Acquired Brain Injury Case Management

Review Discussion Paper February 2007

Disability Services North and West Metropolitan Region

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Contents

Acknowledgments ... iii
1. INTRODUCTION ... 1
1.1 Parameters for the review of ABI case management ... 1
1.2 Project method ... 1
a. Project set up ... 1
b. Consultation phase ... 2
c. Analysis of funding and delivery phase ... 2
d. Reporting phase ... 2
3. SUMMARY OF CASE MANAGEMENT LITERATURE ... 3
3.1 What is case management? ... 3
3.2 Functions, skills and knowledge of ABI case managers ... 4
4. HISTORY OF ABI SERVICE DEVELOPMENT 1991-2005 ... 7
1991: CSDA and HIP ... 7
1992-93 MICHI and ABI case management ... 8
1994: ABI Working Party ... 10
1996: ABI Slow to Recover starts ... 11
1996: Evaluation of ABI Case Management – recognition of the importance of specialisation ... 11
1997: Disability Services Strategic Plan ... 12
2001: ABI Strategic Plan ... 13
2002/3: Program responsibility to Disability Services ... 13
2005: DHS and VCASP Strategic Planning Forum ... 13
5. CURRENT ABI CASE MANAGEMENT SERVICES ... 14
5.1 The Acquired Brain Injury (ABI) Services Unit ... 15
a. State-wide ABI Case Management Service ... 15
b. ABI Community Access Program ... 15
c. Melbourne Case Management Service ... 15
d. State-wide ABI Paediatric Coordinators ... 15
e. Information and Referral ... 15
5.2 arbias ... 16
5.3 ISIS ... 16
5.4 Southern Health Care Network ... 16
6. HOW THE SYSTEM HAS CHANGED ... 18
6.1 More and different people with an ABI ... 19
6.2 Variations in specialist skills and knowledge ... 20
7. DISCUSSION AND CONCLUSIONS ... 23
7.1 Systemic Development ... 23
7.2 Best practice ... 24
7.3 Funding ... 26
8. RECOMMENDATIONS ... 27
8.1 Establish guidelines for priority of access and the allocation of resources for ABI case management service by ... 27
8.2 In the context of the Disability Act (2006), clarify service access and promote systemic service development by ... 28
8.3 Build and strengthen links to other ABI Disability Supports by ... 28
8.4 Build and strengthen links to Disability Support by ... 29
9. APPENDIX A: CONTRIBUTORS TO PROJECT ... 30
9.1 Members of project board ... 30
9.2 Members of project reference group ... 30
9.3 Contributors to consultation process ... 30
9.4 Contributors to the report construction ... 31
10. REFERENCES ... 32

Acknowledgments

This project was the result of consistent and positive collaboration between Disability Services Division, DHS North and West Metropolitan Region and the ABI case management providers.

1. INTRODUCTION

A feature of the current relationship between DHS Disability Services and the Victorian Coalition of ABI Service Providers (VCASP) has been a commitment to collaboration as the mechanism to support continuing development and/or redevelopment of the acquired brain injury (ABI) service system.

Reports from a range of forums indicated that the case management needs of people with an ABI were not being appropriately met. In 2005, Disability Services Division and VCASP agreed to undertake a review of ABI case management services. Disability Partnerships and Service Planning (DPASP) North and West Metropolitan Region, who has lead responsibility for partnerships with the majority of ABI case management providers, assumed project management.

This discussion paper outlines service development in the ABI sector from 1991 to 2006, describes best practice approaches to ABI case management including responses to waiting lists and provides the basis for a work plan. It is envisaged that implementation of the work plan objectives will be undertaken over a 12 month period and will be auspiced by the North and West Metropolitan Region and overseen by steering group comprising key stakeholders.

1.1 Parameters for the review of ABI case management

The overall objectives of this project were to evaluate capacity in the specialist ABI service system and to provide a context for the enactment of the *Disability Act 2006*. Specifically, the project was required to investigate and report on a best practice model for the delivery and funding of case management services for people with an ABI; and ways to improve the efficiency, effectiveness and sustainability of DHS funded case management services for people with an ABI.

1.2 Project method

The project comprised four phases:

a. Project set up

This phase of the project established the consultative and governance arrangements for the project. The project was overseen by a Project Board and advised by reference group comprising representation from community services organisation (for membership, see Appendix).

b. Consultation phase

This phase involved a review of current models of specialist ABI case management and the articulation of a best practice approach to the provision of case management services to people with an ABI. This phase aimed to:

- Document current models of case management.
- Provide a definition of ABI case management (Disability Case Management Activity 17028) and include a definition of secondary consultation.
- Analyse existing service provision models across ABI and other specialist service providers.
- Analyse and determine the role and efficacy of existing secondary consultation and demand management processes.
- Examine whether targets, timelines and throughput strategies meet the needs of the ABI client group. Throughput refers to the process of transition from specialist ABI services and supports to those available more generally in the community.

This was achieved by undertaking a literature review of specialist and generic case management models and undertaking the consultations (see Appendix for contributors). Each ABI case management service also provided demographic data, internal outcome material, the philosophical and theoretical frameworks which underpin the service models and issues regarding the ability to maintain, and capability of, the current service delivery system.

c. Analysis of funding and delivery phase

This phase contributed to recommendations about how best to fund ABI case management services. It involved an analysis of the consultations with service providers and a desk top analysis of case management activity funding and targets in N&WMR including community service organisations funded on a statewide or cross region basis. This material was analysed to consider the feasibility of establishing state-wide and rural targets; developing funding practice and staffing profiles for costing models; providing recommendations regarding an equitable base for allocating targets and identifying differences in the respective target groups of providers that may impact on throughput.

d. Reporting phase

The final report was to include discussion of, and response to, the project terms of reference including a definition of ABI case management; the role and efficacy of secondary consultation and demand management and discussion and recommendations regarding equity and funding formula.

3. SUMMARY OF CASE MANAGEMENT LITERATURE

This section summarises the understandings of case management generally and for ABI case management specifically.

3.1 What is case management?

Case managers provide a single point of contact for people who require a complex range of services and/or require intensive levels of support either an ongoing, short-term or episodic basis. They work with, and for, the individual by enhancing independence and control.

There are various methods of case management and, as with any service model; different terms are used to describe it. This paper commences with the definition developed by Case Management Society of Australia (CMSA 2004). Case management is:

> '*a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes*'.

The term health is used here, in its broadest sense based on the World Health Organisation which states that health is 'a state of complete physical, mental and social well-being, not just the absence of disease or infirmity'. In general terms, case management focuses on the full range of health and social care needs of individuals with complex care needs. Case management is noteworthy for its breadth across health and community sectors and its implication for longer term support in response to people's complex needs and circumstances. Other management and coordination roles are more restricted in their mandate over time and/ or functions (for example, coordination of intake or clinical pathways).

Case management involves working across many boundaries; with health care and various systems that should interlink. Case managers need to understand how each system interacts with the other and the importance of getting that interaction right. Case managers support people in any area of life the individual feels in need of assistance and response to issues that other people take for granted as being able to solve with little consideration (for example, where to love and with whom). This is done by assisting individuals to get the support they need. When case management is expertly performed the complexity of the process often goes unnoticed by others. It is the complexity of the individual's care and support needs and the response provided that distinguishes case management from other models which essentially focus on single need care coordination. In some models, case management is separated from the direct service provision role while in other models the two are combined. However, in small

rural communities the combination of case management and service provision can be the only realistic and viable option.

