Care and Support Pathways for People with an Acquired Brain Injury

Referral and Service Options in NSW

May 2011

Compiled by the Pathways and Protocols Working Group, a sub-group of the Steering Committee for the Interagency Agreement on the Care and Support Pathways for People with an ABI

Key contributions from Ageing, Disability and Home Care, NSW Health, Housing NSW, Lifetime Care and Support Authority and Corrective Services NSW
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Accessibility

To improve accessibility, this document has been produced in tagged PDF format.

For further information on any part of this document please contact the Attendant Care and Physical Disability Unit, Ageing Disability and Home Care. Ph: 02 9374 3621, email hnpACP@dhs.nsw.gov.au
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Introduction

In 2008, an Interagency Agreement was signed between Ageing, Disability and Home Care (ADHC), NSW Health, Housing NSW and the Lifetime Care and Support Authority (LTCS). The purpose of the Interagency Agreement was to improve equity of access in the interface between health, housing and support services to meet the needs of people with ABI in the community.

A number of the tasks in the Interagency Agreement related to formalising referral pathways, cross agency partnerships and improving ABI specific service information and assessment. These include:

Task 15  All agencies will ensure that their staff have information on referral pathways for people with an ABI.

Task 16  All agencies will ensure that referral pathways to access local ABI services will be established and included in local interagency arrangements.

Task 17  All agencies will share available information on waiting lists and service opening to improve local area coordination arrangements and facilitate referral.

Task 18  NSW Health will ensure that staff conducting assessments have detailed information on state-wide services available to clients and their carers in regards to people with an ABI and the contact details of relevant agencies.

Task 24  ADHC will examine the impact of the different program specific prioritisation criteria on supporting people with ABI.

Task 26  All agencies will agree that any interagency agreements or memoranda of understanding developed at a local level regarding the delivery of services to the target group will acknowledge and build on principles outlined in this agreement.

Task 29  All agencies will participate in the development of a clearly stated protocol for the management of systematic breakdown/blockage that can be managed at the local level.

Task 31  All agencies will ensure that in regional and rural settings in particular, agencies will support the development of a suite of local area ABI directories, client information sharing, data management, collaborative assessment and intake process.
Task 58  All agencies will collate and make available in an appropriate format information on local area demand and assessment for ABI clients.

A Pathways and Protocols Working Group comprising members from each of the inter-agency partners was convened to identify appropriate referral pathways and related issues for an adult with an ABI moving through health, disability and community services. This work has produced the following set of pathways guidance charts and Appendix. **Detailed information about all of the services mentioned in the flow charts is shown in the Appendix of this document.**

This document is intended to be used as a guide for clients, carers, case managers and advocates. The document is maintained by the Attendant Care and Physical Disability Unit (ACPDU) at Ageing, Disability and Home Care (ADHC). If you would like more information about this document, please call the ACPDU on 02 9374 3621.

A number of service access issues and blockages in the referral pathways were identified during the development of this document. In order to address these issues, **PART 2: ABI Issues Paper** is currently being developed by the ABI Interagency partners to propose solutions that address some of these barriers for people with an ABI.

This document received input from the following ABI Interagency partners: ADHC, NSW Health, the NSW Agency for Clinical Innovation (ACI), Housing NSW, Lifetime Care and Support Authority (LTCSA) and others including Corrective Services NSW. NSW Health includes Mental Health, Drug and Alcohol Office, Justice Health, Statewide Services Development, Primary Health and Community Partnership Branch and EnableNSW as these are key health services that interface with people with ABI/TBI.
Pathway Example 1: Person with a recent ABI requiring housing and support

CLIENT DETAILS:
Person with an ABI, admitted to hospital for acute care
Unable to return to previous housing situation
Suitable to live in the community with less than 35 hours of support/week

![Diagram showing the pathway from hospital to suitable living arrangement for a person with an ABI requiring housing and support.]

- **Hospital**
  - Other Specialist Rehabilitation
  - Generic Rehabilitation
  - Acute hospital bed

- **Assessment of community care needs**
  - Disability Care Management
  - Hospital Discharge Planning Staff

- **Person is ready for discharge**
  - Referral for HACC supports - requires LESS than 15 hours support/week
  - Application for ACP/HNP - requires 15+ hours support/week
  - Referral to ADHC region for drop in support options 15-35 hours support/week
  - Referral to Boarding House with support such as Active Link Initiative
  - Referral for outpatient general rehabilitation services
  - Referral to Enable NSW for equipment
  - Application for social housing assistance

- **Person is discharged**
  - GP monitors health
  - Client living in suitable property with in-home support

- **Existing CM must refer for longer term case management for MAINTENANCE**
  - Referral and Maintenance - may include community and social participation, skills development, day programs, follow-up of referrals such as equipment and outpatient rehabilitation services.

**MAINTENANCE** refers to responsibility for ongoing review, follow-up of referrals and new referrals for interventions as and when required overtime.

While suitable accommodation is being identified, client may remain in hospital or rehab unit, move in with family/friends, or Temporary Accommodation provided by Housing NSW.
Pathway Example 2: Person with a recent TBI requiring formal support up to 35 hours per week

CLIENT DETAILS:
Person with a recent TBI, admitted to hospital for acute care
Person is able to return to previous housing situation with support
Assumes client is able to live in the community with support up to 35 hours per week
Note: Red arrows show most common pathway.
Pathway Example 3: Person with a previous TBI/ABI with drug/alcohol or mental health issues

CLIENT DETAILS
Person with a TBI or ABI acquired previously
Living alone in community with no formal support
Hospital admissions for falls, mental health issues, drug/alcohol misuse
Triggers need for person to be assessed and referred for supports and interventions
Pathway Example 4: Person with a TBI/ABI with challenging behaviours

CLIENT DETAILS
Person with a TBI from assault, admitted to hospital
Person then admitted to Metro BIRU
Discharged to live with father and brother in community
Challenging behaviour evident during inpatient rehabilitation

The current service system has limited accommodation support options for a person with an ABI or TBI with severe challenging behaviours requiring 24/7 support

In-home support options to live in the community: In complex cases the in-home support will involve a combination of the options below and depends on the other day-time and overnight support available (or that can be brokered) and the informal support available to the client

Referral for ongoing community case management and community participation - case manager will need to source flexible funding options to broker appropriate community participation support as a client with behavioural problems may not be able to participate in group activities

Access to brokerage funds: Case Management service may have brokerage funds, some in-home support options have one-off funds, Brain Injury Association in NSW has some brokerage funds that other case managers can access

Referral for ongoing behaviour intervention and support. Behaviour support and training of support staff can be provided by some BIRP practitioners (depending on capacity/resources). When this cannot be provided by the BIRP, the case manager should seek brokerage funds to purchase this intervention privately

Referral to ADHC Region for consideration of drop in support options x 35 hours/week

Application for ACP/HNP - if client requires 15-35 hours support/week, higher levels can be approved for interim periods

Referral for HACC personal care and domestic assistance social support, respite and case management

Alternative accommodation support options:

Referral to ADHC Region for consideration of alternative support options. This may include YPRAC support options or flexible funding package to remain in the community if client can not live with other people.

Referral for the Integrated Services Project: Intensive accommodation and support for up to 18 months. Note detailed eligibility and priority criteria shown in Appendix 3, Section 3.2.4. Contact the Office of the Senior Practitioner.

Ongoing case management and review is essential to monitor situation for risk and potential breakdown. Particularly if behaviours exacerbate and informal care/family are providing high levels of support

If community living arrangement is unsuccessful and breaks down

If options are unsuccessful - Refer to ISP and ADHC alternative support option

Interagency collaboration/Case conference required to consider options: Client to live separately from carers
Apply for appropriate housing
Client to be referred for centre-based respite care arrangements are considered
Short-term increase in ACP/drop-in support hours whilst behaviours are addressed

Client may enter criminal justice system if behaviours lead to criminal offence

If options are successful

Client may be admitted to hospital or mental health bed as result of behaviours

If options are successful - Refer to ISP and ADHC alternative support option

Note on ISP: this is a short-term project (18 months). The client's ongoing support arrangement will require coordination when the ISP has ended.
Pathway Example 5: Person with a previous TBI/ABI exiting the prison system

CLIENT DETAILS:
Person with a TBI or ABI acquired many years previously (either confirmed or suspected)
Ready to be released from prison
History of mental illness, poly substance abuse, gambling addiction
Requires suitable housing and support to live in the community

Offender Services and Program Staff

Justice Health involved in discharge / release planning

Care and Support Assessment
Risk Assessment LSI-R Tool assesses risk of re-offending. LSI-R score determines risk and level of monitoring required

ADHC referrals go through the Statewide Disability Services, CNSW. However Parole Officers can also make referrals

Referral for HACC supports – requires LESS than 15 hours support/week

Application for ACP/NP - 15+ hours support/week

Referral to ADHC region for drop in support options 15-35 hours support/week

Referral to services for community access / leisure activities

Referral for mental health support / assessment

Referral for drug / alcohol treatment / support group / counselling

Referral for gambling addiction/support group/counselling

Application for social housing assistance

Referrals for Disability Case Management usually not accepted until person is in crisis

Referral not accepted

Follow up or re-refer where required

Person living in suitable accommodation with support

Assessment for priority housing may not occur until person is already released or has a release date

Revocation of parole prior to release can result if suitable housing is not available – person stays in custody as they have no appropriate post release plans

Can result in person being released at end of sentence with no support from Probation and Parole. However Justice Health may still be involved

Can result in homelessness

No parole

Partnerships may occur

Parole Officer, (community offender services)

Can result in person having a fixed address, however application for priority housing will not be activated until person is already released

If parole order requires person to have a fixed address, however application for priority housing will not be activated until person is already released

Ready to be released from prison

Subject to parole

 liaise

liaises

assesses

Can result in homelessness

Referrals for Disability Case Management usually not accepted until person is in crisis
Pathway Example 6:
Applicant or existing tenant of Housing NSW property with diagnosed or undiagnosed ABI/TBI

**CLIENT DETAILS:**
Person with a diagnosed or undiagnosed TBI/ABI
Applicant or existing tenant of Housing NSW
Not currently receiving formal support

1. **APPLICANT** with short and long term housing and support needs
   - 1a. Tenant exhibiting ongoing chaotic behaviour resulting in nuisance and annoyance complaints

2. Applicant submits all completed standard application forms to local housing office: Application for Housing Assistance, Product Supplement, Medical Assessment, any supporting documentation
   - 2a. UNDIAGNOSED ABI: Applicant is identified as a Complex Needs Client (CNC). Application assessment may be referred to the Senior Client Service Officer Specialist (SCSOS) if required.
   - 2b. DIAGNOSED ABI: Applicant discloses that they have an ABI but no concurrent supports in place. Application assessment is referred to the Senior Client Service Officer Specialist (SCSOS) if required.

3. Advocate or support person engaged with client
   - 3a. Gain client consent and try to engage/re-engage advocate on their behalf
   - 3b. Interview the Applicant with the Advocate (if possible) present to determine housing needs

4. Referral to relevant services for assessment where required e.g. Attendant Care Program (ADHC), High Need Pool Service (ADHC), Brain Injury Association, Head East, ICHOSS, Area Health Service, AMS
   - 4a. Provide Temporary Accommodation (TA) in the interim as required

5. Hold case conference to determine if client is able to sustain an independent tenancy with or without support (may include independent living skills assessment)
   - 5a. SCSOS works with Advocate to find appropriate supported accommodation
   - 5b. Develop a Case Plan (with through care continuity) and identify appropriate housing options.

6. If client is considered at risk of harm to themselves or others, engage advocate, clients GP or family member.

**IF ABI DIAGNOSED, Re-engage 5b**

**IF ABI UNDIAGNOSED, Referral to 5b**

5c. If tenant is compliant with supports and medication, engage recommended supports and develop a Case Plan.

