

**National Injury
Insurance Scheme:
Motor Vehicle Accidents**

**Consultation Regulation Impact
Statement Response**

**Quarterly Brain Injury Services Meeting
Group
May 2014
Amended Version**

SCOPE

The views presented in this response draw upon the experiences of QBISM members from public, private and NGO services for people with brain injuries and their families in Queensland. The response integrates data from published literature and recent research projects; previous consultations with QBISM members; the QBISM Positioning Paper: *A Comprehensive Service System for Queenslanders with Brain Injury* (August 2013); the Queensland Government Office of the Public Advocate publication: *People with intellectual disability or cognitive impairment residing long-term in health care facilities: Addressing the barriers to deinstitutionalisation A systemic advocacy report* (October, 2013); and the 2014 Queensland Joint Solutions Forum coordinated by the Young People in Nursing Homes National Alliance. It is acknowledged that this response may not reflect the views of all QBISM group members, due to the limited time frame for developing a group response.

STATISTICAL SOURCES

Australian Institute of Health and Welfare 2011. Disability support services 2009–10: report on services provided under the National Disability Agreement. Disability series. Cat. no. DIS 59. Canberra: AIHW.

Harrison, J., Henley, G., & Helps, Y. (2008). Hospital separations due to traumatic brain injury, Australia 2004-05. (Injury research and statistics series no. 45. Cat. no. INJCAT 116) Canberra: AIHW. Retrieved from <http://www.aihw.gov.au/publication-detail/?id=6442468147>>

Responses to Questions

Question 1: Is this chapter a correct statement of the problem?

Response to Question 1:

Yes, this chapter is a correct statement of the problem. However, it should be noted that the long lasting impacts of catastrophic injury do not only fall on the injured person, but also on many others. The health and wellbeing of family members and loved ones, particularly those who undertake gratuitous care post-discharge, are particularly vulnerable. Failure to deliver timely and adequate rehabilitation, care and support services has significant impacts on the social and economic participation of both people with catastrophic injuries and their families.

Question 2: Do you think there were other problems created by the *status quo* as it stood in 2011?

Response to Question 2:

QBISM members identified other problems created as a result of the status quo as it stood in Queensland in 2011 as outlined below:

- People with ABI lack support to negotiate the pathway through medical services, hospital-based inpatient/outpatient rehabilitation, transition to the community and ongoing community-based rehabilitation to enable optimal outcomes after catastrophic injury.
- Existing fault-based insurance arrangements in Queensland do not ensure certainty, timeliness and access to services along the rehabilitation continuum. Access to specialist community based rehabilitation services, in particular, may be delayed due to disputes over liability to fund services, and a general lack of supply in the public health care system.
- In the endeavour to meet reduced length of stay requirements of the health care system, families or loved ones may be pressured to take clients home from hospital to release beds.
- Family members may feel pressured to undertake gratuitous care, with limited formal support or education available to help them sustain these roles.
- Lack of adequate resources leads to unsuitable and unsupported discharges of people with catastrophic injuries that can result in avoidable readmissions or further decline in functioning and independence.
- Bed Blocking occurs in acute hospitals and slow stream rehabilitation services – as outlined in the Office of the Public Advocate (2013) report on people with disabilities in long stay health care facilities. Prolonged stays in health facilities are most likely for three groups of people with catastrophic injuries including: non-compensable persons who are unable to access adequate funding for community based support; those with insurance claims

pending; and those who have already received compensation settlements but have unexpectedly depleted their settlements, or are unable to purchase adequate services despite their compensation.

