychopharmacological treatment, hypnosis, vocational counseling, neuropsychological consultations, and spiritual support
- co-treatments with other disciplines, when appropriate, to facilitate progress
- financial counseling
- discharge planning and coordination
- community resource referrals

Psychologists, social workers, and counselors may also be responsible for the design, management, evaluation, monitoring and coordination of team-implemented psychosocial interventions. Moreover, it is important for psychologists, social workers, and counselors to continually monitor peer-reviewed literature in order to remain abreast of current evidence and scientific recommendations regarding psychosocial interventions beneficial to those with SCI.

5. Discharge planning

Discharge and after care planning begins at the time of the individual's admission to treatment and continues throughout rehabilitation. An interdisciplinary effort

including the full participation of the individual, the family, and the treatment team is required. Through the discharge planning and evaluation process, the individual is encouraged to develop a plan for maintaining an optimal level of physical, psychological, and social functioning.

The final discharge plan should fully describe those services and resources needed to support the psychosocial and medical elements of the treatment plan. Essential areas for description include: family support, financial status, housing, a personal assistance services plan if indicated, and a post-discharge follow-up plan.

The individual's perception of readiness for discharge from both inpatient and outpatient programs should be formally assessed by the psychologist, social worker, and counselor. Additional information, education or referrals should be provided as needed.

The individual should attend a final discharge conference to review and finalize the individual's plan for discharge from rehabilitation services. When feasible and clinically indicated, the individual's family should likewise attend.

6. Continued assessment and follow-up

A written plan for follow-up psychosocial services shall be developed with the individual and the family when feasible and clinically indicated. The plan shall provide for ongoing community reintegration services and social support through appropriate community referrals that may include:

- assistive technology
- driver's education and training
- educational programs
- financial assistance services
- home health services
- home modification services
- independent living centers, assisted living or skilled nursing facilities
- medical follow-up
- neuropsychological assessment and treatment
- outpatient rehabilitation services
- peer assistance/peer counseling programs
- spinal cord injury association and community-based support groups
- personal assistance/attendant services programs
- psychotherapy or counseling services
- recreation/vocational programs
- sexuality, fertility and couple counseling
- spinal cord injury associations
- substance abuse disorder treatment
- transitional living programs
- transportation services
- vocational rehabilitation services

Periodic psychosocial follow-up and reassessment is recommended (e.g. annual evaluation) either at the originating facility or in the geographic area in which the individual resides. Each follow-up contact or significant event should be documented with a progress note.

B. Additional activities of psychologists, social workers, and counselors

Psychologists, social workers, and counselors are encouraged to participate in the following professional activities:

- continuing education in spinal cord injury rehabilitation and related topics
- community outreach/education
- consultation to improve team effectiveness
- establishment of linkages with community agencies
- program evaluation of psychological and social work services
- patient advocacy and resource development
- research, publications, and presentations
- staff in-service education
- teaching, supervision and mentoring of trainees and less experienced professionals

V. Collaborative activities

Counselors, social workers and psychologists in SCI rehabilitation shall foster collaboration, cooperation, and mutual support in the functioning of the interdisciplinary team to ensure integration and coordination of treatment without duplication of services. The goal of mutual cooperation recognizes that effective team functioning is essential to the provision of quality rehabilitation services. Collaborative activities* should be integrated throughout the continuum of care for the individual with SCI, including inpatient, outpatient, and community based services.

A. Rehabilitative program activities

Psychologists, social workers, and counselors shall strive to support the collaborative functions of the interdisciplinary team in all of its basic program activities:

- intake and orientation
- initial assessment
- treatment planning
- treatment reviews
- progress reviews
- discharge planning and referral
- post-discharge follow-up
- case and program reviews

B. Treatment activities

Counselors, social workers and psychologists shall take an active part in treatment interventions and activities that

are collaborative in nature according to their expertise and interest, the needs and preferences of the individual and current practice in the clinical setting. These collaborative activities, which may involve team members from other disciplines, include but are not limited to:

- community outings
- family conferences
- family education programs
- family therapy
- group treatment
- pain management
- other community integration activities
- patient education programs
- peer counseling coordination
- skill-building groups

C. Administrative activities

1. Psychologists, social workers, and counselors shall be actively involved in those collaborative activities that are or may be administratively mandated for the enhancement of program quality and program development. Examples of such activities include:

- outcome studies
- continuous quality improvement
- program evaluation
- program and policy planning
- ethics committee
- compliance with facility accreditation/license, and local, state, federal regulatory standards
- staff training

