



Acquired brain injury and mental illness:

Issues paper

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Contents

The acquired brain injury strategic plan	1
About this issues paper	2
Definition of key terms	3
Acquired brain injury services in Victoria	4
Acquired brain injury and mental health	6
Mental health services in Victoria	7
Overview	7
Specialist mental health services	7
Services for people with co-existing ABI and mental illness	8
Acquired brain injury and mental health services: national and international comparisons	9
Australia	9
United States	9
United Kingdom	10
Service needs of people with an acquired brain injury and mental illness	11
Assessment and identification of mental health needs	11
Treatment and targeted interventions	11
Access to appropriate mental health care	12
Case coordination	12
Service development directions	13
1. Clarifying roles, responsibilities and service pathways	13
2. Strengthening ABI expertise in mental health services	16
3. Building 'behaviour management' skills of workers and carers	17
4. Supporting carers of people with an ABI	18
5. Developing a knowledge base	18
References	20
Appendix A: Membership of the mental health working group of the ABI stakeholders committee	20

The acquired brain injury strategic plan

The Victorian Government released the Acquired Brain Injury (ABI) Strategic Plan in March 2001. The Plan articulates the Government's policies and proposed service development directions for people who have an ABI.

The ABI Strategic Plan recognises that people with an ABI often have complex needs and require service responses that address the full range of their needs. The plan, therefore, has a strong emphasis on integrated and coordinated services for people with an ABI, their families and carers. It aims to enhance the wellbeing and community participation of this client group by providing more coordinated and improved service responses.

These aims are to be achieved by:

- improving the community's understanding of ABI and awareness of ABI services
- providing information and secondary consultation
- enhancing specialist ABI service provision in the areas of accommodation and community access
- ensuring equity in ABI service development activities
- improving accountability mechanisms for service provision
- ensuring coordination of programs for the ABI target group.

The ABI Strategic Plan has five main elements:

- strategy 1: coordinate and integrate policy and program development
- strategy 2: improve service responses
- strategy 3: strengthen partnerships
- strategy 4: promote quality improvement
- strategy 5: improve monitoring and evaluation.

About this issues paper

Although the Disability Services Division has primary responsibility for service coordination and outcomes for people with an ABI, other divisions of the Department of Human Services (DHS) also have a role in delivering services to these clients and their carers. The Department's ABI External Stakeholders Committee, which was established to oversee the implementation of the ABI Strategic Plan, asked the Mental Health Branch to prepare an issues paper on the service needs of people who have a mental illness in addition to an ABI. To achieve this, the Mental Health Branch established a time-limited working group that reported to the committee. The working group met four times between April and October 2002. Appendix A lists the members of the working group.

There were also two meetings with Workcover and the Transport Accident Commission, which were attended by representatives of mental health service providers, the Mental Health Branch, the Disability Services Division and the ABI Unit (at that time located in the Aged Care Branch of DHS). As a result of these meetings, the Transport Accident Commission (TAC) and Workcover agreed to meet directly with the Brain Disorders Program at Austin Health to explore the potential for collaboration and partnership initiatives.

In December 2002, a draft version of this issues paper was sent to Adult Mental Health Services for comment. This revised version of the paper takes service providers' comments into account.

The purpose of the issues paper is to inform the planning, development and delivery of services for people with a co-existing ABI and mental illness. It examines:

- the challenges faced by people with co-existing ABI/mental illness, and their carers
- the range of current services for people with an ABI and mental illness
- service provision in Victoria compared with other national and international jurisdictions
- options for future service development to better meet the needs of this client group.

DHS has also developed a document titled 'Acquired Brain Injury and Mental Illness: Protocol Between Mental Health and Other Services' (2004). The protocol provides:

- a description of current roles and responsibilities of specialist mental health services in relation to people who have both mental illness and an ABI
- a description of factors that indicate the need for referral to specialist mental health services, and appropriate ways of requesting assistance from these services
- contact details for specialist mental health, ABI-specific and other community support services that may be of assistance to people with dual ABI and mental health problems.

Definition of key terms

‘Acquired brain injury’ is defined as an:

...injury to the brain which results in deterioration of cognitive, physical, emotional or independent functions. It can occur as a result of trauma, substance abuse, stroke, hypoxia, infection or degenerative neurological disease. Impairments to cognitive abilities, sensory or physical functioning can be either temporary or permanent and can cause partial or total disability or psychosocial maladjustment. (Commonwealth Department of Health and Aged Care cited in DHS, 2001)

The term ‘mental health problem’ is used to describe a broad range of emotional and behavioural difficulties. Mental health problems encompass less severe emotional and behavioural problems, as well as ‘mental disorders’ or ‘mental illness’, which generally refer to severe and/or persistent states, and describe a clinically recognisable set of symptoms. These symptoms are characterised by alterations in thinking, mood or behaviour (or a combination of these), associated with distress and/or impaired functioning.

