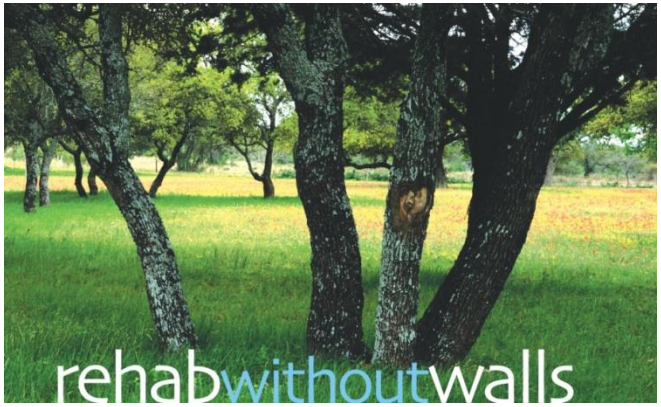
BABICM
British Association of Brain Injury Case Managers



An Introduction to Case Management

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Ms Cathy Johnson
British Association of Brain injury Case Managers
Rehab Without Walls

BABICM

British Association of Brain Injury Case Managers

Founded in 1996 (its our 20th anniversary this year!)

Our Mission

- To provide professional support, information and guidance for BICMs
- To provide national representation for BICMs
- To ensure quality in case management provision
- To provide training

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BABICM Annual Conference, 20th Birthday Celebration 15th & 16th June 2016

"China in our Hands"
"20 years of Brain Injury Case Management"

Hilton Birmingham Metropole - National Exhibition Centre

For further information please contact the BABICM administrators
T: 0161 764 0602 or E: secretary@babicm.org or visit www.babicm.org

Cathy Johnson

- Qualified as a social worker in 1975
- Has worked in Brain Injury since 1984
- Has worked in acute neurosurgical units and rehabilitation
- Set up Rehab Without Walls with Neil Brooks
- Founder member of BABICM and CMSUK
- Chair of BABICM 2007-2010
- Currently managing RWW and still part of BABICM managing council.

Rehab Without Walls

- Established 1995
- Has 21 case managers working across the UK
- Currently managing approximately 200 cases
- Provides brain injury case management to catastrophic and clinical negligence cases 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 and has just had accreditation renewed for the 3rd time

These are the questions I've been asked

- How does a case manager work?
- Who does the case manager represent?
- What mandate does the case manager have?
- What contacts does the CM have?
- How is case management financed?
- How is a referral made?
- How long does case management last?
- What is our relationship with statutory services?
- How is case management seen in society?
- What difficulties do you see?

What I’m going to talk about

- Why case management for brain injury?
- History of case management
- Some key reports/judgments which refer to case management
- Case studies to illustrate what we do and over how long.

History of Case Management

- In 1980's in UK there were very few services for brain injury
- Access to services was hit and miss
- And often dependent upon a key individual who took a special interest in brain injury
- Even then services often ended upon discharge from rehabilitation
- Key people started Headway in 1979
- There was research into the burden on families following brain injury
- We recognised that managing brain injury involved many individual therapies and services
- And that it was for life not just rehabilitation!

History of Case Management

- The idea for case management came from the USA
- Started as a means of cost containment by the health insurers
- At the same time there was a growth in USA of rehabilitation services
- American entrepreneurs turned to UK academics and clinicians for advice
- Those academics and clinicians returned to the UK talking about case management

What is Case Management?

“Case Management is a process devoted to the coordination, rehabilitation, care and support of people with complex, clinical needs. It aims to facilitate their independence and improve their quality of life whilst acknowledging safety issues.”

BABICM

The Warwick Report (1998)

- This was a Government commissioned study of the effectiveness of 12 services given Government funding following tendering in 1991.
- 563 patients ages 16-65
- Patients had the expected range of problems, including impaired memory and thinking, poor emotional control, and reduced strength and impaired balance

National Traumatic Brain Injury Study; University of Warwick, 1998

Warwick Study

"We found that dogged adherence to the team concept led to inefficiency. Where roles and responsibilities within the team and its management structure were ill defined; and where the "team" comprised part time staff with other responsibilities and loyalties, the team's identity tended to reside solely in the team meeting, to the detriment of the important function of multi-disciplinary care planning"