3.2 Functions, skills and knowledge of ABI case managers

All ABI case managers support the CMSA National Standards of Practice Case Management (2004) as a baseline for practice and the starting point for defining ABI case management. CMSA (2004) says that case management requires:

- *A single point of contact* where the relationship with the case manager is the foundation on which the case management process is based, working in partnership with the individual and their carer. Case managers are also a single point of contact for other service providers.
- *Life strengths approach* which acknowledges that every individual has strengths that should be the focus of the interaction between the case manager and the individual. This approach maximises the physical, social and psychological well being of the individual to achieve their optimal level of independence and assist in the participation in the community commensurate with their capacity and choice. Case management facilitates the personal development of individuals.
- *Collaboration* between case managers, other service providers and professionals involved with a person to ensure the best possible result for that person.
- *Individualised* and person focussed support which ensures each person receives the appropriate level and type of support according to their needs, culture, budget restraints, working towards jointly agreed goals.
- *Continuity of care and support* whereby people have a right to expect continuity of service across time and boundaries in order to meet individual needs.
- *Boundary-spanning* whereby case managers draw upon all available resources, both informal and formal to provide support in the most cost effective manner.
- *Culturally appropriate* responses ensuring diversity is respected and catered for.
- *Creativity by* case managers to find innovative ways to meet need.
- *Empowerment* of people being supported, through the provision of information, to manage their affairs as far as possible.
- *Confidentiality* to be maintained at all times in accordance with legislative requirements and program standards.

The aims for ABI case management relate to maintenance of lifestyle, community reintegration, crisis intervention, and viability of approach over time. The effectiveness of case management for people with an ABI depends on provision by professionals with knowledge and experience in this field. There exists a significant body of work, which provides descriptions, analysis and recommendations regarding service enhancement strategies for ABI case management providers. The current review utilised the Ministerial Implementation Committee

on Head Injury (MICHI, 1994) benchmark findings and recommendations, an Evaluation of the Melbourne Citymission ABI Case Management Service (Centre for Health Program Evaluation, 1996), an Evaluation of the LIASE Program (Centre for Health Program Evaluation, 1996) and the Acquired Brain Injury Slow to Recover Program Review (HDG Consulting Group, 2004) to support the analysis of current service provision. Other sources included: ABI/A&D Better Practice Project Turning Point and arbias; Good Practice in Brain Injury Case Management edited by Jackie Parker; Growing up with an Acquired Brain Injury A Guide for Parents Brain Foundation.Victoria.

The Evaluation of Melbourne Citymission ABI Case Management Service (Centre for Health Program Evaluation, 1996) identified principles for case management similar to those described above for case management generally. Issues discussed related to maintenance of an individual approach; building personal relationships; and the minimisation of dependence while being flexible and responsive. The experience from case management should contribute to policy and system development. The primary difference – or addition – was an emphasis on specialisation. In the first instance, teamwork supplies information and a basis for a core of ABI specialisation from which to train other case managers. It was concluded that the provision of good quality case management requires specialisation. 'Specialisation' means good working knowledge of the issues associated with ABI and capacity to work with people with ABI. The difficulties and demands of working with this client group should not be under-estimated. Specialisation is also required to undertake the service development activities required to increase and support each person's use of generic service providers.

Of interest to the current project were the principles and standards regarding specialisation of case management to meet the needs of people with an ABI. The Melbourne Citymission ABI Case Management Service evaluation concluded that the starting point for all case management should be: what does the person with an ABI want and what does the person with an ABI need? Case management services should maintain a focus on meeting the person's needs and not redefining person's needs on the basis of what the case manager or other service providers can or cannot do. For many people with an ABI, their families, carers and support networks, good quality case management requires the development of open, friendly and trusting relationships with case managers. Case Management services must be structured to make this possible. Good case management will over time reduce the dependence of the person on the case manager.

The importance of specialisation in relation to ABI case management was both emphasised and defined. The evaluation concluded that the provision of good quality case management requires specialisation because of the particular 'difficulties and demands of working with this client group.' Specialisation of ABI case managers involves three aspects. Specialisation means a 'good working knowledge of the issues associated with ABI and capacity to work with people

with ABI'. Specialisation is also required to undertake the service development activities required to increase and support people's access to generic service providers and to influence policy development. Specialisation also has implications for teamwork and team support. Where information is available, there is a core of ABI specialisation from which to train other case managers; and therefore capacity for continuity of approach to service provision for people with an ABI; and continuity of relationships with service providers.

The case managers' role differs dramatically when working with different individuals. The tasks a case manager can be involved in vary enormously from person to person and from day to day. Case managers need to understand the process involved, not only in care but also in rehabilitation, finances, the legal system to name a few. Designing rehabilitation goals and programs, finding resources and establishing funding, dealing with clients who are alcohol affected and collecting them from police cells, organising child care or access visits for children of brain injured parents, providing support to parents caring for their children and recruiting workers or dealing with appraisal or disciplinary procedures, can all be part of a normal working week within case management practice.

Case management should allow people with an ABI to learn positive strategies to deal with everyday situations in an organised and pre-emptive way. Case managers need to be flexible and open to learning to manage change effectively, and to recognise the need to balance client choices and risk. Case managers should be aware of barriers to independence but never exclude the possibility of progress, if given appropriate facilitation.

The unpredictability of working with people with an ABI increases the stresses on the case manager. Clinical supervision and a comprehensive set of policies and procedures are required to support case managers.

Arising from these aims, specialist case managers for people with an ABI undertake the following systemic and individually focused functions consistent with case management more generally (National Community Care Management Network 2005). It is their knowledge of people with an ABI and how this applies to case management which emerges as the distinguishing foundation. ABI case management functions are:

- *Comprehensive needs assessment* in collaboration with the person and their families/carers, identify personal needs and function levels to maintain quality of life in the community. This assessment is an ongoing process and draws in specialist expertise as required.
- *Care and service planning* which is developed in consultation with the person nominating short and long-term goals, incorporating family and carer needs, and defining the service responses required.

- *Resourcing the care and service plan* is achieved in a variety of ways including:
  - The use of brokerage funds to purchase services and support (including equipment) to meet individual needs
  - Provision of services from relevant programs
  - Support provided by carers, such as family members or friends
  - Client fees and contributions
  - Seeking funding from alternative sources. Case managers ensure the resources used are safe, efficient and effective.

The consultations were the means to further explore the aims, functions and specialist skills and knowledge of ABI case management identified from the literature.

4. HISTORY OF ABI SERVICE DEVELOPMENT 1991-2005

The following information was sourced in the main from DHS files and should be read as a chronological list of activity. This information has been utilised to identify the assumptions in earlier service responses, how these have been tested and what are the optimum responses in the current context.

1991: CSDA and HIP

The first Commonwealth/State Disability Agreement (CSDA) was signed. The State passed the Disability Services Act, which gave States responsibility for accommodation and support to people with an acquired brain injury.

The Head Injury Project (HIP) a joint initiative of the health Department Victoria, Community Services Victoria and the Transport Accident Commission was established and completed in April 1991. The HIP defined ABI as:

> *…..a non-degenerative injury to the brain that has occurred since birth. It can be caused by an external physical force or by metabolic derangement. The term acquired brain injury includes traumatic brain injuries – such as open or closed head injuries; or non-traumatic brain injuries- such as those caused by strokes and other vascular accidents, tumours, infectious diseases, hypoxia, metabolic disorders (eg liver and kidney diseases or diabetic coma) and toxic products taken into the body through inhalation or ingestion…..*

The HIP proposed a set of principles, which would guide service development for people with ABI. These principles were:

- Prevention of ABI and its effects should be central elements of service delivery

- An appropriate range of services and supports should be available for people with ABI, their families /carers as needed
- Services should be delivered in an accessible and equitable fashion based on need
- Services should be provided wherever possible through generic services, based in the community
- Use of resources in the provision of services should be effective and efficient, and be coordinated across existing boundaries
- Innovation and good practice should be encouraged
- Consumers should be involved in the planning, monitoring and evaluation of services
- Community awareness and understanding of the nature and effects of ABI should be enhanced.

