

# Brain Injury Case Management in the UK

**EBIS Conference**  
**10 December 2010**

Ms Cathy Johnson  
Rehab Without Walls

I will deal with

- History of case management
- How it has developed in the UK
- Development of the British Association of Brain Injury case Managers.
- The role of a case manager and guidelines for best practice.
- BABICM membership policies
- How a new case manager learns and develops expertise
- Competency Framework for Brain Injury case managers.
- Standards for case managers

# History of Case Management

- Grew and developed in USA
- 1989 (JNNP) - UK case management study
  - First set up by Dr Brooks and colleagues
  - Used an NHS case manager and NHS resources
  - Didn't change outcomes!
  - Case manager gained access to services
  - But services didn't provide what was needed

# History of Case Management

- 1991 - Development of an American profession. CMSA established
- 1992 - Steering Group set up in the UK to develop a professional organisation for brain injury case managers
- 1996 - BABICM founded – Dr Brooks first chairperson!
- 2001 - CMS(UK) founded

# History of Case Management

- 2008 - Code of Ethics for case managers launched
- 2010 – Competencies for Case Managers published by BABICM
- 2010 – Toolkit for Children and Young People published by BABICM
- 2011 – New standards for Brain Injury case managers to be published

# BABICM

- Now has 330 members
- 76 are advanced members
- Advanced membership is achieved by a process of peer review for BICMs who have a relevant professional qualification, and who have 2000 hours experience of brain injury case management
- BABICM runs regular training seminars
- BABICM produces a quarterly newsletter
- BABICM is involved in the development of a master's degree in case management

# Websites

- BABICM: [www.babicm.org](http://www.babicm.org)
- RWW: [rehabwithoutwalls.co.uk](http://rehabwithoutwalls.co.uk)

# CASE MANAGEMENT IN THE UK

- Case management is now accepted as a necessary part of rehabilitation and long term management in compensation cases
- The NHS has recognised the benefits of case management in preventing deterioration in the community and has begun a pilot study
- Case management has developed from being only rehabilitation focussed to include the long term management of brain injured people
- This ensures that they get support for life if it is needed.

# CASE MANAGEMENT IN THE UK

- In 2009 BABICM and Rehab Without Walls negotiated with CARF to enable case management practices to seek accreditation for brain injury programmes as well as case management
- To date, in Britain, only Rehab Without Walls has gone through this accreditation process
- There is otherwise no accreditation
- But because of the compensation litigation process, case managers are subject to regular and intense review by their peers and by other professionals.

# Rehab Without Walls

- Established 1996
- Has 22 case managers working across the UK
- Currently managing 220 cases
- Provides brain injury case management but has a small number of spinal injury and other catastrophic injury cases
- Provides expert care/case management reports and neuropsychological reports
- Became CARF accredited in October 2009 for 3 years
- With exemplary performance in risk assessment and business review

# Case Management training

- There is no formal qualification yet available
- Each company provides it's own
- It takes at least 2 years of practice to develop the skills needed to provide brain injury case management
- BABICM has shown this in the competency framework

# What is Case Management?

“ Case Management is primarily a process directed at coordinating resources and creating flexible, cost-effective options for catastrophically, or chronically ill or injured individuals on a case by case basis to facilitate quality in individual treatment goals.”

CMSA

# Process of Case Management

- Assessment including risk assessment
- Plan intervention and prepare a written plan with a time frame
- Coordinate services and implement plan
- Written review & reassess
- Written review & reassess
- Written review & reassess
- Review & reassess .....

## Case Study 2003 - present

- Some cases are insoluble
- Families are not always an influence for good
- Normal life events can cause major problems for people with brain injuries
- Case management has to be able to adapt and change
- Having a solicitor onside can be invaluable
- This case has everything – sex, drugs & rock & roll!!

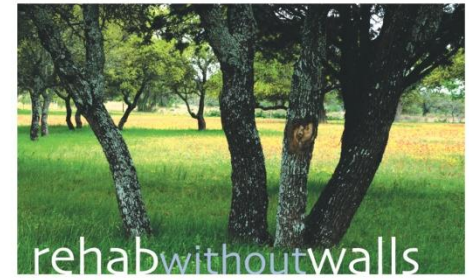
- Girl aged 7 at time of injury she is now in her early 20's
- Sexually abused by uncle as teenager
- Father deceased
- Minor Physical disabilities
- Cognitive, dysexecutive & behavioural problems exacerbated by drug abuse
- Is a "patient"
- Muslim

## Family Issues – at time of referral

- Mother had no authority over children
- 3 older brothers – 2 have been in prison for drug offences, 1 is separated from his wife
- 1 younger sister – physically abused by brothers (SSD contacted) – expelled from school
- Has long term, Muslim sexual partner ( neither family approve of the relationship but subsequently agreed Muslim wedding ceremony)

Client's Name: XXX

# Risk Assessment



Case Management | Neuropsychology Reports | Expert Reports

Activity or Issue:	Risk (effect)	Property/ persons at risk	Before Controls Are In Place			Controls in Place	After Controls Are Put In Place		
			Probability	Severity	Risk Factor		Probability	Severity	Risk factor
Xxx has disclosed rape by her uncle (mother's brother) when aged 12yrs. ISSUE – ACTIVATE CHILD ABUSE INVESTIGATION	Reaction of yy, brother and uncle. Xxx's brothers/rest of family/community find out about her abortion (July 04) as a result of the investigation.	Physical harm to Xxx, mother, yy, and the uncle	4	5	20	Discussions with Receiver and Dr bb. Xxx has capacity to make decision, to not pursue child abuse investigation and police referral. DO NOT REFER	0	5	0

**Additional Information**

Xxx's three older brothers have all recently been released from prison, and therefore the current family situation is very volatile. NB New situation. Xxx moving into independent accommodation with 24 hour care. No change to risk assessment.