The efficient organisation of services

- “The efficient teams … were unambiguously managed by care professionals. Therapy goals were identified, the management pathways to those goals defined, progress monitored, and services concluded if improvements were not occurring …”

- “… a number of cases … rehabilitation resources had been wasted, because problems had remained intractable … in a few cases common sense seemed to indicate that rehabilitationists were putting too much effort into an unrewarding case …”

"An alternative model to the dedicated team is the case management model. The case manager … plans, organises, mobilises … liaises … provide a link … refers …

… case managers … were very effective in facilitating an appropriately staged return to work"

“A particularly important role of the case manager was to maintain contact with the client long after staff from other disciplines had discharged them … The absence of such follow up was apparent amongst the non-case managed patients … Large quantities of therapy could be undermined by inadequate follow-up, especially … when networks of family and friends tend to collapse well after the end of conventional therapy”

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 lawyer onside can be invaluable
- This case has everything – sex, drugs & rock & roll!!

- Girl aged 7 at time of injury she is now in her mid 20’s
- Sexually abused by uncle as teenager
- Father deceased
- Minor Physical disabilities
- Cognitive, dysexecutive & behavioural problems exacerbated by drug abuse
- Lacks capacity to manage her finances
- Muslim

Family Issues – at time of referral

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

Client's Name: XXX

Risk Assessment

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 (duplex) 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 2 daughters

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

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

Mental Health

- 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
- Compulsory hospital admission following CM intervention
- CM acted as responsible adult during interview
- CM liaised with psychiatrist & CPN
- CM completed risk assessment on discharge

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

Summer 2006

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

Summer 2006

- CM 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 client attended medical appointments & monitored contraception
- Support workers taught her independent living skills

Child Care

- Baby born August 2008
- Social Services involved under child protection
- Social Services insisted that the baby have 2 carers available at all times to ensure her safety and this was at our client's cost
- Therefore there were 3 carers on duty 24 hours a day employed by 2 separate agencies!
- Legal case re custody of child – 3 legal teams involved, for child, for client and for her father
- Guardian ad litem appointed for child
- CM was expected to keep this situation stable

2008 -2016

- She now has 2 children who remain with their mother 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
- Both Adult Care and Child Care social workers involved
- Case manager not given permission by Social Services to manage care staff
- Father has not been given custody but given unsupervised access for 2 hours a week

Case Management

- In 13 years CM has been only consistent service
- CM has prepared regular reviews, summaries and risk assessments
- Psychiatrist & CPN withdrew within 3 months of the mental health section
- CM made numerous referrals to SSD for funding care 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

What does this case show?

- The case manager has needed to have knowledge of mental health and child care legislation as well as brain injury rehabilitation.
- The case manager has had to be sensitive to the client's ethnic and religious background
- While also acknowledging the issues of safeguarding in a family where there was a history of physical, sexual and drug abuse
- The case manager has had to work closely with statutory services, legal teams, care agencies, police and medical staff
- Whilst also managing risk not only to the client but also her children

What does this case show?

- The case manager had no statutory authority but was able to maintain working relationships with everyone involved
- The case manager was able to “juggle” all the demands placed upon her
- Long term management and knowledge of the client meant that appropriate decisions could be made
- We’re in this for the long haul!

Wright v. Sullivan 2005

- BICM in UK is funded through the compensation system
- It works separately from the health and social care systems but overlaps with both of these systems for the benefit of the client
- We make referrals to the NHS and to local Social Services and will, if necessary, manage and quality assure their intervention
- In 2005 the legal case of Wright v. Sullivan passed judgment on case management
- We can be instructed by the NHS

Wright v. Sullivan judgement

“The role of a clinical case manager, if she is called to give evidence at the trial, will clearly be one of a witness of fact, as the BABICM guidelines suggest. She is there to give evidence of what she did and why she decided to do it. She will not be giving evidence of expert opinion, and the regime of CPR Part 35 and its Practice Direction will not therefore relate to her evidence. Nor will the Code of Guidance on Expert Evidence which is published in the practice books. The cross-appeal will therefore be allowed, with costs, and paragraph 6 deleted from the judge's order.”