- People without compensation struggle to sustain the costs of prolonged admissions to state rehabilitation and residential facilities, shifting the economic costs of injury onto individuals and their families who often fund or deliver additional services.
- Some families fear that young persons will be discharged from health facilities to Residential Aged Care (RAC), and therefore advocate for young people to remain in costly institutions (hospitals and slow stream rehabilitation facilities) where they believe they will be cared for.
- Prolonged stays in health care settings can result in institutionalisation and loss of functional gains made in rehabilitation, increasing care needs and potentially escalating long term care costs and increasing the likelihood that compensation payments will be inadequate to cover lifetime care needs.
- Due to improved survival rates over the past two decades, there is increasing pressure on disability services to provide funding for catastrophically injured persons – both with and without compensation and those whose settlement funds have (or will) expire.
- There is pressure on not-for-profit service providers to cover gaps in allocated funding, often without sufficient resources or education to manage the effects of catastrophic injury.
- Settlements for lifetime care are prone to early expiration and unable to sustain the support needs of young people with significant disabilities. The longevity of settlement funds varies widely, however specialist brain injury service providers report that funds may expire within five to ten years in some cases of motor vehicle accident (MVA) acquired severe traumatic brain injury (Harrington, 2013).
- Despite advice to delay settlement until a catastrophically injured child reaches maturity and the full extent of their lifetime care and support needs becomes evident, some families settle early and are thus at risk of accepting inadequate settlement sums.
- There is a significant reduction in supports available as catastrophically injured children transition from paediatric to adult acquired brain injury services. Many young people become trapped in institutional care as family caregivers age and become unable to provide additional support, and as service options in the community decline.
- Consumers and their families do not have a good understanding of funding arrangements and services delivered across multiple government departments and service sectors. In the absence of a centralised funder, service access is often fragmented and difficult to negotiate, requiring families to act as case managers as well as providing significant amounts of care.

Question 3: Do you have any data of the quantum of these problems, i.e. existing costs?

Response to Question 3

Queensland has the highest national rate of ABI disability (82,600 cases reporting disability status after ABI compared to 77,800 in NSW, 73,800 in Vic, 31,000 in SA) (Australian Institute of Health and Welfare, 2007). In a single year (2004/05), there were over 8300 hospital admissions related to ABI in Queensland (Turner & Doherty, 2006). It is unclear what proportion of these admissions were attributable to MVA related ABI. However, road traffic accidents accounted for 61.4% of cases of Traumatic Brain Injury (TBI) (N=635) admitted to intensive care units located in major trauma centres throughout Australia and New Zealand over a 6 month period in 2000/01 (Myburgh et al., 2008). Over half (57.2%) of all cases had sustained a severe TBI.

Direct costs for hospital care for all cases of TBI in Australia were estimated to be more than \$184 million in 2004-05 (Harrison, Henley & Helps, 2008). Those hospitalised as a result of MVAs (29.4% of all TBI as Principle Diagnosis cases) had the longest length of stay and the highest overall cost of hospital care (46% of total costs, \$85.6 million) in comparison to other TBI related major injury groups, such as falls (42.2% of TBI as Principle Diagnosis cases, 34% total costs, \$62.7 million), and assault (15% of TBI as Principle Diagnosis cases, 8.5% total costs, \$15.6 million) (Harrison, Henley & Helps, 2008). In 2011, the anticipated length of stay for compensable adults with MVA related severe traumatic brain injury (sTBI) and high and complex care needs in state hospital settings in Queensland was twelve to eighteen months post injury, in the experience of focus group participants (Harrington, 2013). For those unable to access compensation, delays to discharge can be several years.

The Office of the Public Advocate report (2013) provides data regarding the number of young people with disability (including those with severe acquired brain injuries) residing in long stay health care facilities in Queensland and their length of stay. This report includes a cost analysis illustrating the cost saving benefits of supporting more timely transitions from acute hospital units to community based settings for adults with ABI and high care needs.

Question 4: Do you agree these are the main objectives for government action?

Response to Question 4:

Yes, these are the main objectives with additions suggested below.

Question 5: Have any important considerations been left out?

Response to Question 5:

Additional objectives suggested by QBISM members include:

- in a way that is consistent with the principles of the NDIS

- in a way that ensures appropriate, affordable accommodation options are available through partnerships with Disability Services, Housing, Health and the private sector, in line with the principles of choice enshrined in the NDIS.
- in a way that supports the sustainability of informal care networks and the caring role of families

How is equitable defined in regard to the impact of proposed changes on each State and Territory and their residents?