2. Psychologists, social workers, and counselors should be actively involved in collaborative administrative activities which may not be mandated but which serve the overall goal of health promotion and improved quality of life. These include, but are not limited to:

- community organization, advocacy, and social policy change efforts addressing issues pertinent to persons with spinal cord injury
- consultation and collaboration with outside organizations and professionals concerning spinal cord injury
- community outreach services, including injury prevention, health education and promotion
- team-building; other pertinent psychosocial issues

D. Overlapping activities*

The interdisciplinary rehabilitation treatment team often experiences an overlapping of program activities. Responsibilities for assessment, intervention, and program planning in addressing the broad areas of human functioning affected by spinal cord injury do not have precise boundaries and frequently are shared

by various disciplines. Since psychologists, social workers, and counselors are qualified to perform some of the same functions in the provision of psychosocial care, facility policy should define those activities that are unique to each discipline and those which are shared.

Psychologists, social workers, and counselors shall work cooperatively with other disciplines to delineate responsibility for psychosocial assessment and intervention.

VI. Standards as applied to pediatric sci rehabilitation

Family centered care

- Psychology, Social Work and Counseling staff should provide both individual and family counseling as needed.
- The child should be included in and provide assent for (when appropriate) every aspect of the treatment. Siblings should be included in the treatment planning and in the provision of support services, as appropriate.

Anticipatory guidance

- Parents/guardians and the child should be provided with information about physiologic and other issues likely to occur in the future as the child grows and matures into adulthood
- Parents/guardians should be educated about the fact that a large percentage of children with SCI who have not finished growing may develop scoliosis of the spine. In an effort to prevent, delay or limit the development of this complication, some physicians may recommend that the child be fitted with and wear a back brace. Work with the family to identify coping and behavioral strategies to enhance wearing compliance.
- Parents should be encouraged to maintain social boundaries and expectations of their child.
- Parents/guardians should be encouraged to expect their child to do chores and hold them accountable.
- Belief should be promoted in the idea that the child can grow up, play sports, complete school, date, have a family, and be a productive member of society.

Developmentally appropriate care

- The entire staff must be educated regarding child development and what to expect and provide for children at each stage.
- Time must be provided in the patient's schedule for developmentally appropriate activities such as naps or downtime, attachment time, social time and play time in order to promote successful achievement of psychosocial tasks such as identity, mastery and individuation. Furthermore, the child shall be monitored over time to assure the schedule is appropriate for each new developmental stage.
- All attempts should be made when there is more than one patient per room to group youth of similar ages

together (and not with other adult patients) in order to promote networking and socialization amongst the patients and the families.

School issues

- The provision of school services should be provided during rehabilitation, in collaboration with the child's teachers from home, so that the child can continue with school work and not become too far behind his or her peers.
- The child should practice incorporation of adaptive technology/devices in school related functional activities such as note taking, carrying books, opening locker combination, etc. while still in rehabilitation.
- Interaction with the child's school before discharge must occur in order to ensure continuity of medical care. Other foci of the school reintegration process should include education about SCI for the school staff and students, disability etiquette education, accommodation suggestions, emotional preparation for the staff and students.
- The parents/guardians must be educated about special education laws and services that may now apply to their child (i.e. IDEA, Individual Education Plan (IEP), Section 504, Early Intervention, etc.).
- Members of the team should attend the patient's IEP meeting in person or by phone in order to facilitate the making of an appropriate IEP.
- Neuropsychological evaluations should be made available when a child has a concurrent TBI; not only for suggestions to enhance the rehabilitation process, but also for school service planning.

Social needs

- Peer mentors, both same age and those who are older and/or who have been injured longer, should be made available
- Inpatient group therapy for various age groups should be made available.
- Guided access to social networking media including Facebook, Skype, email, etc., should be made available.
- Staff should discuss and/or reinforce the idea of participating in wheelchair and adapted sports and recreation activities as this is a natural environment for the promotion of socialization.
- Patients and families should be provided with online resources: ASIA** website, ASCIP reading list, ISCOS website, etc.

Appropriate physical environment

- Cribs, high/low tables, lower beds, sinks and toilets, etc., must be provided as appropriate.
- Environment should provide for play and social spaces to meet differing needs of young children, school aged children and adolescents including play equipment for all sizes and ages.

- Enough storage space for all sizes of equipment should be available.
- Adequate financial resources to purchase the appropriate equipment should be available.

Security needs

- The unit must be set up to protect the safety of the minor patients including child-safe environment, supervision, secure access, etc.