The HIP developed a comprehensive Head Injury Services Plan with 8 priority areas and 41 recommendations.

1992-93 MICHI and ABI case management

The Ministerial Implementation Committee on Head Injury (MICHI) was established to oversee the implementation of the HIP recommendations. 20 projects were funded, the largest being the development of a specialist ABI case management service. Other significant projects included the development of an information package, a training strategy, educational modules and a family counselling service. MICHI represented a recurrent commitment of approximately $3m.

When considering the development of ABI case management and community integration services, MICHI determined that:

- Services to people with an ABI and their families were provided through a mix of public and private suppliers across many agencies and funders
- Persons with non-compensable ABI were/are especially reliant on publicly funded services. Most people enter the system through public hospitals, which therefore play a central role in determining access to rehabilitation and community services

With regard to efficiency MICHI determined that this was contradicted in many ways including:

- Unfamiliarity with ABI, it is not a common condition and few families would have direct or indirect experience to draw on
- The inherent complexity of ABI and its prognosis, definition of optimal approaches to management is difficult, with few well defined protocols available to be followed
- Substantial variation between people is expected
- Difficulty in acknowledging and defining the needs of the family

- Fragmentation of services, such that there is no simple way of identifying the services which people with ABI and their families may be eligible
- The disability may limit the capacity of those needing the services to interact effectively with the service system, and require particularly careful and sensitive interface

MICHI envisaged that an ABI case management service would facilitate the discharge of people with non-compensable traumatic brain injuries (TBI) from acute hospitals and link them to community services and that independent living skills training would support community access and therefore reintegration.

MICHI established the ABI case management service, awarded as part of a tender process to MCM and LIASE, to the Peninsula CHC, Cranbourne CHC and the Southern Region Accommodation Service.

arbias (incorporated in 1990) was expanded during this time and ISIS, auspiced by the Brimbank Community Health Centre, a pilot case management service in the Western Metropolitan Region, was reviewed and funded recurrently.

The specialist case management service (MCM) pilot was based on the following assertions:

- The complexity and long term nature of ABI
- The range and variable impairment, necessitating an individualised approach to service provision
- The paucity of ABI specific services which means needs must be met from a wide array of existing health and community services
- The inability of many people with ABI to recognise their problems and to advocate on their own behalf due to cognitive impairments

The aims of the pilot were to provide specialist ABI case management for people with ABI with complex care needs in the first few weeks of discharge from an acute health setting or rehabilitation centre. This level of case management will generally be provided on a time-limited basis. In some cases it may require a few weeks of ABI case management before referral to a generalist case management or brokerage service. Specialist ABI case management may also be required to assist a generalist service providing for a client with ABI and complex needs.

The target group for the service are people over 18 years and older who have a diagnosed and recognisable ABI and who are not eligible for compensation.

Not included in this target group are people who are affected by degenerative neurological

disease; with a primary diagnosis of intellectual disability; who are resident in a Community Residential Unit or who are in receipt of a support package that includes a case management component such as Linkages, Early Choices, Making a Difference.

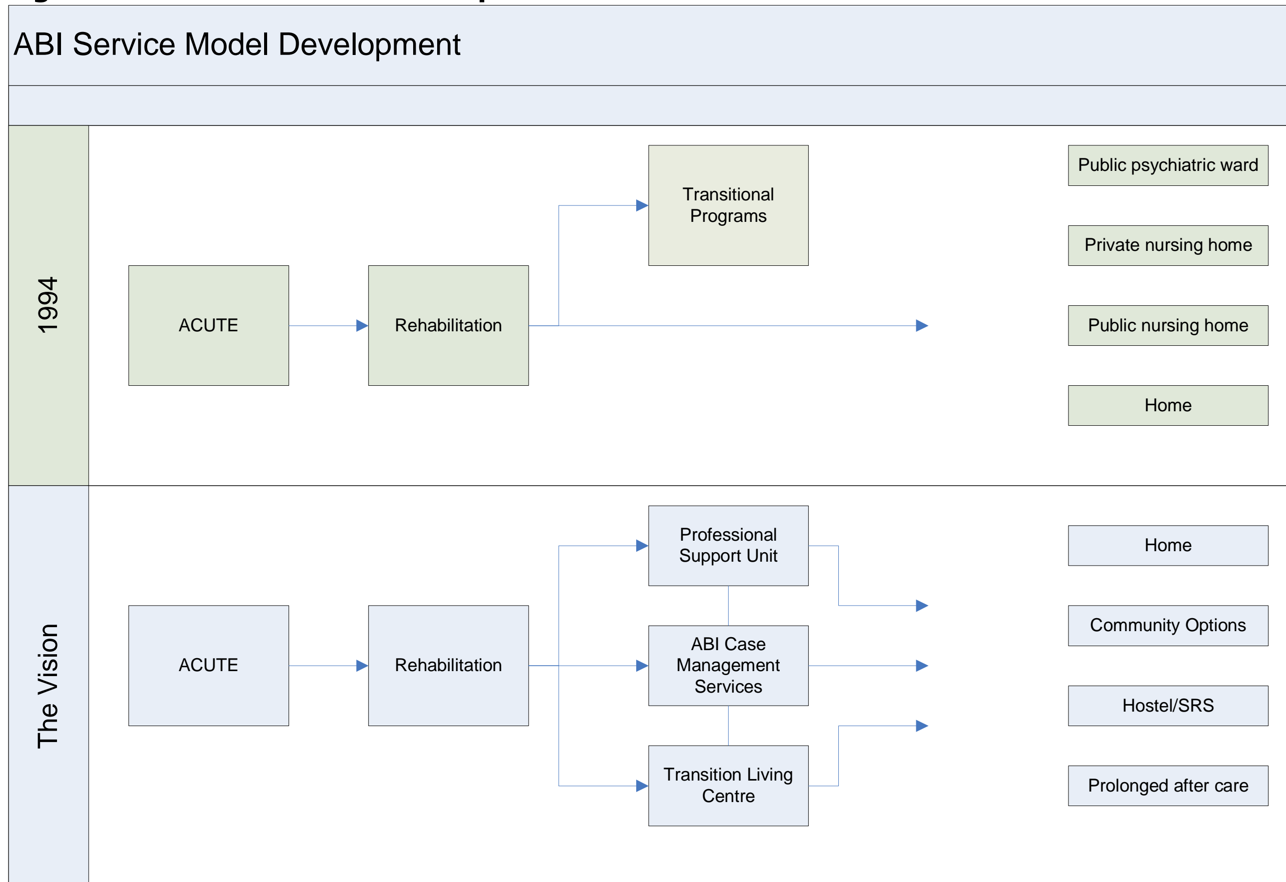
Priority of access to ABI case management must be given to non-compensable people who require ABI case management support in order to be discharged from an acute health facility; who may be at risk of homelessness; and/or who are at major risk of loss of independence and existing quality of life due to lack of case management support.

1994: ABI Working Party

Following the "Way Ahead Workshop" the government established an ABI Working Party to ensure coordination of policy and program development across all Divisions of the Department. Disability Services provided administrative support to the development of a strategic plan for ABI service development within the Department. Five regional pilot projects were funded in addition to information services, carer support, case management, independent living skills development, behavioural intervention and neuropsychological assessment.

