AASW(Qld) submission to Queensland Department of Health Brain Injury Rehabilitation Planning Project

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Introduction

The Australian Association of Social Workers is the key professional body representing more than 8000 social workers throughout Australia. Social work is founded on the principles of social justice, human rights and professional integrity. It aims to enhance the quality of life and support the development of the full potential of each individual, group and community in society through practise that is ethically accountable, professionally competent and transparent.

Acquired brain injury and the intersection of social work: The importance of psychosocial factors

Acquired Brain Injury (ABI) affects a large proportion of our population, as the Department of Health has indicated in the BIR Planning Project Fact Sheet. ABI is a condition that affects not only the individual themselves, but also their families and carers and has long standing implications on every aspect of an individuals' social, emotional, physical, economic and participation life.

Research has found that individuals with a brain injury can make dramatic physical progress within the first six months after an injury but due to the changes in lifestyle, functioning and dependence on others it can create an array of psychosocial issues (Coetzer, Carroll, & Ruddle, 2011; Lorenz, 2010). This means that for many, the psychosocial problems remain a persistent long-term problem (Lorenz, 2010). The majority of individuals who sustain a brain injury are in the process of establishing their independence in the areas of friendships, leisure activities, intimate relationships, families, residence and employment (Coetzer, Carroll & Ruddell, 2011). The issue of social isolation and decreased leisure activities creates a renewed dependence on their families or significant others. Researchers in the field have consistently suggested that the psychosocial factors associated with a brain injury may be the major challenge for many during the rehabilitation and recovery process (Coetzer, Carroll & Ruddell, 2011). It is these psychosocial and emotional difficulties that present challenges to the rehabilitation process and require major lifestyle adjustments for both patients and families.

A rich research literature is emerging on the psychosocial and emotional issues for individuals with a brain injury. The results of these studies provide evidence that individuals who experience a severe brain injury are at high risk for a significant decrease in their friendships and social support. Furthermore they have difficulty establishing new relationships and friendships, have a decline in their leisure activities and may experience an increase in their levels of anxiety and depression (Coetzer, et al., 2011; Kendall & Terry, 2009; Soo & Tate, 2009). Individuals with a brain injury are therefore at high risk of emotional difficulties such as depression as a result of their social isolation. Indeed there have been many studies which have confirmed that the rates of depression and anxiety are higher in patients with a brain injury than the rest of the population (Bryant, Marossezsky, Crooks, Baguley, & Gurka, 2000; Coetzer, 2010; Koponen et al., 2002; Vaishnavi, Rao, & Fann, 2009). The development of anxiety and depression after a brain injury is complex and can be a combination of biological, psychological and social factors.
Kendall and Terry’s (2009) Australian research explored the psychosocial adjustment after a brain injury and found that many individuals experience poor psychosocial outcomes, such as interpersonal and family conflict, emotional distress and behavioural disturbances. Soo and Tate (2009) reported in their research that anxiety in individuals with a brain injury manifests as symptomatology, which is linked to the process of adjustment to the injury and may present as fear or diagnosable disorders such as post-traumatic stress disorder. It is well known that anxiety following a brain injury is not uncommon but it has a far reaching impact on an individual’s overall rehabilitation outcome including their functional ability, interpersonal relationships and employment. If the anxiety symptoms are not managed or no intervention is completed then it has the capacity to escalate. For example, Bryant et al., (2000) found that in a six month follow up study in Australia of 96 patients who were admitted for a major brain injury 27% had satisfied the diagnostic criteria for post-traumatic stress disorder. This demonstrates the significance of having psychological and social support to individuals and families during their hospital admission and once they have been discharged home.

Social workers within the health system have a dual focus: they are concerned with people rendered vulnerable through physical, emotional and situational difficulties or crises that may be temporary or ongoing; and by engaging with these patients or clients they assist the person seeking health care to maximise their recovery and enable medical and other allied health practitioners to fulfil their roles. It is through this unique lens that we offer the following submission that primarily focuses on service gaps and issues and in doing so has also identified opportunities to address these issues.

