

## Current Development of VR Profession in Taiwan



Graduate Institute of RC, TKKW

## Official Professional Title

- Based on the task performed, the professional titles can be certificated with:
  - Supervisor
  - Case Manager
  - Vocational Evaluator
  - Employment Service Staff
  - Vocational Skill Trainer

## Title: Case managers

- Functions:
  - Case Management
  - Intake Interview
  - Assessment
  - VR plan
  - Referring/ coordinating Community-based services
  - Follow-up and Closure
  - Counseling
  - Advocate
- Roles:
  - Case manager
  - Counselor
  - VR Team Coordinator
  - Evaluation
  - Advocator

## Training Credential

- Some training hours in advance or work experiences are required for those college graduates from other disciplines to work as vocational evaluators and case managers.

Certificate Title	degree	Work experiences	Pre-job training	Post-Job Training
Case manager	BA in related areas	One year in services for persons with disabilities	36 hours	
Vocational Evaluator	BA in related areas		160 hours	
Employment Specialist	High school or BA		80 hours if high school or not related areas	80 within one year
Supervisor		3 years in same job title		36 hours

## VR Positions

Titles	Number	說明
Employment Service Staff	700	
Vocational Skill Trainers	300	Mostly part-time
Vocational Evaluators	100	Mostly part-time
Case managers	150	
Total	1250	

## Continuing Education/ Renewal Requirement

- Current: NO requirement
- 2016: 90 hours within 3 three years

## Professional Disciplines and Academic Credential

- After 2003
- Ministry of Education had funded three universities to establish master level graduate programs on rehabilitation counseling.
  - National Changhua University of Education (2003)
  - National Kaohsiung Normal University (2004)
  - National Taiwan Normal University (2004)
- Graduates from these three programs will obtain a degree of master of science in RC.



National Changhua University of Education (2003)



- The institute enrolls 15 students every year.
  - 7 by exams
  - 8 by paper review and interview
- More than 65 students obtained their master's degree from this program since 2003.

## Our students since 2003

Their Bachelor degree before Admission	%
Medical college(OT, PT, ST, Nurses)	20%
Social Work	22 %
Special Education	20 %
Psychology/Education	20 %
Others	8 %
Total	100 %

## Requirement for Our Master Degree

- 40 credits
- 360-hour practicum
- Master thesis
- 2 first-author articles (in conferences or any journal with a review process)



- In 2004, Taiwan Vocational Rehabilitation Association has been established
- The major missions are:
  - Publish the Taiwanese Journal of Rehabilitation Counseling (research articles)
  - Improve vocational rehabilitation services
  - Get funding and support for vocational rehabilitation counseling study from the government
  - Advocate for VR counseling Profession

## Best Outcomes/Practice

- Thought there is little evidence-based research to support for best practice of rehabilitation counseling in Taiwan, we have taken some efforts to make sure the people with disabilities will receive quality services.
  1. There are regulations to define the qualifications for setting up institutes that provide VR services.
  2. There are regulations to define the qualifications of professionals who can perform VR services.
  3. There are plenty of on-the-job training opportunities for the VR professionals to better themselves.
  4. There are annually or biannually program evaluations to oversee the quality and quantity of the VR services.

## Variables Affecting the VR Process

- Major variables could be:
  - Limited employment services resources in rural areas
  - Employers' negative attitudes toward individuals with disabilities, particularly mental illness
  - Lack in development of good work personality for individuals with disabilities
  - Family/societal values: protection vs. independent
  - Less trained employment service practitioners

## Challenges for VR for Individuals with TBI and Dementia

- Hospitals like to keep their patients as long as possible even they have reach stability and need to move ahead.
- The connection and collaboration between health system, VR system, and Social Supports system (social welfare, independent living, family support, etc.,) are weak.

## Welcome to Taiwan



The First Asian-Pacific Vocational Rehabilitation Conference  
in Kaohsiung, Taiwan, November 2005.