Question 5: Do you agree with the description of the base case?

Response to Question 5:

Yes. However, clarification of the role of government in negotiating adequate lump sum settlements for those entitled to pursue compensation, and in meeting the lifetime care needs of those whose compensation settlements expire is recommended under this option. It is unclear who will take on the responsibility to fund lifetime care for those who accept (or have accepted) inadequate settlement funds or whose funds expire.

In Queensland, service access commonly declines post settlements as families cease funding maintenance therapies and support services in an attempt to make settlement funds last. If this results in significant functional deterioration and increased long term care costs, who will meet these additional costs when family care is no longer sustainable?

Formalised systems for monitoring the care and support needs of persons who are catastrophically injured, in the years post settlement, are largely absent in Queensland. Individuals and their families often only contact specialist services in times of crisis or when settlement funds are about to expire. Hence, a proactive approach to supporting the sustainability of family care and preventing functional deterioration over the long term is lacking under the base case.

QBISM members have identified the lack of a range of appropriate accommodation options as one of the key priorities for brain injury service development in Queensland. Under the base case it is unclear how capacity building within the housing and supported accommodation sector will be facilitated to enable a range of accommodation options for people living with catastrophic injuries.

Question 6: Are options 1 and 2 reasonable and appropriate?

Response to Question 6:

Yes. Option 1 appears to be a fairer option. The selected option should be the same in all states to ensure all Australians have equitable access to funding, rehabilitation and support services. Option 1 enables access to care, support and rehabilitation throughout an individual's lifetime, and the adjustment of these supports as individual needs and circumstances change.

Option 2 appears to provide limited capacity for the development of an integrated systemic response to the needs of adults with catastrophic injury in Queensland.

Existing state government MVA insurance bodies, such as the TAC in Victoria, and the Lifetime Care and Support Authority in New South Wales, have invested in building capacity in specialist rehabilitation or lifestyle support services. They have also engaged in collaborations with a wide range of state government services to help improve the post injury pathways of people with brain injuries and their families. A recent inquiry by the Office of the Public Advocate (2013) indicated the need for similar integrated service planning to help better meet the needs for those with complex and high care needs in Queensland. The creation of a state based catastrophic injury insurance scheme in Queensland under option 1 has the potential to provide both the structure and funding required to promote capacity building in specialist rehabilitation services and improved management of transitions through the rehabilitation continuum.

Options need to be fair and equitable, ensuring that the costs of lifetime care are shared equitably across the Australian population. Under the base case (and to some extent option 2) costs are not shared equitably across jurisdictions, with some of the cost of MVA related catastrophic injury transferred onto commonwealth budgets, via funding for health care, community care, residential aged care, and disability support and carers pensions. It appears unreasonable to expect the commonwealth government to continue to fund these costs, which are borne by the Australian tax payer, when residents in states and territories with no fault schemes already pay higher CTP premiums to cover the costs of all catastrophic injuries under their own schemes.

Question 7: Do you agree that there are no feasible non-regulatory options?

Response to Question 7

Yes. Reform to court processes will not foreseeably impact on the adequacy of lump sum settlements negotiated predominantly through out-of-court processes or insure that funds awarded in settlement last an individual's lifetime.

Question 8: Is this a correct assessment of the base case?

Response to Question 8

It is unclear whether the projected costs of providing lifetime care to those whose compensation funds expire is included in the costs estimates provided. Does this need to be factored into the cost estimates?

Question 9: Do you have any data on current impacts such as scheme operating costs, CTP premiums or current NDIS contributions (i.e. prior to 2019-20)?

Response to Question 9

No

Question 10: Do you agree with the identified impact of option 1 on people with catastrophic injuries?

