ACQUIRED BRAIN INJURY IRELAND

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
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The role of Acquired Brain Injury case managers in the rehabilitation pathway in Ireland

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DEDICATION

This report is dedicated to the memory of Peter Bradley.

The story of Acquired Brain Injury Ireland, and its mission to passionately serve and empower people impacted by brain injury, is intrinsically linked to Peter.

His sister, Barbara O'Connell, and her husband Maurice founded the organisation in 2000 to address the gaps in community neuro-rehabilitation services for people with an acquired brain injury. It evolved from Barbara's work to develop a rehabilitation pathway for her brother, to empower him to live a full life and work towards a meaningful future. She was the organisation's first CEO.

Peter's generous donation to Acquired Brain Injury Ireland made this research possible. His life fundamentally changed the landscape of neuro-rehabilitation in Ireland and his legacy continues to live through the work of the organisation every day.

Acquired Brain Injury Ireland owes him a debt of gratitude.

Thank you Peter, the Bradley and O'Connell families.

INTRODUCTION

Acquired brain injury (ABI) case management (CM) is a complex intervention forming part of an integrated care strategy. ABI case managers act as guides for patients and their family members in identifying and accessing appropriate healthcare, social care, and other services.[1,2] While the value of case management is widely recognised by experts, evidence from the scientific literature on the efficacy and impact of ABI case management programmes is scarce, and where it is available, is mixed and highly dependent on the nature of the case management intervention itself and on the research methodology employed in a given study.[2–5] Lukersmith and colleagues maintain that "the significant terminological variance, lack of understanding and a common language for case management and care coordination has impeded quality analysis, policy and planning".[1] The definition and therefore also the evaluation of ABI case management interventions are thus highly context-specific and complex.

In Ireland, case management is recognised as an integral component of the model of care for the provision of specialist rehabilitation services.[6,7] Despite recognition of the value of case management, a lack of adequate public investment and political will historically has obstructed full implementation of the *National Strategy & Policy for the Provision of Neuro-Rehabilitation in Ireland: From Theory to Action*. *Implementation Framework 2019-2021* and results in continued fragmentation of services for people with ABI.[8]

This research study was commissioned by Acquired Brain Injury Ireland (ABI Ireland) and carried out by researchers at the Centre for Health Policy and Management, Trinity College Dublin School of Medicine. The study set out to define the role of ABI case managers as part of the rehabilitation pathway for people with ABIs in the Irish context, and the scope and depth of their interactions with interdisciplinary professional groups operating within rehabilitation services. A first phase of the study, the subject of this technical report, comprises a qualitative component involving a narrative review of the international conceptual and empirical literature related to ABI case management, and a series of focus groups with ABI case managers and interdisciplinary rehabilitation professionals. A later phase of the research study will apply a health economics perspective to analyse the costs and benefits of ABI case management within the Irish neuro-rehabilitation system.

Research aim and objectives

The overarching aim of the qualitative phase of this research study was to examine the role of the ABI case manager and their contribution to the rehabilitation pathway within Ireland's healthcare system.

Specifically, the objectives of this phase of the study were to:

1. Define the role and scope of the ABI case manager and their specific input into the service users' rehabilitation pathway;
2. Map out the scope and span of the relationships with various key stakeholders;
3. Understand the evolution of the case manager role in ABI Ireland in the context of being a specialist role.

Acquired Brain Injury – the policy context

Ireland ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2018, committing to the promotion, protection and full realisation of the rights of persons with disabilities, including the right to habilitation and rehabilitation outlined in Article 26.[9,10] This article calls on states to organise and strengthen comprehensive, person-centred services that support individuals in achieving maximum independence and full participation in all aspects of life.[10] In line with this international obligation and anticipating Ireland's ratification, in 2011 the Department of Health and the Health Service Executive (HSE) published the National Policy and

Strategy for the Provision of Neuro-Rehabilitation Services in Ireland 2011–2015.[7] It proposed a national model for neuro-rehabilitation that would ensure access to services across four tiers: primary care, community-based teams, regional services, and national specialist centres.[7]

Despite the publication of the strategy in 2011, implementation was delayed and continues to be inconsistent fourteen years later.[8] In 2019, the HSE published an implementation roadmap to provide a structured plan for operationalising the strategy.[6] This document acknowledged that services remained underdeveloped, often fragmented, and heavily reliant on voluntary sector provision. It noted persistent gaps across the rehabilitation pathway, from acute care to community supports, and highlighted the absence of dedicated funding, governance structures and data systems as barriers to progress.[6]

The neuro-rehabilitation policy context is also informed by wider health reform efforts, including Sláintecare[11] and the National Trauma Strategy.[12] Both initiatives stress the need for equitable, integrated care, and the alignment of rehabilitation with these goals has been noted in policy documents and implementation plans.[8] Nonetheless, ongoing challenges include the limited availability of specialist services, significant geographical variation, and insufficient system-wide coordination. Effective implementation of the neuro-rehabilitation framework continues to depend on persistent policy attention, inter-agency and cross-sectoral collaboration, and investment in infrastructure and workforce capacity.

ABI Ireland case management service

ABI Ireland's case managers are skilled professionals trained to guide and support brain injury survivors and their families over the course of their rehabilitation and recovery. Their primary goal is to ensure that people with complex care and support needs are supported to live independent lives to the extent possible and desirable.[13] Case management can begin at any point following injury, during acute hospitalisation, in post-acute settings, or even years after the initial injury, depending on the individual's needs. In general terms, they connect the person with brain injury to a range of services delivered in a variety of settings, including hospital, community rehabilitation, and transitional living accommodation. Case managers provide information and guidance to individuals and families about ABI, engage with hospital and rehabilitation services, and liaise with the HSE Disability Services where appropriate. They support access to relevant health and social services, including occupational therapy, psychology, speech and language therapy, and day rehabilitation programmes, and assist with navigating social welfare entitlements, housing supports and respite options.[13] ABI case managers play a critical function in preventing often lengthy and unnecessary stays in hospital and inappropriate placement in nursing homes for people recovering from brain injury.

