Clinical Neuropsychology and Rehabilitation Services for Adults with Acquired Brain Injury
Clinical Neuropsychology and Rehabilitation Services for Adults with Acquired Brain Injury was written by the British Psychological Society Division of Neuropsychology.

The British Psychological Society
St Andrews House
48 Princess Road East
Leicester LE1 7DR

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Executive summary

In 1989 the British Psychological Society proposed a model of services for people with acquired brain injury (BPS, 1989). Since publication of that document, a number of other reports on the management and rehabilitation of people with acquired brain injury have been published and considerable advances have taken place in our scientific understanding of rehabilitation following brain injury. There have been developments in service provision, but we suggest that service provision remains patchy across the UK and does not yet fully meet the needs of people with acquired brain injury.

We identify a number of reasons why comprehensive acquired brain injury services have not been established in a consistent manner across the UK. The reasons include:

- the wide range of potential needs of people with brain injury;
- a lack of specialist knowledge and skills;
- the needs of people with brain injury can fall between the criteria for currently established services;
- a lack of effective coordination of services between agencies and lack of inter-agency planning.

We outline a comprehensive service model, based on proposals by McMillan (2003) and Herbert (2004). The model has a network of services designed to meet the wide range of potential needs of people with an acquired brain injury.

We make the following recommendations, which are consistent with many of the recommendations made in the report of the House of Commons health select committee’s (2001) inquiry into head injury rehabilitation:

- We recommend that all health authorities identify a brain injury service network, with care pathways between elements of the network, to ensure that people with acquired brain injury can move through the system as smoothly as is possible. It is recognised that there will be a wide range of possible pathways because of the huge range of potential needs of people who have suffered brain injury and hence an integrated network of services is required.
- It is imperative that people with a suspected brain injury are assessed and treated by specialist rehabilitation staff as soon as possible after medical stabilisation. We recommend that early management and rehabilitation wards are established for those people staying in hospital more than 48 hours.
- We recommend that specialist facilities should be identified in the service network to provide rehabilitation for those patients with high levels of physical dependency, those who are minimally responsive or those who present with severe challenging behaviour.
- We recommend that the central component of the post-acute community rehabilitation service should be a non-residential community brain injury rehabilitation centre, housing a community brain injury rehabilitation team. This centre would provide day rehabilitation programmes, community treatment interventions, provide a minor head injuries service as well as providing an information resource for families and carers.
- We recommend that there is more effective integration of community brain injury rehabilitation teams and vocational rehabilitation services. Where possible, we believe it would be optimal for a job coach or employment facilitator to be based within the community brain injury centre, working as part of the rehabilitation team.

It is recognised that within local areas various aspects of service will already be provided, but that there will be gaps. It is proposed that by reconfiguring existing provision identified needs may often be met more effectively, without necessarily requiring significant additional funding, though in some cases major gaps in service provision may exist, requiring new investment.

Since the previous BPS report, there have also been a number of developments in the training of clinical neuropsychologists in the UK. We therefore also discuss in this report the specific contribution that is, or could be, played by clinical neuropsychologists within brain injury rehabilitation services.

The tasks undertaken by clinical neuropsychologists include:

- assessment of cognitive functioning;
- assessment of mood and emotion;
- treatment and management of cognitive impairment;
- treatment of mood disorder;
- management of behaviour problems;
● education for relatives, carers and other professionals on brain injury and its consequences;
● research and audit – for example, evaluations of outcome of rehabilitation.

With regard to research, it is noted that the House of Commons health select committee report (2001, para. 41) recommended that the Department of Health allocates more of the R&D budget to research into traumatic brain injury rehabilitation. Clinical neuropsychologists are at the forefront of research in brain injury rehabilitation. Nevertheless, there is a great deal of potential for more research to improve our understanding of how to improve the quality of the lives of people with acquired brain injury.
Introduction

Acquired brain injury (ABI) is the term used to describe damage to the brain resulting from a discrete incident (or incidents) of traumatic injury, illness or infection during the lifetime of the individual. It excludes congenital or birth injuries, and is not used to describe degenerative conditions such as Alzheimer’s disease, Huntington’s disease, Parkinson’s disease or multiple sclerosis. It includes traumatic brain injuries, arising from, for example, assaults or road traffic accidents, strokes, tumours, cerebral infections, and anoxia. Anoxic damage may occur secondary to other conditions such as diabetic coma, cardiac arrest or drug overdose.