Wright v. Sullivan judgement

“ … For the purposes of this litigation it is sufficient to say that a clinical case manager may be appointed to assist a severely injured person whether or not litigation is pending against a third party tortfeasor. The expense may be borne by private funding or by a health authority or a local authority in an appropriate case. Mr Heaton, who appeared for the claimant, told us that English courts were now habitually including the cost of a clinical case manager in their damages awards. In the present case a claim was being made for £3,000 per annum on a full lifetime basis. The thinking which accompanied the development of the idea that a single professional person should be appointed to perform this range of duties for somebody as badly injured as the present claimant must not be confused with the thinking which took forward the preparation and subsequent revision of the Rehabilitation Code …”

Wright v Sullivan judgement

a. A clinical case manager must have a relevant professional qualification;

b. The responsibilities of a clinical case manager include:

- i. advocating for and on behalf of a client;
- ii. protecting a client from vulnerability and abuse;
- iii. maintaining effective communication systems for, amongst others, the client;
- iv. co-ordinating a package of rehabilitation and care/support relevant to his/her needs;
- v. managing such package using evidence-based practice and in line with National standards;
- vi. undertaking an appropriate full needs and risks assessment;
- vii. designing a case management plan to meet the assessed needs;
- viii. implementing the plan taking account of quality, safety, efficiency and cost-effectiveness;
- ix. monitoring progress/deterioration and updating goals and related documentation

c. The relationship between the clinical case manager and his/her client [the injured party] is therapeutic and professional;

d. The clinical case manager owes a duty of care to the injured party;

e. The instruction to the clinical case manager should be from the client or from a representative on his/her behalf [eg a Deputy];

f. Joint instructions can lead to conflicts of interests and are not recommended;

g. The clinical case manager should be responsible for providing factual evidence as to work completed and the underlying reasons for this, if so required.

h. The clinical case manager should only act as a witness of fact as regards the service provided for a case management client.

Summary

- Case management is now an accepted way of managing the long term effects of brain injury
- The case manager's responsibility is to the person who has had a brain injury
- The case manager coordinates and manages all the services needed and makes changes as and when necessary
- The case manager should have an appropriate qualification

What should be expected from a Case Manager?

WHATEVER IT TAKES!

- From setting up care at home to managing the adaptations to a property
- From organising a holiday to getting someone into college or back to work and keeping them there

2nd Case Study

- Client was 14 years old when injured in an RTA
- Labelled locally as a paedophile
- Disinhibited, impulsive, socially isolated
- Cognitive and behavioural problems
- Lived with mother and younger sister
- When received compensation family purchased house
- He moved into the top floor flat
- They occupied the rest

2nd Case Study

- Mother and boyfriend were paid by the financial deputy to provide 24 hour care
- Mother and boyfriend both had drug and alcohol problems
- Case manager introduced support workers, psychologist, occupational therapist
- Introduced day and evening support and activities outside the home
- Found that older brother was physically abusing client

2nd Case Study

- Family buying alcohol with clients' money and all drinking every night
- House and flat were neglected and falling into disrepair
- Case manager brought in police (they were there most nights anyway!) and social services
- Social services began safeguarding process
- Family agreed to leave house
- Client now lives next to sister who provides safe and structured care

What does this case show?

- Long term need for support following brain injury
- Family members are not always a force for good
- Case manager needs to be able to use statutory services when there are risks to the client
- Even other experienced professionals can contribute to problems arising

Issues for the case manager to be aware of

- Variability of clients and their needs
- The variety of skills needed by the case manager
- The need for structure and continuity
- The impact of external influences
- Personalisation
- Risk and safeguarding
- Occupation – not only employment but having something rewarding to do
- Marriage and relationships
- Children and families
- Money
- Ethnicity

Ethnicity

- Our client group is now more varied than ever before
- Each individual and family brings their own cultural expectations
- Many families see support workers as their “ maids” rather than rehabilitation workers or carers
- Accepted medical or therapy practices in one country may not be acceptable in ours
- Our case managers therefore have to be able to work with people from many different backgrounds with many and different expectations

Matching the case manager to the client

- The right case manager will get the best outcome
- I have to know my case managers and make rapid judgments about the clients
- Life and professional experience is essential – case managers have to be professionally “grown up”.
- As is flexibility and being easy to get on with
- While having a backbone of steel

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"**

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