‘Serious mental illnesses or disorders’ are conditions in which:

...a person’s ability to think, communicate and behave appropriately is so impaired that it significantly interferes with his or her ability to deal with ordinary demands of life. Without effective treatment and support, the outcome for the person may be significant disability and/or disadvantage. (Mental Health Branch website, www.health.vic.gov.au/mentalhealth)

Specialist mental health services in Victoria are targeted to people with serious mental illnesses and/or disorders. In this document, the term ‘serious mental illness or disorder’ is used to distinguish conditions likely to require specialist mental health treatment from more common mental health problems, such as mild to moderate anxiety or depression, which can be treated effectively in primary care settings.

The primary care sector includes a range of community-based health and support services such as general practitioners (GPs), district nurses, community and women’s health centres, ethno-specific health services, private psychologists and counsellors, home and community care services and family support services provided by local government and non-government organisations.

There is also a range of services targeted to people with disabilities, including a small number of services specifically for people with an ABI. In this document, the latter services are referred to as specialist ABI services.

Acquired brain injury services in Victoria

The exact number of people with an ABI living in Victoria is unknown, but is estimated to be around 72,800 (Victorian Department of Human Services, 2001). It is not known how many of these clients require mental health care.

Service provision to people with an ABI reflects the fact that ABI is rarely associated with only one set of symptoms, clearly delineated impairments or disability that affects only one part of a person's life (National Institute of Health, 1999). ABI more commonly results in a wide variety of physical, cognitive, emotional and behavioural changes in the affected person. The results of the ABI also impact heavily on family and friends.

The needs of people with an ABI are often diverse and can be changeable over time. Likewise, the needs of family and other carers are also likely to vary.

Not all people with an ABI require specific assistance for the difficulties caused by their injury, but a large proportion of people with an ABI do have special needs in a variety of life areas. While many people with an ABI live in their own homes or with friends or relatives, others, due to their support needs, live in alternative accommodation, ranging from nursing homes to low-level supported accommodation in the community.

People with an ABI include:

- compensable clients—those whose support services are purchased from public and private providers by their insurer (for example, TAC or Workcover)
- non-compensable clients—who must meet eligibility and priority criteria for public services, such as those funded by DHS and the Department of Education and Training.

Headway Victoria's website provides a full listing of services that support people with ABI and their carers. It can be viewed at www.headwayvictoria.org.au.

Service responses for people with an ABI are characterised by a number of features:

- Compensable clients are usually able to access a wider range of services on a fee for service basis than non-compensable clients.
- Services are more accessible in some geographic areas than others.
- Not all service types are equally available (for example, counselling and social support programs are limited).
- Most specialist ABI programs are small in size and are usually targeted at those with complex needs. These services are only able to support a limited number of clients and may have long waiting lists.

Most specialist ABI services are designed to provide short-term case management and support with the aim of transferring the client to a community service provider. Given the limited number of alternative options, however, these services often provide long-term support.

The protocol between mental health services and other service providers (DHS, 2004) provides details of specialist ABI services funded by the Victorian DHS. These include:

- the ABI Behaviour Consultancy team (under the auspices of Epworth Hospital), which provides short-term behaviour management support to people aged 18 to 65 with an ABI who are not compensable. The team works with clients and families in their own homes or in a supported accommodation setting, and provides advice, training and education to service providers working with ABI clients.
- Melbourne City Mission ABI programs, which provide short-term case management and a limited outreach program to compensable and non-compensable clients of all ages, particularly those who have special needs as a result of brain trauma. The agency also administers Assisted Community Living Packages—low support packages of up to approximately \$5,000 that can be used flexibly to assist people with an ABI to maintain their living arrangements.
- Acquired Brain Injury Services (ARBIAS), which has developed expertise in providing support to people whose ABI is the result of drug and alcohol use. ARBIAS provides:
 - short-term case management
 - an information service that can be accessed by generic providers and carers people with an ABI
 - a neuropsychological assessment service
 - Assisted Community Living Packages
 - a long-term accommodation support program for ten clients living in the northern metropolitan region.
- the Slow to Recover program, which provides case management and funding packages to allow eligible non-compensable clients with a severe ABI to obtain slow-stream rehabilitation and accommodation support. It is targeted primarily at younger people, with priority given to those aged five to 45 years, then to the 46-50 year age group, then to the 50-55 year age group.