1. Service gaps and issues

The AASW Queensland Branch (herein the AASW), through consultation with Social Workers working in the field in Queensland and interstate, has identified some key service gaps and issues. These relate to the importance of providing appropriate psychosocial support, which, as we have demonstrated, is crucial for the overall better outcomes for individuals and their families and carers. Along with the primary and underlying causes of disease, ill health and injury, addressing contributing social and economic conditions is essential to effective health care and the overall health and wellbeing of individuals and communities (Wilkinson & Marmot, 2006). Understanding and responding to the social determinants of health is a key role of social work.

Insufficient inpatient beds

It is our view that there are insufficient beds for rehabilitation within the public health system to meet statewide needs. Currently the statewide service has 26 beds for adults who have ABI and admits between 112-122 patients per year. The benchmark is 30 beds per 100,000 which constitute a shortfall of 313 for the state. This does not meet the demand and need for patients with ABI, with the result that these individuals are often cared for in other hospital units. Furthermore, the AASW understands that over the last two years, six of these beds were closed for 18 months due to budget cuts, which further reduced access for patients. This is problematic in terms of longer term impacts for patients with ABI and has significant implications for the longer term outcomes of these individuals.
**Opportunity:** The AASW suggests that the long term costs associated with bed closures to such a significant service would be far greater than any short term gain and recommends that ABI rehabilitation beds need to remain open at all times.

The lack of early rehabilitation beds in the state is also problematic, with individuals being managed in other wards where there are significant limitations to early intervention in terms of stimulation and therapy to improve longer term outcomes. For serious/complex presentations of individuals with ABI, the focus of health provision is often on life sustaining measures and treating the acute issues, i.e. emergency, ICU, as patients become more medically stable. Patients are then often transferred to medical/surgical wards, where there are not rehabilitation specific services being provided. While the transfer is often welcomed by families (i.e. lower acuity represented), it is also quite a significant transition for families to need to contend with in terms of new staff, retelling their stories etc. This is regularly a ‘holding bay’ measure until rehabilitation beds become available, and often coincides with when families and patients start realising the extent of the brain injury and the subsequent consequences that they face.

A rehabilitation framework provides a significant support for both the patient and their families, and this is different to an acute framework of care. Therefore by having patients cared for in a non rehabilitation unit for extended periods of time because of a lack of rehabilitation facilities can result in poorer outcomes for the patient and their family. Social Workers have emphasised the impact on families in terms of psychosocial wellbeing. Having earlier access to appropriate rehabilitation and the rehabilitation framework is important as it works with the family to understand and adjust to the changes to their loved ones and the journey ahead. The grief, loss and trauma associated for families as they journey through the acute stages through to rehabilitation are significant and need to be recognised. Early intervention is crucial to avoid a whole range of negative outcomes for the families including carer stress, family breakdown, family inability to provide appropriate levels of support, poor health outcomes for the family, loss of income and employment due to the stress involved.

Implementing a rehabilitation philosophy is often difficult in an acute ward setting as the staff do not have the resources, capacity and indeed understanding around the psychosocial needs of family. Importantly, the lack of early intervention through appropriate access to rehabilitation can result in the patient having to be admitted to a nursing home which is highly problematic; particularly given the age group of patients is 18-65 years of age. Clearly early intervention can prevent inappropriate care options. The grief and loss and stress for the family in such situations is significant.

