Supplementary table S9: **Meta-aggregation process for 'synthesised finding' 7** (16 findings which formed 3 categories).

Findings → **U = Unequivocal C= Credible**	**Categories** →	**Synthesised Finding (SF)**
No support or transitional help when at home in the community. TBI [98] ***U***	**Early period of transition to the community requires coordinated approach within and between services to prevent delay of support and rehabilitation provision (ABI, MS).**	**SF7: People with ABI and MS consider that a coordinated approach between community rehabilitation and support services is required to ensure continuity during transition to the community, and case management services may fulfil this role. Limited access to formal community rehabilitation and support services is experienced, for some people.**
Inter professional team working and referral between services recognized. BI [83] ***U***		
A need to enhance the outpatient's connection with community services, vocational and support services. ABI [90] C		
Continuity of care and services after returning home …'it's after that you run in to problems' TBI [114] ***U***		
Delays in organising formal support including lifestyle support services, advocacy groups, charity organisations and transportation services. ABI [132] ***U***		
Long process of Insurance funding and approval required perseverance with Doctor to ensure necessary communication between him and insurance company took place MS [97] C		
Concern and frustration over the limited number of services that offer post-discharge rehabilitation to individuals with ABI: the intensity of therapy provided; the limited duration of post-discharge therapy services; and the delay experienced in commencing outpatient services. ABI [131] ***C***		
Six participants reported that case management services performed the following roles during the transition phase: family and caregiver support, initial post-discharge follow-up/contact, emotional and psychological support, and referral/linkages with other services. ABI [131] ***U***	**Support from case management services fulfilled multiple roles and was valued during the transition phase (ABI).**	
Case management support limited at 1 month post discharge but was valued by those who received it. ABI [132] ***U***		
Negotiating the rehabilitation maze: Intensity of post discharge services varied but was generally lower than participants' pre-discharge expectations. ABI [132] ***U***	**Formal community rehab and support services (therapy, vocational support, transport, care at home were perceived to be limited by most people (ABI and MS).**	
Reassurance gained from knowledge that they could contact professionals if needed once the formalised RTW programme had ended. BI [83] ***U***		
Unmet needs and dissatisfaction with dissatisfaction with access to rehab and support services (nurse, GP, Doctor, OT) MS and ABI [14] ***U***		
Shortages of home care workers to support at home. ABI [111] ***U***		
Little or no support or guidance on when and whether to return to work TBI [108] ***U***		
Concern for continuation of day care programmes and associated activities [114] ***U***		
Difficulty in accessing post-discharge therapy services led some participants to: (1) turn to ''generic'' (,non ABI specific) rehabilitation services; (2) try alternative/ complementary therapies; or (3) ''make-up'' their own rehabilitation program (e.g., using a home gym, going for walks etc.) ABI [131] ***C***		