A number of small ABI-specific services have been developed in some regions. These provide a range of supports, including social and recreational programs and independent living training. The Disability Services Intake and Response (telephone: 1800 783 783) can provide up-to-date information about regionally based ABI services.

Acquired brain injury and mental health

People with an ABI are more likely to suffer from mental health problems, compared to the general population. Mental health problems might precede the brain injury or might occur as a consequence of having experienced an ABI. Jennet (cited in Fleminger, Greenwood and Olver, 2002) suggests that mental health problems are even more prominent than physical problems as causes of morbidity and disability following an ABI.

The changes in mental function caused by an ABI are complex. Brain injuries may produce various symptoms, including changes in executive functions, thought and emotional regulation. People may also experience mental health problems related to grief and loss, resulting from enormous trauma and changes to their health, functional capacity and lifestyle. There are often major social sequelae to an ABI, including loss of employment (with subsequent financial hardship and loss of social roles and networks), marital strain or separation and loss of friendships and family relationships (Hemingway and McAndrew, 1997; National Institute of Health, 1999). Without support, people with an ABI are at risk of living significantly impoverished lives.

Mental health problems common among people with an ABI and among their carers include adjustment disorders, depression, anxiety, and drug and alcohol abuse. In addition, the brain injury itself can cause symptoms similar to syndromes such as psychosis and dementia. Most problematically, an ABI can lead to significant problems with impulse control, social skills and self-awareness. These problems may manifest as agitated, difficult, disruptive, inappropriate and/or aggressive behaviour. Such behaviour may or may not be associated with a serious mental illness or disorder.

It is these challenging behaviours and loss of insight that often cause the greatest concern to carers and workers assisting people with an ABI (Fleminger, Greenwood and Olver, 2002). Aggressive behaviour encompasses both verbal aggression and physical aggression against self, objects and other people; it may range from sporadic explosive outbursts through to constant irritability and anger (Fleminger, Greenwood and Olver, 2002). The other pattern of changes that can emerge following an ABI, and which also causes significant difficulty amongst carers and workers, is that of inactivity and a lack of motivation.

As noted previously, the impact of an ABI on other family members is often profound. Muir and Haffey (cited in Hemingway and McAndrew, 1997), coined the term 'partial death' to describe the sense of loss family members may experience and 'mobile mourning' to indicate the ongoing nature of the grief. Forced role changes among family members of people with an ABI are common; partners and families may need support in order to avoid a sense of burden.

As well as the mental health problems that occur as a consequence of an ABI, there is also a need to consider the needs of people with a pre-existing mental health problem or disorder (that is, people who had a mental health problem prior to the development of the ABI). Most complex are those people with premorbid personality and/or substance abuse disorders.

Mental health services in Victoria

Overview

A range of individuals and organisations, in both the public and private spheres, provide mental health care. The two largest State Government funded providers of mental health services are community health services and specialist mental health services (community and hospital). Commonwealth funding enables people to access GPs and private psychiatrists. All types of mental health services have a role to play in caring for people with an ABI and their families.

There are a number of reforms currently occurring in the primary health care area; these are likely to produce significant benefits for people with mental health problems. At the State level, Primary Care Partnerships are working towards coordination and integration of primary care services, with a view to providing better access for clients, streamlined assessments processes that avoid duplication and promote more comprehensive needs' assessment, and better case coordination. In addition, initiatives are being planned to strengthen counselling services provided in the community health sector, with the potential for a more standardised approach to service delivery and more effective treatment of high-prevalence mental health problems, such as depression and anxiety disorders. The Commonwealth Government has recently introduced incentives to encourage GP involvement in mental health service delivery and to increase GPs' access to support from allied health practitioners and psychiatrists.

Specialist mental health services

As noted previously, specialist mental health services provide specialised care to people with a serious mental illness. The protocol between mental health services and other service providers (DHS, 2004) describes and provides contact details for specialist mental health services in Victoria.

Briefly, the specialist public mental health system consists of clinical services and psychiatric rehabilitation and disability support services. Clinical mental health services are managed by public hospitals and provide assessment, diagnosis, treatment and clinical case management to people with a serious mental illness. Psychiatric rehabilitation and disability support services are provided by non-government community organisations.

Specialist mental health services in Victoria are provided on an area basis, and are often referred to as area mental health services (AMHS). They include adult mental health services, child and adolescent mental health services and aged persons mental health services. Each of these service categories provides inpatient psychiatric services in addition to a range of residential and other community-based services, as described in Appendix A of the protocol.