Response to Question 10

It is anticipated that option 1 will also result in additional quality of life impacts for people with catastrophic injuries and their families. The process of seeking compensation can interfere with the adjustment process after severe traumatic injury, and the adversarial nature of the litigation process adds to the experience of stress and trauma at a very stressful time (Gething et al. 2002). Harrington (2013) found that while people with MVA related sTBI and their families experienced 'pressured lives' in response to difficulties accessing adequate funding, services or support in Queensland, those compensated under the no fault TAC scheme in Victoria experienced a 'sense of security' in response to their clear entitlement to lifetime care and support. This sense of security helped to alleviate anxieties related to the claims settlement process, supported the sustainability of family care roles, and enabled the ongoing workforce participation of family members. Although these findings should be viewed with caution, due to the small sample sizes involved, they are consistent with the proposed benefits of no fault reforms to common law schemes.

Question 11: Do you have any data or analysis on the expected change in insurance premiums for individuals under option 1 (including on the level of current premiums)?

Response to Question 11:

No

Question 12: Do you have any data on any of the other identified impacts on individuals, businesses and the community under option 1?

Response to Question 12:

The presence of multiple CTP insurers in Queensland results in no consistent approach to services for individuals with catastrophic injury. Having a centralised funding and administrative body under the NIIS will alleviate inconsistencies and inequities for individuals and help build a strong community of services and supports.

Question 13: Are there any costs or benefits for individuals, business and the community under option 1 that are not identified here?

Response to Question 13:

Option 1 lays the foundation for capacity building in specialist rehabilitation and lifestyle support services which are currently lacking in Queensland. Early and sustained access to intensive rehabilitation after ABI helps to reduce disability, restore function and improve participation. Additionally, access to multidisciplinary

teams with specific expertise in brain injury rehabilitation improves long term outcomes, decreases care needs and has the potential to significantly reduce long term care costs (Turner-Stokes, 2008). It is anticipated that adoption of option 1 will significantly improve functional recovery and participatory outcomes for both those entitled to pursue a common law claim, and those who are not, as funded access to specialist rehabilitation services is included under this option. Enhancement of specialist service system capacity in Queensland also has the potential to benefit those acquiring ABI from non-injury related causes.

Question 14: Do you have any data on the identified costs on States and Territories of option 1? Specifically, can you provide updates of number of annual expected claims, average size of expected claims and annual expected total costs including administration?

Response to Question 14:

Two common law settlements exceeding 9 million dollars have been reported in the media in Queensland in the past six years including a \$9.6 million settlement awarded to a twelve-year-old boy who sustained non-MVA related, catastrophic injuries in an accident at his Southport School and a \$9.5 million settlement awarded to a woman seriously injured during a police chase on the Gold Coast. It is unclear whether the value of these settlements will significantly affect the average size of expected claims in Queensland under option 1, but it may impact on anticipated claims costs if the base case is retained.

Question 15: Are there any other costs or benefits to States and Territories of option 1 that are not identified here?

Response to Question 15:

In addition to risk mitigation strategies focused on decreasing serious road traffic accidents, state governments may decrease the lifetime costs of injury through increased investment in developing an organised system of trauma care which includes the full continuum of rehabilitation services. The trauma system developed under the TAC in Victoria has been shown to reduce mortality rates and improve functional outcomes after serious injury (Gabbe et al., 2011, 2012).

Question 16: Do you agree with the impact of option 1 on the Commonwealth Government?

Response to Question 16:

Refer to response to Question 6

Question 17: Do you expect that jurisdictions will alter insurance premiums to target the risk profile of individual motorists?

Response to Question 17:

This would not reflect the history of the scheme in Queensland which has adopted a 'community rating' for CTP premiums in the past. However, it is unclear whether this would be retained under proposed changes.

Question 18: Do you have any information as to what the design of each State and Territory insurance provisions will be?

Response to Question 18:

No

Question 19: Do you have any data of the impact of option 1 on insurance design or insurance providers?

Response to Question 19:

No

Question 20: Do you believe this is a correct assessment of the likely impact of option 1?

Response to Question 20:

Yes

Question 21: Do you believe that States and Territories could pool their insurance? If so, what impact would this have on premiums and would it be government underwritten or provided by the private sector?

Response to Question 21:

Pooling of insurance by states and territories may negate the capacity or incentive for strategic service planning across health, disability and housing departments at a state level.