**Completed By:** Ms aa (Brain Injury Case Manager) & Dr bb (Consultant Neuropsychologist)  
**Review Date:**

**Probability x Severity = Risk**

Probability		Severity	
0	Negligible	0	No injury or damage
1	Very unlikely	1	First aid only/trivial damage
2	Unlikely	2	Minor injury/minor damage
3	Probable	3	3 day injury/moderate damage
4	Very likely	4	Major injury/severe damage
5	Almost certain	5	Critical injury or damage

Risk	
0 – 1	No action required.
2 – 6	Record the risk and keep it as low as possible.
7 – 16	Record the risk and add further control to reduce it.
17 – 24	Consider stopping the activity until essential controls are in place & seek advice.
25	Stop the activity immediately and seek advice.

## **Accommodation – on referral**

- 1930's semi detached house on busy main road
- House in complete disrepair – no floors, no kitchen/bathroom, walls outside being held up externally
- House had been condemned

## **Accommodation now**

- Living in her own home with her daughter

## Initial input in 2003:-

- Recruit Muslim support worker
- Identify appropriate local & cultural activities
- Ensure house is habitable
- Apply for alternative accommodation
- Review benefits & ensure she was receiving what she was entitled to
- Refer to local statutory services ie health & social services
- Introduce psychologist & psychiatrist re behaviour

## **Key issues dealt with by Case Manager in first 12 months**

- Relationships with partner and family
- Partner and brothers providing drugs
- Drug abuse - smoking cannabis and using crack cocaine
- Money management ( client and family)
- Pregnancy & contraception
- Child abuse – 13 referrals to Social services but no action
- Mental health/sectioning

## **Relationship with partner/ Pregnancy & contraception**

- Family & social disapproval of relationship
- Partner only around for sex and when she received her benefits
- Became pregnant before marriage
- Abortion arranged at her request with mother's & partner's approval
- Kept secret from rest of family and community to ensure her safety

- Arrested for attacking local children in the street
- When police came tried to strangle herself with the telephone cord
- In police station stripped and ran naked around the station
- “Sectioned” following CM intervention
- CM acted as responsible adult during interview
- CM liaised with psychiatrist & CPN
- CM completed risk assessment on discharge

- In last 7 years CM has been only consistent service
- CM has prepared regular reviews, summaries and risk assessments
- Psychiatrist & CPN withdrew within 3 months of section
- CM made numerous referrals to SSD for S47 assessment – no unmet need!
- CM made 13 referrals to SSD to report child abuse by brothers to younger sister – no response
- Family still in dispute – brothers wouldn't let partner into house
- Compensation case settled in 2006

## Summer 2006

- CM moved QN into own home with team of female Muslim carers
- Partner had not seen her for 3 months until she moved into new home
- Problems of drugs, alcohol and sex as well as money management
- Ongoing problems with mood swings

## Summer 2006

- Installed CCTV outside to monitor visitors
- Family/partner abusive towards carers
- Client/family/partner dealing drugs!
- CM contacted police to ask for & received support
- CM ensured QN attended medical appointments & monitored contraception
- Taught her independent living skills

- Baby born August 2008
- SSD involved under child protection
- SSD insisted that baby have 2 carers available at all times to ensure its safety at our client's cost
- Therefore there were 3 carers on duty 24 hours a day employed by 2 separate agencies! At a cost of £8000 per week paid for out of her compensation
- Legal case pending re custody of child – 3 legal teams involved
- Guardian ad litem appointed for child
- CM was expected to keep this situation stable

## Current Situation

- The baby's alive and is still with her under Placement with Parent regulations
- Social services are now funding one support worker to assist her with child care – only one support worker in the home at any one time
- Father has not been given custody but has unsupervised access for 2 hours a week
- QN now making own decisions and has more control in her life
- New case manager now involved

# What does this case show?

- The level and variety of skills needed by CMs
- The level of knowledge of legislation and services needed by CMs
- How a case will change and develop over time
- Everyone involved in the case must work together to ensure success – if the client , the CM, support team and financial deputy had not worked closely together and trusted one another this girl would have been significantly at risk
- External agencies and their legal responsibilities can impact both negatively and positively upon our involvement
- CM is a long term process

## In conclusion

- Case management is still (relatively) young
- Case management is the way I'd want to be managed myself
- At it's best it's an unbeatable way of managing chronic disability
- Even not at it's best it rivals or exceeds current conventional service delivery
- We're still developing
- We've now far exceeded our initial vision of commissioning, coordinating, and quality assuring relevant services
- The good case manager does **“Whatever it takes”**