Thank you



**若年性認知症と高次脳機能障害者の  
社会保障のあり方に関する調査研究**

(H26年度厚生労働省科学研究、H26-政策-一般-009)  
(主任研究者 筑波大学 八重田淳)

高次脳機能障害者リハビリテーションと就労支援  
ジェニー・ポンスフォード教授講演

**Rehabilitation and Work Support for  
Traumatic Brain Injury**

**Special Lecture by  
Professor Jennie Ponsford  
Monash University, Melbourne, Australia**

日時： 平成 27 年 3 月 30 日 (月) 17:00-19:00  
場所： 筑波大学文京校舎 432 教室  
(東京都文京区大塚 3-29-1)

# 高次脳機能障害者リハビリテーションと就労支援 ジェニー・ポンスフォード教授講演

Rehabilitation and Work Support for  
Traumatic Brain Injury  
Special Lecture by  
Professor Jennie Ponsford

## Dr. Jennie Ponsford略歴

Dr. Jennie Ponsford is Professor in the School of Psychological Sciences at Monash University, and Director of the Monash–Epworth Rehabilitation Research Centre at Epworth Hospital in Melbourne, Australia. She is the author of “Traumatic Brain Injury: Rehabilitation for Everyday Adaptive Living” (2<sup>nd</sup> ed, 2013)

日時：平成27年3月30日(月)17:00–19:00

場所：筑波大学文京校舎 432会議室

(東京都文京区大塚3-29-1)

\*FD研修兼 同時通訳付き

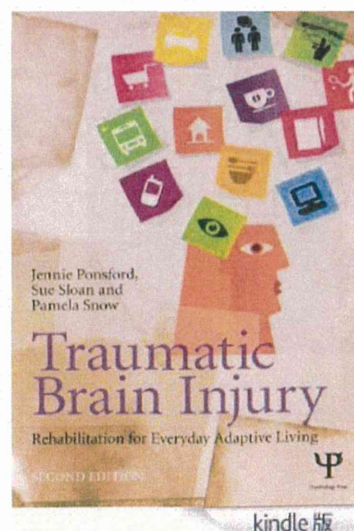


H26年度厚生労働省科学研究 若年性認知症と高次脳機能障害者の社会保障のあり方に関する調査研究  
(H26-政策-一般-009)

## 講師紹介

# Jennie Ponsford, Ph.D.

Jennie Ponsford, BA (Hons), MA (Clin Neuropsych), PhD, MAPsS, is a Professor of Neuropsychology in the School of Psychological Sciences at Monash University and Director of the Monash-Epworth Rehabilitation Research Centre at Epworth Hospital in Melbourne, Australia. She has spent the past 33 years engaged in clinical work and research with individuals with brain injury. Her research has investigated outcomes following mild, moderate and severe traumatic brain injury (TBI), factors predicting outcome, including return to work and study and the efficacy of rehabilitative interventions to improve outcome, with current intervention studies focusing specifically on fatigue and sleep changes, anxiety and depression and substance use following TBI. She has published over 190 journal articles and book chapters on these subjects, as well as two books on rehabilitation following traumatic brain injury. She also directs a doctoral training program in Clinical Neuropsychology at Monash University and her students are actively engaged with her research program. Professor Ponsford is the Immediate Past-President of the International Neuropsychological Society, Past-President of the International Association for the Study of Traumatic Brain Injury and the Australian Society for the Study of Brain Impairment (ASSBI), and serves on the Executive of the International Brain Injury Association and ASSBI. She is a member of the Editorial Board of seven international journals. In May, 2013 she was awarded the Robert L. Moody prize for Distinguished Initiatives in Brain Injury and Rehabilitation.



## Addressing psychiatric disorders following traumatic brain injury



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School of Psychological Sciences

## Frequencies of Psychiatric Disorders

Gould, K. Ponsford, J., Schönberger, M., & Johnston, L. (2011). *Psychological Medicine*, 41, (10), 2099-2109.