There are also several statewide services, including specialised mother and baby units, eating disorders units, and neuropsychiatry units. Statewide services for people with an ABI are discussed below.

Services for people with co-existing ABI and mental illness

The Brain Disorder and Injury Service at Royal Talbot Rehabilitation Centre is the major ABI-specific service funded by the Mental Health Branch. This provides an integrated approach for people with a serious mental illness who require specialised assessment, treatment, rehabilitation and extended care for traumatic brain injury and/or organic brain disorders.

The target group for this service is adults aged 16–64 who have an ABI or organic brain disorder, and a serious mental illness, and whose condition is such that they cannot receive rehabilitation or effective care in other settings. Mental Health funds three programs in the Brain Disorder and Injury Service, all of which have a statewide function:

1. The Acquired Brain Injury Rehabilitation/Psychiatry Program comprises ten beds for rehabilitation and management of behaviour disorders and a three-person community integration program that supports individuals in the transition to community living.
2. The Extended Care Program is a 20-bed unit providing slow-stream rehabilitation. It receives Commonwealth nursing home funding and some additional State funding.
3. The Community Brain Disorders Assessment and Treatment Service (CBDATS) provides a specialised mobile intervention service with assessment and consultancy functions to support the residential components of the program. It uses teleconferencing facilities to assist with delivery of a statewide consultancy service.

In addition, the Royal Melbourne Hospital Neuropsychiatry Service provides assessment on both an outpatient and inpatient basis and has a limited treatment capacity for clients with an ABI. The Bouverie Centre (Victorian Family Institute) ABI team provides statewide specialist services to families and professionals. Core functions include counselling for a small number of families, consultation and training services to professionals and research on family adjustment to ABI. The Mental Health Branch provides core funding to the centre, while funding for the ABI team is provided by Disability Services.

Acquired brain injury and mental health services: national and international comparisons

Australia

There are no Commonwealth or State Government policy documents specifically about the mental health service needs of people with an ABI; however, general reviews of services for people with an acquired brain injury point to the importance of individual and family counselling and specialised behaviour management programs (Hearn, 2000). Service provision for non-compensable clients with an ABI is fairly uniform across Australia. Although primary care services—such as GPs and community health centres—provide treatment and support to people with an ABI and their families (particularly in rural and remote areas), the bulk of service delivery and case management is provided through community organisations. In many states, however, the capacity of community agencies to support people with an ABI who have complex needs is severely limited outside the capital cities.

In some states—for example, New South Wales and Western Australia—ABI organisations receive funding to provide a mix of case management and residential and/or community based direct service provision, and are geared towards supporting people with an ABI to participate in the community. In other states, organisations are funded to provide case management and brokerage support with a view to linking people with generic services or purchasing relevant services from community agencies. In this model, the agency assesses the client's needs, develops an outcome-based plan, links the client to appropriate services, and monitors his or her progress. There is no direct service provision.

In all states, community-based clients with an ABI considered to need treatment for mental illness are referred to the specialist mental health service system. As in Victoria, these services are targeted to people with serious mental illness, and ABI clients and service providers encounter difficulties in gaining access to them at times. Anecdotal reports from the relevant health departments and peak bodies suggest that specialist mental health services in other states and territories treat a relatively small number of clients with dual ABI and mental illness. Rural and remote mental health services are exceptions to this general trend, with mental health services in these areas taking a lead role in case management and treatment of people with an ABI (probably due to the absence of other services).

Several states have specific ABI/mental illness inpatient rehabilitation units. In New South Wales, these units also provide a limited amount of post-discharge community care.

United States

Information from the Brain Injury Association of America indicates a complex system in the United States, with services and funding arrangements varying from state to state. Many services have to be accessed through a general practitioner. In addition, many health care plans in the United States limit the 'mental health care' visits a person can make in a calendar year, which creates another barrier.

Public ABI-specific agencies are not widespread in the United States. There are many private, non-profit centres for traumatic brain injury in the country, and many work with people receiving public assistance, but there is a limited number of places available. In addition, health agencies in each state can, and do, differ in the services they offer to people with an ABI.

In order to receive community-based services that they would normally not qualify for, many Americans apply for Medicaid waivers. These waivers allow states to redirect (federal) Medicaid funds earmarked for 'inpatient' services to community-based treatment alternatives, including case management, homemaker/home health aide services, personal care services, adult day health, rehabilitation and respite care. To receive approval to implement waiver programs, state Medicaid agencies must demonstrate that, on an average per capita basis, the cost of providing home and community-based services will not exceed the cost of caring for the same types of people in an institution.