5d. Advocate, GP or prior support. If no prior support contact Attendant Care Program (ADHC), High Need Pool Service (ADHC), Brain Injury Association, Head East, ICHOSS, Area Health Service, AMS where required
Pathway Example 7: Person with TBI/ABI requiring formal support for more than 35 hours per week

CLIENT DETAILS:
Person requires more than 35 hours of formal support to live in community
No other informal supports available
Relevant for newly or previously acquired ABI or previously acquired TBI (pre 2007)

The current service system has limited options for a person with an ABI or TBI requiring 24/7 formal support. The options in current service system, are shown below:

- **Case Management and access to Brokerage Funds:** Ongoing case management is essential for coordinating the range of supports required. Some Case Management services have brokerage funds, some in-home support options have one-off funds. Brain Injury Association in NSW has brokerage funds available to other case management services for purchasing specialised interventions.

- **Application for ACP/HNP:** For in-home support, Interim approval of more than 35 hours may be approved.

- **Referral for HACC Program:** Personal care and domestic assistance, social support, respite and other service types.

- **Referral to ADHC Region for consideration drop in support and flexible support options, day programs, respite, community participation and living skills development.

- **Supported accommodation options:**
  - Referral to ADHC Region for consideration of supported accommodation options.

- **Residential Aged Care Facility:** Not a suitable option, especially if client is a younger person and if they do not require 24/7 support. All other options should be exhausted before referral to RACF is seriously considered.

- **Referral to BIRP if client is has had a TBI:** BIRP Rehabilitation program continues into community.

- **Rehabilitation goals identified:** Previous ABI/TBI, living in community, no longer coping on current care levels.

- **Engage Case Management/Advocate:**

- **Assessment of Community Care needs, requires more than 35 hours per week:**

- **Living at home with range of supports:**

- **Living in supported accommodation with range of supports:**

- **In-Reach Supports:**

- **Referral to ADHC Region for YPIRAC Program if person is 50 years or under:**

- **Specialist and hospital re-admissions as required:**

- **GP monitors health:**

- **Ongoing case management and review is essential to monitor range of interventions in place and monitor for risk and potential breakdown:**

- **Episodic case management with specialist services (BIRP, D & A, MH Services):**

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Commonwealth Carelink Centres provide free information about disability services in local areas, including services for people with an ABI. Ph: 1800 052 222, www.commcarelink.health.gov.au.

Carers NSW is an association for relatives and friends caring for people with a disability, mental illness, drug and alcohol dependencies, chronic condition, terminal illness or who are frail.

It is the peak organisation for carers in New South Wales and the only state-wide organisation that has carers as its primary focus. It is part of a national Network of Carers Associations and works collaboratively to lead change and action for carers. Head Office: Ph: (02) 9280 4744, Fax: (02) 9280 4755

Opening hours are Monday to Friday 9am to 5pm (EST)

For carer information, support and counselling Contact Carers NSW Freecall: 1800 242 636

After Hours call Lifeline: 13 11 14

For carers wanting emergency respite call 1800 052 222, Email: contact@carersnsw.asn.au, Website: www.carersnsw.asn.au

Brain Injury Association of NSW: Freecall 1800 802 840, Ph: (02) 9868 5261, Fax: (02) 9868 5619. Website: www.biansw.org.au Email: mail@biansw.org.au.

The Brain Injury Association of NSW is the state-wide peak organisation dedicated to serving all persons affected by acquired brain injury—those with acquired brain injuries, family members, friends, professionals, and the broader community. The BIA NSW provides a service that can help you find the support you need anywhere across the state. And as a member of Brain Injury Australia, they can put you in contact with a number of support networks right across the country. Information about health, disability and community services available to people with an ABI across NSW is provided on the Brain Injury Association in NSW website.

Brain Injury Australia: Phone: (02) 9591 1094, www.braininjuryaustralia.org.au, Email: nick.rushworth@braininjuryaustralia.org.au. Brain Injury Australia is the Australian peak organisation working for people living with acquired brain injury.

BIA Queensland: website: www.braininjury.org.au/, The Brain Injury Association of Queensland is the peak body for people with acquired brain injury in Queensland. The website includes fact sheets that might be useful.
The Brain Foundation: www.brainfoundation.org.au. The mission of the Brain Foundation is to reduce the incidence and impact of diseases, disorders and injuries of the brain, spine and nervous system through the provision of support, community education and research.

arbias Ltd: www.arbias.org.au. arbias Ltd provides services for people with acquired brain injury from any cause, while their main specialisation is in the areas of alcohol and other drug related brain injury.

Stroke Recovery Association NSW: The Stroke Recovery Association is a focal point for information about stroke recovery and prevention. They provide telephone counselling, information kits, coordinate stroke recovery clubs, stroke seminars and workshops, referral to other services, a library, newsletter and coordination of Stroke Awareness Week. Ph: 1300 650 594 email info@strokensw.org.au and website www.strokensw.org.au.

Paraplegic and Quadriplegic Association of NSW (ParaQuad NSW)
ParaQuad provides a support system that aims to meet the needs of people with a spinal cord injury and their families at every stage of life. The services are designed to help clients with spinal cord injury to have the same opportunities as everyone else to participate in the community. For more information visit www.paraquad.org.au

Some general disability organisations:

www.ideas.org.au
Information on Disability and Education Awareness Service (IDEAS) provides information and a referral service for people with disabilities.

www.da.org.au
Disability Advocacy NSW help people of all ages with any type of disability or mental illness get fair treatment.
APPENDIX 2
Rehabilitation in NSW Health for Adults

2.1 General Rehabilitation

Inpatient rehabilitation services have a primary goal of restoring, improving and maintaining the functional ability of the patients, ensuring they can be safely discharged with the assistance of equipment, aids and modifications to their home. Functional ability relates to carrying out tasks of daily living including personal hygiene, self-bathing, feeding, toileting, stair climbing, dressing, bowel and bladder control, ambulation, chair and bed transfer, and walking or wheelchair use.

General rehabilitation wards in public hospitals provide a multidisciplinary approach (involving medical nursing and allied health services) for people who have a variety of medical reasons for needing rehabilitation (e.g. orthopaedic/amputee; cardiac/heart attacks; neurological/stroke; trauma, pain, post operative etc). The majority of clients admitted to general rehabilitation wards are elderly.

2.2 Specialist Rehabilitation

Specialist rehabilitation services are required when the needs of a specific client group are better managed by providing discrete services to meet similar needs. Specialist rehabilitation services are managed within general rehabilitation by providing staff with specialist training (e.g. cardiac rehabilitation, stroke rehabilitation) or by organising rehabilitation services into dedicated units e.g. the NSW Brain Injury Rehabilitation Program (BIRP) to develop expertise in providing specialist rehabilitation to meet the specific needs of the client group.

Agency for Clinical Innovation (ACI) was established in January 2010 as a board governed statutory health corporation. ACI builds on the work of the Greater Metropolitan Clinical Taskforce (GMCT) and works with the NSW Bureau of Health Information, Clinical Excellence Commission and the Clinical Education and Training Institute to improve health outcomes.


2.3 The ACI Brain Injury Rehabilitation Directorate (BIRD)

A network of the NSW Agency for Clinical Innovation

The ACI established the Brain Injury Rehabilitation Directorate in 2002 to
provide an organisational structure to engage clinicians and consumers in a state wide coordinated approach to improve the specialty clinical services in the existing network of brain injury rehabilitation for adults, children and young people following a severe traumatic brain injury (TBI).

A TBI refers to an injury to the brain arising from an external force. An acquired brain injury (ABI) is an umbrella term that includes TBI but also refers to other forms of non-congenital, non-progressive brain injury arising from illness (e.g. stroke), infection (e.g. meningitis), toxins (e.g. alcohol), anoxia/hypoxia (e.g. near drowning) and surgical misadventure.

The BIRD manages a web-based training resource developed by NSW BIRP clinicians with project funding from key stakeholders. Access to the site is free of charge and the web link is: www.tbistafftraining.info/

The BIRD is collaborating with ADHC in the development of ABI awareness and case management modules to improve understanding and awareness of ABI issues for staff in disability services and may be useful for staff in other services, families and carers.

2.4 NSW Brain Injury Rehabilitation Program (BIRP)

The BIRP was established in 1990 as a joint initiative between the NSW Department of Health and the Motor Accidents Authority of NSW to provide a comprehensive traumatic brain injury rehabilitation service (Cuff Report, 1987).

The development of the NSW BIRP provides a dedicated network of services to develop expertise and skills in the provision of specialist rehabilitation services to people with a traumatic brain injury aged 0-65 years to manage the physical, communication, cognitive and psychosocial changes. The majority of clients are aged 16-35. The service provides goal directed rehabilitation to improve function (e.g. mobility), reduce activity limitations (e.g. memory strategies) and increase social participation (e.g. return to work, interpersonal relationships, social communication skills). The model includes staff education and training, research and service development.

The principles underpinning the provision of rehabilitation by the NSW BIRP are:

- Early intervention
- Goal-directed Rehabilitation
- Client and family involvement
- Service provision in the least restrictive environment
- Interdisciplinary team approach
- Continuum of care
- Case Management
- A commitment to innovation and best practice
In NSW there are 14 units in metropolitan and rural BIRPs that operate in Area Health Services (AHS). Adult and paediatric services are managed separately with transition to adult services managed as a component of individual planning.

**Adult services**

- Three dedicated acute inpatient rehabilitation wards in the Sydney metropolitan units including Westmead BIRP, Liverpool BIRP and Royal Rehabilitation Centre Sydney BIRP.
- Eight dedicated Transitional Living Programs (TLP) in metropolitan and rural regions at Westmead BIRP, Liverpool BIRU, RRCS BIRP, Hunter BIRS, Midwestern BIRS, New England BIRS, Goulburn BIRS, South Western BIRS
- 11 dedicated Community/outreach services in metropolitan and rural regions Westmead BIRP, Liverpool BIRU, RRCS BIRP, Hunter BIRS, Midwestern BIRS, New England BIRS, Goulburn BIRS, South Western BIRS, North Coast BIRS, Illawarra BIS
- One dedicated vocational rehabilitation service (Head 2 Work) operates within the Liverpool BIRU. This service is WorkCover accredited. The focus is return to work, job seeking, job trials and transition from school to employment for people with severe ABI/TBI. Driving assessment and training is available from an accredited occupational therapist.
- One dedicated community living unit operates within the Liverpool BIRU to provide short term accommodation for booked respite, crisis accommodation in response to changed living circumstances and to provide access to the community team and/or specialist therapy services and programs.

**Paediatric Services**

The Paediatric Brain Injury Rehabilitation Services are managed differently to adult services. Children with TBI are not managed in specific brain injury rehabilitation inpatient units. They are admitted to hospital and managed within the broader diagnosis of acquired brain injury (ABI). Children with an acquired brain injury and a high level of complexity require an interdisciplinary team approach to management. The specialist Paediatric Brain Injury Rehabilitation Teams work in both the inpatient and community settings as the length of hospital stay is relatively short. The interdisciplinary team provides the full spectrum of rehabilitation services from inpatient to non-inpatient services. Please visit the website: [www.health.nsw.gov.au/gmct/birp](http://www.health.nsw.gov.au/gmct/birp) for the details of the NSW BIRP paediatric programs, descriptions of specific service types and contact details.

**Referral to the NSW BIRP**

Entry to the NSW BIRP occurs at different points in the recovery continuum.
• Pathway 1 is admission from the acute hospital ward to one of the 3 Inpatient Adult Brain Injury Rehabilitation Wards or admission to a paediatric general/rehabilitation ward with one of the 3 metropolitan children services. The referral to the TLP and community team is part of the continuum of care.

• Pathway 2 is when BIRP involvement starts with the community team for non inpatient services and specialist community rehabilitation as a continuum of recovery. This can include admission to the TLP.

• Pathway 3 occurs when the person is not referred to the NSW BIRP as a continuum of acute care. The referral is in response to difficulties living in the community possibly related to the TBI. The entry point is the Community Team. The primary referrer is usually the GP although referrals can be from the person, family or service provider.