ABI Ireland currently employs nine case managers who provide case management services in 12 counties in Ireland: Cavan, Cork, Dublin, Kildare, Laois, Longford, Louth, Meath, Monaghan, Offaly, Westmeath, and Wicklow (see Table 1). Despite growth of the case management service in recent years, there are significant gaps in service coverage, with residents with neuro-rehabilitation and support needs in the majority of counties unable to access the service.[14]

Two ABI case management service models

There are two models of case management in operation. In the first model, ABI Ireland retains full operational control. Referrals are managed internally, decisions regarding ABI Ireland service eligibility are made by the organisation, and case records are held on ABI Ireland's database. In the second model, case management is delivered as a function of the local HSE Physical and Sensory Disability Team. In this arrangement, the case manager is based within the HSE team, referrals are made through HSE channels, and documentation is integrated into the HSE system. In the latter model, the ABI case manager does not have full autonomy over service access decisions.[13]

Eligibility for the service generally includes adults aged 18 to 65 with a non-progressive ABI who have the capacity to benefit from case management and who consent to engagement. The duration and intensity of case management support varies, depending on individual needs and local resource availability.[13]

Table 1. Active ABI case managers by Community Health Organisation (CHO), counties covered, service model, and Whole Time Equivalent (WTE)

CHO	COUNTIES COVERED	SERVICE MODEL	ABI CASE MANAGER WTE
1	Cavan, Monaghan	HSE model	0.8 WTE
5	Waterford, Wexford	ABI Ireland	0.5 WTE
6	Wicklow, Dublin South East	ABI Ireland	0.5 WTE
7	Kildare, West Wicklow, Dublin West, Dublin South City, Dublin South West	ABI Ireland	0.5 WTE
8	Laois, Offaly, Longford, Westmeath	ABI Ireland	1.0 WTE
8	Meath	HSE model	1.5 WTE
8	Louth	HSE model	1.0 WTE
9	Dublin North, Dublin North Central, Dublin North West	ABI Ireland	0.5 WTE

Note: The following counties do not currently offer ABI case management services: CHO 1: Donegal, Sligo, Leitrim; CHO 2: Galway, Roscommon, Mayo; CHO 3: Limerick, Clare, North Tipperary; CHO 4: Kerry, Cork; CHO 5: South Tipperary, Carlow, Kilkenny.

REVIEWING THE LITERATURE ON ABI CASE MANAGEMENT

Case management (CM) emerged internationally as a key strategy within efforts to deliver integrated, coordinated care for individuals with complex and chronic needs. Initially developed in response to the movement to deinstitutionalise health and social care services, CM has evolved into a flexible, cross-sectoral role that operates across fragmented health and social systems to ensure more person-centred, continuous support. In Australia, Lukersmith and colleagues highlight the considerable variability in CM definitions and functions across different contexts.[15] Their scoping review positions CM as a mobile, holistic, and person-centred model of support that is shaped by funding structures, workforce configurations, and the complexity of individual needs. CM is seen as essential for enabling both vertical integration (across levels of care) and horizontal integration (across sectors such as health, social care, housing, and education).[15]

To address the lack of consistency in CM terminology and reporting, the same Australian research team developed the Brain Injury Case Management Taxonomy (BICM-T), a classification system outlining core intervention domains including holistic assessment, coordination, emotional support, education, and advocacy.[1] The taxonomy is intended to improve communication, policy development, and evaluation by providing a shared language for describing CM interventions in ABI contexts. Genrich and Neatherlin, writing in the United States of America (USA), similarly note the lack of standardisation in CM education, qualifications, and competencies, even as the role has become more central to integrated care delivery.[16] They emphasise that CM emerged as a response to policy shifts prioritising cost containment and efficient care coordination. Across settings then, CM is widely viewed as a mechanism for improving continuity of care and supporting system navigation, particularly for individuals with complex, ongoing needs.