Gaps to effective and timely services to patients have short and longer term implications for families and carers. Psychosocial factors surrounding ill health and disability such as ABI are key indicators for quality of life, without sufficient support and scaffolding for the families/carers as well as the patients, poor quality of life outcomes become evident. This can include relationships breakdown, isolation of patients and families, mental health issues and so on. Whilst a patient is based in acute rehabilitation services, this vital aspect of holistic health care is provided to patients and their families/carers. However, once a patient is in the community or in a non rehabilitation unit this is not the case. Therefore the impact of limited acute rehabilitation beds has consequences for the health and wellbeing of patients and their carers/families (Bulsara, et al., 2010).
**Individuals with Mild ABI**

There is a spectrum of brain injury that the Hospital and Health Services and the general community are dealing with. This encompasses anything from mild (and not often presented to hospital immediately post injury/illness) to the more severe and complex brain injuries that require acute hospital admission/presentation, ward medical management and then rehabilitation units. The AASW understands that approximately 80% of ABIs are mild, and that there is a lack of presentation to hospital early on. Therefore, rehabilitation measures or appropriate support measures are not always implemented in a timely manner, with the result that these individuals subsequently present to Emergency Departments, GP presentations, Mental Health presentations and so on, in relation to: anxiety, depression, anger management, behaviour management, cognitive decline etc. A potentially large cohort includes sporting related injuries and violence/assault related injuries where the presentations are delayed.

**Opportunity:** The AASW suggests that more timely and targeted education campaigns for the early identification and linkage to primary care providers/supports post these injuries would be of benefit. Furthermore, building on existing evidence based programs that provide ED dedicated information resources, single consultation services and phone follow up would provide further support.

**Gaps to localised services**

Gaps exist in relation to localised services resulting in the need to transfer more serious cases to tertiary (and sometimes secondary) health facilities that are outside of the patient (and their families) local communities. The result is that family members, who remain with the patient during admission, including their rehabilitation stay, are required to spend considerable periods of time away from their homes and community. This can be many months and while the Patient Travel Subsidy Scheme exists, it is inadequate as it does not cover accommodation, travel, food and other out of pocket expenses. It also fails to consider loss of income, the additional support families back home require with a significant carer absent, or travel back and forth from the home community.

The emotional, physical and psychological costs associated for carers are high, but often invisible to the health care facility whose primary focus is the client. Yet we also know that greater positive outcomes are achieved for the patient in hospital, where the consistent presence and support of family and carers, where available, exists. Currently the patient’s journey to recovery is hindered by the financial and practical constraints in relation to this issue.

Furthermore, there are limited community supports for families post discharge from rehabilitation settings. Where family supports do exist, it is important that these carers are not overwhelmed or burdened and that we consider efficient and effective carer supports. Without carer supports, we know that patients will end up being readmitted to hospital or needing residential placements. Prevention has greater benefits in terms of quality of life for the patient and their family, the economic cost of greater participation in the employment community, the cost to the health system, and cost to the residential care system.

The limitations to appropriate specialised rural and regional services remains of great concern. While the cost of setting up services across Queensland is high, the longer term
costs of not having accessible services in terms of health and wellbeing outcomes for patients and their families is higher.

**Opportunity:** The AASW suggests that there needs to be greater focus on balancing the acute health service provision with greater accessible and affordable services in regional, rural and metropolitan communities. This involves recognising the spectrum of care and support that is required for both the individual patient and their carers and family. The economic advantage of such services is clear in terms of longer term outcomes for individuals and their ability to participate meaningfully in the community. Suggestions to address this gap include development of community health teams that can work with patients and families in their communities, and greater use of tele-health link ups.

### Case Study One: Bill

Bill is a 51 year old sports therapist who was living independently prior to his ischemic stroke in November 2011. He was initially treated in his home town of regional Queensland and transferred to a major tertiary hospital in Brisbane for further acute medical management. Once stable he was transferred to Queensland's inpatient brain injury unit for ongoing rehabilitation in January 2012.

Bill had been separated from his wife for 8 years and had two young adult children. His daughter relocated to Brisbane from North Queensland to be closer to her father and his son worked in the mines but was based in Brisbane. During his rehabilitation it was identified that Bill had lost the ability to communicate appropriately in social situations and would regularly swear, make sexual comments and laugh at inappropriate times. He presented with child like behaviour and at times would be emotionally manipulative towards his children.