In the late 1980s and early 1990s there were a number of papers outlining comprehensive rehabilitation services for people with acquired brain injury (Fussey & Giles, 1998; Oddy et al., 1989; Wood & Eames, 1989; Wade, 1991; McMillan & Greenwood, 1993; Greenwood & McMillan, 1993). There was broad agreement about the components of an effective service, and the model proposed by the British Psychological Society in its 1989 report Services for Adults with Acquired Brain Injury was consistent with these recommendations.

In the intervening years there have been reports identifying omissions, gaps and failings in services, particularly in relation to poor communication and follow up, and there have been repeated calls for better coordinated services. These reports include:

- Social Services Inspectorate (1997) report A Hidden Disability;
- Centre for Health Services Studies, University of Warwick (1998) National Traumatic Brain Injury Study.

The restructuring of NHS and Social Services over the past 15 years and, particularly, the more recent emphasis on primary care and decentralisation have had a major, and not always helpful effect, on service provision for people with acquired brain injury. While the concepts of seamless and integrated services involving health, social services and vocational support are well rehearsed and well supported, implementation of these ideas has been difficult to achieve and hence service provision remains patchy across the UK.

At the same time, there have also been some positive developments in brain injury services across the UK and research published on the effectiveness of rehabilitation interventions after brain injury. The present report therefore begins by addressing the question of why it has proved difficult to establish comprehensive and consistent ABI rehabilitation services across the UK to date. Taking into account the recommendations of key recent reports, the experience of service developments and findings from research, a revised model of service provision for people with acquired brain injury is then proposed.

In addition, this report will consider the specific contribution that clinical neuropsychology services can make to meeting the needs of people with acquired brain injury. Clinical neuropsychology has developed as a profession over the past twenty years and is now an integral part of service provision for people with acquired brain injury. The contribution made by clinical neuropsychology includes, but extends beyond, the provision of reliable and valid assessments of clinical need, and advice concerning rehabilitation interventions and placement. Research is a key function of clinical neuropsychology services, as is staff training and development.
Why has it proved so difficult to establish comprehensive ABI services?

1. The needs of people with ABI are highly variable
Acquired brain injury can potentially cause a huge range of physical, cognitive, emotional and behavioural problems. As a consequence, it is hard for any one service to meet the full range of needs. Some of the needs may be obvious, for example physical care needs that require ‘hands-on’ care or significant memory or temper control problems that require active management. However, other needs are more subtle, such as changes in personality or changes in planning and problem solving skills. Problems in these areas may only become apparent several months or years after the injury, but may dramatically affect relationships with family and friends or the ability to obtain and maintain employment. People with brain injury frequently experience social isolation as they are unable to return to previous work or leisure activities either as a result of their physical limitations, or more commonly as a consequence of the cognitive and behavioural difficulties. It is recognised that such social isolation exacerbates family breakdown and increases the likelihood of mental health problems subsequent to the brain injury both for the individual themselves and for family members (Oddy et al., 1985). Service provision therefore needs to meet the need for meaningful activity and in a way that supports active participation. This does not necessarily mean “hands on” care but may include support or guidance from specialist professionals and/or appropriately trained and experienced support workers. Patterns of recovery too are highly variable and needs change over time. Some people need a lot of support initially, but then recover sufficiently well to need little or no longer term input. Some people have clear needs from the time of injury and for the rest of their lives. Some make a good initial recovery, but difficulties only become apparent later as greater demands begin to be made (e.g. upon return to work). Others may have needs, but for various reasons may initially reject services, and then need access to support later on.

This paper will propose a service-network model that would provide the flexibility required to address the wide range of needs of individuals as they progress through the recovery, rehabilitation and adjustment process after brain injury.

2. The need for specialist knowledge
The fact that many of the problems that arise from brain injury are subtle, often described with terms such as ‘hidden disabilities’, highlights the need for staff to have specialist knowledge. For example, a particular challenge to service provision is the common problem of lack of awareness of deficits i.e. where the person with the brain injury does not recognise their difficulties or the effects these difficulties have on their life or the life of their family. Identifying this problem and finding a way of engaging the person with the brain injury in an agreed shared programme of care or support is a major challenge for rehabilitation and longer term support services, and is a good example of why such services need to be specialised rather than generic – unless the staff are trained and experienced in the hidden nature of many problems arising from brain injury, people will continue to slip through the net of service provision and yet have considerable unmet need.