Specialist mental health services are provided by a mix of public and private agencies. Access for people with an ABI depends on their insurance program. Most people have private insurance. Medicaid (for low income earners) and Medicare (for older Americans and early retirees with a disability) provide a safety net for people who do not have private insurance. Each program funds access to mental health services in different ways, thus there is no uniform approach to people with an ABI and mental illness in the United States.

United Kingdom

The 2001 Health Committee report to the UK House of Commons summarises the situation for people with traumatic brain injury in the UK. The report identifies a number of difficulties with the current service system, including lack of clear pathways and contact workers/case managers for people with significant impairment due to an ABI. The report makes a number of recommendations about the need for:

- better data on the prevalence, severity and impact of head injury
- more support for carers and families
- clearer service pathways
- development of a case management system that gives people with an ABI and their carers a designated worker to guide them through the care system
- more community-based rehabilitation, with a particular focus on social and vocational needs
- stronger involvement of GPs and other primary and community-based services.

While noting that a high proportion of people with an ABI will also have mental health problems, the report suggests that head-injured people should be offered mental health services 'only when appropriate ... and such intervention should be directed by a neuropsychiatrist' (Health Committee, 2001, paragraph 32).

Service needs of people with an acquired brain injury and mental illness

Although varying degrees of recovery from an ABI can occur, there is typically some degree of permanent impairment, ranging from mild to severe. Services are often directed at the reduction of disability and handicap and helping people to participate as fully as possible in the community, rather than a full return of function. Outlined below are some of the key issues that need to be borne in mind in the development of service responses for people with co-existing ABI and mental illness.

Assessment and identification of mental health needs

Given the significant cognitive, emotional and behavioural disturbances that can result from an ABI, it can be difficult to distinguish changes that are due to the ABI from those of a co-existing mental illness. In Victoria, a dual assessment system has evolved, with some providers referring to specialist mental health services at an area level (AMHS) and some providers referring directly to CBDATS and the Neuropsychiatry Service at the Royal Melbourne Hospital.

As discussed in the next section, specialist mental health services are being supported to develop greater expertise in the assessment of co-existing ABI and mental health problems. It is expected that, over time, they will usually be the first port of call for such assessments. This acknowledges the right of people with an ABI to access specialist mental health services on the same basis as other people in the community requiring mental health assistance.

It is important to highlight, however, that memory and learning difficulties can complicate the provision of psychological and social treatments. Mental health clinicians need specific training and skills in order to work optimally with this group.

Currently, many AMHS clinicians have limited experience of, knowledge of, or skill in working with people with an ABI. In many cases, specialist neuropsychiatric assessment may be required to confirm the diagnosis of mental illness and determine the level of impairment and treatment needs. The service development directions described in the next section of this paper recognise that AMHS clinicians require specific information, training and access to specialist support in respect of ABI clients.

Treatment and targeted interventions

Common treatments for ABI include cognitive/behavioural remediation (including the use of compensatory devices), psychotherapy (particularly with family and carers) and pharmacotherapy. People with an ABI often require a combination of these interventions, but no clearly effective treatment regimes have been established for treating many ABI complications. There is some consensus, however, that interventions are most successful when they are structured, systematic, goal-directed and individualised, and when they involve learning, practice and social contact in a relevant context (National Institute of Health, 1999). Behavioural interventions, particularly for disruptive and dangerous behaviours, are best provided in context, be that the family home or residential support unit. This points to a key role for mobile outreach services.

Interventions also need to take the time that has elapsed since the ABI into account. Because physical health, mental health and social needs change over time, it has been suggested that effective models of care should provide for long-term support (Olver, Ponsford and Curran, 1996), tailored to stage and presenting issues, on a continuous or intermittent basis.

Access to appropriate mental health care

Specialist mental health services—particularly services for adults—are targeted to people with a serious mental illness requiring treatment. As a result, they tend to focus on people with psychotic disorders and, to a lesser extent, people with severe mood disorders, anxiety disorders and personality disorders.

Since most people with an ABI do not exhibit psychotic symptoms (that is, thought disorders, delusions or hallucinations) even though they may exhibit significant cognitive, emotional and behavioural disturbances, they are often not eligible for specialist mental health services. Many of these clients have needs that are beyond the skill base of primary care providers and other generalist services, however, unless appropriate support and augmentation is in place. Service providers particularly require assistance in knowing how to manage difficult or disruptive behaviours.