Figure 1 describes the service system in 1994 and the vision for the future. In 1994, people with a traumatic ABI moved from acute hospital to rehabilitation, and then either to transitional programs or directly to alternative living arrangements, perhaps with little assistance. The vision recognised the importance of various transition arrangements as people moved from acute hospital and rehabilitation and envisaged coordinated contributions from various specialist professional staff, ABI case managers and the transition living centre (which was never developed) to support people moving to longer term living arrangements, be they at home, or in various staff residential settings. That is, the importance of specialists to support transition from the recovery phases of acute hospital and rehabilitation to the establishment of longer term community living arrangements. One implication of this model was that all people with an ABI transitioning from acute hospital or rehabilitation to community arrangements would be supported by an ABI case manager.

Figure 1 ABI service development: 1994 & the MICHI vision



1996: ABI Slow to Recover starts

The ABI Slow to Recover (STR) Program was established targeting the needs of people with significant brain injury, who are difficult to accommodate and require prolonged high levels of clinical care. A review of the specialist ABI case management service was completed. The key recommendations provided for the continuation of the service.

1996: Evaluation of ABI Case Management – recognition of the importance of specialisation

An evaluation of the MCM Case Management Service ABI was completed (Centre for Health Program Evaluation, 1996). A summary of the recommendations from this review included:

- Case management services should continue to be available to people with ABI and their families throughout Victoria and based on need.
- The current structure of a single statewide ABI specialist case management service working with and closely linked to regional and local ABI specialist and generalist case management should continue.

- Regional and local case management services should continue to be developed.
- There should continue to be a Melbourne-based specialist case management service which can provide ABI case management services to fulfil a lead provider role.
- The Melbourne-based specialist ABI case management service should have a statewide role.
- The Melbourne-based specialist case management service should provide a short-term transitional case management service to its clients.
- The specialised transitional case management service must also fulfil a number of lead provider functions.
- Eligibility for transitional case management should be based on need. The target group should be anyone with an ABI, less than 65 years old and not immediately able to access a local generic disability or generic case management service.
- If it is at all possible, case management should be provided by a case manager who works near the residence of the person with an ABI. This principle had implications for state-wide services or those with dispersed geographic delivery.

These recommendations were not intended to be interpreted as suggesting that only those people with very high needs should have access to case management. The principle meant that if someone is expected to be able to benefit from case management, it should be available to them when they need it. Rather than restrictively define eligibility, it should be accepted that an important part of a case management service is to respond appropriately to referrals, to refer on where appropriate and to work intensively with those requiring the special expertise of the case manager. At that time there was no waiting list for case management, unlike the present.

However, it is only in relation to specialisation about ABI systemically and at the level of the individual, that ABI case management differed from more general discussions about case management (See Summary of literature).

1997: Disability Services Strategic Plan

Disability Services completed a strategic plan, which identified five key roles critical to achieving outcomes for people with an ABI, namely prevention, first response and diagnosis, assessment and treatment, rehabilitation and community support. The report recommends the DHS Executive agree to consolidation of coordination responsibility for ABI in the Aged Care, Community and Mental Health Division (ACMH).

In accordance with the strategic plan for ABI, coordination was transferred to ACMH. ACMH formed a Strategic Planning Group with representatives from the Department, TAC, Workcover as well as service providers and advocacy organisations. The group had 3 sub-committees

focussing on ABI and Accommodation and Support; ABI and Access to Mental Health Services; and ABI and Alcohol and Drug Services.

During this time three new funding packages were announced, targeted to case management (including the provision of recurrent funding to ISIS WMR and LIASE SMR), a new community brokerage program Activity Community Living (ACL), neurological assessment, family counselling, 3 supported housing initiatives, behavioural intervention, Information, Training and Secondary Consultation Projects (ITAS) rural regions and the Brain Disorder Injury Service.

2001: ABI Strategic Plan

In March 2001 the ABI Strategic Plan was launched. The plan made recommendations regarding the coordination and integration of policy and program development, the improvement of service responses, strengthening of partnerships, promotion of quality improvements in monitoring and evaluation. Important achievements included:

- The recommendation to transfer of responsibility to Disability Services of all ABI specific programs (excluding ABI/Mental Health programs and the ABI: STR Program, pending the outcome of a review).
- Expansion of neurological assessment services.
- Development and distribution of ABI information.
- Training on ABI/AOD and training to mental health workers.
- Development of information strategies for aboriginal, culturally and language diverse, and rural communities.
- Development of a state-wide ABI training plan.

2002/3: Program responsibility to Disability Services

In 2002/03 ABI programs and programmatic responsibility were transferred to Disability Services.

2005: DHS and VCASP Strategic Planning Forum

Since transfer of ABI programs to Disability services, the following initiatives have been developed and implemented in conjunction with the ABI sector via the DHS/VCASP Strategic Planning Forum including:

- Establishment of an ABI Paediatric Coordination Service (Melbourne Citymission).
- Expansion of the ABI/AOD Case management in rural regions (range of organisations).
- Commencement of the Koori Partnership Program (VCASP).
- Commencement of the ABI Accommodation Guide (VCASP).
- Review of Information, Training and Secondary Consultation in rural regions.

- Transfer of the ABI: STR program (Disability Services Division and the Southern Health Care Network, Metro Health and Aged Care Services).
- Commencement of the Juvenile Justice Scoping Project (Melbourne Citymission)
- Completion of the ABI Information Product Project (arbias, Headway Victoria and Brain Foundation).
- Commencement of the ABI Case Management Review.
- Publication of an ABI/mental health issues paper and protocol (Metropolitan Health &Rural Services).

5. CURRENT ABI CASE MANAGEMENT SERVICES

The current ABI service system involves two inter-related arms, case management and support services. The various support services include behaviour intervention, family therapy, advocacy and information, neuropsychological assessment and information, and various specialist intervention and accommodation support options. These services are provided through a range of providers.

This review of ABI case management is occurring within a complex and changing environment and must be positioned within this context. Other current DHS initiatives which will have an impact on case management services to people with an ABI include the implementation of the *Disability Act 2006*, the development of the Disability Support Register and the emphasis on priority of access, and work exploring the interface with acute and sub-acute care (Metro Health and Aged Care Services; Hospital System including the Royal Talbot). Cross program and interface issues are also developing with generic and other disability sectors, with rehabilitation and community sectors, for example, the expansion of the ABI/AOD Clinical Consultation Program (Drug Policy and Treatment); the Disability/Child Protection Protocol; Justice Department Corrections Disability Framework; Court Integration Program; Disability/Juvenile Justice Protocol; Multiple and Complex Needs Initiative (MACNI) and Rehabilitation for example, Paediatric Services (MCM), Slow to Recover (Southern Health Care Network).

In addition, there are related initiatives which may affect responses to people with an ABI, for example the *my future, my choice initiative.*

ABI case management is provided by four service providers. Figure 2 (pp 13) provides an overview of the current ABI service system and ABI case management services. ABI case management services are provided by specialist teams within community based provider settings. Each one has a different history of development, funding, priority setting and role. The following details have been provided by each of the ABI case management providers.