Bill required full assistance with all of his activities of daily living and was wheelchair bound. He was incontinent but with regular toileting this could be managed successfully. Bill’s thinking, reasoning and problem solving skills were severely impaired as a result of the stroke. His strengths were long term memory around football and fond memories of bringing up his two children. His daughter and son identified early in his admission that they would not be able to provide the ongoing care he required. As such DSQ funding was sought with the initial assessment being completed in January 2012. During this time a range of options were explored by Social Work including: ongoing rehabilitation in his home town and slow to recover services in Brisbane such as Jacana and Casuarina which may have been suitable however, funding of these services were cut. The only services that were left and appropriate were based in Brisbane.

Once all active rehabilitation was completed the Social Worker observed a decline in Bill’s emotional and psychological well being. This also impacted his behaviour and how he responded to the team caring for him. Bill became institutionalised and very fearful of going off the ward or meeting new people. His daughter was his strongest advocate with DSQ and he received a funding package in March 2013, 14 months after his initial admission to the rehabilitation unit.
Insufficient rehabilitation services

There are some important implications arising from the lack of suitable and appropriate rehabilitation services for individuals with ABI, particularly during the early stages of rehabilitation. These include:

- Patients being prematurely discharged home without sufficient rehabilitation and support in the community with the result being poorer outcomes in terms of health and wellbeing.
- Patients becoming bed locked in inappropriate wards due to lack of beds in an acute rehabilitation unit, for example remaining in acute or orthopaedic wards. This limits access to the level of intense multi disciplinary therapy and rehabilitation that is required. The realities of these wards is that there is no capacity to provide the degree of support that patients require and research shows us that this has negative outcomes in terms of the degree of recovery possible.
- A further issue identified is that during what can be a long ‘holding pattern’ for patients who are not able to be moved to a rehabilitation unit in a timely manner, families and patients often receive the message that things will be better once they move to the rehabilitation unit. Social Workers have identified that this can lead to families developing expectations that there will be a ‘miracle cure’ for the patient once they reach the specialist support of the rehabilitation unit. Yet, this is not the case, and delays to rehabilitation result in poorer outcomes. This creates additional emotional stress and trauma for families and carers (Bulsara, et al., 2010).
- Once patients are admitted to the Rehabilitation Unit, Social Workers are allocated to each patient and their family, thereby providing a much needed coordinating, case management and support role. This is missing for those patients who remain in a ‘holding pattern’ in other wards, with significant implications in terms of the psychosocial support for patient and family. Research shows us that paying attention to the psychosocial needs of the patient and family is crucial to better health and wellbeing outcomes (Bywaters, 2009; Haines, Foster, Cornwell, Fleming, Tweed, Hart & Mitchell, 2010; Irwin, Solar & Vega, 2008; Keefer, et al., 2001; Simpson & Jones, 2013).
- The lack of after-hours psychosocial support through social work services, and rehabilitation services is problematic for family members and carers who have to work during the week/day. This means the services provided are not able to be responsive to families who are already experiencing high levels of stress and who need to take time off work to attend hospital appointments during business hours. The additional stress has implications for the family/carer’s mental and emotional health, financial and employment situation.

**Opportunity:** The AASW recommends that flexibility is required to provide after hours psychosocial and allied health rehabilitation support services to patients and their families.