• Pathway 4 occurs when previous clients of the NSW BIRP are referred back to the service (self referral/others) because difficulties arise or circumstances have changed. The entry point is with the community team for review and to identify rehabilitation goals.


**Admission criteria**

1. The primary focus for the NSW BIRP is children, young people and adults who have had a severe traumatic brain injury. This provides key admission criteria:

   • Evidence of a severe TBI from the mechanism (e.g. closed, penetrating), the circumstances (fall, MVA) and course e.g. ambulance report, hospital medical file/reports, client/family history, time in hospital and diagnostic tests (e.g. CT Scan),
   • The injury is severe as measured by the Glasgow Coma Score (loss of unconscious),
   • The injury is severe/extremely severe as measured by the period of post traumatic amnesia (PTA),
   • For children under 8 years, severity is determined by radiology tests (eg CT Brain scan) and/or the rehabilitation specialist as being significant.

Post traumatic amnesia (PTA) is the stage of recovery after a traumatic brain injury during which “The patient is confused, amnesic for ongoing events and likely to evidence behavioural disturbance” (Levin et al, 1979). Measuring the duration of PTA provides a guideline to the severity of brain impairment. PTA is assessed in hours/days from the time of injury and severity identified as follows:
Traumatic head injury – mild/moderate (PTA* ≤ 24 hrs)
Traumatic head injury – severe (PTA* 2 - 7 days)
Traumatic head injury – very severe (PTA* 8 - 28 days)
Traumatic head injury – extremely severe (PTA* 4 - 12 weeks)
Traumatic head injury – extremely severe (PTA* 3 - 6 months)


2. Resident of the catchment area for the BIRP community/outreach team. For specific entry criteria to each NSW BIRP and for the different programs visit www.health.nsw.gov.au/initiatives/birp/

3. People with ABI from other causes are considered depending on clinical need, capacity, and availability of resources and in response to local needs.

4. People with mild TBI are not usually admitted to the NSW BIRP. The Brain Injury Rehabilitation Directorate (BIRD) collaborated with the Motor Accident Authority in the development of the Guidelines for the management of people with mild TBI. These guidelines are available at www.maa.nsw.gov.au

The NSW BIRP usually liaises with the referrer to discuss options for people who do not meet the admission criteria. In some circumstances consultation and assessment may be offered to assist the referring agency respond to client goals.

Data Management
The ACI Brain Injury Rehabilitation Directorate (BIRD) collects clinical and outcome data about clients admitted to the NSW BIRP and provides annual reports to the Directors and Managers of the NSW BIRP and to Primary Health and Community Partnerships Branch NSW Health. This information is used for monitoring trends, evaluation, quality improvement and BIRD projects. BIRD data reports can also be provided in response to specific requests. Individual units can access and use their own data.

2.5 Stroke Services New South Wales

A network of the NSW Agency for Clinical Innovation
The ACI Stroke Services New South Wales (SSNSW) Network was established in 2002 to develop a coordinated approach to care across New South Wales (NSW) by sharing available resources and promoting expertise.
SSNSW involves more than 1,000 health clinicians, consumers and carers who work closely together and partner with NGOs (e.g. Stroke Recovery Association NSW (SRANSW), Heart Foundation NSW) to improve stroke care.

SSNSW currently includes 37 recurrently funded stroke services in metropolitan and rural and remote NSW. The focus is early admission to an acute stroke unit or service to minimise the extent and impact of the stroke.

There are 26 defined acute stroke units (a designated geographical unit coordinated by a multidisciplinary team of health professionals for the exclusive care of stroke patients) identified in the 37 stroke services. The remaining services are based on the model of mobile stroke teams with patients being placed in delineated beds in a general medical or rehabilitation setting and provide care by educated allied health and nursing clinicians.

The average length of stay in an acute stroke unit is eight days. People admitted for stroke care to neuroscience wards, medical/surgical wards etc may or may not be managed by a stroke team (as above but not confined to a particular ward) depending on their location.

There are two community stroke outreach teams and rural stroke coordinators but acute/post acute stroke services generally cease at discharge, soon after discharge or when outpatient therapy is completed.

Coordinating care for the transition from hospital to the community can be complex and providing a functional threshold for the outcome of the stroke can assist in this process.

The physical outcome resulting from the stroke is usually evident within 7 days. SSNSW score disability by the Rankin Scale Method prior to admission and 7-10 days after the identification of onset of stroke:

- 0 – No symptoms at all
- 1 – No significant disability despite symptoms: able to carry out all usual duties and activities
- 2 – Slight disability: unable to carry out all previous activities, but able to look after own affairs without assistance
- 3 – Moderate disability: requiring some help, but able to walk without assistance
- 4 – Moderate severe disability: unable to walk without assistance, and unable to attend own bodily needs without assistance
- 5 – Severe disability: bedridden, incontinent and requiring constant nursing attention
- 6 – Death
- 7 – Unknown
The Rankin Scale Method leans toward measurement of loss of physical or functional ability. It is likely that anyone with a Rankin Scale Score 1-5 could have both cognitive and physical changes resulting from the brain injury. However the scale does not have any measure of cognitive change following the stroke.

Measurement of cognitive change following a stroke would be included in the OT assessment. Referral for a neuropsychological assessment would be in response to a specific needs e.g. ability of the person to manage their own finances or the need for a guardian.

Following acute care, a percentage of patients will be referred for inpatient stroke rehabilitation in a general rehabilitation ward or be discharged and referred for therapy outreach community stroke services.

In NSW there has been an extensive program of education (primarily for allied health and nursing staff) to increase the knowledge of staff working in the acute and post acute settings.

The pathway is usually determined by where the acute care was provided and the discharge destination. Primarily stroke rehabilitation is hospital based as an inpatient or outpatient and longer term follow up is transferred to the general practitioner. The average length of stay in stroke rehabilitation is 24 days.

Various staff can be involved in planning transition to the community including nurse consultants, case managers and stroke liaison workers. Information will be provided to their general practitioner (includes the Rankin Score). Referrals will be initiated for outpatient therapy and identified community services.

Depending on the services required by the person there may be attendance at a 3 monthly follow up clinic with a clinical nurse specialist/clinical nurse consultant with access to a staff specialist/neurology registrar if needed for medical issues.

A brochure will be provided at discharge from the SRANSW to support the person and his/her carer with self initiated access to information, counselling, support and peer involvement.

The NSW Health Information Exchange (HIE) identified approximately 12,000 people being discharged from SSNSW services with an ABI in 2007 with relevant stroke ICD Codes (between I61 and I64):

- 81% were discharged to the community
- 5% were less than 45 years old
- The majority of readmissions within 28 days are not related to further strokes but rather functional incidents including falls etc

The model of stroke rehabilitation in NSW is currently under review.

- There are no full time equivalents of social workers directly appointed to units/services of SSNSW. These services are obtained
on request during the inpatient stay when a specific need is identified.

- The focus of the current model of care is functional and does not address the cognitive or behaviour changes when brain impairment results from the stroke. No system currently exists to incorporate neuropsychological principles into stroke rehabilitation except upon request by the multi disciplinary team.
- The discharge destination or referral pathway depends on the recommendations of the multidisciplinary team (acute and post-acute) and could include referral to community-based services and NGOs.

<table>
<thead>
<tr>
<th>Locations of Stroke Services NSW</th>
<th>Contact details (Call number and request to be connected with stroke unit/service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armidale Hospital</td>
<td>(02) 6776 9500</td>
</tr>
<tr>
<td>Bankstown-Lidcombe Hospital</td>
<td>(02) 9722 8000</td>
</tr>
<tr>
<td>Bathurst Base Hospital</td>
<td>(02) 6330 5311</td>
</tr>
<tr>
<td>Belmont Hospital</td>
<td>(02) 4923 2000</td>
</tr>
<tr>
<td>Blacktown Hospital</td>
<td>(02) 9881 8000</td>
</tr>
<tr>
<td>Bowral &amp; District Hospital</td>
<td>(02) 4861 0200</td>
</tr>
<tr>
<td>Broken Hill Base Hospital</td>
<td>(08) 8080 1333</td>
</tr>
<tr>
<td>Calvary Hospital (Newcastle)</td>
<td>(02) 4921 1211</td>
</tr>
<tr>
<td>Campbelltown Hospital</td>
<td>(02) 4634 3000</td>
</tr>
<tr>
<td>Coffs Harbour &amp; District Hospital</td>
<td>(02) 6656 7000</td>
</tr>
<tr>
<td>Concord repatriation Hospital</td>
<td>(02) 9767 5000</td>
</tr>
<tr>
<td>Dubbo Base Hospital &amp; Health Service</td>
<td>(02) 6885 8666</td>
</tr>
<tr>
<td>Fairfield Hospital</td>
<td>(02) 9616 8111</td>
</tr>
<tr>
<td>Gosford Hospital</td>
<td>(02) 4320 2111</td>
</tr>
<tr>
<td>Hornsby Ku-ring-gai Hospital</td>
<td>(02) 9477 9123</td>
</tr>
<tr>
<td>John Hunter Hospital</td>
<td>(02) 4921 3000</td>
</tr>
<tr>
<td>Lismore Base Hospital</td>
<td>(02) 6621 8000</td>
</tr>
<tr>
<td>Liverpool Hospital</td>
<td>(02) 9828 3000</td>
</tr>
<tr>
<td>Nepean Hospital</td>
<td>(02) 4734 2000</td>
</tr>
<tr>
<td>Maitland Hospital</td>
<td>(02) 4939 2000</td>
</tr>
<tr>
<td>Manly Hospital</td>
<td>(02) 9976 9611</td>
</tr>
<tr>
<td>Manning Hospital – Taree</td>
<td>(02) 6592 9111</td>
</tr>
<tr>
<td>Orange Base Hospital</td>
<td>(02) 6393 3000</td>
</tr>
<tr>
<td>Port Macquarie Base Hospital</td>
<td>(02) 6581 2000</td>
</tr>
<tr>
<td>Prince of Wales Hospital</td>
<td>(02) 9382 2222</td>
</tr>
<tr>
<td>Royal North Shore Hospital</td>
<td>(02) 9926 7111</td>
</tr>
<tr>
<td>Royal Prince Alfred hospital</td>
<td>(02) 9515 6111</td>
</tr>
<tr>
<td>Shoalhaven District Memorial Hospital</td>
<td>(02) 4421 3111</td>
</tr>
<tr>
<td>Sutherland Hospital</td>
<td>(02) 9540 7111</td>
</tr>
<tr>
<td>St George Hospital</td>
<td>(02) 9113 1111</td>
</tr>
<tr>
<td>St Vincent’s Hospital</td>
<td>(02) 8382 1111</td>
</tr>
<tr>
<td>Tamworth Rural Referral Hospital</td>
<td>(02) 6767 7700</td>
</tr>
</tbody>
</table>
2.6 New South Wales Spinal Cord Injury Services

A network of the NSW Agency for Clinical Innovation

State Spinal Cord Injury Service (SSCIS)

People who acquire a brain injury as well as a spinal cord injury may be referred to a Spinal Cord Injury Unit, part of the NSW Spinal Cord Injury Service.

Recent statistics from the SSCIS indicate that approximately 40-50% of all admissions to Spinal Cord Injury Units have a TBI (Davidoff, 1992). In many cases, the TBI is not severe in terms of behavioural and ongoing cognitive impairment, but affects insight, motivation and future community participation (Sommer, 2004). The rehabilitation model is focused on achieving goals, health education and supporting carers. An outreach service is also available that may involve referral to community based therapy and development of a plan to continue therapy and rehabilitation in the community.