Disorder	Lifetime Pre-Injury	During 1 <sup>st</sup> Year Post-Injury	At 12 Month Assessment
Any Disorder	54.1	61.5	45.9
Mood	23	41.8*	32.8*
Anxiety	22.1	44.3*	28.7*
Substance	36.1	13.9	7.4
Adjustment	9	4.9	4
Psychotic	4.1	1.6	0.8
Eating	4.0	2.4	0.8

\* Rates significantly higher than population rates

## Most frequent diagnoses post-injury:

### Mood disorders

- 29.6 % Major Depressive Disorder
- 18% Depressive Disorder NOS

### Anxiety disorders

- 32.8% Anxiety Disorder NOS
- 13.1% PTSD
- 7.4% Specific Phobia
- 4.1% GAD
- 3.3% Panic Disorder
- 3.3% Social Phobia

### Substance use disorders

- 5.7% Non-Alcohol Substance Dependence
- 4.9% Alcohol Dependence
- 4.1% Alcohol Abuse

Adjustment disorder 4.9%

## Can psychological therapy be effective in individuals with TBI?

3

## Adaptations of therapy

- It is usually necessary to adapt psychological therapy methods to minimise the impact of cognitive impairments on potential benefit from therapy.
- Focus on concrete behaviours/ goals
- Written summaries/handouts, visual cues, use of a notebook to record strategies or video- or audio-recording.
- Use of catchy phrases, cue cards, mobile phones/handheld computers to provide prompts
- Behavioural experiments in reality testing, goal-setting and review may enhance self-awareness
- Repetition and booster sessions



- Some individuals with severe cognitive impairments may benefit more from changes to the environment, behavioural or pharmacological interventions.



## Background Assessment



- Use of case formulation and hypothesis-testing approach, considering predisposing, precipitating and perpetuating factors and strengths to promote change
- History from multiple sources should cover:
  - Details of TBI and other injuries, cognitive strengths and weaknesses, and behavioural changes.
  - Factors relating to person, including age, developmental stage, social roles including employment, pre-injury medical and psychiatric history, goals, family, other relationships, cultural factors, other social networks and supports
  - Post-injury factors including issues relating to accident circumstances, pain, family support, rehabilitation, other support services, other life stressors.

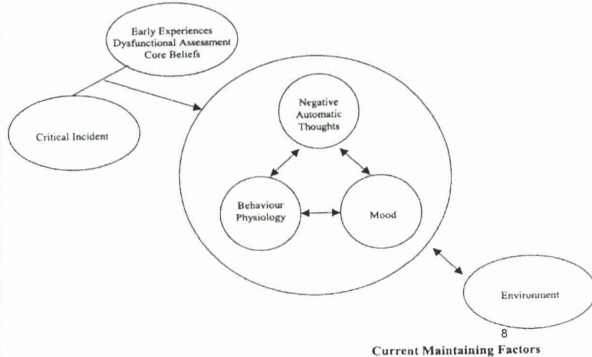
## Cognitive Behavioral Therapy (CBT)

- A structured therapy focusing on changing unhelpful behaviours and beliefs about the world to reduce negative emotions



## Cognitive Model of Depression

Past Events & Predisposing Factors



## Steps in CBT for depression



## CBT for anxiety

- Education about anxiety response
- Why avoidant behaviour is not helpful
- Monitor Triggers/responses/unhelpful thoughts
- Develop coping statements
- Relaxation training
- Activity scheduling
- Graded exposure/practice
- Skills training and maintenance
- Relapse prevention

## Cognitive Behavioral Therapy (CBT)

- Has empirical support as gold standard psychological treatment for anxiety and depression
- Most frequently used psychological therapy technique in TBI population
- Benefits of use with TBI population
  - Structured technique
  - Can use written aids, cues and repetition, homework, involve close other
  - Can focus on concrete behavioural strategies and goals
  - Adaptable to group format
    - Opportunity for peer support
    - Decreases sense of social isolation
    - Cost effective



## Efficacy of CBT based intervention following TBI

- CBT based intervention has been used with success following TBI for treatment of:
  - Depression (Montgomery, 1995)
  - Anxiety (Scheutzw & Wierciszewski, 1999; Hodgson et al. 2005; Tiersky et al., 2005; Hsieh et al., 2012, a,b)
  - Emotional distress (Bradbury et al., 2008; Tiersky et al., 2005)
  - Anger (Alderman, 2003; Medd & Tate, 2000; O'Leary, 2000)
  - Psychosocial functioning (Ownsworth, McFarland & Young, 2000)
  - Self-esteem and problem solving skills (Rath, Simon, Langenbahn, Sherr & Diller, 2003; Anson & Ponsford, 2006)

## Individual CBT for depression post-TBI

- Few well-designed studies
- Two recent randomized controlled trials evaluating the efficacy of CBT for depression did not find a significant reduction in depression symptoms on BDI-II post-treatment (Ashman et al., 2014) or on HAMD -17 at 16 weeks post-recruitment (Fann et al., 2014).