3. People with acquired brain injury often fall between established services
Rehabilitation and longer-term support services have traditionally been established to meet diagnostic categories (learning disability, physical disability, mental health) and many people with acquired brain injury do not meet referral criteria for these services. This means that they miss out on expertise that could be helpful and are not able to access certain kinds of support.

4. Inter-agency working is not always easy to achieve
Acquired brain injury is, for many people, a life-long condition, and one that affects most aspects of life including health, personal and domestic activities of daily living, social functioning, education, employment and leisure. However, services that are currently available are typically not ‘joined up’, in terms of funding, inter-agency referral and joint-working.
A revised model of service provision: The ABI service network

The model proposed in Figure 1 draws on models suggested by McMillan (2003) and Herbert (2004). It is recognised that within local areas various aspects of service will already be provided, but that there will be gaps. It is proposed that a reconfiguration of existing provision may often better meet identified need, without necessarily requiring significant additional funding, though in some cases major gaps may exist in service provision requiring new investment. Beyond the acute hospital-based phase, the focus of the proposed model is the Community Brain Injury Service (CBIS). This forms the core of the service provision and the main resource.

Acute and post-acute care

The Royal College of Surgeons (RCS) has provided a clear proposal on how head injuries (traumatic brain injuries) should be managed in the very acute stage post-injury. The current report is intended to build upon the suggestions of the Royal College of Surgeons to indicate the services required for rehabilitation following acquired brain injury. The RCS report recommends that patients with head injury should be transferred to rehabilitation facilities as soon as they are medically stable. There is now a considerable body of evidence to support this contention. Failure to do so can result in inappropriate management, which often leads to physical and behavioural complications. (Johnson & Balleny, 1996). McMillan (2003) suggests that for those people with ABI admitted for more than 48 hours, an early management and rehabilitation ward is needed. The functions of this ward would be to monitor prolonged coma and recovery, provide a safe environment, prevent contractures and sores developing, maintain posture, offer active rehabilitation for those who are able, taking account of likely fatigue, and as soon as appropriate discharge to the next step in rehabilitation (McMillan, 2003, p.280). A variety of onward routes would exist, reflecting the range of possible needs. Some patients will have significant physical disability and need to transfer to a rehabilitation environment with expertise in the management of physical disability, as well as the skills to manage cognitive, mood, and behaviour difficulties. Other patients will have less physical disability, but the level of cognitive impairment may still be sufficient to mean that discharge home is not appropriate and inpatient rehabilitation is required.

Patients with high physical dependence

Although the vast majority of patients with acquired brain injury do not have a major physical disability, there is a small group of the most severely brain injured people who remain highly physically dependent over many months following their brain injury (Greenwood & McMillan, 1993). These patients may require assisted breathing or tube feeding. Active rehabilitation is nevertheless imperative to minimise the effects of spasticity, contractures and heterotopic ossification. Specialist skills are required to maintain nutrition and communication. These patients (less than 1 in 200,000 population per annum) require specialist neurological rehabilitation with an emphasis on physical rehabilitation. In the early stages, where the pace of recovery is unclear, such patients are best managed within a post acute unit where their potential can be realised. However, if it becomes more apparent that they will need a prolonged period of specialist rehabilitation and physical care, they may benefit from the high level of expertise available in specialist centres for people with heavy physical care needs which may include services for people who are minimally responsive.

Patients who are minimally responsive

There is a small subgroup of patients who require long-term coma care. These patients remain in an unresponsive state for several months, or even longer. They require specialised medical, nursing and therapeutic care in order to maintain their physical well-being. This helps avoid the complications of immobility and malnutrition. The specialised assessment of such patients is essential as some may suffer from the “locked-in” syndrome, a condition in which a person may appear to be in a coma because of their inability to respond but in fact retain considerable or full awareness and cognitive ability. The highly specialised nature of this work has meant that services have developed within a small number of centres, predominantly in the independent sector and this is likely to continue.
Figure 1: The ABI service network
Community brain injury rehabilitation centre (non-residential)