Further data from admissions to the NSW Spinal Cord Injury Service indicate that:

- 7% have severe cognitive deficits resulting from an ABI
- 10% have mental illness co-morbidities at time of injury
- 50% of their clients have a substance misuse issues (not all have an ABI)
- Only 5% of all admissions are not able to return to pre-injury home situation

Services of the State Spinal Cord Injury Service

The SSCIS coordinates the care of patients with spinal cord injury (SCI) in the following specialised spinal units:

- Adult Spinal Cord Injury Units (SCIU) at the Royal North Shore and Prince of Wales Hospitals.
- Paediatric rehabilitation services at the Sydney Children’s Hospital, Randwick and The Children’s Hospital, Westmead.
- Spinal Cord Injury Rehabilitation at the Royal Rehabilitation Centre Sydney (Moorong SCI Rehabilitation Unit) and at the Prince of Wales Hospital.
- Comprehensive multidisciplinary community based spinal cord injury services are provided by the Spinal Outreach Service (SOS)
and Rural Spinal Cord Injury Service (RSCIS) based at the Royal Rehabilitation Centre Sydney. A Rural Spinal Cord Injury Service Coordinator is located with the Rural Brain Injury Services in each of the four rural area health services. The SOS and RSCIS provide nine multidisciplinary clinics per year in rural areas. All people discharged to community living following an acute SCI are referred to the SOS who provide 18 months of follow up and transition support to community living.

- Regional centres that provide inpatient and follow up services are based at the Port Kembla Hospital Rehabilitation Service and the Royal Newcastle Centre. The Hunter Spinal Cord Injury Service in Newcastle offers a comprehensive multidisciplinary community based rehabilitation service for individuals with spinal cord injury (SCI).

Each SCI service provides a range of inpatient and non inpatient services for people with a spinal cord injury. Referral criteria and contact details for these services is available on www.health.nsw.gov.au/gmct/spinal/referral.asp

Referral of adults with a Spinal Cord Injury

It is recommended that people who have sustained an acute spinal cord injury are transferred to one of the specialist spinal cord injury units within 24 hrs of injury. However, in the case of multiple trauma this transfer may occur following stabilisation of other severe injury, including brain injury, in line with recommendations outlined in the NSW Trauma Services Plan (Dec 2009). Trauma referrals to specialist services are coordinated by the Aeromedical and Medical Retrieval Services (AMRS) (ph 1800 650 004).

Non trauma or delayed Spinal Cord Injury trauma referrals

Referral patterns and contact details for SCI Services for non traumatic or delayed transfer of trauma patients in NSW and for specialist advice about the management of patients with a SCI are provided in the following table.

<table>
<thead>
<tr>
<th>NSW State-wide Spinal Cord Injury Service Referral Network (Adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referring Area Health Service</strong></td>
</tr>
<tr>
<td>South Eastern Illawarra AHS</td>
</tr>
<tr>
<td>Greater Southern AHS</td>
</tr>
<tr>
<td>South Western Sydney AHS</td>
</tr>
<tr>
<td>Australian Capital Territory (ACT)</td>
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</table>
Referral of Children with a Spinal Cord Injury

Spinal Cord Injury services for children under the age of 16 years are provided by the Children’s Hospital at Westmead (CHW) and The Sydney Children’s Hospital (SCH) at Randwick.

- The Children’s Hospital, Westmead - Ph: (02) 9845 2816
- Sydney Children’s Hospital, Randwick - Ph: (02) 9382 1685

Length of stay

Length of stay in the acute SCIU will vary according to severity of the injury and level of impairment. Following acute management, people with a SCI participate in a multidisciplinary rehabilitation program aimed at achieving the individual’s goals for safe return to community living.

References


2.7 Enable NSW

Following a traumatic brain injury, stroke or spinal cord injury people may need equipment and resources to reduce activity limitations and manage disability. Enable NSW is responsible for the administration of the NSW Health disability support equipment programs including the:

- Program of Appliances for Disabled People (PADP): including Specialised Equipment Essential for Discharge (SEED) and the Young People in Residential Aged care (YPIRAC)
• Prosthetic Limb Service
• Home Respiratory Program (HRP): including Home Oxygen Service (HOS), Adult Home Ventilation Program (AHVP), Children’s Home Ventilation Program (CHVP)

Applications can be submitted when planning transition home from hospital or when at home.

The Consumer Application Form for all of the programs can be downloaded from the EnableNSW website.

Contact: 1800 362 253, website: www.enable.health.nsw.gov.au, email: Enable@hss.health.nsw.gov.au
APPENDIX 3
ADHC Program Options

3.1 In Home Support Options

3.1.1 Attendant Care Program (ACP)

The purpose of the ACP is to enable people with a disability to live at home with care and support to compliment existing informal and/or community supports.

Eligibility: People with a physical disability or those who require personal assistance to complete activities of daily living including people who are aged 16-65 years, are able to manage living in the community accessing appropriate community supports, live in their own home, the family home or in leased accommodation where they are managing the lease, can exercise control over their environment and direct and supervise their attendant carers or need the assistance of a third person to assist them to manage their care and are ineligible, not prioritised or are unlikely to require other ADHC provided or funded accommodation support services in the short to medium term.

Eligible applicants who need the assistance of a third person to assist them to manage their care due to their complex needs, limited decision making capacity or a deterioration of their cognitive function may include people with an: ABI and a physical disability (or who need physical assistance to complete tasks of daily living) including those who have had a stroke, degenerative and neurological conditions including rapidly degenerative conditions and ventilation dependency (over 24 hours) in which case the package may be jointly funded and managed. More detail can be found in the ACP Guidelines (click on link).

3.1.2 High Needs Pool (HNP)

HNP services include the provision of agreed basic support services up to the approved hours per week to assist people with daily self-care and living tasks to help them live more independently in the community. The objectives of the HNP are to provide an integrated range of basic personal care and support services which assist approved clients from the HACC target group with tasks of daily living and to help approved clients to be more independent at home and in the community. The following HACC service types are available and may be approved as part of a HNP service: personal care, domestic assistance, respite care and low level home maintenance.

Eligibility: HNP services target frail aged people, young people with a disability and their carers, who require higher support levels. To be eligible for the HNP, there must be a minimum need of 15 hours per week (60 hours per 4 week period) and a maximum need of 35 hours per week.
(140 hours per 4 week period). More detail can be found in the HNP Guidelines (click on link)

**How to Apply/Refer:** The ACP and HNP have the same application process. Go to Application for High-Level In-Home Support (click on link). Complete the form and fax or email to the ACPDU using details provided on form, include supporting letters from GP, specialists and Case Manager.

### 3.2 Supported Accommodation and Targeted Initiatives

#### 3.2.1 Innovative Accommodation Framework: Accommodation Support Models

ADHC funds a range of accommodation support options for people with a disability (including people with ABI). These include: group homes, village and cluster model accommodation, villas and apartments, collocated models and specialist supported living services (previously large residential centres). Some models provide up to 24 hour support, drop in support and flexible packages of funding. More information about the models of supported accommodation ADHC funds and is developing can be found in the Innovative Accommodation Framework (click on link) on ADHC’s website.

There are a number of initiatives that target people with a brain injury including: Disability Housing and Accommodation Support Initiative (DHASI); Young People in Residential Aged Care (YPIRAC) Program, Integrated Services Project; Boarding House Relocation Program and Active Link Initiative to support people living in Boarding Houses.

**Eligibility** for ADHC accommodation support are people with a disability as defined by the NSW Disability Services Act 1993 whose support needs assessment indicates the appropriateness of supported accommodation. Allocation of supported accommodation places is dependent on vacancies, location, matching support needs and priority of need.

More detail can be found in the Allocation of Places in Supported Accommodation Policy and Procedures (click on link)

**How to Apply/Refer:** Requests for a supported accommodation place should be directed to ADHC Regional Information and Referral Teams. ADHC Regional Offices (click on link)

#### 3.2.2 DHASI Initiative

DHASI aims to assist people with complex housing needs to access social housing with support required to maintain their tenancy and well being. The primary objective of DHASI is to provide drop in support (support and assistance with essential activities of daily living), in a social housing setting.
DHASI provides up to 35 hours of support per week, and is available initially in ADHC's Northern Region (Tweed Heads and Lismore) and Metro South (South West Sydney) Regions, expanding into other ADHC Regions through to 2010/11. More detail can be found in the Disability Housing and Support Initiative Program Description (click on link).

**Eligibility:** Places are directed at people aged 18-65 years old, assessed by ADHC as having an intellectual disability or an ABI and who can function in a community setting with a maximum of 35 hours per week of drop in support.

**How to Apply/Refer:** Contact your local ADHC Regional Office for information on DHASI places in other Regions. Contact numbers for all ADHC Regional Offices can be found on our website. ADHC Regional Offices (click on link)

### 3.2.3 YPIRAC Program

YPIRAC aims to provide better living options and support for younger people with a disability living in, or at risk of entry into a, residential aged care facility (RACF). The program is jointly funded by the NSW and Australian Governments and managed in NSW by the ADHC. The services offered under the program may include recreational and diversional therapy, allied health services such as physiotherapy and occupational therapy, clinically necessary equipment, participation in day programs and community access, support to visit family and friends and assistance to maintain family and social relationships, accommodation, home modifications and transitional case management and advocacy support.

**Eligibility:** You may be able to receive assistance under the YPIRAC Program if you: have a disability as defined in the Disability Services Act 2006, acquired after the age of 18 years, are a NSW resident; are aged under 65 years, however the priority group is people under the age of 50, are living permanently in RACF, or at risk of entry to RACF (however priority group is people living permanently in RACF), and are not eligible to receive assistance through another existing program. However in some cases additional supports may be provided to complement other programs.

**How to Apply/Refer:** For further information Ph: 1800 467 622 Email: ypirac@dadhcnsw.gov.au. Or see the YPIRAC Factsheet (click on link).

### 3.2.4 Integrated Services Project

Aims to establish coordinated cross-agency responses for adult clients who have been identified from across the service system as having complex needs and challenging behaviour. The Project provides a range of additional time-limited services to clients and their support network including comprehensive assessment, behaviour intervention, supervision, case coordination and accommodation support.
Eligibility: Aged 18 years or over, and meet the following criteria:

- Exhibits behaviour that is of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour that is likely to seriously limit or deny access to and use of ordinary community facilities.
- Has one or more disability and/or diagnosis including intellectual disability, mental illness, mental disorder, acquired brain injury including alcohol and drug related brain impairment, or dementia, or there is a dispute about diagnosis or disability.
- Requires an intense level of ongoing coordinated multiple agency support but is not receiving this Service Response from existing services, or the high level of support required is unsustainable.
- The individual is either (at least one of the following must apply):
  - in an acute public hospital but cannot be discharged because they have no residence to go to due to the multiplicity of need including the serious risk posed to themselves or others OR
  - homeless or living in an environment where they are at serious risk of physical or emotional harm OR
  - continually admitted to and discharged from public hospitals or presenting regularly to accident and emergency departments or blocking residential respite care and severely restricting or prohibiting access to other clients due to the risks posed by their behaviour OR
  - long term and or regular contact with the juvenile justice or criminal justice system with no rehabilitative outcomes.
- The individual has been deemed ineligible or denied access to services or resources from one or more government agency that are considered essential by the referring agency.
- There is clear evidence that all local support options have been exhausted.

How to Apply/Refer: The ISP is administered by the Office of the Senior Practitioner in ADHC in partnership with Housing NSW and NSW Health. Nominations are called for approximately 3 monthly and must be submitted by the Area/Regional offices of the nominating NSW Government Human Services Department. A nomination form can be obtained from the Office of the Senior Practitioner, ph: (02) 9841 9246.

3.2.5 Initiatives provided under the Boarding House Reform Program (BHRP)

The BHRP refers to a strategy introduced by the NSW Government in 1998 to improve the standard of accommodation and support to residents of LRCs (Large Residential Centres) formerly Licensed Boarding Houses; to relocate LRC residents whose needs could not be appropriately met in
LRCs to other supported accommodation and to prevent inappropriate entry to LRCs; for LRCs to remain viable options of accommodation and services where safety and affordability satisfy minimum benchmarks. The following programs are included in the BHRP:

**Relocation Program:** aims to establish alternative accommodation for residents of LRCs requiring increased support. Funding was also provided to support the people relocated from LRCs to more appropriate supported accommodation and for services to people remaining in LRCs.