The history of privatisation within the New Zealand ACC scheme and subsequent reinstatement of government underwriting of the scheme would seem to indicate that government underwriting is a preferable option for Lifetime Care and Support Schemes.

Question 22: Do you believe this is a correct assessment of the impact of option 2 on individuals, businesses and the community?

Response to Question 22:

No. Consideration of the lost potential for recovery related to limited access to early intervention services and timely transitions through the rehabilitation continuum under this option is recommended. The Office of the Public Advocate report (2013) and YPINH report (2014) on the *Queensland Joint Solutions Forum* both highlight the functional deterioration experienced by young adults with disabilities residing in long stay health care facilities in Queensland. Under option 2 it is unclear whether these issues will be addressed. If there is no requirement for state governments to meet minimum benchmarks of the NIIS within a designated time period, it is unclear whether state institutional care will remain the fall back option for meeting the long term care needs of adults with MVA related catastrophic injuries and high care needs. Institutional care options, if adopted, may adversely impact on the quality of life and recovery of both those unable to access compensation currently and those who will lose their entitlement to awards for future care under this option.

There is potential that state governments may de-invest in delivery of specialist rehabilitation services to catastrophically injured adults with high and complex care needs under this option. A previous government inquiry (Review of the Queensland CTP Scheme, 1999) highlighted that while access to rehabilitation can significantly improve an individual's quality of life it may not be translated into decreased claims costs. Access to rehabilitation under option 1 would be an entitlement for all persons catastrophically injured in MVAs. This would not be the case under option 2. In the absence of clear entitlements, it is unclear whether rehabilitation will be provided to those who are slow to recover after injury who require ongoing access to rehabilitation services to enhance their participatory capacity. Importantly, failure to provide rehabilitation in these cases means that opportunities for improvement may be overlooked. Similarly, access to specialist community based rehabilitation services which can improve social and workforce participation after injury may not be supported.

Specialist rehabilitation services for people with catastrophic injuries in Queensland have predominantly been delivered in state hospitals. Historically, a hospital and emergency services levy has been collected at the time of vehicle registration to cover a reasonable proportion of the estimated cost of providing public hospital and emergency services to compensable patients. In 2008, the cost of providing health care services, including rehabilitation, to CTP insurance eligible patients had consistently exceeded the revenue from the hospital services levy, with the state health department meeting the shortfall (Queensland Health, 2008, p.53). This was in contrast to other Australian jurisdictions, such as New South Wales and Victoria, which allow full cost recovery for health care services provided to compensable persons (Queensland Health, 2008, p.53).

Adequately funded public hospital and emergency services play an important role in promoting: timely access to required trauma and rehabilitation services while liability is determined on a claim; equity of access across compensable and non-compensable populations; and the development of integrated multidisciplinary care pathways. However, under current funding arrangements, most Queensland Hospitals do not offer the comprehensive suite of rehabilitation services (including community based rehabilitation teams for people with ABI) available in other

jurisdictions (QBISM, 2013). A reliance on the rehabilitation services provided by public hospitals appears to have provided limited impetus (or funding) for development of private sector services in many areas. Hence, even those with private health insurance funding may not be able to access the specialist rehabilitation services they require to optimise outcomes after injury under option 2 (as private sector services may not exist in their local area). Those from regional and rural areas are at increased risk of inadequate service access, due to limited service capacity in these areas. Neglect of service development in this area restricts Queensland to a reliance on costly inpatient services rather than more sustainable community or private services.

Question 23: Do you believe this is a correct assessment of the impact of option 2 on State and Territory governments?

Response to Question 23:

The impact of option 2 on State and Territory governments is reliant on the negotiated level of responsibility for health care funding at a state level. If hospital admission costs are funded at a state level, then the Queensland state government would bear the full burden of current cost inefficiencies in the health care system. Under current funding models part of this cost is borne by the Commonwealth Government.

The potential for functional deterioration under option 2 could also significantly increase lifetime care costs for people with catastrophic injury who enter the NDIS at a later stage. These increased costs would be borne by the Queensland state government under option 2.