At the heart of the community brain injury service, there should be a community brain injury rehabilitation centre, which should provide a number of services that meet the rehabilitation needs of the majority of people who suffer a brain injury and of their families. Exactly how the service is delivered will depend to some extent on existing provision and will be affected by geographical location, for example rural versus urban services. However, the centre should seek to provide services such as day-patient rehabilitation programmes, outreach/community rehabilitation, a minor head injuries clinic (as suggested by the Royal College of Surgeons (RCS) report), a resource and information centre (as suggested by the RCS and the British Society of Rehabilitation Medicine reports), and a source of support for carers. Such a centre would also be able to develop strong links with voluntary groups such as Headway and, where necessary, provide facilities for the activities of such groups.

Evidence exists for the effectiveness of community based brain injury services. A study by Powell et al. (2003) suggest that an interdisciplinary community team focused on acquired brain injury and working on time-limited, goal-oriented interventions can produce significant gains when compared to an information-only control group. We propose that such teams should be available in all localities.

Since our previous report in 1989, a number of community rehabilitation teams have been established. Most teams, however, focus on rehabilitation of physical disability, with stroke and multiple sclerosis being the most common referrals. Few teams have been set up to work solely with individuals with an acquired brain injury (McMillan & Ledder, 2001). Although some such teams have been set up on a short-term, experimental basis, wide variations exist in terms of team composition, management arrangements and the aims of the service (Enderby & Wade, 2001). More significantly, in McMillan and Ledder’s (2001) study of community rehabilitation teams in South East England, it was found that less than three per cent of those disabled by traumatic brain injury had received help from a community team and only two out of 35 teams specialised in the consequences of cognitive impairment and psychosocial changes.

It is also noted that community teams would need to be able to refer to regional or national centres of excellence for the provision of specific rehabilitative input and have clear systems for managing follow-up. Highly specialist input to assist in the development of specific compensatory strategies for cognitive disabilities may be required (see Wilson et al., 2000). Such services for cognitive-neuropsychological rehabilitation are scarce, but it is important that such services should be accessed if appropriate. The development of new and cost-effective technologies in this area, particularly as regards information technology systems for managing cognitive disability, is an area of particular importance for purchasers of services to be aware (Wilson et al., 2001, Wright et al., 2001).

This service model would provide the best opportunity to ensure a satisfactory service for families and carers. The vast majority of care and support to individuals with a brain injury has always been provided by their families. This is unlikely to change. It is therefore essential that such families receive sufficient support, information and assistance to allow them to fulfil this role for the maximum benefit of the brain injured client and the least possible degree of distress for the family. This is consistent with the recommendation of the House of Commons Health Committee on Head Injury Rehabilitation (2001) which states ‘we recommend that the statutory services re-evaluate their procedures to ensure greater involvement of the families of head injured people in the person’s recovery and rehabilitation and the provision of support systems for the family independently of the treatment of the head injured person’.

Vocational rehabilitation

Studies of return to work following acquired brain injury show varying rates of return depending on the severity of the initial injury (Haffey & Adams, 1991; Kreutzer et al., 2003). However, all studies point to the fact that many people with acquired brain injury are unsuccessful in their attempts to return to work, even many of those with mild to moderate injuries. A considerable body of evidence has developed over the last 15 years from around the world to suggest that specific vocational rehabilitation can significantly increase the chances of a successful return to work and that this is cost effective (Wehman et al., 1994; Abrams et al., 1993). The evidence suggests that although different models of rehabilitation have been applied, including varying levels of preparation for such a return, the involvement of a ‘job coach’ can be highly successful. The role of this individual can include seeking suitable opportunities for the individual, negotiating with employers over a suitable job.
description and number of hours of work, supporting those in the workplace who will be working directly with the brain injured individual to help them understand and accept the needs of the individual with the brain injury, accompanying the individual to the workplace in the initial phases followed by a gradual withdrawal but continuing to provide support and to troubleshoot as required (Wehman et al., 1989a, 1989b, 1995). The major problem in the development of such services in the UK has been a lack of agreement as to who should fund such a service. Specific vocational rehabilitation projects have to date been funded by all of the main agencies (Departments of Health, Social Services and Employment). It is proposed that the most appropriate way of delivering a vocational rehabilitation service would be for a Job Coach/Employment Facilitator to work as part of a community team based in the non-residential community rehabilitation centre, liaising with wider vocational rehabilitation services.