**Personal Care, Primary And Secondary Health Care:** The key services provided to people under the BHRP remaining in LRCs are personal care, primary and secondary health care, and escorted medical and dental transport.

**Active Link Initiative (ALI):** ALI providers assist people who live in LRCs to develop skills to participate in the community. This includes community integration activities comprising skills development, social and recreational activities. They do this by organising activities in the community, in the LRC and at the ALI providers’ centre.

**Eligibility/ How to Apply/Refer:** Residents of LRCs in NSW requiring support are eligible. Referrals for the Relocation Program, Personal Care, Primary and Secondary Health Care Programs and ALI Program can be made by contacting the local ADHC Regional Office.

### 3.3 Community Participation and Day Activities

#### 3.3.1 Post School Programs

**Community Participation Program:** is aimed at school leavers who have a moderate to high disability (as defined by the Disability Services Act 1993) who require an alternative to paid employment or further education in the medium or longer term. Types of Community Participation Packages include Centre Based with Community Access, Individual Community Based options and Self-Managed Packages. For more information go to the [Community Participation Program Guidelines](#) (Click on link)

**Transition to Work:** A two year program which supports school leavers with a disability to develop skills that will assist them to move to employment, vocational education and training or higher education.

**Eligibility:** A person must generally be either: (1) a school leaver with moderate to high support needs who has completed Year 12; and has an intellectual, physical or sensory disability, is eligible for a service under the NSW Disability Services Act 1993; and is assessed as eligible by DADHC; and is a resident of NSW; or (2) a current Community Participation service user (this includes people who transferred from the former ATLAS Program); or (3) a person who has been approved to transfer from the Transition to Work Program, and (4) is not undertaking paid employment for more than 4 hours per week, full time vocational education or higher
education. More information about eligibility is detailed in the Post School Programs Guidelines on Eligibility (click on link)

**How to Apply/Refer:** Referrals to these programs are via the ADHC Regional Offices (click on link). For further information, please contact the Day and Post School Programs Team, Email: dayprograms@dadhc.nsw.gov.au ph: 1800 761 030

### 3.3.2 Life Choices and Active Ageing Programs

The Life Choices Program is for people 25 to 54 years old and Active Ageing is for people aged 55 – 64 years (40-64 years for Indigenous Australians). Both programs aim to assist people with moderate to very high support needs to achieve their goals and participate as valued and active members of society. This includes providing flexible day programs and activities that meet individuals’ goals, health and activity levels, life stage, interests and changing support needs. The programs provide a greater range of service model options, including Centre Based with Community Access, Individual Community Based Options or the Self Managed Model.

**Eligibility:** A person who has an intellectual, psychiatric, physical or sensory disability and is eligible for a service under the NSW Disability Services Act 1993; and is assessed as eligible by ADHC; has moderate to very high support needs; is a resident of NSW; and is not undertaking paid employment for more than 8 hours per week, full time vocational education or higher education. For more information please see the Life Choices Guidelines and Active Ageing Guidelines on the ADHC Website.

**How to Apply/Refer:** Referrals to these programs are via the ADHC Regional Offices (click on link).

### 3.2.3 ADHC Funded Community Participation Initiatives

ADHC funds a range of community participation services provided by NGOs. Services provide support to access the community, living and life skills development, leisure and recreation and respite.

**Sydney Metro Regions:** ABI Community Support Program - provided by ABI Specialist Services NSW (formerly Wareemba Community Living). Covering Metro Sydney, Bathurst, Orange and Parkes, this includes development of social and living skills. ABI Social Support Program (HACC funded) - provided by the ABI Group Inc (Seekers) in Metro North - Hawkesbury and Penrith LGAs, provides life and social skills development. Head East Eastern Sydney - learning and life skills development for people with an ABI (covers Botany, Randwick, Waverley, Woollahra, and City of Sydney). Headway ADP - Metro South (includes SWSAHS) provide a range of skills development courses and support.

**Southern Region:** Headway Illawarra - Southern Region Illawarra and Shoal Haven Areas (including South Eastern Sydney & Illawarra)
Area Health Service) provides a range of community access and skills development programs.

**Northern Region: Hastings Headway** – Port Macquarie provides community access programs including life skills development for people with an ABI. **Northern Region drop in support service** for people with an ABI – provided by Accommodation Network, includes living skills development.

**Western Region: ABI Community Support Program** – provided by ABI Specialist Services NSW (formerly Wareemba Community Living). Covering Bathurst, Orange and Parkes, this includes development of social and living skills.

**Hunter Region: Head Start** - Community access, support and living skills for people with ABI - individualised support and small group support. **Central Coast Disability Network** – Community Access and Support Program for people with an ABI – includes skills development.

**How to Apply/Refer:** Commonwealth Carelink Centres provide information about contacting these services, Ph: 1800 052 222 or via [www.commcarelink.health.gov.au](http://www.commcarelink.health.gov.au). Referrals should be made directly to the service provider.

### 3.4 Case Management Options

#### 3.4.1 Local Support Co-Ordination

Local Support Coordination is a personal, flexible service that aims to increase the links between people with a disability, their families and their local community. The Local Support Coordinator works with people with a disability to help them determine their own needs, set their own goals, and identify informal and mainstream community supports that will make a difference to their lives.

**Eligibility:** Local Support Coordination is available to people who have an intellectual, physical, neurological, psychiatric or sensory disability and require significant personal help and support. The Local Support Coordinator can be contacted for information, as well as ongoing support and assistance.

**How to Apply/Refer:** Local Support Coordination is available in Western, Southern, Northern and Hunter Regions. Referrals are via the [ADHC Regional Offices](http://www.adhc.health.nsw.gov.au) (click on link).

#### 3.4.2 ADHC funded Case Management and Brokerage Services

ADHC funds a range of NGOs to provide case management and brokerage services to people with a disability (including people with an ABI).

**Eligibility:** Case management services are funded for people with a
disability as defined by the *Disability Services Act (1993)*. However individual NGO services have prioritisation criteria depending on their service capacity. Some NGOs have been funded to provide a case management service to a specific disability group, such as people with an intellectual disability, people with spinal cord injuries, people with Multiple Sclerosis and people with an ABI.

**How to Apply/Refer:** Information about these services can be provided by [ADHC Regional Offices](#) (click on link), however referrals should be made directly to the service provider.

In addition to the general disability case management, ADHC also funds a number of **ABI specific case management, specialised assessment and brokerage services, these include:**

- **Brain Injury Association in NSW: Case Management and Brokerage Service** – Freecall 1800 802 840, Fax: (02) 9868 5619, email: mail@biansw.org.au, website: [www.biansw.org.au](http://www.biansw.org.au)
- **arbias Ltd: arbias ABI Specialised Services NSW** - Ph: (02) 9708 0027, Fax (02) 9793 8002, email: sgrant@arbias.com.au, website [www.arbias.org.au](http://www.arbias.org.au)
- **McCarthur Disability Case Management and Brokerage Service:** Ph: 4620 1400, Fax: 4627 0098, Mobile: 0408 683 345, email: mcop@campbelltown.nsw.gov.au, website: [www.campbelltown.nsw.gov.au](http://www.campbelltown.nsw.gov.au)

This is not an exhaustive list as many general disability case management services also have ABI specialisms. Please refer to the Brain Injury Association’s Service Directory for a more comprehensive list of ABI case management services available [www.biansw.org.au](http://www.biansw.org.au)

### 3.5 Respite Options

#### 3.5.1 ADHC funded Respite Options

ADHC funds a range of NGOs to provide respite services to people with a disability (including people with an ABI). There is a range of respite models available including centre-based respite, flexible/combination respite, host family respite and in home respite.

**Eligibility:** Respite services are funded for people with a disability as defined by the *Disability Services Act (1993)*. However individual NGO services have prioritisation criteria depending on their service capacity. Some NGOs have been funded to provide respite for a specific disability group, such as people with an intellectual disability, people with spinal cord injuries, people with Multiple Sclerosis and people with an ABI.
How to Apply/Refer: Information about these services can be provided by ADHC Regional Offices (click on link), however referrals should be made directly to the service provider.

3.5.2 The National Respite for Carers Program

The National Respite for Carers Program supports carers of older people and those with disabilities to take time out from their caring role.

Phone number: 1800 052 222 or 1800 059 059 (emergency after hours)
Website: commonwealth carelink.

3.5.3 The National Carers Counselling Program

Carers have access to short-term professional counselling and assistance to manage issues such as stress, loss and grief through the National Carers Counselling Program, delivered by Carers Australia.

Contact Carers Australia on the national Freecall number: 1800 242 636.

3.6 ADHC ABI Staff Training

Commencing in February 2011 ADHC is providing ABI Awareness training. The training is aimed at frontline staff, information, referral and intake staff, case managers, service managers and supervisors. The training is being provided by arbias Ltd on behalf of ADHC. To register your interest please contact arbias Ltd by email: training@arbias.com.au

ADHC is also developing a series of web-based e-learning training modules. The e-learning modules include:

- Acquired Brain Injury - Awareness Module
- Acquired Brain Injury - Case Management Module
- Video resources
- Service pathways information
- Resources for individuals and workplaces

A summary of the content of the e-learning and the facilitated workshops resources is now available at: http://www.abistafftraining.info/
APPENDIX 4
Home and Community Care Program (HACC) Options

The HACC Program is a joint Australian, State and Territory Government initiative. In NSW, ADHC is responsible for the administration of the Program, which provides a range of basic maintenance and support services for frail older people, people with a disability and their carers. HACC services help people who would otherwise be prematurely or inappropriately admitted to residential care to live independently in their own home and the community. Services provided through the Program include:

- Home modifications or maintenance – assistance to maintain a person’s home, garden or yard to keep it safe.
- Social support – assistance to meet a person’s need for social contact and participation in community life.
- Transport – practical assistance with group or individual transport needs.
- Domestic assistance and personal care – help with cooking, cleaning, washing, ironing, bathing and dressing.
- Nursing care – support in the management of particular health problems such as diabetes and incontinence.
- Case management – a collaborative and person-focused process for managing support to people with chronic, ongoing or complex conditions or situations.
- Meals and other food services – the preparation and delivery of meals or other food items, which contribute to meeting a person’s daily nutrition requirements.
- Centre-based day care – group activities to assist with social interaction which are conducted in a centre-based setting.
- Respite care – support to carers through the provision of flexible and responsive alternatives to the usual care arrangements.
- Formal linen services – the provision and laundering of linen.
- Goods and equipment – loan or purchase of goods and equipment that help the person with their mobility, communication, personal care or health care.
- Allied health – such as podiatry, physiotherapy, occupational therapy, speech pathology and dietetics.
- Assessment – activities to establish eligibility needs and access to services.
- Client care coordination – the coordination of activities undertaken to facilitate access to HACC services for people who need help to gain access to more than one service.
HACC Services are provided by a range of service providers across the state. Local Government, community and voluntary organisations, religious and charitable organisations, and commercial organisations, as well as State and Territory Government agencies may provide HACC services.

**How to Apply/Refer:** NSW Home Care Services is one provider and takes referrals through a central point, Sydney Metropolitan Areas contact 1800 350 792, Regional and Rural NSW contact 1800 881 144.

Other HACC service providers can be found by contacting Commonwealth Carelink on 1800 052 222 or via [www.ccommcarelink.health.gov.au](http://www.ccommcarelink.health.gov.au)
APPENDIX 5
ABI Rehabilitation Assessments And Interventions

5.1 Members of the rehabilitation team

Allied health intervention can be provided by members of the rehabilitation team, as a sole practitioner or as part of a dedicated service. Allied health intervention is usually goal orientated in one to one sessions, as part of a group and involving family/others when appropriate. The client is a core member of the rehabilitation team. Their family may be involved and included. In circumstances where the client has difficulties with decision making or is unable to participate because of injury sequelae there may also be an identified person responsible or guardian appointed who are included in the rehabilitation team.