5.1 The Acquired Brain Injury (ABI) Services Unit

The MCM ABI Services Unit comprises five program areas: State-wide ABI Case Management Service; ABI Community Access Program; Melbourne Case Management Services; State-Wide ABI Paediatric Coordinators; and Information and Referral Services.

a. State-wide ABI Case Management Service

A short-term specialist ABI case management service for people throughout Victoria, who have a moderate to severe injury, who are aged from 18 to 64 years and who are non-compensable. The service is targeted at people less than two years post injury and specialises in the transition of people with an ABI from hospital and rehabilitation settings back to the community. Staff in this service area are also contracted to provide case management for people receiving ABI: STR funding. ABI case management services are occasionally sub-contracted to rural organisations. Current Equivalent Full Term (EFT) is 6.5.

b. ABI Community Access Program

A specialist ABI program providing case management and independent living training to people living in the northern and eastern suburbs of Melbourne who are more than two years post-injury, aged 18 to 64, non-compensable and on low income. This service also contains the maintaining Access Program and the Accommodation Outreach Service. Current EFT is 5.2.

c. Melbourne Case Management Service

This service provides short-term episodic case management for compensable adults and children throughout Greater Melbourne and Geelong on a fee for service basis. Funding for people receiving this program comes from insurance agencies such as TAC, Workcover and the Supreme Court's Senior Masters Office. Current EFT is 3.1.

d. State-wide ABI Paediatric Coordinators

This specialist service provides information, mentoring and support to families and people working with children and young people with ABI throughout Victoria. The service targets children and young people who have experienced a time of uninterrupted development and then sustained an ABI-generally with associated loss of consciousness. Current EFT is 2.

e. Information and Referral

This program handles requests for information, screening and assessment and referrals to ABI Case Management Service and the ABI Community Access Program. This position currently has no dedicated funding. The current EFT is .6.

5.2 arbias

arbias was established to provide services for people with alcohol related brain injury and whilst it has expanded to provide services for people with acquired brain injury from any cause it maintains its specialisation in the areas of alcohol and other drug related injury. The target groups are those with complex needs due to dual disability, alcohol/drug related/behavioural or psychiatric problems. Current EFT is 3 5. Other positions are funded via Southern Region DHS, Slow to Recover (STR), Home and Community Care (HACC) and fee for service funding (TAC, Workcover etc.).

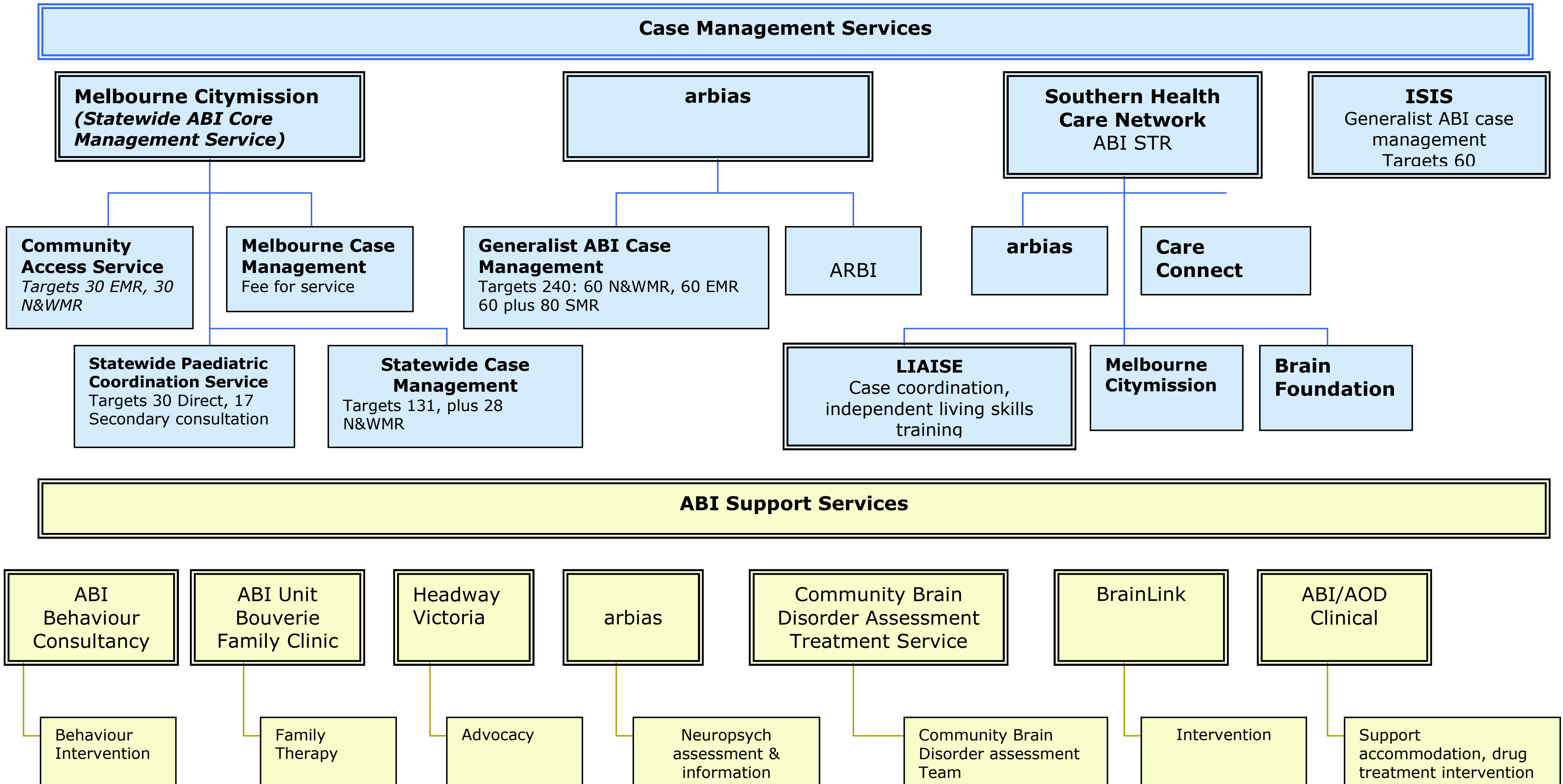
5.3 ISIS

The program aims to enable people with an ABI, who live in the Western Metropolitan area to live as independently as they are able by maximising their self-sufficiency and linking them into community services and activities. The program has several components including community development, information provision, secondary consultation, case management and flexible care packages. The target group includes those people who have complex care needs, which are influenced by their ABI. The current EFT is 3.4.

5.4 Southern Health Care Network

This program provides individually targeted slow-stream rehabilitation services to people with a severe ABI who have the potential to achieve functional gains in their level of independence, and thereby designed to assist these people to achieve optimum levels of independent functioning. The program identifies the rehabilitation and clinical care needs of individual clients, and contracts core services and provides coordination through specialist case management. The STR funding to contracted agencies is based on the principle of 1 EFT for 15 complex or 30 maintenance clients. The current EFT is 7.

Figure 2: ABI Case management and support service mapping



6. HOW THE SYSTEM HAS CHANGED

ABI service providers reported a number of distinctions between ABI case management services established in the 90's and those provided now. There has been an increase in the funding and therefore targets for ABI case management services together with the expansion of ABI disability supports and ABI specialisation within generic case management services. Fee for service options are available now within specialist ABI teams. In response to the increasing numbers of people seeking support, unlike at the time of MICHI, most ABI organisations have also developed an intake function. Finally, the range of ABI responses now includes services for children and young people.

These initiatives were reported by current ABI service providers to have had a positive effect on the service system. Overall, there is more thorough assessment, appropriate referrals and diversion from specialist services if they are not appropriate. The Fee for Service development has introduced a suite of tools to measure progress and allocate resources. Specialisation within generic settings has eased and promoted entrance to non-ABI specific services such as other support packages and community health services. The expansion of ABI Disability Support Services has reduced waiting times for neuropsychological assessment, AOD intervention and information. New services for children and young people has established an early intervention response which potentially alleviate risk factors and minimise the likelihood of later crises or more intensive requirements for support being required.