Case coordination

Given the complexity and diversity of the services that may be required, it is likely that no single service provider will be able to meet all the needs of a person with an ABI. Clients often use multiple services simultaneously, with one study reporting an average of 4.2 services per client (Hodgkinson, Veerabangsa, Drane and McCluskey, 2000).

In addition, as highlighted by Olver et al. (1996), effective models of care need to provide long-term intervention on a continuous or intermittent basis. Many people with an ABI require a specific worker to act as a case manager or case coordinator. In recent years, a trend has emerged across a number of countries to emphasise the role of primary care providers as frontline providers and coordinators of health and mental health care. Where specialist services are required for clients with higher-level or more complex needs, the trend is towards access through primary care (rather than directly and independently) and joint management on an on-going shared-care basis, or on a medium term episode-of-care basis.

This model has been adopted in Australia at both a Commonwealth and State level. Consumers and carers are increasingly being encouraged to access specialist health and mental health treatment through general practitioners and associated primary care services. In Victoria, these links are being streamlined through the development of Primary Care Partnerships, which comprise a range of primary care agencies working towards functional integration and coordination of local services.

Service development directions

As the preceding discussion indicates, people with an ABI and their carers require help from both generic and specialist services. Effective systems of care allow for matching of client and carer needs to the most appropriate service. There is also a need to reduce any overlap between providers and to create clear distinctions between each service element, as well as effective coordination.

Based on the suggestions of the ABI–Mental Health Working Group, and others who provided input to this paper, the following broad service development directions have been formulated:

1. clarifying roles, responsibilities and service pathways
2. strengthening the capacity of mental health services to work with ABI clients
3. building the behaviour management skills of those who work and care for people with an ABI
4. supporting carers of people with an ABI
5. developing a knowledge base.

1. Clarifying roles, responsibilities and service pathways

People with an ABI can access specialist mental health service assessment and treatment, either through their local AMHS, the CBDATS or the Neuropsychiatry Unit. While such a system allows primary care and specialist ABI services to access CBDATS and the Neuropsychiatry Unit, the further development of AMHS clinicians' skills in this area of mental health care will:

- reduce pressure on the limited resources of CBDATS and the Neuropsychiatry Unit
- address crisis presentations
- provide an opportunity for the client's problem to be managed by locally available services.

Clients who require specialist mental health assessment or treatment and services making referrals on their behalf are encouraged to approach their local AMHS as the first option. The AMHS will then provide an assessment and make decisions regarding the client's eligibility for mental health service. Assessment will be provided to people with an ABI who appear to be experiencing a serious mental illness, including:

- clients with psychosis
- clients with a severe mood disorder
- clients at serious risk of self-harm or suicide
- clients with a severe impulse control disorder.

The protocol between mental health services and other service providers (DHS, 2004) provides further details on the role of AMHS and the circumstances in which referrals should be made. AMHS will require additional support if they are to become the predominant mental health service response for people with an ABI and serious mental illness. Rural AMHS, in particular, require more access to advice and support from CBDATS and the Royal Melbourne Hospital Neuropsychiatry Unit. The positioning of

specialist mental health services as the front line for assessment and treatment of people with a comorbid ABI and serious mental illness will need to be phased in over time, allowing AMHS to build staff expertise and strengthen their relationships with CBDATS and the Neuropsychiatry Unit.

People with an ABI who are eligible for specialist mental health services will receive their treatment from the most appropriate service component, including primary mental health and early intervention (PMHEI) teams. PMHEI teams have been developed across the state to support primary care providers in their work with people with high-prevalence mental health problems such as depression and anxiety. PMHEI teams can provide education, consultation and short-term shared care to assist primary care providers treating people with an ABI.

Continuing care teams within AMHS provide treatment of mental illness and case management support in collaboration with primary care services. Crisis Assessment and Treatment teams are available to assess and assist current clients of mental health services and to assess people not currently registered as clients who present with a psychiatric crisis, particularly clients at risk of self-harm or suicide.

It should be noted that specialist mental health services are, by their nature, targeted to tertiary interventions. Given their specialist nature and the fact that they are subject to a very high level of demand, direct intervention by AMHS will be focused on resolving mental illness symptoms and will usually be delivered on a short-term or intermittent basis. Primary care workers and community support agencies should continue to have the lead responsibility of providing support and/or case management to clients with an ABI and mental illness.

In general, it is preferable for the client's GP to coordinate referral for specialist mental health services assessment, in liaison with other workers who are involved in the client's care. In this way there is an opportunity to first try to resolve the mental health needs at a primary care level.