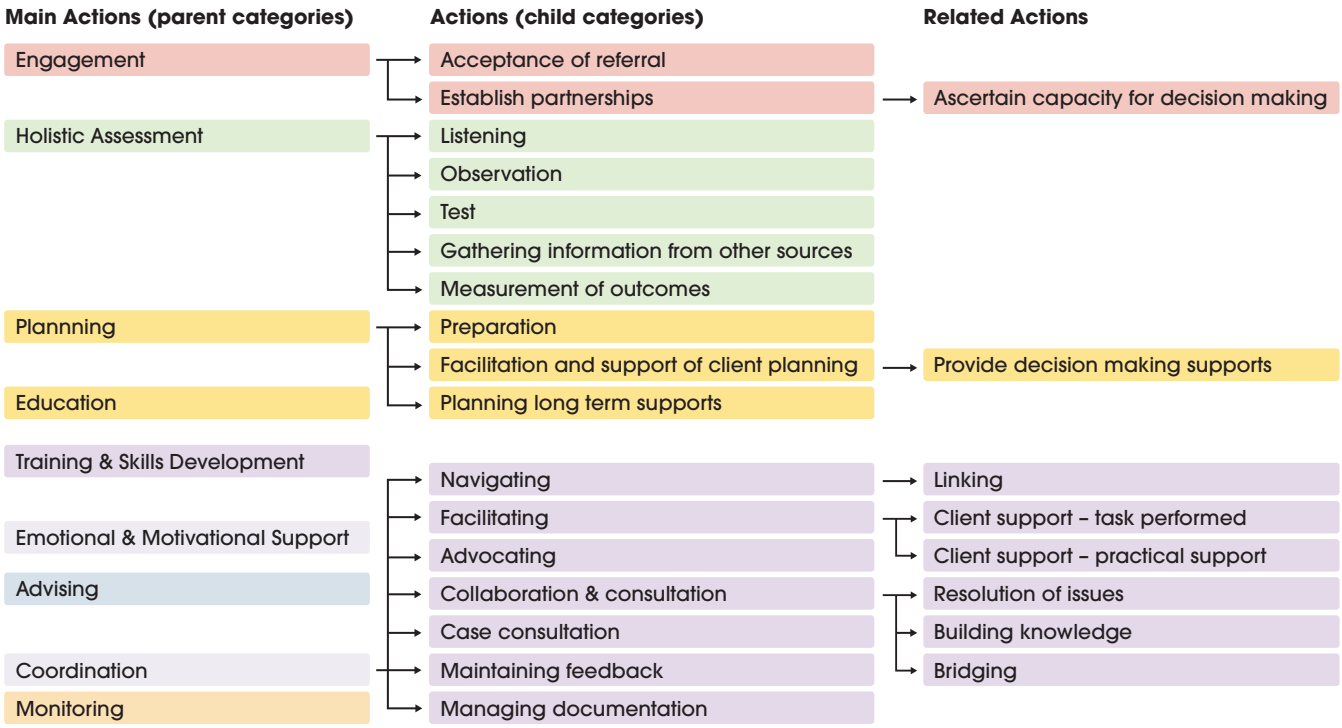
Definitions and models of ABI case management

Definitions of ABI CM from the literature tend to converge around a shared set of functions, which include assessment, planning, coordination and monitoring, though the scope, level of formalisation, and point of entry can differ.

Lukersmith et al. define community-based ABI case management as a multidimensional and collaborative process designed to support health, functioning, and participation.[1] Their Brain Injury Case Management Taxonomy (BICM-T) (see Figure 1) recognises that CM interventions must be flexible and responsive to changes over time, reflecting the dynamic nature of ABI recovery. A systematic review of the evidence by Leonard and colleagues finds ABI case managers described as advocates and coordinators who must navigate fragmented service systems on behalf of clients experiencing cognitive and behavioural impairments that make self-management difficult.[3] They highlight the importance of specialist expertise and long-term engagement. A scoping review by Young et al. maps the limited literature on community-based CM for children and adolescents.[17] The review identifies the return to school and adjustment to family life as key transition points requiring CM support, but notes that many interventions are poorly described and lack outcome data.[17] Stiekema and colleagues' qualitative study from the Netherlands highlights the ongoing, long-term needs of people with ABI and their partners, including psychosocial adjustment, changing roles and identities, and a desire for continuous, individualised support.[4] The findings underscore the need for CM approaches that extend beyond medical rehabilitation and remain engaged throughout the long-term recovery process.[4] Taken together, these studies suggest that while there is broad agreement on

Figure 1. Lukersmith et al.'s Taxonomy Tree for Community-based Case Management in Brain Injury (BICM-T)[1]

Source: Figure reproduced under Creative Commons license CC-BY-NC-ND, Lukersmith et al. (2016)[1]



the key functions of ABI CM, there remains a need for clearer definitions, better intervention reporting, and greater alignment between client needs and service structures.

Evidence on the effectiveness and value of case management for ABI

The international evidence base on the effectiveness of CM for people with ABI is growing but remains limited and fragmented. While CM is frequently recognised as a valued support mechanism for navigating complex systems, enhancing continuity of care and improving client and family satisfaction, its measurable impact on clinical, psychosocial, and functional outcomes is less clearly established.

Leonard and colleagues' 2024 systematic review examined the evidence base for case management interventions specifically for people with ABI.[3] Their review included both adult and paediatric populations and spanned qualitative, quantitative, and mixed-methods studies from countries including the United Kingdom, USA, Australia, and Canada. A significant contribution of their review is its emphasis on the challenges of evaluating CM as a complex, highly contextualised intervention. The authors found that CM is commonly associated with positive experiential outcomes, including improved communication, emotional support, and satisfaction among both clients and their families. Case managers were described as pivotal in building trust, maintaining continuity across transitions, and helping individuals and families navigate disjointed care systems.

As detailed earlier, however, Leonard and colleagues' review highlights a persistent lack of standardisation in how CM is defined, delivered and evaluated.[3] There was significant heterogeneity across the included studies in terms of case manager qualifications, intervention intensity and duration, as well as service setting. Critically, very few studies employed validated or comparable outcome measures, making it difficult to draw firm conclusions about the effectiveness of CM. The authors note that while participants consistently valued their relationship with case managers and perceived benefits in coordination and access, evidence for improvements in clinical outcomes, participation, or cost-effectiveness remains limited and inconsistent.[3]

In organising their findings, Leonard et al. identified three overarching themes.[3] First, the lack of shared metrics or frameworks for evaluating CM makes it difficult to determine what constitutes success in this context. Many studies relied on satisfaction surveys or qualitative feedback, and few captured long-term outcomes or broader life impacts. Second, they found that the most consistently valued components of CM were relational in nature, including strong communication, flexibility, emotional support, and responsiveness to family needs. These elements, though hard to measure, were reported as essential to the perceived effectiveness of CM. Third, the review underscored the importance of CM across the continuum of care. Rather than functioning only at discharge or in crisis points, CM was often most effective when it extended into longer-term support phases, enabling sustained engagement and adaptation.[3] Leonard et al. also address structural and policy-level issues. They point to the lack of regulation, training standards and oversight that appears common across countries in the CM for ABI field. Their review concludes with a call for greater collaboration across research, practice, and policy to develop a common set of outcomes for ABI case management, improve intervention fidelity, and ensure more consistent service delivery.[3]