- While early discharge patients with mild to moderate ABI have access to outpatients, this is often too little too late. Early intervention for all patients who suffer an ABI results in far more positive outcomes, including the ability of individuals to reach as much of their potential as possible. Delays to rehabilitation can result in missed opportunities for gains, which in turn results in a range of consequences including: financial and economic impact on the health and welfare system due to an inability to return to work, or education and therefore engage in employment for both the patient and their families; psychosocial impact in terms of mental health and other associated issues experienced by patients and their carers and families. The financial and emotional costs associated with this cannot be understated.
- Requirements are for patients to have single or double rooms as part of the rehabilitation unit; this is not always the case and compromises the effectiveness of the rehabilitation process.
Increased privatisation of health services such as ATAPS, Private Providers, Mental Health Treatment Plans, Chronic Condition Management Plans creates additional challenges for patients and their families with ABI in that the option exists for 10 sessions/support each financial year. Some services only charge the Medicare rebate but this is not assured, hence resulting in out of pocket gap charged by private providers. For families who cannot afford the gap fee they will be unable to access the services. Marmot (2010) identified that one in five healthcare dollars is spent addressing problems related to poverty, which is an inefficient way of spending much needed health care funding. Action taken to reduce health inequalities will have economic and social benefits (Marmot, 2010). Yet the current system is creating another layer of inequality regarding universal access to services. Without services being funded to provide specialised brain injury services, and to provide supports to families, families will be forced to have to utilise these types of plans. This is inadequate and insufficient for dealing with and addressing the magnitude of the issues we see. Without timely, targeted and funded support services, the concern is that many of these individuals will end up in aged care facilities, residential placements or in hospitals.

**Case Study Two: Tom**

Tom was living alone and working full time as a statistician prior to elective surgery in October 2013 for ongoing issues around his encephalomeningitis and shunt management. He has two young boys aged 7 and 12 who live with their mother but he had access every fortnight prior to his surgery.

After the surgery Tom was left with memory difficulties, visual deficits and needing a wheelie walker to mobilise. Tom was deemed by the team as not being able to return to independent living after trialling him in the independent living unit. He was unable to remember to pack clothes, make a meal, lock the door, did not use his walker for safety and forgot to take his medication. As a result a DSQ assessment was completed in December 2013 to assist Tom to return to the community with support. This assessment indicated he required 20 hours or more support per week. He remains on the ward and has not yet been able to access a funding package to transition him into the community. This has had a detrimental effect on his spiritual, emotional, psychological and physical well being. Tom is tearful during most conversations, will not provide eye contact and can identify that he is losing the skills to manage himself and to mix with others in a social setting. This is further exacerbated by his social anxiety that was present prior to his surgery. The Social Worker is continuing to work with Tom around his emotional and psychological well being while he waits for funding.

**Issues in relation to paediatric services**

There is minimal support for children and their families to have access to case management in a timely manner post-discharge from rehabilitation services. The co-ordination of services in the early stages post-injury is critical for the child (and family) community re-integration process. It is difficult for families who have not been exposed to health and disability services systems to access supports and funding. There needs to be scope for Social Worker case managers to have an ongoing co-ordination role with the child and family during this critical period.

Family recovery is a parallel process to the child’s recovery and the role of psychosocial support through appropriate social work services is needed. Acute and rehabilitation services need to have adequate Social Work resources to ensure that families are supported.
as they deal with the cumulative stressors associated with the child’s injury. The family is the first system that a child enters following injury so it is important that we support the family to adapt to their child’s changed needs.

Supporting children and young people’s recovery in the community also involves engaging with the school systems. It is important that there is adequate provision for Social Workers and health workers to provide education and support about a child’s injury and how it will impact on their learning. This involves educating the educators so that the education system is able to provide timely integration support to children as they re-enter their educational environment post-injury.

Children with severe behavioural changes following their injury require ongoing support. Importantly, the NSW Agency for Clinical Innovation (ACI) Report Challenging Behaviours Project: Paediatrics found that following a traumatic brain injury (TBI), more than half of the paediatric clients (51%) experienced challenging behaviour (Sabaz, 2012, p.2). Furthermore, the Project identified that “TBI can derail the normal developmental trajectory for children and adolescents, resulting in difficulties with learning and education; forming and maintaining friendships and relationships; and achieving long-term life goals” (Sabaz, 2012, p.2). Families report that this is an area that they find most challenging over a prolonged period of time. Social work as part of a multidisciplinary team of clinical psychology, neuropsychology and speech pathology, play a significant role in working with families to address issues relating to challenging behaviours.