Direction 1a

Relevant program areas within DHS, particularly the Mental Health Branch and Disability Services Division, will adopt clear and consistent policies on the roles and responsibilities of various services for people with dual ABI and mental illness. These will be based on the following principles:

- AMHS are responsible for providing clear, relevant information and advice to clients, carers and/or services requesting assistance in respect of ABI and mental illness issues.
- People with an ABI who are assessed as having a co-existing serious mental illness (for example, psychosis or a severe mood disorder) have the same right to access AMHS services as others with serious mental illness.
- Crisis Assessment and Treatment services are responsible for assessing and providing preliminary treatment to people with an ABI who are at serious risk to themselves or others, and providing short-term intensive treatment to people with an ABI and serious mental illness who can be managed safely in the community.
- The Brain Disorder and Injury Service at the Royal Talbot Rehabilitation Centre and the Royal Melbourne Hospital Neuropsychiatry Unit are available to provide specialist advice and support to AMHS in respect of ABI clients.
- Where other services are involved in a person's care at the same time as he or she is receiving specialist mental health treatment, mental health clinicians will work in collaboration with the other providers, and will adopt shared care approaches to service provision where appropriate.
- Where specialist mental health services provide direct care for clients with an ABI and serious mental illness, this will often be time-limited and focused on alleviating symptoms of mental illness. Specialist mental health services will establish or maintain a client's links with other support services, so that these will be available once the client's condition has stabilised or maximum recovery has occurred.
- Where specialist mental health services are not appropriate, or no longer appropriate, primary care providers, general disability services and specialist ABI services are responsible for ongoing care coordination and the provision of support to people with an ABI and their carers.
- While ABI clients and carers may approach AMHS directly, in general it is preferable for referrals to be made by the client's GP or a worker from another primary care, disability or specialist ABI service. This ensures that links with other services involved in a client's care are established from the outset of his or her involvement with specialist mental health services.

Direction 1b

The Mental Health Branch will disseminate the document 'Acquired Brain Injury and Mental Illness: Protocol Between Mental Health and Other Services' (DHS, 2004) to ensure broad understanding of the role of specialist mental health services vis-à-vis other DHS-funded services working with ABI clients.

Direction 1c

In the context of its commitment to improving triage and intake processes within AMHS, the Mental Health Branch will provide further guidance for specialist mental health services on assessing eligibility and priority for service provision.

2. Strengthening ABI expertise in mental health services

The involvement of specialist mental health services in the treatment of people with an ABI is currently fairly limited. This relates in part to eligibility criteria for specialist mental health treatment; however, it is also partly due to service providers' lack of confidence and skill in assisting people with an ABI, and their uncertainty regarding treatments that can be useful for these clients.

As noted earlier, one option for addressing these issues is to further develop Community Brain Disorders Assessment and Treatment Service as a statewide service providing education, consultation and short-term shared care support to specialist mental health services at the local area level.¹ In such an arrangement, CBDATS would have a greater role in providing:

- assessment and advice regarding eligibility for specialist mental health services
- education and training to improve the skills of specialist mental health clinicians in responding to people with an ABI and mental illness
- secondary consultation and clinical guidance to specialist mental health clinicians assisting clients with an ABI and mental illness
- short-term direct service provision for people with an ABI and mental illness in collaboration with the specialist mental health services.

Significant progress has already been made towards enhancing the capacity of CBDATS to support specialist mental health services. The Mental Health Branch provided a total of \$112,000 in 2002 to allow CBDATS to deliver training to specialist mental health staff and to develop an information website. CBDATS also provides a limited secondary consultation service on a statewide basis, predominantly through phone-based discussion. As specialist mental health services become more confident in assessing and treating ABI clients with serious mental illness, it is expected that, over time, there will be less need for CBDATS to provide direct support to primary care services and generalist services.

1 Subject to negotiation with TAC and/or WorkCover regarding funding, this enhanced service could be made available to compensable clients on a fee-for-service basis.

Direction 2a

The Mental Health Branch, in consultation with Disability Services, will continue to develop the role of CBDATS in providing education, training, consultation and shared-care treatment to specialist mental health services working with ABI clients.

Direction 2b

The need for all AMHS services to have access to specific information and training on the needs of ABI clients will be reflected in the Mental Health Training Strategy.