Communication needs

- Should facilitate open communication between the staff and the family regarding who is responsible for what aspects of the child's care while he or she is inpatient. It is important for both the staff and the parents/guardians to be aware of the various stages of development and of the regression in these stages that the child may demonstrate post-injury.
- Parents/guardians should be encouraged that in addition to learning their child's care, they will need to take care of themselves (i.e., naps, day trips, meals out, periods of respite) throughout the acute rehabilitation period in order for them to be good caregivers.

Education needs

- In addition to teaching the child his or her own care, at an age appropriate level, in order to optimize independence and safety at every developmental stage at least one caregiver must be trained in the care of the child.
- Should educate the patient at an age appropriate level and the family members that the child with an SCI is at a higher risk for abuse.
- Should work with other staff members as appropriate to provide the patient at an age appropriate level and with parental permission and the parents/guardians with sex education including the areas of performance, fertility/infertility, pregnancy, etc.

Additional staffing needs

- Recreation therapy and/or Child Life staff should be present in order to provide an environment for the child to play during rehabilitation and to provide information about play, sports, and travel opportunities after discharge.
- Certified teacher should be present during rehabilitation stays lasting longer than two weeks in order to facilitate the child's learning and educational progress.

Accommodations

- Accommodations in the facility must be provided for at least one parent/caregiver to stay with the child while in rehabilitation. Furthermore, accommodations for two parents/caregivers should be provided during the acute rehabilitation so that the two caregivers can provide support for each other and take turns being with the child during this difficult time.
- Daytime visits from siblings should be encouraged as much as possible during the acute rehabilitation process.

Psychosocial outcomes in pediatric SCI

- As expected, youth with SCI seem to experience lower levels of participation and quality of life when compared with normative data.^{44,45}
- Youth seem to be developmentally appropriate in terms of the content of their participation.⁴⁵
- Parent/caregiver mental health is a stronger predictor of how parents rate their child's quality of life than the child's own mental health.⁴⁶
- On a positive note, children with SCI as a whole report experiencing levels of anxiety and depression that are within the normal range when compared with normative data.⁴⁷ Youth with SCI appear to be emotionally resilient.

Transition issues

- Parents/guardians should be provided with anticipatory guidance regarding transition issues from one developmental stage to the next (i.e., early childhood to Kindergarten, then to middle school, then to high school, then to college/vocational training, then to adulthood and work).
- Starting at age 14, the team should begin the transition process to adult care.
- A timely initial referral to the local vocational rehabilitation services should be made in order to take advantage of that valuable resource.
- The child should assume increasing responsibility for his or her own care as he or she ages.

Advocacy for SCI pediatric research

- A better understanding of this special population and its needs (including demographic and injury related characteristics, coping and problem solving profiles, psychosocial and health outcomes, secondary conditions, caregiver characteristics and psychosocial outcomes, etc.) will provide clinicians with more guidance regarding the provision of excellent and optimal care.

VII. Standards as applied to geriatric SCI rehabilitation

Older adults with SCI

The aim of this section of the Standards is to help psychosocial care providers better understand the physical and psychosocial changes that are to be expected among persons aging with SCI. Just like in youth, it should be kept in mind that adults develop at varying rates and in unexpected ways. Clinicians must remain open to new evidence indicating that initial hypotheses based on theory were incorrect, or that the patient's developmental focus has changed. Psychologists, Social Workers and Counselors involved in geriatric SCI rehabilitation are encouraged to review additional resources^{48–50} from which the following points have been derived:

- Generally, the effects of normal aging on body systems may be amplified among persons with SCI.
- Older adults with SCI may have lower functional gains during rehabilitation, but longer lengths of stay
- Older adults may be less likely to discharge to community settings as compared to younger persons with SCI, but this may not be true for all settings and systems of care.
- Physical functioning declines at high rates among persons with SCI. On average, persons injured at younger ages maintain stable functioning for about 20 years. In contrast, persons injured while over the age of 55 experience functional declines in 5–7 years. Needs for assistance in ADLs may occur at relatively young ages among persons with SCI.
- SCI tends to exacerbate normal developmental intrapsychic conflicts. Older adults are normally concerned with leaving behind something of value or worth remembering, and reconciling past mistakes with current insight. Rehabilitation should help older persons with disabilities resume healthy personal growth, functioning and independence.
- While some older adults are dependent on others prior to SCI, others act as caregivers for impaired spouses or siblings, and some are custodial grandparents. SCI may create a family crisis if it is difficult to find others to fulfill those roles while the older patient is hospitalized.
- Older adults with SCI may be less active in their communities and more likely to be unemployed than their younger counterparts.
- In spite of aging-related problems, most persons with SCI experience advancing age with low levels of psychological distress and high levels of QOL
- Life satisfaction may increase as a person lives longer with SCI.
- Depression is less common in older as compared to younger persons with SCI. However, rates of depression are higher among older persons with SCI than older adults from the general population, so it is important for providers to remain vigilant for depression. Studies of non-disabled populations find that when depression does occur in older adults, it is more likely to be severe and resistant to treatment. In addition to measures used with any adult, the degree to which a person still enjoys time with grandchildren (who are not in their custody) is a good screening measure for depression severity in older adults.
- Older adults may have decreased cognitive reserves and lowered threshold for delirium. Consequently, they can present with symptoms of delirium for an extended period following anesthesia, infection, metabolic disturbances, etc. Risk of negative side effects is typically increased for commonly used psychoactive drugs in SCI care such as anticholinergics, opioids or neuropathic pain agents as well as for alcohol and illicit substances. Older adults may need prolonged recovery time

