Case Managing the Environmentally Governed in the Ungovernable Environment of the Community:

Neurobehavioural Disability in the Badlands We Call Home

Dr Mark Holloway Head First LLP

Today we will cover….

- What form of case management do we mean?
- When it doesn’t work, what does it look like? Why?
- When it works, what does it look like? Why?
- Barriers to successful community management of the environmentally governed
- Working with inter/trans disciplinary teams
- Working with inpatient services

What “case management” are we talking about?

- Clinical not simply organizational (although co-ordination is key)
- Skilled and knowledgeable, able to learn (not care management/loss adjustment)
- Present and proactive (not telephonic reactive model only)
- Guided by rehabilitation principles (neuro-functional approach)
- BUT
- Based in the messy reality of society, family and home
- Able to manage inter/trans-disciplinarity, 24h on call, assertive (with services)
- Integrative
- In for the long-haul

Post-discharge from neuro-behavioural unit reality……

Oh dear, this is not looking good…..

- Simon, abject failure of services and law?
- Pre-morbidly…….. Complicated….
- Post-ABI, very disinhibited, impulsive, crack user, very literal
- Environment very risky, limited funds, no carry over, no staff safety
- Police, ex-partner, not considered detainable. Died in bath
- Camilla, lack of buy-in by family
- Pre-morbidly, not in the least complicated, 2 x severe ABI's
- Did well in rehab, did well initially in community, vulnerable to others
- SW collusion? Hard to maintain staff, yo-yo drug rehab
- Family not able to "hurt" her by saying no, MCA ineffectual
- Will die

A mini-behavioural unit in the community

- Barry: Pre-morbid v complex, drug use, very engaged family
- Failed by state, failed by non-specialist CM, MCA assessments v poor
- Declaration of BI, removed from community, did exceptionally well in reward based rehab system, low'ish cog, v dysexecutive, v governed by environment
- CM/psych created a unit in community, trained staff at inpatient unit, glorious result, become slightly looser over time
- Sarah: Pre-morbid v complex mental health +++IQ, mother v involved
- 13 years in units, handover took 6 months
- Psychologist lead SW plan, no stand alone therapy, all "puppet-therapy"
- Rigid (necessarily so) no ability to relax this, very hard to maintain staff, paid very highly

It’s chaos Jim but not as we know it..

- Matt: High IQ, low insight, very personable, very threatened by his ABI
- “Will be cured” when he returns home, unit not good enough
- A difficult 5 years, risks (drugs, disengagement, funding, staff burn-out)
- Will not accept “goals”, plans or overt structure, acts contrary to these at all points, will not accept the language of rehab being used in his presence
- Unpick the package slowly, continuity of CM, SW and physio
- Adorably difficult, costs now 20% of what they were. Took 15 years to achieve
- Very genuine progress, may, on occasion, ask for help
- Orchestrated invisible efforts behind the scenes with staff, family, CM and therapists

Barriers: Services

- General lack of ABI knowledge amongst services
- Failure to assess fully, verbal output model
- Naïvely applied social model of disability
- Stat services structures do not match need
- Services blaming clients for behaviour or family for failure to do what they stated they would so. Clients not always easy to “like”
- Uni-disciplinary budget-protecting nay-sayers who hope it is someone else’s problem, delay-creating, austerity-ridden professionals who never sit in mum’s front room (is not an opinion I would share out loud, that would be disinhibited of me and an unwise decision)

Barriers: Practical

- Where are the support staff you need? (These are NOT care workers)
- Employment law and reality of management of humans
- Wider community, not always welcoming or helpful
- Delays in agreeing funding, recruitment, training, housing
- Community neuro-rehab, we don’t all work in the same building
- Crisis management, never one crisis at a time
- Situations fluid, fast moving, viewed differently by parties
- Use of the law

Barriers: Human

- Insight will define how this is structured and managed, challenging it in the community may cause disengagement
- 3rd parties can and do destabilise situations, not always unintentionally
- Burn-out, by everybody
- Conflicting needs of parties
- Disengaged/opposed family, it cannot work until this has been addressed
- Unexpected problems or serendipity
- Co-morbidity and mortality of client/family/friends (environment changes)

So, what does it look like when it works?

- Chaos, initially, sometimes for a long time, sometimes sporadically
- Expensive, to begin with especially
- Fragile and tenuous at points
- A long haul where change is the only constant (or not possible)
- Measurement is complex and sometimes facile
- A repeating wheel of difficulty, do we get better at predicting and reacting or do the issues become more predictable and easier to react to?
- First 10 years are the worst
- The community is not a locked unit, never will be, the ABI issues are the same, the control, power and management are entirely different

So, what does it look like when it works? *(take 2)*

- Team support each other, absence of blame, presence of care
- Less stand-alone therapy, more of a team environmental approach
- Responsive, flexible, common goal amongst team
- Leadership from behind (CM)
- Difficult conversations held supportively with family etc, engender a whole team approach
- Ride the storm but be prepared to act decisively if risks/environment is unmanageable
- Engage stat services, police, courts etc, on their terms, use their language
- Support worker **the** most important paid person **by far**, value them

Working with inpatient teams

- Even the best units are inward looking and can fail to conceptualise the reality which is The Raft of the Medusa
- Get in early with the unit, stay in, ask the stupid questions, ask how this works in the absence of a locked door, a unit, total environmental control
- Get community staff into the unit
- Take the unit staff out to the community
- Get all SW documentation, RAx etc looked at by inpatient team, get them to co-author
- Create a follow up review with members of the inpatient team
- CM can create more effective, safer, more client and family focused and sustainable discharge

Thank you for your time and patience

- Any questions?

- mark.Holloway@head-first.org

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