**Challenging behaviour**

An important minority of those who suffer an acquired brain injury develop challenging behaviour. There is evidence that appropriate care in the acute stage of recovery can reduce the incidence of this but, also evidence that the incidence of challenging behaviour increases rather than decreases following discharge from hospital (Johnson & Balleny, 1996). A number of centres specialising in the management of challenging behaviour have developed over the last 25 years, mainly in the independent sector. Evidence has accumulated that appropriate management, intervention and environmental control can significantly reduce the severity of challenging behaviour and allow the individuals to lead more independent lives. There is a considerable body of evidence that suggests that behavioural problems have the most damaging effect on the ability to live independently and to return to work. All brain injury services should be able to accept and successfully manage mild and moderate degrees of challenging behaviour. However there is a continuing need for residential challenging behaviour units on a regional or supra-regional basis. Such centres should embrace neurobehavioural models of rehabilitation (Wood & Worthington, 2000). There is also a need for longer term resources for those whose challenging behaviour limits their ability to reintegrate into a community setting.

**Residential rehabilitation centres and care homes: Slow-stream rehabilitation**

Although the majority of patients with acquired brain injury can and should be managed by appropriately resourced community services, there are others who, without presenting the extremes of challenging behaviour, do require some form of residential rehabilitation. Such a need depends legitimately not only upon the severity and nature of their brain injury, but also upon the nature and degree of support available from their families. At present many such patients are placed in nursing and care homes with little or no specialist input or review. Such patients often receive a poor service and lose the opportunity to make further progress. A recent survey of 92 people, under 64, with ABI living in nursing homes in Glasgow (McMillan & Laurie, 2004) found that more than a third exhibited challenging behaviour. Only two were receiving behavioural rehabilitation supervised by a clinical psychologist. A minority of these residents received proactive reviews from a consultant during the one-year study period. About a quarter received input from a physical disability community team (PDCT) but such teams noted difficulty in achieving rehabilitation goals because nursing home staff did not continue treatment regimes between team visits. The majority were on psychotropic medication with infrequent review. It is recommended that longer term residential rehabilitation or care facilities should be in community settings, rather than hospital sites, and should be in facilities specialising in ABI which have the aim of increasing the person’s ability to adapt and cope with the impact of their brain injury and to lead as active and constructive lives as possible.

**Supported housing schemes**

Whilst the vast majority of people with brain injury will return to a degree of independence in the community, either living alone or with family members, there are a number of people whose continuing disabilities are such that they need a high degree of support and supervision in order for them to integrate successfully into a community setting. There needs to be a range of schemes offering varying levels of support from twenty four hour supported accommodation through to a few hours a week of input. The type of support required for the cognitive or behavioural changes associated with ABI is not readily provided by home care or nursing agencies without specialist training. Local services need to identify a specialist provider or to train their own staff to provide appropriate input.
**Case management**

One approach to improving coordination of care at least on a case by case basis has been the development of ‘case management’ services both within the statutory sector (McMillan et al., 1988) and within the independent sector. One aim of case management is for a Case Manager to support the person with brain injury in accessing all of the relevant services. Greenwood et al. (1994) identified that case management did increase the chance, and range, of contact with services, but did not increase the duration of contact or result in a demonstrable improvement in outcome. They argued that case management was not a substitute for adequate service provision. The Centre for Health Services Studies National Traumatic Brain Injury Study (1998) reported more positively on the longer term monitoring provided by case managers. The present report highlights the wide range of services required to meet the varied needs of people with ABI. This complexity in service provision means that it is easy for individuals and their families to fall through the service provision net unless there are very close links between the elements of the network. We suggest that in the absence of well-integrated, comprehensive brain injury services, brain injury case managers fulfil an important role in supporting people in accessing appropriate services, though the effectiveness of case management is limited by the availability of appropriate services. Case management is however particularly useful in the situation where funding is available through an insurance based compensation claim, which allows services to be purchased from a wide range of potential sources.