Findings from this review align with earlier international literature, including a systematic review by Lannin and colleagues from 2014 which similarly found weak evidence of effectiveness across functional outcomes and stressed the need for high-quality trials focused on participation and life impact.[18] In the late 1990s in the USA, Patterson et al. highlighted CM's theoretical potential to improve engagement and reduce long-term complications, while at the same time noting the lack of robust empirical evidence available at the time.[19] More recently, in 2025, Stiekema et al. published findings from a large-scale pragmatic randomised controlled trial in the Netherlands to test the feasibility and effectiveness of early case management following ABI.[2] Their intervention, which combined online needs monitoring with access to a case manager, did not demonstrate significant differences between the intervention and control groups on psychosocial outcomes. Low engagement with the monitoring tool and limited uptake of CM support contributed to these findings. The authors concluded that early, low-intensity CM may not be appropriate for individuals with relatively mild ABI and recommended targeting CM to those with more complex and evolving long-term needs.[2]

The international evidence suggests that while case management holds considerable promise as a relational and coordinating support in ABI care, assessing its impact is challenging because CM is highly dependent on the contextual factors of the specific intervention, including timing, intensity, client complexity, and the way in which CM services are implemented and evaluated.

RESEARCH STUDY METHODOLOGY

The research team conducted a series of focus groups with case managers and key health and social care professionals involved in the rehabilitation pathway for people impacted by brain injury in Ireland. Focus groups are well suited to gathering multiple perspectives on a given topic, building consensus, and identifying cases where perspectives diverge and the reasons underlying different viewpoints.[20] More specifically, a total of 23 participants were recruited for the following five focus groups:

- two in-person focus groups with ABI Ireland case managers
- two online focus groups with ABI Ireland clinicians who sit on interdisciplinary teams with case managers and engage with them on a regular basis in the course of their work (social workers, rehabilitation support specialists, psychologists, occupational therapists, speech and language therapists)
- one online focus group with referring professionals.

In addition to the focus groups, the research team engaged in a series of meetings with members of ABI Ireland's operations and management team to gather contextual information on the development of and current ABI case management service. Together with the literature, these meetings informed the development of the focus group topic guide.

Recruitment process

ABI Ireland staff acted as critical gatekeepers for the focus groups, first contacting eligible ABI Ireland employees via email, inviting them to participate. The invitation email included an Invitation Letter to potential participants from the research team, and a link to an online Google Form. The Google Form included relevant Participant Information, the Consent Form to participate and to be contacted by the research team by email and, in the case of the four focus groups with case managers and clinicians, the option to select from two possible dates on which to attend. Completed Google Forms were automatically submitted to the research team, who subsequently followed up with participants to confirm their availability and provide logistical information.

A different approach was taken in the recruitment of referring professionals as the target group was not ABI Ireland employees, but rather professionals working in regional or national rehabilitation hospitals and centres and step-down facilities, who have experience referring people with ABI to ABI Ireland's case management service. For this reason, a public call for participants meeting specific eligibility criteria was circulated on ABI Ireland's website and through social media. The call included a link to a Google Form including Participant Information and a Consent Form. Individuals who completed the form were contacted directly via email by the research team and asked a series of screening questions to confirm eligibility before being confirmed for participation.

Data analysis

Focus groups were audio recorded, and the recordings transcribed data using Otter.ai software. Following cleaning of the transcripts and pseudonymisation of participants' names and other identifying data, the transcripts were uploaded into NVivo qualitative data analysis software for analysis. Thematic analysis methodology was applied to the data analysis, following Braun and Clarke's 21 systematic, six-step approach. Thematic analysis follows a primarily inductive approach to data analysis whereby the researcher iteratively codes the data to identify emerging concepts and themes and does not prescribe a particular theoretical framework from the outset. Braun and Clarke's approach involves the following stages of analysis: 1) Familiarisation with the data, 2) Initial coding, 3) Search for themes, 4) Refining themes, 5) Defining themes, 6) Reporting.

Ethics

The qualitative research component of the study was approved by the Research Ethics Committee of The Centres for Health Policy & Management and Global Health, School of Medicine, Trinity College Dublin on 16 April 2025, and by the Research Ethics Committee of Acquired Brain Injury Ireland on 2 April 2025.

Participant profile

In total, 23 participants took part in one of five focus group sessions, with each focus group organised by professional role (see Figure 2).

Of the 23 participants, ten are active or former ABI CMs employed by ABI Ireland and attended one of two in-person focus groups. A further 10 participants were recruited as health and social care professionals working on interdisciplinary teams with CMs and attended one of two focus groups held online. Six of these participants are clinical psychologists, two are occupational therapists, one is a social worker, one a speech and language therapist. The remaining three participants were recruited as professionals with experience referring people to ABI CMs and attended one focus group held online. Two of the participants in the latter group are medical social workers, and one is an adult disability coordinator.

The ten case managers' level of experience in the role ranged from six months to 19 years, with the majority in the role for more than two years. In all cases, participating case managers came to the role following prior work experience in various, related health and social care posts. Five of the case managers, half of those participating in this study, had previously worked as Rehabilitation Assistants, a post which generally requires a minimum of QQI Level 5 qualification in health or social care, or a related field. Two case managers were qualified social workers and had previously worked as social workers in disability services. The remaining three case managers had prior experience and qualifications as occupational therapist, registered nurse, and youth case worker, respectively. Significant prior knowledge of and experience working within rehabilitation services for people with acquired brain injuries was a shared characteristic among the participating case managers.