There are a range of clinicians who work on the rehabilitation team, each member of the team has a particular specialty and contributes information from their assessments to planning intervention. Some clinicians work on the same goals but with a different focus e.g. client able to safely cross a road requires the physical therapist (physically able) and the occupational therapist (orientation). The members of the team can include:

5.2 Case Managers

Case Managers are usually the primary contact person, with whom individuals can raise issues, express concerns and ask for extra information. There are a number of different case management service models in health and community services so it is important to contact the service and find out how case management operates in the specific organisation. Examples of case management models include:

- direct service case management model
- case monitoring/coordination model
- brokerage (support options) model
- advocacy models (identifying needs and lobbying to ensure they are met)
- managerial models (most common as part of managed care services)

5.3 Neuropsychologists

Neuropsychologists can assess the impact that a brain injury has had on a person’s cognitive abilities, their strengths and weaknesses e.g. memory and thinking. They can explain what problems these changes have on thinking including decision making, planning and organising etc. They may offer ideas on how to manage these changes.
5.4 Nurses

Nurses usually involved with the training and education of families and paid carers as a component of inpatient rehabilitation and transition to home planning. Services from registered nurses may be required following discharge for some tasks eg changing supra pubic catheters (SPC), wound care assessment and treatment. In the community these services are generally available from the local community health centre or from private nursing agencies. Visit www.aciansw.org.au/resources for more information on the tasks that require a registered nurse.

5.5 Occupational Therapists (OT)

OT’s focus on developing and maintaining people’s skills to carry out their everyday occupations such as work/school, self care, leisure and play. The OT will look at how skills may have changed for a person after a traumatic brain injury and then suggests new ways to do things or modified equipment to help a person be independent in that activity. This includes identifying levels of care and support required to complete tasks. Some OT’s will have accreditation to provide driving assessments. Visit the OTNSW website to find out more: www.otnsw.com.au/ot/

5.6 Physiotherapists (PT)

PT’s help maximise physical functioning after a traumatic brain injury. They can assess and treat posture, movement, muscle strength, coordination, balance and stamina. Recommendations are made concerning transferring, walking, and fitness. They can provide advice on splints and walking aids, develop a fitness/mobility plan and provide training to family and care staff training. For more information visit the Physiotherapy Association website: www.physiotherapy.asn.au

5.7 Psychiatrist/ Psychologists

Both psychiatrists and Psychologists work in the area of ABI/TBI, and often work together. There are some significant differences between the two professions in the following areas. Psychologists assist people with everyday problems such as understanding and adjusting to their ABI/TBI or better managing their temper and the impact of behaviours by learning strategies to reduce the consequences of change after ABI/TBI. They help people to develop the skills needed to function better and to prevent ongoing problems. Their treatments are based on changing behaviour and emotional responses without medication. Psychiatrists treat the effects of emotional disturbances on the body and the effects of physical conditions on the mind. They are doctors and can prescribe medication. Some combine medication with other forms of therapy. Both can provide education to the person, families and others about managing behaviour changes. Visit the Australian Psychological Association website to find out more: www.psychology.org.au/community/about/
5.8 Recreation Officers

Recreation Officers can assist to identify potential leisure and recreation pursuits. They may also provide details of appropriate community resources in relation to sport, leisure options, respite and community living. These services are often required as an alternative to employment for people who are not yet ready for vocational rehabilitation or who do not have vocational goals as a result of injury severity.

5.9 Rehabilitation Specialists (Doctors)

Rehabilitation Doctors monitor and treat medical issues following a person’s injury. They usually start working with an individual while they are in the hospital and then provide review after discharge in outpatient clinics. Involvement includes (but not limited to) medication review, liaison with other doctors (specialists and GPs) organising medical tests and medical clearance (e.g. return to work and driving). Rehabilitation Assessment (Brain Injury Specific): This is usually conducted by a Rehabilitation Physician (usually linked to a BIRU or TLU) to review rehabilitation needs and ability to participate in brain injury specific rehabilitation and review clients’ current health status and further health needs that may require intervention.

5.10 Social Workers (SW)

SW’s work within the principals of social justice, enhancement of quality of life and the development of full potential for each individual, group or community in society. They are able to assist people to deal with the emotional and social results of an ABI/TBI. This can include assisting clients and their families adjusting to changes in their lifestyle, relationships, work and leisure activities. This assistance can be in the form of counselling, direct support, advocacy, advice and referral to other services and agencies. They can provide information and support for families and friends to manage the changes experienced by the person and the impact on relationships. For more information visit: info@aaswnsw.com.au

5.11 Speech Pathologists (SP)

Speech Pathologist’s previously called speech therapists they are concerned with the diagnosis management and treatment of individuals who are unable to communicate effectively or who have difficulties with eating and swallowing. This includes assessment and treatment of how a person after an ABI/TBI understands speech, expresses themselves, their reading and writing skills as well as communication with others socially. A Speech Pathologist can assess swallowing and hearing difficulties, trial communication aids and train the person, their staff/family on how to use them. For more information visit: www.speechpathologyaustralia.org.au/information-for-the-public/
5.12 Other Therapeutic Interventions and Assessments

Vocational Rehabilitation and Functional Vocational Assessment: A functional vocational assessment is required to plan vocational rehabilitation for a return to pre-injury employment, for job seeking, to improve skills for vocational opportunities and achieve employment. This is usually carried out by an occupational therapist as part of a specific referral to a vocational service.

Living Skills Assessment: This is a comprehensive assessment to review the impact of cognitive and physical changes for self care and equipment needs, physical abilities for functional activities such as transferring and mobility, physical aspects of personal care, safety and security, ability to be left alone and to occupy time, requirements for accessing the community, money handling skills, identification of leisure and recreation options, awareness/ability to organise own time, use of memory aids such as a diary/checklists and meal planning/preparation. This assessment can be completed by a single therapist (usually Occupational Therapy) or by a multidisciplinary team in the person’s home and community or as part of a residential program in a dedicated unit.

Others include: Counselling, family therapy, rehabilitation psychology, medical tests e.g. sleep studies, orthoptist/ophthalmologist, dietician, group therapy programs e.g. ABI/TBI education & information, exercise physiologist, skill based learning e.g. social communication, memory groups, recreation programs, peer support programs.
APPENDIX 6
Housing NSW Product Options

Housing NSW has a range of products and services available to eligible clients. These products and services broadly fit into two categories:

- **Social Housing** (secure and affordable government subsidised rental housing for people on low incomes with housing needs, including public housing, Aboriginal Housing Office properties and community housing)
- **Private Rental Assistance** (assistance to set up or maintain a tenancy in the private rental market)

Social housing assistance in NSW is provided under a single application system called Housing Pathways. This means there is a common application form and assessment process to access housing assistance from Housing NSW and 27 community housing providers. A single statewide waiting list, called the NSW Housing Register has been created for properties owned by Housing NSW, participating community housing providers and properties owned by the Aboriginal Housing Office. For further information about Housing Pathways and full details of the community housing providers participating in Housing Pathways please visit our website [www.housingpathways.nsw.gov.au](http://www.housingpathways.nsw.gov.au)

Housing NSW does not offer any assistance specifically targeted to clients with ABI, however, clients with ABI who apply for housing assistance will have their disabling condition considered during the assessment process. Following a housing needs assessment, clients with ABI may be eligible for higher levels of assistance (such as a package of private rental assistance, rather than a single product) or may be granted priority for social housing, in recognition of the barriers they may be facing in resolving their own housing need.

Examples of assistance Housing NSW may provide to clients with ABI:

### 6.1 Private Rental Brokerage Service

Housing NSW provides a private rental brokerage service (PRBS), which is available in certain locations across the state. The target group for this type of assistance are eligible clients who are homeless or at risk of homelessness and have a support service and case plan in place. The service aims to assist clients by developing and enhancing their capacity to access the private rental market, with the client directing the process as much as possible to build their confidence and skills. This is achieved by coaching, guiding and supporting the client and developing relationships between local real estate agents/landlords and Housing NSW staff.
6.2 Tenancy Guarantees

A tenancy guarantee of up to $1000 is available to landlords/agents to cover rental arrears and/or property damage over and above the rental bond. The tenancy guarantee encourages private sector landlords and agents to rent properties to people who are having difficulty entering the private rental market. Tenancy guarantees are available in all Housing NSW offices and in nine community housing offices across the state.

6.3 Rentstart

The Rentstart scheme provides a range of financial assistance for eligible clients to help them set up or maintain a tenancy in the private rental market. The type and level of assistance provided is based on the client’s individual circumstances and needs, and is intended to:

- Assist clients to establish or keep a sustainable tenancy in the private sector
- Provide quick financial help with housing related costs to clients in need, particularly those facing homelessness
- Assist current tenants whom Housing NSW has assessed as ineligible for an extension to their public housing lease due to their income and assets, to make the move to private rental accommodation

Rentstart is available in all Housing NSW offices during normal office hours and over the phone from the Housing Contact Centre (Ph 1300HOUSING). Under Housing Pathways, participating community housing providers will facilitate a client’s access to Rentstart. Eligibility criteria applies, see the Private Rental Assistance Policy on the Housing Pathways website.

There are four main types of Rentstart assistance:

- Rentstart standard – basic financial assistance with up to 75% of a rental bond
- Rentstart plus (and Temporary Accommodation) – see below
- Tenancy assistance – assistance to maintain a private tenancy through help with payment of rental arrears
- Rentstart move – basic financial assistance with up to 75% of a rental bond. This is only available to public housing tenants leaving public housing because they are ineligible for a further lease when their current fixed term lease ends

6.3.1 Rentstart Plus

Rentstart plus provides additional assistance for people facing severe financial barriers to private rental accommodation, severe housing stress or who are homeless. Housing NSW will pay:

- Up to 75% of bond, directly to the Rental Bond Board. However, for
some eligible clients in especially high need, 75% of the bond will be insufficient assistance because their particular circumstances have left them without any financial resources. In these cases, Housing NSW may pay up to 100% of the bond

- Up to two weeks advance rent (three weeks for furnished accommodation), or
- Up to four weeks rent in temporary accommodation

Housing NSW may also assist clients moving into accommodation such as caravan parks, boarding houses and hostels. Housing NSW will pay up to 75% of key money or security bonds.

6.3.2 Temporary Accommodation

Under Rentstart plus, Housing NSW may offer payment for temporary accommodation if the client meets the criteria for Rentstart plus, but it would be impractical to assist with private rental accommodation. There are additional requirements if the applicant is a child or young person.

Housing NSW may pay accommodation costs for lower cost accommodation such as caravan parks and motels. Housing NSW will not provide assistance for clients moving into Supported Accommodation Assistance Program (SAAP) funded properties. However, it can be paid to assist clients who are moving out of SAAP funded properties.

6.4 Social Housing

Social housing provides secure, affordable housing for people with a housing need on low incomes. Social housing is subsidised by the Government and encompasses both public and community housing owned or managed by Housing NSW, the Aboriginal Housing Office and community housing providers.

To ensure that social housing assists clients who are most in need, the eligibility criteria for social housing concentrates on assisting:

- Clients on low income that need support to help them live independently, and
- Clients on low income that have problems finding affordable housing in the private market that is suited to their needs.

For more information on social housing, see the Housing Assistance Options Policy on the Housing Pathways website www.housingpathways.nsw.gov.au

6.4.1 Priority Housing Assistance

Priority housing aims to meet the urgent housing needs of applicants who require long-term housing assistance.

To be eligible for priority housing, applicants must meet all three of the following criteria:
1. Eligible for social housing, and
2. In urgent need of housing, and
3. Unable to resolve that need themselves in the private rental market.

For more information on eligibility for priority housing, see Eligibility for priority housing – urgent housing needs on the Housing Pathways website.