from an episode of delirium. Clinicians must exercise caution before making a diagnosis of dementia or acquired brain injury in the context of recent delirium for older adults with SCI, ruling out treatable or reversible causes. A cognitive baseline is important to establish through interview and/or cognitive testing for older adults.

Recommendations for practice

General recommendations

- Psychosocial care should be structured yearly or regularly to systematically screen for problems related to aging to allow for early identification and minimization of complications.
- Older adults with SCI may require accommodations in health care settings such as sensory and memory aids, longer appointments, and greater lengths of treatment. Paradoxically, once motivated for change, older adults without cognitive impairment may progress more quickly than younger adults in psychotherapy due to a desire to make the most of their remaining life span.
- Leisure skills and family/social roles may augment or replace vocational goals for older adults.
- Assessment sources include the older person with SCI as well as proxies such as family members and caregivers, based on informed consent.
- Psychosocial assessment should include the needs and abilities of family members as well as the person with a SCI.
- Identification of what made lost activities valuable can facilitate finding the most beneficial replacement. For example, for the patient who is unable to return to work, identify how much relative value was assigned to the income, the sense of accomplishment, the respect/esteem, the social interaction, etc.

End-of-life care

- Caregivers should consider common psychosocial needs of persons who are dying, family members, and the caregivers themselves.
- Inpatient and/or outpatient hospice services should be made available, depending on preference and availability of instrumental social supports. Honoring wishes to die at home is critical whenever feasible.
- For the dying, there may be concerns about making meaning of their life, for example, developing a sense that they have contributed to younger generations (generativity), and/or a need to accept how they have lived (integrity).
- The dying should be assisted in maintaining a sense of self, versus experiencing their death as an impersonal case.
- Support system members often benefit from both emotional and practical forms of support.
- Support system members cope better if they feel that they have helped the patient.

- Bereavement care should be considered.
- Interventions should include identifying and providing linkage to psychosocial, financial, cultural, spiritual, bereavement support resources.

Long-term care planning

- Psychosocial care should assist individuals with living in their own residences and communities as long as possible.
- Psychosocial care should strive to identify those persons at risk for housing instability, from various causes, e.g. economic and social instability, eviction for behavioral disorders.
- Housing that adequately and safely meets a person's needs is central to aging well with SCI.
- Caregivers should gauge the fit between the older person and their home environment; this assessment should help the team find strategies to maximize environmental factors that enhance the person's functioning, security, comfort, and social connections.
- Person-environment fit assessment should incorporate review of health care needs

Advocacy

- Older adults with SCI are at increased risk for problems associated with disempowerment, i.e. losses of social status, influence over others, and the ability to control one's own life.
- Psychosocial care for older adults with SCI should address the person's social status and their ability to control their immediate environment and their community.
- Older adults with SCI should be involved in directing their care and other services.
- Information necessary to make informed care and social service decisions should be provided, in the formats, reading level and languages most appropriate for the person in question.
- Psychosocial interventions should assist older adults with SCI in thinking about their needs, options for meeting needs, making plans to address needs, and linking with resources.
- "Environmental" enhancements, such as automated bill paying, digital medication reminders, agent payee services, etc. may enable older adults with cognitive impairments to continue self-directed care.
- Older adults with SCI should be given opportunity to interact with people who have real-life experiences similar to their own.
- Psychosocial care providers should advocate in their communities on behalf of and in partnership with older adults with SCI.
- When issues of decision-making capacity or need for guardianship arise, clinicians offer careful assessments based on accommodations for motor or sensory impairments, such as hands-free testing approaches.
- Advocacy for research in SCI geriatric issues.

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