However, a new 'bottle neck' in the transition or throughput model has developed. At the time of the MICHI recommendations (see Figure 1), people with an ABI were not able to leave rehabilitation and they had no ready means to move to other living arrangements. MICHI proposed case management, transition living arrangements and secondary consultation as the means to support moves back to community living. In practice, ABI case management and secondary consultation have been provided together (the secondary consultation component was not funded) within specialist ABI agencies and the transition living arrangements were not developed. It is now apparent that people with an ABI have been able to move from rehabilitation to ABI case management support, but find it difficult to move to other forms of generic support due to an absence of expertise in the community sector, and absence of capacity for secondary consultation from the ABI case management providers to more generic support agencies. The best examples of effective capacity building of generic agencies were described using secondary consultation as undertaken by the Paediatric Coordination Service (Melbourne Citymission ABI Unit)

There are increasing numbers of people with ABI seeking services. The main mechanism identified by MICHI (1994) to respond to demand for services was the provision of specialist

short-term case management in conjunction with an expectation of throughput or transition to generic community based services.

It should be noted that at the time MCM ABI Case Management Service was reviewed in 1996 waiting times were approximately one month so the implications of people waiting and how organisations form and support people on waiting lists were not defining issues in service development. Consistent with this approach MICHI did not provide ABI case management providers with brokerage arguing that this would foster co-dependency and limit the need to gain access to generic services. In hindsight it would appear that this approach did not account for the complexity and support requirements of the 'non-core' target group or the difficulty of implementing an approach which relied on transition to generic services. Transition assumes the willingness and skill of all parts of the service system to be involved. In the current review, difficulties with entry to generic services emerge as a significant barrier to community re-integration. The experience of ABI case managers is that generic services are reluctant to accept referrals given the degree of disability and associated behaviour of the ABI group. Unexpectedly, sourcing brokerage dollars from a range of possible sources to support service access currently comprises a significant aspect of a case managers' role, both in identifying appropriate sources and completing the paperwork required. These activities can dominate the roles of ABI case managers and reduce their availability for secondary consultation and education to the generic and community providers.

6.1 More and different people with an ABI

In general ABI case management services were reported to continue to be provided in accordance with the original service specifications. The recovery process for a person with traumatic ABI from MICHI times has generally been understood as a 'one way' flow from point of injury, to various acute medical responses, rehabilitation and then the community. The range of specialists involved with each stage of the process is complex and varied. The critical role for the ABI case manager in spanning the transition from the acute hospital and rehabilitation stages and then into the many facets of community re-adjustment was emphasised. The success of this aspect of the service response can be attributed to broader community knowledge and awareness of ABI, increased awareness of generic service providers of ABI services and the pathways and partnerships established with the acute and sub-acute health service systems. There are solid improvements for some groups of people with an ABI, for example, people with catastrophic head injury are well supported through STR.

What appears to have changed, and is having a direct effect on service system capacity to respond, is an increase in the number of people with an ABI presenting with complex care needs often many years post injury. People are being referred and accepted to MACNI from generic providers but not from specialist ABI case managers. It would seem that the specialist system is supporting people but has limited capacity to strengthen skills and knowledge of generic services if they identify new individuals. This group of new individuals were not

identified in the original MICHI framework and were not the group ABI case managers were designed to respond to. The main task for ABI case management was pitched at the transition from rehabilitation to community settings. Analysis of active client and wait lists indicate that this more recently emerged group of people with an ABI is characterised by an active alcohol or other substance misuse issue, a mental illness, a personality disorder, family breakdown, intellectual disability, homeless or at risk of homelessness and an ABI. Generally this client group have had prior involvement with a number of service providers over a long period of time and continue to be resource intensive. The needs of this client group are not easily reconciled with a throughput model of service responses, in the main due to the crisis nature of the intervention provided and the extreme difficulty or unlikelihood of involving an adequate level of non ABI specialised services.

MICHI envisaged that the independent living and case coordination service would work with complex clients, longer term, directly supporting their re-integration into the community. This approach is limited to two ABI services, LIAISE (Southern Health Care Network) and CAP (MCM) and requires a more systemic approach to extend effectiveness. Another apparent gap from the initial MICHI developments is the lack of time available to be spent with people with an ABI determining what they want from the service system. Other issues identified from the consultations relate to limited collaboration across service providers about case management, capacity of services to fund innovative approaches, limited options for services and service access and problems at interface between case management and other ABI disability supports or disability supports more generally. ABI case management is often prolonged in particular due to requirements to interface with AOD/ Mental Health Services in order to maintain optimal responses.

6.2 Variations in specialist skills and knowledge

Further information regarding the impact of brain injury on the person with ABI and their families/carers and the consequences for the role and specialist skills of ABI case managers has been gathered from the consultations. These variations occur with different target groups (for example, children and young people, people with alcohol-related ABI) and depending where people are in the service system (i.e. admission to hospital, rehabilitation, discharge and community reintegration). Table 1 is an indicative list of the differing skills and knowledge reported to be required of case managers arising from the circumstances and nature of ABI.

Table 1 Variations in ABI case management skills and knowledge

Target group/ sphere of operation	Case manager role, skills and knowledge
People with ABI in the acute and sub-acute health system	*At admission*: • Grief and trauma processes & strategies. • Hospital processes, key personnel-roles and responsibilities • Please note that Hospital social work department may be involved at this stage • Assessing severity • Potential impact on recovery, rehabilitation and community integration • Identification of potential options-appropriate to degree of disability-identify cost effective resources *At inpatient –acute-rehabilitation* • Provide information to family members -understanding of the causes and impact of brain injury, investigations that take place and the terminology • The case manager is responsible for ensuring that the client understands the information that is available about the nature and ramifications of the brain injury, often translating obscure terminology into everyday language
People discharging from rehabilitation, and moving back to the communit*y*	• Ongoing support to the person's family-establish a positive, professional relationship with the individual and his or her family, who are often at odds with each other in as period of turmoil and change • Understanding and provide information regarding the roles of rehabilitation professionals, general rehabilitation techniques and procedures (and to appreciate a well-coordinated approach to rehabilitation) • Expertise in establishing rehabilitation programs in the home • The work could also involve client advocacy, family education and support, developing rehabilitation goals and care plans, monitoring and evaluating the quality of rehabilitation programs and adapting care plans in liaison with other professionals. The preparation of support worker guidelines and risk assessments is essential for the coordination of appropriate care plans and interventions. Recruiting, training and managing support workers (either via direct employment or agencies), dealing effectively with potential crisis • On-going assessment, identifying and supporting access to services in the community. • Awareness of risk and ability to provide strategies that will minimise risk • Strategies to support integration • Social and independent living skills training provision • Motivational and engagement strategies
People living in the community with alcohol or substance related brain injury	*Systems*- Drug Treatment Services & service options- *Assessment*-level of cognitive functioning, general health hygiene and nutritional status, degree of mobility (balance and coordination), any co-existing psychiatric or physical disability, personality, coping strategies and existing skills, services in place, support provided by family and friends, accommodation, compensatory strategies that work