Figure 2. Participant distribution across focus groups

FG. 1 Case Managers
(May 19, in-person)
4 participants

FG. 2 Case Managers
(May 22, in-person)
6 participants

FG. 3 Clinicians
(May 21, Online)

1 Occupational therapist
1 Social Worker
3 Clinical psychologists

FG. 4 Clinicians
(May 28, Online)

1 Occupational therapist
1 Speech and language therapist
3 Clinical psychologists

FG. 5 Referring Professionals
(June 3, Online)

2 Medical social worker
1 Adult disability coordinator

Figure 3. Professional backgrounds of participating case managers

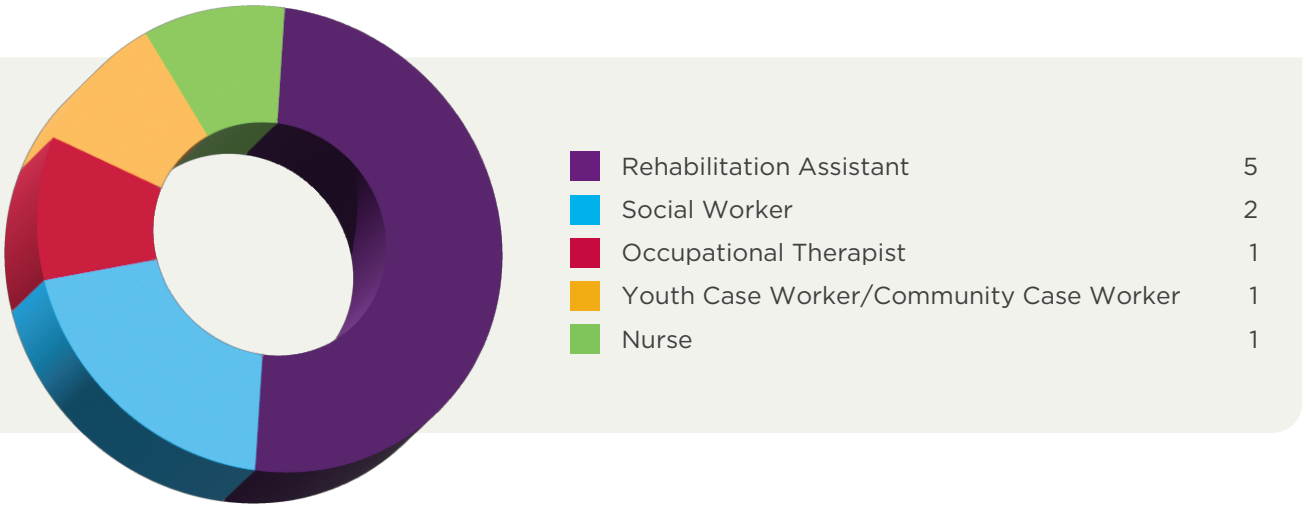


Table 2. Focus group participants by professional role

PART. ID	PROFESSIONAL ROLE
Participant 1	Case manager
Participant 2	Case manager
Participant 3	Case manager [and community services manager]
Participant 4	Case manager
Participant 5	[Former] case manager
Participant 6	Case manager
Participant 7	Case manager [and community services manager]
Participant 8	[Former] case manager
Participant 9	Case manager [and community services manager]
Participant 10	Case manager [and community service clubhouse manager]
Participant 11	Occupational therapist
Participant 12	Clinical psychologist
Participant 13	Social worker
Participant 14	Clinical psychologist
Participant 15	Clinical psychologist
Participant 16	Clinical psychologist
Participant 17	Clinical psychologist
Participant 18	Occupational therapist
Participant 19	Speech and language therapist
Participant 20	Clinical psychologist
Participant 21	Medical social worker
Participant 22	Adult disability coordinator
Participant 23	Medical social worker

FINDINGS

Thematic analysis of the five focus group transcripts generated four core themes that speak to the scope, complexity, and impact of the ABI case management role within the Irish neuro-rehabilitation system. These themes reflect shared experiences as well as points of divergence among case managers and their interdisciplinary colleagues. The four themes identified are as follows:

1. 'The many faces of case management': Defining the role;
2. Broad and variable tasks, responsibilities, and skillset;
3. Perceived value of the case management role; and
4. Facilitators and barriers of the case management role.

Each of these is explored in detail below, supported by illustrative quotations.

1. 'The many faces of case management': Defining the role

Across all focus groups, participants highlighted the inherent difficulty of articulating a definition of the ABI case manager role that accurately captures its breadth and adaptability. Participants universally described the role as highly dynamic, shaped by local service structures, team composition, and each service user's unique case and rehabilitation and support needs. This fluidity, while described as an appealing feature of the role by the participating case managers themselves, complicates efforts to standardise or codify the role. One case manager reflected on this challenge, noting the extent to which case management is shaped by a range of factors:

> *"[...] it's that difficulty about defining it, because it is so broad and big, and some case managers might do this and some might do that, and it's just hard to define it as a standalone occupation, something more that you kind of grow into. Bring different experiences from your work life to"*
>
> *— [Participant 9].*

Another case manager echoed this sentiment, stressing the near impossibility of summarising the full scope of the role:

> *"[...] there's no one size fits all, I always find that with case management, you'd never be able to put down on paper all that a case manager does, it's impossible"*
>
> *— [Participant 1].*

Despite these variations, there was general consensus on the defining purpose of the role, which is to act as a central point of contact, providing person-centred coordination of services and supports for individuals with ABI as they move from hospital to community settings. Case managers described their function using terms such as "link," "advocate," "navigator," and "security blanket," underscoring both the relational and practical dimensions of the work. Participants' efforts to define the role closely align with the BICM-T taxonomy developed by Lukersmith and colleagues[1] (see Figure 1), encompassing coordination, planning, holistic assessment, education, emotional support, and monitoring.

