

A Response to 'Rehabilitation Abroad' article

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In the March/April 2004 issue of ACNR, Dr Neil Brooks wrote an article 'Rehabilitation Abroad' arguing for the benefit of rehabilitation outside the UK. He used an example of a young man (KL) who sustained a severe head injury and received rehabilitation at the Kliniken Schmeider clinic in Germany. KL is now attending The Oliver Zangwill Centre for Neuropsychological Rehabilitation (OZC) in Ely, Cambridgeshire. The team at the OZC together with KL and his wife, would like to respond to this article. We believe that we are in a unique position to make these points both because we are a British Rehabilitation centre and because we are now working with KL. He and his wife have consented and contributed to this response.

Although we agree with Dr Brooks that brain injury rehabilitation in the UK has its limitations, needs additional funding, expansion and co-ordination of services, we also feel that he has overlooked some of the strengths to be found in British brain injury rehabilitation. We believe his comments are sometimes over-generalised and selective.

By considering all of the British services together and then comparing an averaged view to one specific German centre, Dr Brooks has provided a contrast that rhetorically supports his argument. However, we feel that this account masks several critical issues pertaining to Brain Injury services, both in the UK and abroad. Dr Brooks' article assimilated the range and diversity of rehabilitation services together into an 'inadequate mass', serving to highlight the specific contributions of the German unit as a timeless, ubiquitous solution to UK provision as a whole.

First of all, this construction provides little recognition of the variability of service provision across the UK. This variability includes poor services in addition to services of world-wide excellence. In addition, a variety of rehabilitation philosophies within this UK spectrum have been documented^{5,6,7,8}, contrary to Dr Brooks' assertions.

Secondly, Dr Brooks' assimilation of UK services ignores the transition of service provision that clients may typically require following a brain injury in the UK, moving from acute care to post-acute rehabilitation and benefiting from psychosocially orientated community outreach follow-up and long-term integration into their local community. The latter need is hard to meet when the treatment centre is in a different country from the client's own home. Differing services provide a valuable input at differing points along this transition. It is acknowledged that this variability can lead to unpredictability for clients and families across time, and optimal communication and liaison across services can serve to produce a chronological experience of brain injury services that is greater than the sum of its individual parts. Indeed, our own partnership with Rehab without Walls in meeting KL's evolving needs is collectively valuable in this respect.

In ignoring this progression from acute to long-term support, and in referring to the German unit as a 'one-stop shop', it is uncertain if Dr Brooks is really implying that this unit can provide these services at all points along this transition. As a service that has been providing community-based input to KL since his return from Germany, we have reflected that the philosophy and work conducted there was in itself not orientated towards the long-term psychosocial needs of clients and families several years after injury. These are needs that Dr Brooks himself has empirically demonstrated^{1,2,3}, and which we feel the collaboration of UK-based components of KL's post-acute package are predominantly addressing. KL's



Members of the Oliver Zangwill Centre team.

wife reflected that while accessing the German unit was itself unproblematic, she was unsure what effect this distance may have had on family relationships in the long term.

Dr Brooks' argument may have also been clarified by an explicit description of what the German unit does actually offer. Having commented on the fact that Rehabilitation Teams in the UK 'may exist in name only', it would have been helpful to have specified whether 'team' was referring to a multi-disciplinary or interdisciplinary team approach. It would have also been useful to explain in detail which professional groups comprised the team in the German Unit and specified the nature of their interactions.

To suggest that the existential needs of clients are 'alien to many neuro-rehabilitation services in Great Britain' is not the experience that we have found from many of the neuro-rehabilitation services we come in to contact with. Our workshops focusing on psychotherapy approaches such as Cognitive Behavioural Therapy are attended by rehabilitation professionals from teams all over the UK, who are very keen to prioritise issues of subjectivity, identity and meaning during the discussions at these events. Dr Brook's suggestion also appears to ignore the growing literature on psychotherapy approaches and the psychosocial dimension of Traumatic Brain Injury (TBI) (eg, last year's special edition of Neuropsychological Rehabilitation that brought together a collection of UK-based perspectives on varied psychosocial topics). Many British units adopt a holistic goal setting programme encouraging/allowing clients to incorporate individual and spiritual needs, and to share common thoughts which surround the rehabilitation process of that individual. On reflection, KL and his wife felt that issues such as reclaiming pre-injury identity, coping with the emotional consequences of TBI and rediscovering meaning following the injury, were dimensions of experience that he has explored since his return from Germany.

From our discussions with KL and his wife, it is clear he received intensive physiotherapy during his stay, however there was limited functional based work or psychology input that he required including use of current, evidence based treatment to treat neuro-psychological deficits. There is little evidence that computer based exercises generalise to real life situations⁴. However, KL was given cognitive remediation/restorative exercises for example computer based work including practising line bisection. This resulted in improved scores on a computer based line bisection task but continued difficulty with generalising this to functional tasks in his community such as finding objects in the supermarket to his affected side.

KL's key points of the benefits of Kliniken Schmeider

- Pleasant, adapted living accommodation which was in the rehab centre

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- Good recreational facilities- table tennis, pool, swimming pool, use of drum
- Daily physical therapy focusing on balance and co-ordination - learning to ride a tricycle
- Breathing exercises
- Meeting other people with head injuries- some of whom had their injuries many years previously
- Group work
- Able to visit other countries easily from Germany e.g Switzerland
- Able to buy cigarettes easily and cheaply in the local town

KL's key points about the benefits of the rehabilitation he is currently receiving at the OZC

- Psychological support which has been 'a personal boost' leading to improved confidence and 'not feeling embarrassed anymore'
- Cognitive aspects seem 'much easier' eg shopping
- Group-work
- Long-term goals and needs 'what's important to me' eg work and bikes
- Home visits have proved very productive 'to go over stuff learnt at OZ' in the home environment leading to increased independence in functional areas.

References

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The OZC experience of treating clients from overseas

We have on occasion admitted clients from other countries including Canada, Israel, South Africa and Greece. We do not see this as ideal as one of the main aims of rehabilitation is to enable people with brain injury to return to their own most appropriate environment. Also, there is often considerable time and financial constraints to be considered and limited knowledge of service provision in the client's own country in order for intervention to be effective. Nevertheless, sometimes it is 'the lesser of two evils' to admit people here if there are no appropriate services in their own countries. In such cases the discharge from rehabilitation and consequent follow-up must be managed carefully.

Conclusions

Our input in tandem with Dr Brooks' service continues to be a successful partnership in providing continuing and progressive support for KL's evolving needs and those of his family. We feel that this longitudinal UK provision requires highlighting to situate and most helpfully advocate the value of a time-limited input from a unit such as Kliniken Schmieder as a specific component. It was the contrast by Dr Brooks, of this unit with UK brain injury services as a whole, that seemed to us to mask the national-level collaborations that provide a world-wide standard in post-acute brain injury care.