### 6.4.2 Private Rental Subsidy

A private rental subsidy contributes to the cost of a client’s weekly rent in private rental accommodation. The amount of rent a client actually pays is similar to the amount they would pay as a tenant of Housing NSW. The subsidy is available from Housing NSW for clients who meet the eligibility criteria and may provide:

- Choice between private rental accommodation and social housing, and
- Mobility within and between these options, or
- Access to affordable accommodation while waiting for a suitable social housing home, or
- Access to affordable accommodation for up to 12 months.

For more information on private rental assistance, see the Private Rental Assistance Policy

Further detail on the types of products and services Housing NSW offer is available on the website www.housingpathways.nsw.gov.au
APPENDIX 7
Mental Health Program Options

Throughout 2011 NSW Health will be progressively establishing a state-wide mental health intake service (1800 011 511) called the Mental Health Line. This line will provide a free 24-hour service staffed by qualified mental health clinicians who can help consumers, their carers and the wider community link to appropriate local mental health services for follow up and treatment.

7.1 Mental Health - 24 hour Telephone Contacts

- **Northern Sydney Central Coast Area Health Service:** 1800 011 511
- **South Eastern Sydney and Illawarra Area Health Service:**
  South Eastern Sydney: 1300 300 180
  Illawarra: 1300 552 289
- **Sydney South West Area Health Service:** 1800 011 511
- **Sydney West Area Health Service:** 1800 650 749
- **Greater Southern Area Health Service:**
  Western (former Greater Murray): 1800 800 944
  Eastern (former Southern): 1800 677 114
- **Greater Western Area Health Service:**
  Central and Far West: 1800 011 511
- **Hunter New England Area Health Service:**
  Hunter: 1800 655 085
  New England: 1300 669 757
- **North Coast Area Health Service:** 1300 369 968

Mental Health Services provide a whole of life response to the provision of mental health treatment, community support, recovery and ongoing core programs with a focus on those people with severe and persistent mental illness. Services are provided across community and inpatient and links to other service providers across the private and non-government sectors. For particular responses and services referral should be discussed with local Area Health Services.

7.2 Other Mental Health Programs and Services

7.2.1 Early Psychosis Program

Early psychosis services have been established in metropolitan Area Health Services and increasingly in rural NSW. Evidence shows that preventing and intervening early for young people who are developing psychosis can dramatically improve outcomes. Early intervention can lessen disability and disruption to school or work for the young person, lower the risk of relapse, and reduce family disruption and distress.
7.2.2 NSW Family and Carer Mental Health Program

This initiative explicitly recognises the need for families’ and carers’ participation. Under this program, mental health services facilitate family and carer involvement in consumer assessment, treatment and intervention (where appropriate) and supports family and carer roles in local mechanisms for systemic participation. The program focuses on the delivery of:

- **Family friendly mental health services** - supporting and training staff to include explicitly families and carers in the service system and be responsive to their unique needs.
- **Mental health family and carer support programs** - direct support services delivered through NGOs that provide education and training to build coping skills and resilience, individual support and advocacy, infrastructure support for peer support groups.
- Improved access to generic family and carer supports.

7.2.3 Programs and Initiatives for Children, Adolescents and Families

NSW Health via MH-Kids, the policy and planning unit for child and adolescent mental health in NSW, is responsible for the following programs and initiatives:

- NSW Children of Parents with a mental illness (COPMI) program
- Parenting Program for Mental health
- Safe Start
- School-Link

For more information please click on the link: [Programs and Initiatives for Children, Adolescents and Families](#)

7.2.4 Recovery and Resource Services Program (RRSP)

The RRSP is designed to increase the capacity of NGOs to provide support and access to quality mainstream community social, leisure and recreation opportunities and vocational and educational services for people with a mental illness, based on the best available evidence and practices. It is an integral part of the continuum of care provided by Area Mental Health Services (AMHS).

7.2.5 Specialist Mental Health Services For Older People (SMHSOP)

Each Area Mental Health Service in NSW has a Specialist Mental Health Services for Older People (SMHSOP) clinical service component comprising staff that have the specialist clinical knowledge and skills to manage the complex mental health issues presenting in older people across a range of service settings. These specialist services are delivered by old age psychiatrists, specialist psycho-geriatric nurses and allied
health professionals such as psychologists, occupational therapists and social workers with expertise in mental health problems affecting older people. SMHSOP services include the following service types:

- Specialist community-based services;
- Acute inpatient services;
- Non-acute inpatient services;
- Residential or long-term care services, which may be delivered through partnerships with aged care providers, and
- Specialist staff and programs for people with moderate-severe, persistent behavioural and psychological symptoms associated with dementia and/or mental illness.

A program of service development is underway to expand the range and capacity of SMHSOP services in each Area Health Service. MHSOP clinical functions include:

- Specialist clinical assessment and treatment;
- Consultation/liaison with other key services and health care providers;
- Capacity building with other key services;
- Joint care planning and case management with general practitioners (GPs) and other health care providers, and
- Mental health promotion, prevention and early intervention programs.

7.2.6 Vocational Education, Training and Employment (MH-VETE) Program

The Mental Health Vocational Education Training Employment (MH-VETE) program is designed to work with consumers and services to ensure there is a coordinated pathway and targeted plan to address consumer education and employment needs.

7.2.7 Youth Mental Health Services

The Youth Mental Health Services Model has been developed to meet the needs of young people aged 14 to 24 years by increasing early access to mental health services. In line with the NSW Community Mental Health Strategy 2007-2012, the Youth Mental Health Services Model promotes enhancing awareness of mental health across the community, stakeholder groups and service networks.

The focus of the model is on early intervention and prevention with flexible approaches to service provision, and access as early as possible to a range of health services relevant to young people. These services will provide evidence-based intervention at the early stages of mental illness. They will bring together specialist youth mental health services, general practitioners, drug and alcohol workers and other relevant services.
Through a pilot program, the Central Coast Young People’s Mental Health Service has developed a prototype Youth Mental Health Services Model in Gosford, called ycentral and a set of agreed principles for development of youth mental health services across NSW.

7.2.8 Housing and Accommodation Support Initiative (HASI)

HASI is a major partnership program jointly funded by NSW Health and the Department of Housing and operated at local levels between NGOs, Area Mental Health Services and Housing services. It provides stable and secure accommodation linked to clinical and psychosocial rehabilitation services for people with a mental illness or disorder and a range of levels of psychiatric disability.

The initiative is designed with a recovery focus to assist people with a mental illness or disorder requiring accommodation support to participate in the community, maintain successful tenancies, and improve their quality of life.
APPENDIX 8
Drug and Alcohol Referral Options

8.1 Drug and Alcohol Support Telephone Contacts

Greater Southern Area Health Service
- Accessline West - 1800 800 944
- Accessline East - 1800 809 423
- Alcohol and Drug Information Service (ADIS) - 1800 422 599 - for information, referral and counselling 24 hours a day
- Family Drug Support - 1300 368 186
- Controlled Drinking by Correspondence Course - 1800 006 577
- Online D&A Counselling services www.counsellingonline.org.au

Greater Western Area Health Service
- Drug & Alcohol Helpline - 1300 887 000
- Cannabis HelpLine - 1300 663 098

North Coast Area Health Service
- Northern Rivers Area - Drug Help Line - (02) 6620 7612
- Mid North Coast - 1300 662 263 during business hours
- Alcoholics Anonymous (AA) - (02) 6686 8599
- Alateen - (02) 6680 8456
- Narcotics Anonymous (NA) - (02) 6687 2290
- Family Drug Support - 1300 368 186

Hunter New England Area Health Service
- Central Intake - Northern Region - 1300 660 059
- Central Intake - Southern Region - (02) 4923 2060
- Alcohol & Drug Unit, Calvary Mater Hospital - (02) 4014 4796
- Lakeview Withdrawal Services - Belmont Hospital - (02) 4923 2060
- Opioid Treatment Program N.C.H.C. - (02) 4016 4514
- Stimulant Treatment Program - (02) 4923 6776
- Cannabis Clinic - (02) 4923 6760

Sydney South West Area Health Service
- Alcohol and Drug Information Service - 1800 422 599
- Withdrawal service 02 9767 8600

Sydney West Area Health Service
- Alcohol and Drug Information Service - Sydney (02) 9361 8000 - country 1800 422 599
- Western cluster 02 4734 1333
- Eastern Cluster 02 9840 3355
South Eastern Sydney and Illawarra Area Health Service

- Alcohol and Drug Information Service - Sydney (02) 9361 8000 - country - 1800 422 599
- Central network: 1300 652 226

Northern Sydney Central Coast Area Health Service

- Alcohol and Drug Information Service - (02) 9361 8000 or 1800 422 599

8.2 Other NSW Health Drug and Alcohol Initiatives

8.2.1 Adult Drug Court

The Adult Drug Court is a specialised court, operating under the Drug Court Act 1998 with the aim of breaking the cycle of drug dependency, criminal activity and imprisonment. The Court targets drug-dependent adult offenders who are facing a custodial sentence and offers the option of drug treatment while on parole or probation. The system works with close cooperation between the Department of Health, Justice Health, two Area Health Services and a range of NGOs which assist in providing drug treatment including residential rehab. The court operates from the Parramatta Court complex further information can be found at: http://www.lawlink.nsw.gov.au/Lawlink/drug_court/l_drugcourt.nsf/pages/adrgcrt_aboutus

8.2.2 Cannabis Clinics

Dedicated cannabis clinics are located at Parramatta, the Central Coast, Bathurst/Orange, Sutherland, Newcastle and the North Coast. The clinics have been set up to stand apart from the mainstream drug and alcohol treatment services and provide intensive clinical interventions and treatment to dependent cannabis users with complex needs, including clients with mental health issues. Further aims of the clinics are to reduce the health, social and legal problems and risk of harm associated with cannabis use, and to assist people using cannabis who want to become abstinent.

8.2.3 Community Drug Action

Community Drug Action Teams (CDATs) are community groups supported by the Government to increase and improve general community awareness about drugs and to help communities develop their own responses to local drug problems. These projects are practical and creative, reflecting the different needs and culture of the communities for which they were developed. The ‘Community drug action’ section of communitybuilders.nsw provides information resources and support for Community Drug Action Teams to undertake their work and showcase projects.
8.2.4 Co-Exist (Multicultural state-wide co-morbidity referral program)

Co-Exist is a multicultural co-morbidity service for people from culturally and linguistically diverse communities. The service caters for clients with chronic illness, mental illness, drug and alcohol-related issues, gambling problems and overuse of prescribed medications.


8.2.5 Consultation-Liaison (CL)

Consultation-Liaison is designed to ensure that medical and nursing staff can obtain appropriate advice when they encounter patients who have problems arising from misuse of drugs and alcohol.

CL services operate in the Greater Southern, the Greater Western, Sydney South West, and the Hunter/New England Area Health Services, and also at the Children's Hospital.

8.2.6 Drug info @ your library

Drug info @ your library provides up to date information about alcohol and drugs through local public libraries in New South Wales. It is a joint initiative between NSW Health and the State Library of NSW. Web resources and public library collections are selected and regularly updated by specialist staff at the State Library of New South Wales in consultation with experts in the field.

8.2.7 MERIT

The MERIT program is a court based diversion program that allows arrested defendants with illicit drug use problems to be assessed for suitability to undertake treatment and rehabilitation under bail conditions. As a result of that assessment, Magistrates can bail defendants to attend dedicated drug treatment services created through specific MERIT program funding. MERIT is available in more than 60 local courts across all eight Area Health Services.

8.2.8 Opioid Treatment Program (OTP)

The NSW Opioid Treatment Program (OTP) seeks to reduce the social, economic and health harms associated with opioid use. The OTP delivers pharmacotherapy and associated services to opioid dependent patients in NSW through the public sector (including Justice Health), and private sector (private clinics, general practitioners, psychiatrists and pharmacies). There are currently three types of opioid treatment pharmacotherapy available in NSW: methadone, buprenorphine and buprenorphine-naloxone.
8.2.9 Stimulant Treatment Clinics
NSW Health funds a stimulant treatment program on a trial basis at two clinics. One clinic is located at the Wesley Mission in Newcastle West and the other is at St Vincent’s Hospital, Darlinghurst. The clinics provide a range of services to stimulant users within a stepped care framework to match the special needs of each patient. The clinics operate from 8am to 4.30pm Monday to Friday. Contact phone numbers for both clinics are: (02) 9361 8088 (metro) 1800 101 188 (regional/rural).

