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# Commentary: Head injury

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It has been estimated that every year 8 per 100 000 of the population suffer severe head injury, 18 per 100 000 suffer moderate head injury and 250–300 per 100 000 suffer mild head injury (Medical Disability Society, 1988). It is likely that 100–150 per 100 000 of the population have significant disability as the result of head injury (Department of Health, 1994).

The case history illustrates that head injury patients will, in many cases, have a wide range of impairments, disabilities and handicaps (orthopaedic, neurological, psychiatric, psychological and social), which require input from a variety of medical and other health professionals as well as social services in order to make up a comprehensive package of care for the individual with support for the carers.

In terms of day-to-day management, it is often the neuropsychiatric sequelae of head injury which pose the greatest challenge to services. It would seem sensible, therefore, for there to be a psychiatric bias to the constitution of the patient care team, with staff who are experienced and confident in the treatment of people with cognitive disabilities and associated behavioural disorders, including the management of violence and aggression.

Such skills are particularly available within the psychiatric sub-specialities of learning disability and forensic psychiatry, and there may be advantage in having nursing and other staff from this kind of background forming the backbone of the staff of the head injury unit having direct care of the patient.

There may also be benefits in siting head injury units on the same campus as existing psychiatric facilities, or at least in close proximity to them. J. B.'s case illustrates some of the difficulties in having to rely on accessing outside psychiatric services with no direct involvement in the head injury unit.

The current organisation of service provision in the UK for such people renders it difficult to initiate, sustain and monitor a programme of care requiring, as it does, coordination across a wide range of disciplines and agencies.

There is considerable scope for joint planning and joint commissioning of services. Indeed, it could be argued that it is essential that such collaboration takes place both between different health providers and between health providers and other agencies, principally social services and the voluntary sector.

Services should aim to meet the needs both of the brain-damaged individual and his or her carers with a view to maximising their independence and quality of life (for example, the provision of respite care facilities), as well as minimising the impact on society of any adverse behaviours that may have arisen or been exacerbated following the injury.

The prevalence of disability following head injury suggests that there is an argument for the provision of dedicated brain injury rehabilitation services. This has been recognised by a number of district health authorities and the independent sector who have already developed specialised services. The Department of Health has also acknowledged the potential need for specialised head injury rehabilitation services and in 1992 established a five-year initiative across 12 pilot sites with the aim of looking at different approaches to the provision of such services. The sites are: Rayners Hedge Physical Rehabilitation Service, Aylesbury; Royal Cornwall Hospitals Trust, City Hospital, Truro; Derbyshire Royal Infirmary and Derby City Hospital; Frenchay Healthcare NHS Trust, Bristol; Regional Neurological Rehabilitation Unit, Homerton Hospital, London; Leeds Head Injury Team, St Mary's Hospital, Leeds; Regional Rehabilitation Centre, Hunters Moor Hospital, Newcastle upon Tyne; City Hospital Nottingham; Rivermead Rehabilitation Service, Oxford; Central Sheffield University Hospitals; Brain Injury Rehabilitation Group, North Staffordshire; and Evesham Community Hospital, South Worcestershire.

Evaluation of the pilot sites will be a challenging process. The style of different services has been

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influenced to a degree by local conditions, and meaningful outcome measures need to be developed. The perceptions of the patients and carers about the service and their quality of life needs to be given due weight. Activity levels are easier to measure but do not in themselves provide a reliable index of service quality.

When central funding ceases in 1997, the future of these services will depend on funding by the local purchasers. Purchasers need to be made aware of the volume and severity of the health need, the extent and effectiveness of current provision, and the estimated cost-effectiveness of any proposed developments. The latter may be couched, for example, in terms of reduced demand on other existing services or in a reduced requirement for extra-contractual referrals (ECRs) to another provider. Alternatively, the attraction of ECRs from outside the service may facilitate purchaser funding for part of a proposed development which the purchasing authority may otherwise consider not viable. Purchasers are increasingly looking at 'health gain' for a population, with an emphasis on outcome measures and disease prevention. There is also recognition of the role of other agencies such as social services and the voluntary sector and a desire to liaise with these and other non-health care agencies.

## References

Medical Disability Society (1988) *The Management of Traumatic Brain Injury*. London: Royal College of Physicians.

Department of Health (1994) *Report of the Brain Injury Rehabilitation Conference, Peterborough*. Document F66/003 IP 5K DEC 94. Heywood, Lancashire: BAPS Health Publication Unit.

## Multiple choice questions

1. Drugs which may be useful for aggression include:
   a beta-blockers
   b tricyclics
   c buspirone
   d benzodiazepines
   e lithium.

2. Manifestations of head injury include:
   a depression
   b anxiety
   c inappropriate social behaviour
   d loss of drive or initiative
   e emotional lability.

3. The most appropriate service models for head injury are:
   a medical
   b psychiatric
   c nursing
   d social
   e multi-disciplinary.

MCQ answers

| 1 | 2 | 3 |
|---|---|---|
| a T | a T | a F |
| b T | b T | b F |
| c T | c T | c F |
| d F | d T | d F |
| e T | e T | e T |

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