A small number of children have catastrophic injuries and require a tracheotomy; PEG feeds management and assistance with all care needs. Currently, there are no appropriate supported care facilities for children and young people under the age of 18 years. This constitutes a significant gap in services for these young people with far reaching implications.

Limited services exist for paediatric patients, particularly those children and young people who do not traditionally ‘fall’ under the category of ABI, but who have brain impairment due to post oncology tumour treatment, children with significant epilepsy that has left them with cognitive impairment and so on. Limited rehabilitation, therapeutic and accommodation support services for such children have longer term implications for their ability to maximise and reach their full potential, quality of life, ability to participate meaningfully in society, and the pressure and stress to families.

**Opportunity:** The AASW suggests the need for greater focus on holistic health care provision for children and young people as part of the overall Rehabilitation Planning Project. This involves ensuring sufficient psychosocial and multidisciplinary care services during admission and post discharge to support children and young people and their families to achieve the best outcomes possible. This cannot be achieved without a whole of systems approach that involves health, education, disability services and communities departments, along with the involvement of the community and non government sector.

The AASW further suggests that the Department of Health consider the eight principles and associated recommendations developed by the ACI project in reviewing the rehabilitation needs of young people:
1. Early identification and intervention is required to prevent challenging behaviours becoming entrenched patterns of client functioning.
2. An interdisciplinary approach to managing challenging behaviour is required at all levels and types of impairment and disability.
3. Clients require adequate levels of long-term care, support and environmental modification.
4. Consideration must be given to the medical, psychosocial and environmental context of children’s challenging behaviours (i.e. whole-of-client approach).
5. There is a need for equitable access to all services throughout the state based on need.
6. Client-centred communication pathways must be established and maintained to ensure smooth and timely delivery of education services needed by clients.
7. Specialised assessment and management is required for challenging behaviours in the TBI paediatric population.
8. The community and social participation of TBI clients needs to be promoted (Sabaz, 2012, pp. 5-7).

Transition programs
There is no transition program or funding in Queensland that works with the individual and their family to transition back to the community. When patients are discharged home that becomes a crucial time when patients and their families really start to understand the significance of their injury on multiple levels, yet there are inadequate services to assist them in the community. While the literature shows that most family’s care for their loved ones at home this is not always possible. For some families it becomes apparent that they cannot care for the patient’s level of care needs once they are discharged home, creating further stress, trauma and complexity.

The current system provides intense therapeutic support in hospital through to nothing, thereby placing the full burden of care on a family/carer, which is not appropriate. A graduated transition program for support in the community is required. There is also a lack of step down and residential facilities for brain injury patients post discharge from facilities, including rehabilitation in the home services. While some services exist currently such as CARS and CBRT, they are restricted by capacity and are not brain injury specific services. The cost of funding these services would be significantly less than maintaining a rehabilitation or inpatient bed, and also reduces the risk of infection, disease, institutionalisation and co morbidity.

**Opportunity:** Funding accessible and appropriate transition programs would fill this significant gap to service delivery, with the potential for better health outcomes for patients, and their families/carers.

Appropriate accommodation options
At a community level, suitable accommodation remains a barrier to ensuring optimal health outcomes. This includes families who live in inappropriate housing to cater for the needs of a child or adult with significant disabilities resulting from the ABI, existing overcrowding in homes resulting in inappropriate care options and difficulties with accessing suitable public housing. For patients who cannot return home because of inadequate or inappropriate housing, there are limited options: these include inappropriate placement at a residential aged care facility, or remaining in hospital for over 12 months as appropriate housing options are found. Social Workers have identified this as a significant challenge for patients and families, resulting in the institutionalisation of the patient, loss of sense of identity for the patient and family, the associated guilt that results, increased risk of co morbidity for the
patient, and an increased risk of physical and psychological distress for the family. As importantly, this has negative consequences for the recovery and long term options for the wellbeing and health of the patient.