8.2.10 Youth Drug and Alcohol Court
The Youth Drug and Alcohol Court is a trial program that operates within the NSW Children’s Court system. The program provides young offenders with drug and/or alcohol problems with case management and drug treatment services while under judicial supervision. Sentencing is deferred while the young person participates in the program, which can last up to 12 months. The program is only available to residents of Sydney, with regular court sittings at Bidura, Parramatta and Campbelltown Children’s Courts.

Contact details for of these services in each Area Health Service can be found by calling the relevant AHS intake number or information service as stated above.

8.2.11 Justice Health Connections Project
The Justice Health Connections Project is a state wide service for adults in Correctional Centres in NSW preparing for release, who have a history of problematic drug use. Connections provides comprehensive pre-release assessment and care planning in relation to health, financial, education/employment, family and children, accommodation and a range of other issues. The project assists the individual with the transition to the community, through practical assistance e.g. obtaining Medicare cards and other identification, and assistance in accessing and engaging with services in the community. Connections provides additional assistance to those who have complex needs such as mental health concerns, cognitive impairment and those who have served long custodial sentences. The Connections Project can be contacted on (02) 9811 0100.
APPENDIX 9
Lifetime Care And Support Scheme

The Lifetime Care and Support Authority is a NSW state government statutory corporation established by the Motor Accidents [Lifetime Care and Support] Act 2006. The Authority is funded by a levy on compulsory third party insurance premiums paid by motorists registering their vehicles in NSW via their Green Slips.

The Authority has established the LTCS Scheme to manage the provision of reasonable and necessary treatment, rehabilitation and attendant care for eligible people. The LTCS Guidelines set out the eligibility criteria and establish the types of services usually provided by the Scheme. The Scheme is “no-fault” and people may be eligible regardless of their role in the motor accident. Services are provided for eligible people for their lifetime. Service provision is based on an assessment of individual need.

Amendments to the Act in 2009 included a ‘buy-in’ provision to allow a person injured in a motor accident before the commencement of the Scheme to become a participant. An injured person may ‘buy-in’ if they meet the eligibility criteria and pay an amount determined by the Authority to fund the future treatment and care needs of the injured person. Buying into the Scheme is voluntary.

Anyone severely injured in a motor accident in NSW on or after 1 October 2007 may make an application to the Lifetime Care and Support Authority. Children aged under 16 years injured in a motor accident in NSW on or after 1 October 2006 can also apply.

To be eligible for the Lifetime Care and Support Scheme, one of the following severe injuries must have occurred as a result of a motor accident:

- moderate to severe brain injury
- spinal cord injury
- severe burns
- multiple amputations
- permanent blindness

The Authority has a growing presence in the disability service sector. It is establishing a range of contracts for services, providing specific funding for the development of services and funding targeted at research activities.

For more information please visit the Lifetime Care and Support Authority Website http://www.lifetimecare.nsw.gov.au/index.aspx

General phone enquiries: 1300 738 586
Fax: 1300 738 583
Email: enquiries@lifetimecare.nsw.gov.au
APPENDIX 10
Corrective Services NSW (CSNSW)

10.1 Statewide Disability Services (SDS)
As part of the Offender Management Division, the specialist SDS unit provides a number of services to meet the additional support needs of offenders with disabilities under the management of CSNSW in custody and the community. Services include:
- specialist disability advice and consultation to staff and external stakeholders
- identification and assessment of offenders
- development of policies, procedural guidelines and directives to facilitate the integrated delivery of services and programs
- preparation of referrals to Ageing, Disability and Home Care and other agencies
- sourcing and provision of equipment for offenders with physical or sensory disabilities
- state-wide training of staff.

10.1.2 Neuropsychologists in SDS
SDS has two Neuropsychologists who undertake assessments where an offender is suspected of having an ABI or Dementia. The primary focus of these assessments is to determine suitability to undertake programs and issues pertaining to the management of individual offenders in custody or the community.

10.2 Additional Support Units (ASUs)
CSNSW has four ASUs that accommodate offenders who, because of their disability, require placement outside the mainstream correctional environment for assessment, general management, or to participate in specific programs to address offending behaviours. Staff within the ASUs liaise extensively with external service providers to ensure offenders have access to appropriate support services within their local community once released from custody.

10.3 Community Based Management
CSNSW supervises all offenders serving community based orders, using case management principles. Intervention aims to assist offenders make appropriate changes in order to reduce the likelihood of re-offending. All case plans incorporate responsivity factors, including disability. Case management includes individual and group work programs, surveillance and monitoring, and drug testing. Supervising officers also refer offenders to relevant Human Service, Criminal Justice and non-government agencies.
and continue to liaise with these agencies once the offender has engaged with services.

CSNSW also provides support and interim accommodation for those offenders under community supervision or parole or probation. These are called Community Offender Support Program Centres (COSPs). There are 5 across the state including one at Bundaleer in Windsor which offers priority placement to residents with an intellectual disability, mental health problem, ABI or dual diagnosis.

CSNSW also has a number of special projects to assist offenders with complex needs including the Co-existing Disorders Project which aims to improve awareness, management and pathways for offenders with dual drug, disability (including ABI) and/or mental health problems to access Human Services. The Parolee Support Initiative provides low-high support to supervised parolees with dual mental health and disabilities who are at risk of homelessness. The Targeted Housing Support Project for Ex-Prisoners aims to achieve a reduction in the rates of homelessness and a reduction in rates of re-offending for ex-prisoners with complex needs (including ABI). Eligible ex-prisoners are assisted to integrate back into the community by providing stable, comfortable and secure housing with sustained support services which specifically address their social and criminogenic needs.

10.4 Information and Referrals to SDS

If you have a client, friend or family member that has a disability, is in custody or under the management of Community Offender Services, and would benefit from specialist assistance, please contact SDS on (02) 9289 2136 or via email at SDS@dcs.nsw.gov.au, Website: http://www.correctiveservices.nsw.gov.au/offender_management (click on link)
APPENDIX 11
Other Services

11.1 ABI Services NSW

ABI Services NSW values are Respect; Integrity; Equality; Trust; Inclusiveness; Honesty; Commitment. Their mission is to provide a specialist support service which maximises the ability of individuals who have an acquired brain injury, to live in their own homes, participate to their fullest extent in their local community and be a respected valuable member of society.

ABI Services NSW do this by maintaining and promoting independence and providing opportunities for socialisation and community integration with quality service provision. As brain injury is individualised our support is tailored to suit each person’s individual needs and choices in everyday living situations in their home and local community.

ABI Services NSW are a not for profit specialist service for people with an acquired brain injury which has been operational since 1986. We were formally known as Wareemba Community Living. Our Management Team and Community Support Workers bring extensive experience and knowledge of working with people with an acquired brain injury.

ABI Services NSW provide:

- Individually tailored support to meet the unique needs of our clients identifying short and long term goals
- Recreational activities on an individual and group basis
- Case Co-ordination and Case Management
- 24 hour operation with on call facility for crisis management and emergencies
- Specialist Supported Accommodation (Bathurst)

**Eligibility:** People with an acquired brain injury, aged between 14 years to 65 years at time of referral. Clients eligible for service provision must have funding from either an Attendant Care Package, other source of individual funding from ADHC, Lifetime Care and Support Scheme acceptance, Compensation Settlement or Insurance Company approval.

**Service Coverage:** All areas in the greater Sydney Metropolitan area, Central West of NSW covering Bathurst, Orange, Parkes, Cowra and Dubbo.

**Contact:** Phone: 02 9649.7299, email Kerry Stafford, Executive Director kstafford@wcl.org.au. For more information visit us at www.wcl.org.au, or email us at info@wcl.org.au
11.2 arbias ABI Specialist Services

arbias ABI Specialist Services provides case management, specialised assessment and intervention to people with an ABI in NSW. The service includes:

- intake and response
- home visit
- case management
- access to specialised assessment and intervention
- monitoring and review

**Eligibility:** People aged 16-65 years who have a significant brain injury (including dual diagnosis with mental health, drug and alcohol issues) who have complex support needs.

**Service Coverage:** The service commenced in October 2010 covering metropolitan Sydney areas. However the service aims to expand to provide state-wide support throughout 2011.

**Funding:** The service is funded by ADHC and is available free of charge to people who do not have other compensation payments. arbias Ltd can also provide services to compensable clients for a fee.

**Contact:** For more information please contact arbias on (02) 9708 0027, fax: (02) 9793 8002, email sgrant@arbias.com.au, website www.arbias.org.au

**Training:** arbias Ltd will also provide a series of ABI training sessions on ABI awareness and case management from May 2011. For more information and to register your interest, please contact arbias Ltd at email: training@arbias.com.au

11.3 ReNew Neurobehavioural Services

ReNew offers a new model of neurobehavioural rehabilitation and services for people with an ABI living in Australia. Adopting the approach used by the Brain Injury Rehabilitation Trust (BIRT) in the UK, it provides a continuum of assessment, rehabilitation and ongoing support in a community setting. ReNew is a non-profit joint venture between the EW Tipping Foundation and Rehabilitation Australia. ReNew supports people to regain the functional and social skills they need to live as independently as possible.

Research carried out in the UK shows that the neurobehavioural approach achieves highly successful outcomes for people with an ABI. This includes a significant reduction in aggression from admission to discharge, reducing the level of direct supervision required, enabling people to engage in productive activity and significant savings in care costs over time. The neurobehavioural approach is delivered by a multi-skilled, inter-disciplinary clinical team including Senior Neuropsychologist/
Clinical Psychologist, psychologists, speech and language therapists, physiotherapists and occupational therapists as well as Rehabilitation Support Workers.

**ReNew Services NSW:** Outreach neurobehavioural services are available in NSW following referral on a case by case basis, depending on the needs of the person. Furthermore, an assessment and rehabilitation facility is currently being developed in Sydney.

**Service Eligibility:** adults aged 18 – 65 years with an ABI who have complex needs requiring a high level of support; show behaviours of concern; may be at risk of their current living arrangement breaking down; are ready for discharge from hospital but would benefit from some community based rehabilitation to increase their independence; have the potential to improve their functional skills and level of independence; and would benefit from specialist ongoing support in their own environment.

**Funding:** ReNew is self funded and therefore relies on a fee for service. Fees will depend on the nature and duration of service intervention.

**Referrals and information:** Referrals can be made by individuals and service providers and are followed up by pre-admission screens to determine if admission would be of benefit to the person as well as the goals of rehabilitation.

**Contact:** Rashmi Sharma, Ph: 0403 412 224, or Rowan Cockerill, Ph: 03 9564 1000, email info@renewservices.org.au, website www.renewservices.org.au/

### 11.4 Private Case Management Services

Private case management services generally provide a comprehensive range of rehabilitation and consultancy services that are cost-effective and responsive to the needs of people with acquired brain injury, their families, insurers and government and community organisations. For more information contact any of the following:

- All About Rehabilitation, Ph: (02) 4633 9999

### 11.5 Community Participation Programs

**www.headwayadp.org.au**

**Headway Adult Development Program** is a community access service located in Bankstown. They offer individual support and group programs for people with an ABI.

**www.headway.org.au**

**Headway** is a community access service located in the Illawarra area. They offer individual support and group programs for people with an ABI.
HeadEast is a community based service for people with an acquired brain injury (ABI) and their families, living in the Eastern Sydney area. They offer individual support and group programs for people with an ABI.

11.6 Vocational Services

Breakthru Employment Solutions provides vocational rehabilitation services and personal support programmes for people with a disability.

CRS Australia delivers vocational rehabilitation services to assist people who have a disability or injury to get a job or return to their job.