Participants emphasised case managers' vital awareness-raising role, helping people with ABI and their families gain perspective on the nature and trajectory of brain injury. One case manager explained:

> *"The family only knows that their loved one, what we might see on the relative scale of things as minor changes [...], might be huge for the family and for the client themselves, [...] to have that perspective, to see that there's such a scale, and every brain injury is so different, to be able to share that just because they can't do this, but they can still do X, Y and Z, and we can work on this, and we can get them linked in with the right supports, does help to provide that bit of perspective"*
>
> *— [Participant 9].*

2. Broad and variable tasks, responsibilities, and skillset

The case management role was repeatedly described as multifaceted and unpredictable. Participants used phrases such as "no typical day" and "everything to everyone" to capture the extent to which tasks vary not only across cases, but also across service areas and team contexts. This variability was noted by one referring professionals, who found that the scope of the case manager's involvement differed markedly across clients:

> *"They are kind of managing that person when at home and linking them with services and providing support... it's very hard because each case I've had, I think the case manager has had different, you know, roles"*
>
> *— [Participant 21].*

In each of the focus groups, participants noted that because of the inherent flexibility associated with case management and the lack of an established professional group boundary for the role, case managers working in interdisciplinary team (IDT) settings were often expected to absorb various tasks not explicitly in the case manager job description:

> *"[...] within MDT [multidisciplinary team] and IDT models where people try to avoid silos, everybody ends up doing a bit of something. [...] But as opposed to occupational therapists and speech and language therapists and all the rest of it, case management is a little bit newer, isn't as well defined. [...] And so, if there's ends of jobs to be done, that will get chopped towards them"*
>
> *— [Participant 17].*

Participants also described the significant relational work involved in the role. This included liaising with a broad range of services both internal and external to ABI Ireland, building trust with other professionals, negotiating complex discharge and referral pathways, and navigating different institutional cultures. One participant described the important work case managers do liaising and negotiating with other service providers 'behind the scenes', on behalf of service users:

> *"Increasingly, hospitals are putting services under extraordinary pressure to accept discharges and they are in turn under pressure with delayed discharges. And so, a case manager has to go 'hold on, let's make sure that this is the right pathway for this person'. The skills involved are liaising, negotiating, building trust, chairing meetings. That piece is vast"*
>
> *— [Participant 15].*

This relational aspect extends also to emotional support, which case managers frequently provided to clients and their families. Many participants reflected on the blurred boundaries between providing emotional and motivational support to clients and providing psychological counselling or therapy, with one case manager stating,

> *"[...] sometimes you get caught in the emotional piece and just stepping back and reaching out to you know ask, what am I here for? What's my goal here with this? What can I do and what's not my responsibility? I used to find that helpful, like a reflection"*
>
> *— [Participant 5].*

Several participants, particularly those not in the case manager role themselves, described confusion around the scope of ABI case management and what tasks could reasonably be expected. As one participant, a clinical psychologist, remarked,

> *"It took me a while to understand what the case manager does, because at some point I thought, 'now I see it', and then I got it wrong again. [...] I don't know, whether it's down to people to carve that kind of aspect in a way that is specific, that is accurate, that is productive, that is bounded in a good way and doesn't get drowned in a million of different things"*
>
> *— [Participant 16].*

The absence of a formally recognised professional designation for case management was noted as both a strength and a vulnerability. While it allowed for diversity in backgrounds and flexibility in function, it also exposed case managers to role ambiguity and limited access to supervision and career development opportunities. In many cases, case managers found themselves covering gaps in service provision, particularly where disability teams lacked dedicated social work posts:

> *"The role of case management very much reflects social work. [...] Often describe it as [...] [second] class social workers. We're not social workers"*
>
> *— [Participant 8].*

This extended to navigating complex systems involving housing, legal and financial supports – areas where case managers did not always feel adequately prepared or supported.

In the absence of health data infrastructure enabling tracking of service users across care settings, case managers' long-term involvement was often contrasted with more episodic engagement by other services. One referring professional stated that while they can only offer anecdotal evidence, the value of the services case managers provide is clear.

> *"[...] once they leave the hospital, I don't have anything to do with them. I can't follow them up. But ABI [Ireland] have and any of the cases we've linked in, I've spoken about, they're still seeing them. They're following up, making sure the home care packages are going in and are sufficient to support the family"*
>
> *— [Participant 21].*

3. Perceived value of the case management role

Across all professional groups, participants emphasised the critical value of the case management role, particularly in navigating the complexity and fragmentation of the Irish neuro-rehabilitation system. Case managers were repeatedly described as the "glue" or "linchpin" that holds the rehabilitation journey together, ensuring continuity, appropriate sequencing of services, and a person-centred focus. One participant described how, in the absence of case management, the pathway for individuals with ABI could become chaotic and counterproductive:

> *"It prevents people having a very fractured and counterintuitive rehab journey [...] in the absence of case management, it can be almost chaotic, with incredibly long wait times between different services and the order in which people got services at times would be very counterintuitive"*
>
> *— [Participant 20].*

The same participant pointed to broader implications for health system efficiency, noting that earlier, coordinated intervention can also reduce long-term costs:

> *"[...] early is best and you know early rehabilitation has benefits in terms of the financial cost to the state. Over lengthy periods of time, if you can get people back to work, they're not on social welfare, all those sorts of things. And I think in the absence of a functioning case management system nationwide, that sort of a landscape is going to probably persist"*
>
> *— [Participant 20].*

Participants across all focus groups highlighted the vital role case managers play in preventing vulnerable individuals, particularly those under 65, from being inappropriately placed in nursing homes due to lack of follow-up support. One referring professional maintained,