Of great concern is that we are seeing more placements of younger people with brain injuries into residential aged care facilities, often in high care/dementia units. This is not only inappropriate but also detracts from the aged care needs for these services. A further complicating factor is the aged care reform (and asset tests etc) which will also subsequently become an issue for this group of individuals if this continues. In addition, young people can often wait up to two years for funding from Disability Services to be able to access accommodation and therapeutic support. The lack of policy strategy around this group of individuals is a gap that needs addressing with urgency.

**Opportunity:** The Brain Injury Rehabilitation Planning Project provides a timely opportunity to review the spectrum of services that can contribute to better outcomes for individuals with ABI and their families/carers. The AASW suggests that a whole of government and community response is required in relation to the issues of accommodation and ensuring that there are appropriate accommodation options available. The long term gains of appropriate services provides greater benefits to the short term costs.

**Management of challenging behaviours**

Some individuals with ABI exhibit challenging behaviours associated with their diagnosis, yet there are no specialist services to work with these individuals either in the home or community. Even where individuals source private providers of rehabilitation, the experience is that patients with challenging or complex behaviours or needs are sent back to the hospital as the specialist service. Thereby further emphasising the importance of increased beds and services.

**Opportunity:** The AASW strongly recommends that attention is needed to develop specialist services and strategies to more effectively work with and provide appropriate services to individuals who experience challenging behaviours. This requires increased acute rehabilitation and post discharge outreach and community services, ongoing training and education of service providers, and attention to appropriate accommodation services.

**Interface between ABI services and disability funding**

The issue of disability funding has been identified as a current systemic level gap in that patients often do not receive any disability funding for a considerable period of time, the AASW has been advised this can take up to two months. This can result in patients remaining in hospital inappropriately or not being able to access the appropriate level of accommodation and services in the community. Further attention is needed to the interface between NDIS when this is rolled out and this particular group of individuals in terms of service provision.

**Opportunity:** The AASW suggests that the Brain Injury Rehabilitation Planning Project provides an opportune time for the State Government to review the interface between disability funding and services, and health services, to ensure better collaboration and access to services.
Access to vocational rehabilitation services

Currently no specific vocational rehabilitation services are available, which impacts on outcomes for patients. Holistic health care requires that an individual is able to return to their maximum potential, which in turn has economic and social benefits for the individual and community. Without sufficient attention to vocational rehabilitation we are sentencing patients with ABI to limited participation in the community and society. The benefits of doing so far outweigh any short term associated costs.

Opportunity: The AASW suggests that the Brain Injury Rehabilitation Planning Project provides an opportune time for the State Government to review the availability of suitable vocational rehabilitation services for individuals who have ABI. We recognise that this involves a whole of Government response.

2. Planning for success

The AASW recommends that there are a range of opportunities in addition to those mentioned to meet the challenges and gaps identified. These include:

- Greater integration of service delivery is crucial, involving the private and public sectors, as are developing clear pathways for the continuum of care.
- Services need to be available in the community as well as sufficient services within acute and specialist rehabilitation facilities.
- Multi-disciplinary teams with a strong psychosocial focus is crucial.
- The application of Rehabilitation guidelines is central to this to ensure service delivery is evidence based and holistic, with appropriate attention to the psychosocial needs of individuals who experience ABI and their families.
- Ongoing multidisciplinary research is critical to evaluate the effectiveness of services being provided, which includes the psychosocial aspects for individual patients and their families. It is only through collaborative research and evaluation that we can ensure effective service delivery. Social Work provides a core role in terms of the psychosocial aspect of service delivery and is committed to working alongside colleagues to further develop our understanding and evidence base.

Conclusion

The AASW commends the Department of Health on their current review of Brain Injury Rehabilitation Planning Project. Social Work is a key discipline as part of a multi discipline team that works with individuals and their families who experience ABI. As such we are committed to ensuring the best outcomes possible for patients and their families, and to working with our allied health and health colleagues to achieve better outcomes, innovation and sustainability of effective services. As the Queensland Branch representing Social Workers in the health and community sector, we welcome the opportunity to continue to consult with the Department of Health in relation to this significant area.
References