3. Building ‘behaviour management’ skills of workers and carers

As noted above, some people with an ABI display disruptive, aggressive or inappropriate behaviours; managing such behaviours is one of the main challenges confronting people who work with, or care for, ABI clients. While often regarded as a ‘mental health problem’, such challenging behaviours do not necessarily mean that the person has a mental illness. While the behaviour might be linked to mental illness or mental health problems such as depression, it might also be caused by the brain injury itself or by substance abuse, boredom, social isolation or underlying personality problems. Identifying the cause of the behaviour is critical to managing it successfully.

Where challenging behaviour is the result of (or exacerbated by) social and environmental factors, primary care and community support agencies will often be able to provide remedial interventions. The involvement of specialist mental health services will depend on the presence or absence of serious mental illness.

While some workers in both primary care and community support agencies have built up considerable expertise in working with people with an ABI—in particular, support of people with emotional difficulties or disruptive behaviours—many have limited training and experience in managing these issues. The ABI Behaviour Consultancy is the major provider of behaviour management support in relation to ABI clients; the service is currently limited to non-compensable ABI clients who do not have a coexisting mental illness. The high prevalence of behaviour problems in ABI clients, and the lack of training that many service providers have in managing these issues, suggest the need for increased training and education of community providers.

The ABI Behaviour Consultancy has an established relationship with CBDATS, which it calls upon from time to time to provide psychiatric consultancy, particularly in regard to medication management or where the diagnosis is uncertain. It may be beneficial to increase the level of mental health consultancy that CBDATS can provide to the behaviour consultancy. An alternate approach would be to buy in services for non-compensable clients from private or non-government behaviour management providers, using flexible funding packages.

Direction 3

The Disability Services Division has recently provided additional recurrent funding to the ABI Behaviour Consultancy and has also made a flexible pool of funding available to DHS regional offices to allow them to purchase services for clients with ABI-related behavioural issues. Disability Services has successfully negotiated for ABI to be included in the Certificate IV national competencies. A training resource package is being developed to assist training provided to cover ABI issues, including behaviour management, in the Certificate IV course. The Division will maintain its commitment to these types of initiatives.

4. Supporting carers of people with an ABI

This issues paper has noted the pressures on those who care for friends and family members with an ABI, particularly where the person has a mental health problem in addition to an ABI. Given the benefits to the client (and carers) if carers are supported in this role, the DHS should work towards expanding the availability of support services for carers of people with an ABI. Options that will be explored further include:

- strengthening the ability of the Bouverie Centre to provide consultation and advice to other services working with ABI clients and carers³
- ensuring that the guidelines for flexible funding packages for people with disabilities include the capacity to purchase counselling support services for carers if required
- ensuring that the development of new products under the 'Implementing the ABI Information Strategy' includes information for carers (for example, on issues relating to ABI and mental illness and available services).

Direction 4

The Mental Health Branch and Disability Services will work together to explore opportunities for further developing the capacity of existing support services to meet the needs of families and other carers of people with an ABI.

5. Developing a knowledge base

A review of the national and international literature for this issues paper revealed a range of books, articles and reviews relating to ABI and—to a lesser extent—ABI and mental health issues. However, these are largely focused on issues of prevalence, presenting problems and specific interventions, rather than service delivery models and funding approaches. There is a clear need for more information about service needs and effective service models for people with co-existing ABI and mental health problems.

3 The additional involvement of TAC and WorkCover would mean that such programs could be targeted to both compensable and non-compensable clients.

Direction 5

The Mental Health Research and Evaluation Framework, currently being developed by the Mental Health Branch, will reflect the need for further research and evaluation of service models and practices for people with a diagnosis of both ABI and mental illness. The framework will emphasise the need to identify service interventions that are of direct benefit to clients. With regard to ABI and mental illness, there will be particular focus on the need for:

- collaboration and joint support by Mental Health Branch and Disability Services Division
- involvement and engagement of all key stakeholders
- wide dissemination of research findings to carer groups and services that work with ABI clients.

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Appendix A: Membership of the mental health working group of the ABI stakeholders committee

- Eastern Area Mental Health service—Glenda Pedwell, manager, CCU and MST Services
- Northern Area Mental Health Service—Robyn Humphries, acting manager
- ARBIAS—Marilyn Hague, chief executive officer
- Royal Talbot CBDATS—Professor Mal Hopwood
- Eastern Area Community Health Service—Jane de la Fronde, coordinator, Eastern ABI Network Linkages Working Group
- Melbourne City Mission—Julie Fleming, manager, Community Access Program and Fee for Service Case Management Service
- Epworth Hospital ABI Program—Helen Harrington, manager, Community Brain Injury Programs, Epworth/Bethesda
- Mental Health Branch, DHS—Jenny Smith, manager, Service Planning and Development