> *"One of the biggest areas of need [...] is when a younger person has to go into a nursing home for a variety of reasons. And I know if they just had a bit of support on the other end, in a few months' time when they've continued to improve, hopefully they can get back to the community with a bit of support. [...] it is a wasteland basically, especially if a person doesn't have family that can follow up, their vulnerability just multiplies. And those are the people that tend to get lost in the system"*
>
> *— [Participant 23].*

For those who are referred to an ABI case manager, the benefits were often described as transformative:

> *"The ones that I have seen that have had the benefit of ABI intervention, particularly case management, have really flourished"*
>
> *— [Participant 23].*

However, the overall effectiveness of case management was seen to be contingent on the wider system of supports available in a given area. The lack of equitable service distribution was a recurring concern, with one participant stating,

> *"You've got ranging from a full clinical team to, you know, counties with no service at all. No case manager, nothing. So, it's a post code lottery"*
>
> *— [Participant 15].*

Case managers themselves described the role as deeply relational and grounded in trust, often serving as the consistent point of contact for the person with ABI from early in their recovery process:

> *"It is about your relationships with people and building up those relationships, whether it's home support or respite, or a different service, the case manager is key"*
>
> *— [Participant 8].*

The case managers' knowledge of ABI and their ability to translate and validate the lived experience of brain injury was particularly valued:

> *"On paper their brain injury looks very mild, but the changes that they see in themselves are drastic. [...] I think a lot of it is about validating what he's going through and helping him understand that is actually part of the brain injury. [...] sometimes, because you're the one who understands the brain injury side of things, they want to talk to you, because you can validate that, whereas maybe a regular counsellor doesn't know that much about brain injury"*
>
> *— [Participant 9].*

One participant also emphasised the case manager's critical role in external systems, including medical-legal contexts:

> *"[...] in the medical legal sphere where they're largely eyes and ears for other professionals who frankly don't have a clue about person-centred services [...] so they're dealing with solicitors and judges [...] Which has a very valuable role"*
>
> *— [Participant 17].*

While participants consistently affirmed the value of case management, they also pointed to a significant disconnect between how the role is perceived by colleagues and how it is resourced and supported by the system. One participant articulated it in the following way:

> *"[...] roles like case management are treated like the sprinkles on top, like you're lucky to get that rather than seen as a core part of the journey despite all of the right words around rights-based approaches and biopsychosocial model and all those fancy things"*
>
> *— [Participant 19].*

4. Facilitators and barriers of the case management role

Participants identified several factors that support or hinder the effectiveness and sustainability of the ABI case management role. Among the key facilitators, personal motivation and resilience of individual case managers emerged as a strong theme. Case managers' prior experience in health and social care roles, including rehabilitation and disability services, was seen to provide a solid foundation for navigating complex systems. Peer support structures, including informal check-ins with colleagues and the "pop-in" clinics organised by ABI Ireland, were also highly valued by the participating case managers, with one stating,

> *"Those pop-in clinics where we're talking about our clients is probably the most positive team interaction and support that we've had for years"*
>
> *— [Participant 1].*

Another case manager called for additional opportunities to engage with colleagues, highlighting the importance of peer support in what can be an emotionally taxing role:

> *"It can be very isolating and lonely when you're coming out of really complex houses, people are mourning the change in the relationship, or their status and all that. It's a lot. It is a lot to hold. I feel people should have an opportunity to link with colleagues on a more regular basis, because it's heavy"*
>
> *— [Participant 2].*

Good working relationships with colleagues and service providers, availability of relevant data at the point of referral, and access to further training and education were also seen as supportive. In terms of training, several case managers noted that access to training in counselling and trauma-informed care would be particularly useful, both to be able to provide better services to their clients, and to develop skills to manage the emotionally taxing aspect of the role. One case manager who had previously availed of such training stated,

> *"I started to do a counselling course [...] I must say, you know, and I know we're not counsellors but I must say that it helped me a lot just to sit with the families and to sit with the clients and to be there, you know?"*
>
> *— [Participant 8].*

Overall, case managers who were embedded in well-resourced, collaborative interdisciplinary teams tended to report a greater sense of role clarity and professional fulfilment.

A range of barriers were also identified. Chief among them was the heavy reliance on individual motivation in what was described as a highly demanding, under-resourced role:

> *"[...] you feel like you are this magician [with a] magic wand that you are going to sort out everything, and everybody's expecting that you're going to sort out everything. I really can't. I can make the referrals, I can follow up, I can chase things, but if the resources aren't there, there is nothing that I can do"*
>
> *— [Participant 7].*

The complexity of the Irish health and social care landscape means that new case managers face a steep learning curve. Moreover, the availability of supervision and team support varies dramatically depending on location. One case manager described their work as,

> *very isolating [...] since COVID [...] I only go into the office one day a week, there's nobody"*
>
> *— [Participant 2].*

In contrast, another described a more collegial, supportive work environment, saying,

> *"I am in the office all the time, and it's an open office, and there's craic, and there's dramas, and I work with people [...] like they have their own stresses you know, so we all need to support each other"*
>
> *— [Participant 1].*

Structural constraints such as recruitment embargoes, the lack of fully staffed IDTs, and poor integration across services were also cited as significant barriers and challenges to the case managers' work. One participant, themselves a member of an IDT stated,

> *"There's not an equal distribution of OTs or social workers [...]. That has a huge impact on how the case management team would perform"*
>
> *— [Participant 11].*

Another participant concurred, saying,

> *"We don't have the full MDT in whatever part of the country you're talking about in the bigger picture for neuro-rehab"*
>
> *— [Participant 20].*

Participants also expressed concern regarding the sustainability of roles that are part-time or combined with other responsibilities:

> *I think it would be quite tricky when you're on 10 or 12 hours a week, you have to balance another post either within the service or somewhere else [...] So it would be wonderful to see posts that are moving towards full time"*
>
> *— [Participant 14].*

The dual structure of the ABI case manager service model generated differing experiences of role clarity and integration. While some participants felt that sitting within the HSE disability team allowed for better continuity and fewer missed referrals, others found that this dual accountability could be confusing and at times conflicting:

> *[...] when you sit within the disability team, I think there's less of a chance of maybe people falling between the cracks, because if the referral isn't coming directly to ABI [Ireland] and it's coming to HSE, you'll still get it as a case manager within that HSE team. [...] I suppose the difficulty sometimes comes with the HSE expectation of what you do as a case manager within that setting and what your role actually is. And you know, sometimes you feel like you're wearing two different hats"*
>
> *— [Participant 5].*

Finally, participants underscored the wider policy context and historical underinvestment in disability services as a fundamental barrier to achieving an equitable and integrated case management system:

> *If you look at Ireland's treatment of people with disabilities in the last 15 years, it's really typical that we have such an important interface with people with disabilities, and across the country we're talking about .4 of a role and .6 of a role. It's a totally unprofessional approach to the first point of contact with people with disabilities in the community"*
>
> *— [Participant 15].*

IMPLICATIONS OF THE RESEARCH AND THE FUTURE OF THE ABI CASE MANAGEMENT ROLE

This study offers important insights into the scope, complexity, and value of the ABI case manager role in Ireland. As findings from the five focus groups highlight, defining the role is inherently difficult because it is fundamentally adaptive, person-centred, and shaped by the varying contexts in which it is implemented. Participants of the study described case management not as a fixed intervention but as a flexible, relational function, one that draws on a diverse skillset and evolves in response to the needs of service users, gaps in services, and the nuances of highly localised rehabilitation services and systems. As such, the findings align with the international literature presented earlier in the report, which points to the difficulty of evaluating ABI case management interventions due to their highly context-specific nature. The lack of consistent terminology and role definition has hindered the development of robust evaluative frameworks. In both Irish and international contexts, ABI case management is best understood as a relational and coordinating intervention that operates across clinical, social, and practical domains. Its success depends on when it is introduced, the complexity of the client's needs, the presence of an interdisciplinary team, and the degree of system-level integration.

Despite challenges in defining its parameters, the research found consistent recognition by all participants of the role's significant value, not only for people impacted by ABI, but also for their interdisciplinary colleagues and the neuro-rehabilitation system more broadly. Case managers were described as a critical link in the rehabilitation journey, helping to avoid fragmented care, advocating for appropriate supports, and maintaining continuity across what is fundamentally a disjointed and resource-constrained rehabilitation system. Their input was particularly valued in situations involving complex social needs or long-term follow-up, where other services were unavailable or time limited. There was strong agreement among participants that service users with ABI who received case management support were more likely to achieve positive outcomes, and less likely to "fall through the cracks" of the system.

However, the research also revealed that the very factors which make ABI case management effective – its flexibility, responsiveness, and system-bridging function – also leave the role vulnerable to ambiguity, role drift, and under-recognition. It is critical to underline that these vulnerabilities are not individual but structural. A central finding of this study is that fragmentation is not simply a contextual barrier for ABI case managers, it is rather a foundational feature of the system in which they operate. Layers of fragmentation between acute and community services, between the HSE and voluntary providers, and between policy vision and local implementation, create a landscape in which case managers are frequently relied upon to bridge structural gaps with limited institutional support.

The dual service model currently in operation, whereby case managers are employed directly by ABI Ireland or sit within HSE Disability Teams adds to this complexity. While both models have the same purpose aiming to deliver coordinated, person-centred care, in practice they reflect different operational environments, reporting structures, and degrees of integration. In addition, as the focus group discussions between participants working in different service areas made clear, every area within these models operates slightly differently. Referral pathways, supervision arrangements, and access to

interdisciplinary supports vary not only between HSE and ABI Ireland services, but also between counties, and even between teams within a single organisation.

This variation is compounded by inconsistent staff composition across rehabilitation services. In some areas, case managers are embedded within well-established and well-resourced ABI Ireland IDTs with occupational therapists, social workers, psychologists, and speech and language therapists. In others, they work in relative isolation or within teams lacking key roles. These differences shape not only what case managers do, but what the case manager role is understood to be by their colleagues, contributing to confusion and poorly aligned expectations across service areas.

These operational complexities are underpinned by chronic underfunding of the sector. As nearly all participants noted, ABI case management is frequently implemented in conditions of scarcity, with a number of active case managers occupying part-time posts. In addition, case managers do not have access to formal professional supervision and are afforded limited continuing education or training. These working conditions may undermine the sustainability of the role in future, and place service users at risk of unmet need where case managers are unavailable or overextended. The heavy reliance on the individual commitment and resilience of CMs is not a viable substitute for systemic support.

Looking ahead, the study findings lead to some explicit, potential next steps in the areas of rehabilitation system and research:

Rehabilitation system

- The HSE and relevant stakeholders recognise the case management role as a core element of an effective, equitable, and person-centred neuro-rehabilitation pathway rather than an optional add-on
- The HSE address the uneven distribution of case management services across the country to reduce geographic disparities in access to ABI rehabilitation supports. This should be achieved through the provision of specialist brain injury case managers for everyone with ABI living in Ireland
- The development of a consistent national framework that clearly defines the case management role, standardises training, and integrates case managers into fully resourced relevant IDTs.

Research:

This research reinforces

- the international academic recommendation for the development of a set of outcome indicators for ABI CM
- the need for research specific to Ireland on the impact of CM for people with ABI.

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