	Approach-assertive case management-characterised by intense service, low case-loads and a multidisciplinary team structure. Reaches out to clients, maintains regular contact and responds rapidly to early signs of problems *ABI Specific services* • Implement ABI Behaviour/Compensatory strategies • Engage and train support workers to implement behavioural strategies • Neuropsychological assessment • Support to generic services re ABI issues • AOD Services *Legal* • Guardianship and Administration Board and legislation • Application of the Alcohol and Drug- Dependent Persons Act 1968 • Access to the legal system including the provision of information, transport to attend court, support to meet sentencing requirements Generic-Primary health care services, Accommodation, provision of support to attendant carers. Drug Treatment Intervention and treatment approaches- Motivational Interviewing Stages of Change Harm minimisation Impact of cognitive impairment on capacity to participate in treatment Compensatory strategies to improve efficacy of drug treatment Application of Clinical Treatment Guidelines
Children and young people	• Understanding of normal childhood and adolescent behaviour eg as children develop and grow, they build up an ever increasing 'bank' of memory, learning, knowledge, language and life skills. The younger the child is when ABI occurs, the smaller is the bank of the stored learning The young child has less to draw on • Strategies-teach him or her the necessary skills and/or develop compensatory strategies • Careful and thorough assessment • Interpretation and coordination of assessments from the range of professionals • Planning which involves the young person, family and professionals • Planning that accounts for the young person's independence, family life and social and life skills, community involvement, schooling and within these broad areas, to look at more specific language, physical, cognitive and social skills • Reassessment and planning over time. Knowledge of impact on key transition points • Selection, support and training of therapists/attendant care workers

7. DISCUSSION AND CONCLUSIONS

The aims for ABI case management emphasise the maintenance of each individual's lifestyle (including rehabilitation), community re-integration, crisis intervention, and sustainability of approach. In common with disability policy generally, practice principles emphasise person-centred practice: consumer
participation and decision making and openness to consumer complaints and grievance procedures.

The skills and knowledge of ABI case managers can be articulated as building on case management competencies generally as a foundation and refined according to the specialist skills and knowledge required to respond to particular people with an ABI (such as children; people with catastrophic injury; people who misuse alcohol; people who have lost contact with the service system) and in the knowledge of the systemic issues arising from where the optimum services response can be developed (such as links needed with mental health, rehabilitation, community health etc).

There has been considerable service development in the ABI sector since the initial Head Injury Project (HIP) made public its findings in 1991. In general, service development has been characterised by the implementation of strategies focussing on service entry (across boundaries) and transition, assessment, information provision and carer support, capacity building and community reintegration. Such development has occurred in the absence of other service responses notably little development of day support or accommodation and support for this group. The service development approaches since MICHI have been supported by initiatives and expansion across a range of programs including case management, behavioural intervention, neuropsychological assessment, ACL packages, independent/social skills training and secondary consultation. Service development has been validated by an emerging evidence base, which acknowledges the significant and variable impact of ABI on individuals and their families, the specialist knowledge required to work effectively in this field and the importance of monitoring of individual outcomes. The current project has where appropriate built on what is already known to be effective.

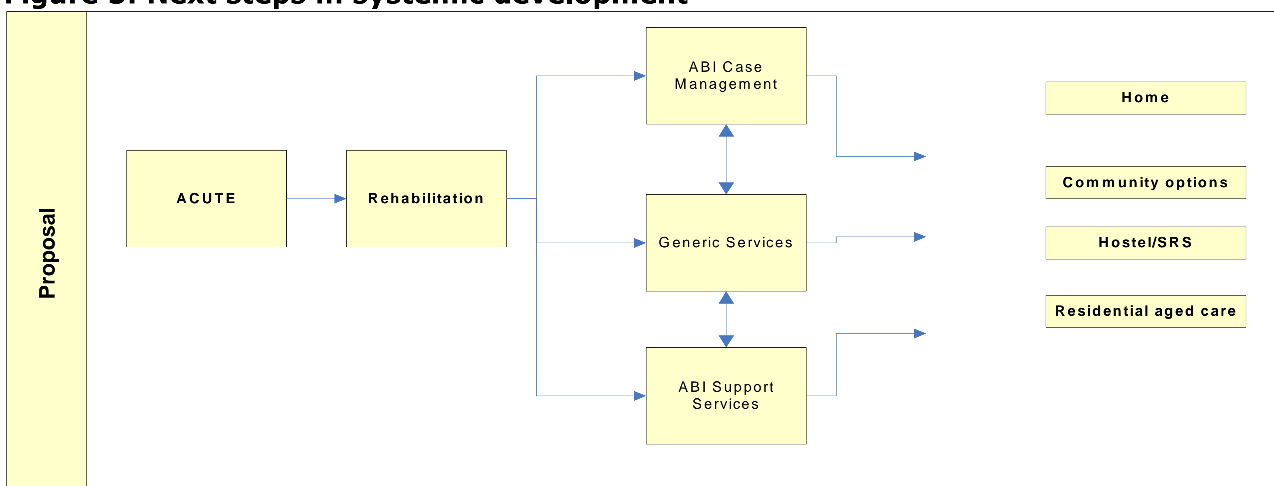
7.1 Systemic Development

The system for supporting people with an ABI must be founded on a long term view, over people's life times and life stages, which can be maintained while still allowing flexibility and responsiveness to emerging issues at the level of both the individual and the service system's ability to respond. Just as the system has learned since MICHI, new issues will be apparent in time following this series of initiatives. It remains important to identify which people are the

highest priorities for access to services including ABI case management and what is the nature of the collaborative relationship between ABI specialist and generic providers and how best ABI specialists can resource and extend the capacity of generic providers through managing demand for services, waiting list management, brokerage and secondary consultation.

The recommended approach is summarised in Figure 3 (pp28). There remains the assumption of throughput from acute to rehabilitation to specialist ABI case management and support services in partnership with generic services. The new approach recognises that people with an ABI may present to generic providers who then need assistance from specialist ABI staff. Such partnerships involve mechanisms to prioritise access to specialist support, secondary consultation, waiting list management (including interim and short term responses) and opportunities for review and change to the provision of support provided for an individual as or if circumstances change. Such support is aimed at improving access to, and viability of, typical living arrangements and supporting other aspects of community living such as education or recreation while aiming to improve the self esteem, personal independence, awareness and confidence of each person with an ABI.

Figure 3: Next steps in systemic development



7.2 Best practice

Currently the service system is flexible and responsive to variations in support needs. There is a sound recognition that 'one size (of service response) does not fit all' and that people with an ABI need to be globally understood as 'complex' due to the frequent concurrence of risk factors for poor outcomes such as alcohol and drug use, homelessness, and mental illness. Factors which need to influence service delivery models include brain development and recovery and potential for rehabilitation to reduce the likelihood and severity of long-term disability; certain ages at risk-young men; men over 40 years; AOD and mental health issues; and catastrophic injuries.

This review was an opportunity to re-visit the recommendations arising from MICHI and to ascertain how the service system has developed and determine if the assumptions from MICHI are still relevant. The likelihood that people with an ABI can transition from specialist ABI case management and other support hinges on increasing the capacity – both volume and skill- of the wider community service organisation responses. For example, there has been some alleviation of the pressure to meet demand for service due to systemic work such as AOD, the Mental Health protocol and access to individualised packages through Disability Services. A key assumption from MICHI was one of throughput from specialist to generic and community providers. After many years now of trialling the MICHI model, it is apparent that original assumption of 'flow through' did not account for complexity or demand. There has not been the capacity for ready transition from ABI services to generic AOD/ accommodation or mental health services. These generic services lack the skills and knowledge to support people with an ABI.

Specialist ABI providers have not consistently prioritised resources to provide secondary consultation in order to improve the response capacity of generic services. It is now known that the provision of secondary consultation to generic providers is critical. Secondary consultation has application at individual and systemic levels. Secondary consultation by specialist ABI staff involves wider staff training, information dissemination, modelling of practice, supervision of staff in other organisations, mentoring, problem solving and specialist assessment and intervention.