## CBT for anxiety post-TBI



- Hodgson et al. (2005) : RCT of CBT for social anxiety in 12 individuals with mild and moderate brain injury of mixed aetiology. Significant gains in general anxiety, depression for treatment group vs wait-list control, maintained at one-month follow-up.
- Bryant, Moulds, Guthrie and Nixon (2003) 5-week *group* CBT programme to treat acute stress disorder in 24 participants with mild TBI. At treatment completion, fewer in CBT group (17%) met criteria for PTSD compared to participants receiving non-directive counselling (58%). Gains maintained at 6-month follow-up.
- Treatment of PTSD in severe TBI remains an under-researched area.



## Difficulties engaging clients in psychological therapy

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## Motivational Interviewing (MI)

- Facilitates engagement in therapy and motivation to change.
- Involves exploring the pros and cons of maintaining the current situation (eg. Anxiety) and the pros and cons of attempting to change it in an empathic and non-directive fashion.
- Consider values – “Who I want to be”
- Decision is left to the client
- Efficacy demonstrated as a stand-alone treatment & as a motivational enhancement therapy prior to formal treatment in conditions impacting on cognitive function
- Application incorporates strategies suited for people with TBI (e.g., directive, using summaries).

Medicine, Nursing and Health Sciences  
Sub-Faculty of Biomedical and Psychological Sciences

### Motivational interviewing and CBT for Anxiety and Depression in TBI: A randomised controlled trial

Prof Jennie Ponsford	Dr Adam McKay
Assoc Prof Meaghan O'Donnell	Dr Kerrie Haines
Assoc Prof Nicole Lee	Yvette Alway
Dr Ming-Yun Hsieh	Dr Marina Downing
Dr Dana Wong	

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## Randomised Control Trial

### Aim

To evaluate in a RCT the efficacy of two interventions (MI+CBT & CBT +Non-directive counselling, NDC) compared to a treatment as usual control group, in alleviating anxiety and depression following TBI

### Hypotheses

1. 'MI+CBT' & 'CBT +NDC' would show greater anxiety and depressive symptom reduction compared to treatment as usual control group
2. Participants receiving MI would show better treatment response to CBT than those receiving NDC

## Method

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## Participant recruitment

### Eligibility criteria

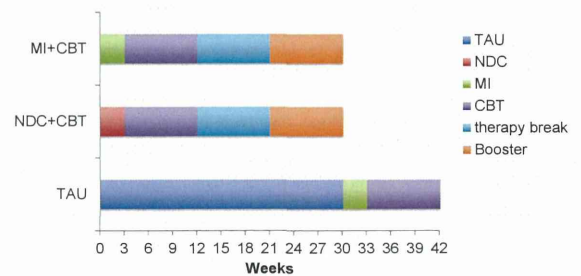
- Mild to severe TBI
- > 17 years of age
- Sufficient English skills to participate in therapy
- Not active psychosis or acute suicidal
- Anxiety and/or depression identified by self or referrer but confirmed on screening assessment

### Recruited from:

- Epworth Hospital, Melbourne
- The Victorian Rehabilitation Centre, Melbourne
- Community practitioners



## Study Design



## Therapy Program

- Treatment guided by MI and CBT manuals, which we adapted for the study.
  - Delivered by clinical psychologists or neuropsychologists
  - 10% of sessions evaluated for treatment integrity
- **MI** core components of:
  - Exploring ambivalence, developing and resolving ambivalence, and enhancing commitment to change and supporting self-efficacy.
- **NDC**
  - Participant-directed with therapist non-strategic reflective listening
- **CBT** core modules of:
  - relaxation, behavioural activation, cognitive re-structuring, structured problem solving, graded exposure, and relapse prevention.

## Adapting Therapy for TBI

### Modifications included:

- Concrete behavioural goals
- Handouts & summaries
- Pictorial cues
- Repetition
- Use of external memory aids

### Problem Solving - Taking time to



### For CBT:

- Basic CBT model
- Simplified cognitive re-structuring techniques
  - emphasis on "coping statements"