Question 24: Do you believe this is a correct assessment of the impact of option 2 on the Commonwealth Government?

Response to Question 24:

This assessment does not highlight potential cost increases to the Commonwealth Government by way of funding for Health, Commonwealth Rehabilitation Services, Carers Pensions, Carers Allowances, and Residential Aged Care (RAC) subsidies (if RAC remains a placement option while state based schemes are developing their policy response). Lack of specialist rehabilitation services, particularly in the area of vocational rehabilitation, may increase reliance on Disability Support Pensions for those unable to pursue common law settlements for economic loss.

Question 25: Do you believe this is a correct assessment of the impact of option 2 on injured people and service providers?

Response to Question 25:

There may be significant impacts on specialist private sector rehabilitation and case management services which predominantly cater for adults catastrophically injured in motor vehicle and workplace accidents if private CTP insurers are no longer required to cover these costs under option 2. Introduction of both the NDIS and the NIIS will require all service providers in the community to 'step up to the plate' and

meet the increased demands of the sector. Retaining the existing expertise within specialist private sector services which provide services to CTP, TAC and LTCSS scheme participants, will help to enhance workforce capacity in response to increased demands. Maintenance of specialist expertise in state hospital and slow stream rehabilitation services is also vital.

Question 26: Do you believe this is a correct assessment of the costs and benefits of option 2?

Response to Question 26:

No. Refer to responses above.

Question 27: Do you have any data from consultation that has been conducted?

Response to Question 27:

The data presented in this response draws upon the experiences of QBISM members from public, private and NGO services for people with brain injuries and their families and other sources as outlined in the scope of this document.

Question 28: Do you have any comments on how each of the options meet the identified objectives?

Response to Question 28:

See responses above.

Additional consideration needs to be given to how the introduction of the NDIS and NIIS will meet the identified objectives for children with disabilities and their families. Parenting is integral to a child's development but the current system in Queensland does not always allow for adequate counselling for parents or engagement of families in the rehabilitation process which is known to result in improved outcomes. Therefore parenting capacity is compromised, and natural supports are depleted, leading to poorer outcomes for the child.

It is very unclear in paediatrics how the NDIS and the NIIS will affect services. There are concerns that current government therapy services (e.g. DSQ funded NGO's) will lose substantial funding which will lead to less integrated multidisciplinary services available to families.

Children with SCI or ABI have complex care needs, requiring tertiary level services. Currently, for children with funds via CTP or Better Start (cerebral palsy funding), it is difficult to find clinicians with the expertise or resources (equipment for trial, assessments etc.) to provide required services. There are negligible multi-disciplinary private practices for children.

Parents need specialist advice to make informed choices about service access. Who will pay for a child's health costs when they have further complications due to a

family's ill-informed decisions to contract services which are not based on evidence or best practice guidelines? In order to ensure private therapies are evidence based and best practice, will there be supporting funds for research and health funded specialist tertiary services to provide/input into standards for ongoing care for children?

What if a child's or adult's injury is not deemed to be catastrophic? There are many children and adults who would fall into this category but still need services and support. People with SCI and ABI have complex disabilities. Many have comorbid medical or mental health conditions, or challenging behaviour, all of which can result in a high reliance on health care services and family care. Failure to meet these needs, or to respond in culturally sensitive ways to those from indigenous and other culturally and linguistically diverse communities, may undermine health, to the extent that individuals then become NDIS eligible. Under the base case and option 2, the Queensland state government would incur the additional liability of funding these NDIS participants.

Additional Comments from QBISM Members

The Base Case and the options only cover 'lifetime care and support' and not productivity losses. Any decision on the Options must include a strong emphasis on vocational rehabilitation and/or mechanisms to support claimants to pursue heads of damages for productivity losses (and the associated productivity losses of their caregivers).

Both Option 1 and Option 2 should include an opportunity cost for the value of lost wages forgone by the carer as part of the rehabilitation component and the potential for caregivers to provide rehabilitation or therapy assistance for their relatives in the absence of sufficient and more expensive therapy services.

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