Prioritising access to support is critical and it involves providing a response to people placed on waiting lists, which supports appropriate referral to generic and local services and supports. Generally, new referrals are responded to in chronological order, there is reduced ability and awareness in the service system about responding to people before crises occur. That is, there is little ability to provide an early intervention response to enable the identification of risk factors rather than crisis events (which can be less resource intensive and more durable in effect). What happens while people are waiting for services and how priority of access is determined is a new challenge for the developing ABI sector. An adequate intake function including the capacity to provide a short-term case management response by diverting, identifying risk factors early and potentially minimising acceleration to crises is one way to respond to people waiting. *The Disability Act (2006)* positions issues for people with an ABI within the broader disability sector, providing a new legislative framework to support access to services and supports. The legislation mandates the need to prioritise need in response to demand for disability supports.

MICHI did not recommend allocation of discretionary funds as it was believed at the time that this would limit community re-integration. In reality, the absence of such funds have limited

community re-integration and restricted the flow through of people to broader community support agencies. The ACL packages have demonstrated the advantage of small and discretionary packages to respond to individual's circumstances. It is concluded that access to individualised packages will increase the capacity of generic service providers to respond, with support via secondary consultation.

Throughput in the way it was envisaged in MICHI, and in response the new client groups, depends on effective mechanisms to prioritise access and secondary consultation, together with the continuation of long term (ABI specialist or not) case management, including monitoring and supporting community re-integration.

7.3 Funding

Even though it is early days in ABI sector development, overall, specialist ABI service providers have achieved a lot while supporting people with difficult and complex circumstances arising from ABI. Providers willingly support people requiring a range of responses. The relatively new service system would not benefit from a highly regimented approach to defining the program's activities and funding specifications as this would jeopardise the adoption of flexible, collaborative and innovative responses to people's diverse needs prior to the development of a more robust service system. Historically, funding to the ABI sector has not been consistent, contributing to an unequal base for organisations, though this has been enhanced by the more recent introduction of individualised packages. There are concerns about equity of funding and performance targets between service providers and for individuals whereby funding levels can be difficult to quantify meaningfully or reliably and this is not a simple issue to resolve. Responding too swiftly could undermine the emerging strength and efficiencies of the sector upon which people with an ABI depend for collaborative service responses. The strength of the current funding arrangements is the flexibility and willingness of the ABI sector responses. The current analysis reveals only preliminary data about funding given the complexity of the relationship between the components of the service system and individual outcomes. A more comprehensive analysis was beyond the scope of the project however further examination is required.

Future development should account for closer collaboration between ABI service providers and DHS Disability Client Services while future funding allocations should reflect current initiatives such as the use of Individual Support Packages and the use of the Disability Support Register for long term and ongoing supports.

8. RECOMMENDATIONS

The following recommendations have implications for the further development of ABI case management, other ABI supports, relationships with other specialist sectors (such as mental health) and other disability and generic community providers. It is the coordinated contribution of all of these components which, as a conclusion of the current review and consistent with MICHI, are needed to provide the best ongoing and timely support to people with an ABI post acute and rehabilitation phases of recovery. The recognition of the critical role of ABI case management in secondary consultation and partnership with other providers, as a means to support both an efficient and appropriate throughput model of delivery and the reality of demand and priority access, is an important development proposed from this review. Throughput refers to the process of transition from specialist ABI services and supports to those available more generally in the community.

8.1 Establish guidelines for priority of access and the allocation of resources for ABI case management service by

- Defining the core business of ABI case management services, including the functions of short and long term case management, secondary consultation and priority of access to services.
- Defining the pathways between ABI case management services and generalist disability case management services.
- Increasing the capacity to provide an early intervention response to people with an ABI on the waiting list for ABI case managers including short term intervention and access to discretionary funds to support diversion. This includes the capacity to respond in a timely manner to crises across multiple ABI case management services.
- Review targets and associated unit prices within current ABI case management. This review will be undertaken to further understand and address the funding and target anomalies that currently exist across the ABI case management system. The review will address the range of functions provided by case management services, such as, intake and secondary consultation and will enable implementation of throughput strategies and engagement of and support to other disability generalist supports and the generic service system.

8.2 *In the context of the* Disability Act (2006), *clarify service access and promote systemic service development by*

- Documenting service pathways for people with an ABI, consistent with the throughput model of service relationships proposed in this report (Figure 3).

Establishing within ABI case management services, enhancement of intake management strategies, specifically short-term case management, priority of access criteria and consideration of integrated intake functions.

- Develop protocols between ABI case management and other disability and generic services (such as Community Health Centres) defining secondary consultation roles of ABI case managers (through staff training, information dissemination, modelling of practice including promoting skills development, supervision of staff in other organisations, mentoring, problem solving and expert assessment and intervention) and the implications for the capacity to engage and provide support to people with an ABI by more generic providers.
- Reviewing existing partnership arrangements and protocols between ABI case management and
    - mental health
    - drug treatment services
    - acute and sub acute health
    - DHS Intake and Response, Disability Client Services

- Ensuring that all protocol development within and between ABI case management, ABI support providers and wider sectors includes:
    - statement of service eligibility and service scope all community service organisations and DHS
    - agreement on processes to determine priorities and resource allocations
    - agreement on processes to manage wait lists
    - agreement on throughput strategies
    - protocols/partnership arrangements across services to support agreed processes
    - review mechanisms
    - workforce development strategies.

8.3 Build and strengthen links to other ABI Disability Supports by

- Coordinating growth between ABI case managers and other ABI supports (through behaviour support, family therapy, neuropsychological assessment) to ensure coherent service development.
- Realigning the priorities for ABI case managers and other disability ABI supports to priorities identified in this review.

8.4 Build and strengthen links to Disability Support by

- Monitoring and strengthening access to wider disability resources, such as, ACL packages and Individual Support Packages for people with an ABI, in particular through the use of the Disability Support Register.
- Using this review as an opportunity to re-shape ACL packages consistent with the findings of the review.
- Ensure formal pathway exist between ACL packages and access to Individual Support Packages to meet on going support needs.

9. APPENDIX A: CONTRIBUTORS TO PROJECT

9.1 Members of project board

Janine Toomey	Manager DPASP (N&WMR), Chair
Jenny Dalling	A/Manager Housing and Support, Community and Individual Support Branch (DSD)
Larkin Nightingale	Project Officer Individualised Planning and Support, Community and Individual Support (DSD)
Sue Goding	Team Leader Housing and Specialist Services DPASP (N&WMR)
Will Dunn	Program and Service Advisor DPASP (N&WMR)
Kerry Stringer	Project Manager DPASP (N&WMR)
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Liz Hughes	Team Leader Specialist Support, Community and Individual Support Branch (DSD)

9.2 Members of project reference group

Kerry Stringer	DPASP (NWMR), Chair
Sonia Berton	arbias
Nola McPhee	Melbourne Citymission
Merrilee Cox	Headway Victoria
Jeanette Wallish	ISIS Primary Care
Bronwyn Harding	Southern Health Network
Sharon Strugnall	Brain Foundation

9.3 Contributors to consultation process

Extensive consultation with key stakeholders was undertaken to develop the examples of best practice and ABI specialisation provided. All providers of specialist case management services to people with ABI in the Metropolitan Regions of Melbourne were consulted. The participating community service organisations included:

- arbias
- Melbourne Citymission ABI Specialist Unit
- Headway Victoria
- ISIS Primary Care
- Southern Health Care Network-ABI:STR Program and LIASE
- Organisations contracted to provide ABI: STR case management-Care Connect, Brain Foundation, MCM and arbias

9.4 Contributors to the report construction

Dr Chris Fyffe and Will Dunn (N&WMR) made a significant and invaluable contribution to the compilation and analysis of data, review and editing of the report.

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