The network of services outlined above would meet, we suggest, the needs of the majority of people with brain injury. We turn now to the specific function of clinical neuropsychologists within this service model. The document ‘Commissioning Clinical Neuropsychology Services’, published by the British Psychological Society (2004), provides information on the training, functions, and recommended numbers of neuropsychologists. Here we concentrate on the contribution of the clinical neuropsychologist in the brain injury rehabilitation services.
The contribution of the clinical neuropsychologist

What is a clinical neuropsychologist?
Most clinical neuropsychologists working with adults are clinical psychologists by professional training who have undergone further training and gained experience in the field of clinical neuropsychology. Clinical Psychologists are trained in psychological assessment and formulation, psychological therapies, behaviour management, and are skilled in providing clinical supervision, teaching and undertaking research. There is now an accredited qualification in Clinical Neuropsychology. This is the Division of Neuropsychology Practitioner Full Membership Qualification (PFMQ), which is awarded by the British Psychological Society. The PFMQ is awarded to candidates who already hold a qualification in clinical psychology and can demonstrate additional specialist knowledge (assessed by four examinations), clinical experience (assessed through examination of supervised clinical practice log and case reports), and specialist research skills (assessed through the examination of a research thesis).

What are the key tasks undertaken by the clinical neuropsychologist?

Assessment
Neuropsychological assessment is the cornerstone of any ABI service. Such an assessment measures the extent and nature of cognitive deficits and can monitor any change in these. As such it identifies the likely difficulties a person will encounter in their day to day lives and provides the basis for designing a rehabilitation programme. A key part of the assessment is an examination of mood/emotional problems, which is important in its own right, but also in relation to performance on cognitive tests as low mood or anxiety can affect performance on cognitive tasks.

Advice regarding rehabilitation programmes and techniques
At present cognitive rehabilitation is based primarily on relearning and compensation through the use of strategies (Wilson, 1997). As such psychological theory, practice and techniques provide the basis for rational, evidence-based rehabilitation. Clinical neuropsychologists may work on a one-to-one basis with patients to devise interventions to help those individuals manage cognitive problems, or may offer advice to other therapists on the management of cognitive problems in relation to coping with everyday task demands.

Clinical neuropsychologists are also able to assess and treat mood disorders, with appropriate psychological therapies. Research has shown that mood disorders are very common in ABI (Williams & Evans, 2003). For example, population based research in Denmark identified that the risk of suicide is considerably elevated for people with acquired brain injury (Teasdale & Engberg, 2001). In a recent editorial comment in a leading British journal (Lewis, 2001), it was noted that the mental health needs of people with acquired brain injury are not adequately addressed. A call was made for more effective and efficient systems for ensuring that the mental health needs of people with brain injury are properly assessed and managed. Clinical neuropsychologists have the appropriate training to be able to undertake this task in conjunction with colleagues from other disciplines (e.g. neuropsychiatry). Evidence is growing that the application of psychological therapies, adapted for people with cognitive impairment arising from brain injury, are effective in reducing psychological disorder after brain injury (see Williams & Evans, 2003, Williams et al., 2003).

Management of behavioural problems
A strong body of evidence suggests that a combined approach of medication and psychological approaches to changing behaviour provides the optimal means of helping those with challenging behaviour. Monitoring outcome of such approaches also involves psychological methods of behavioural observation, recording and evaluation. As such the clinical neuropsychologist often acts as the leader of the clinical team where challenging behaviour is prevalent (Oddy, 2000; Wood et al., 1999).

Outcome evaluation
The increasing emphasis on evidence-based practice means that the measurement of rehabilitation outcomes has received considerable attention. Significant advances have been made in outcome evaluation using psychometrically valid techniques. Outcome may be measured in terms of the return of skilled behaviour and greater independence, measures of mood, self-esteem and psychological well-being, measures of participation in so-called normal activities and roles and in self-ratings of quality of
life. As with all measures of individual differences it is important that such instruments have sound psychometric properties and are reliable and valid.

Another important facet of outcome evaluation (and of the process of rehabilitation in general) is goal planning. There is general acceptance that brain injury rehabilitation should be built around the formulation of specific goals. This enables a focussed, case-centred approach to rehabilitation and enables efficacy to be measured in terms of goal attainment (Powell et al., 2003; Williams et al., 1999).

Clinical psychologists are trained in the use of outcome evaluation tools and so can offer advice on the application of appropriate tools within brain injury rehabilitation services.

Teaching
A key task for brain injury rehabilitation services is to provide education and training to relatives, and care staff as well as in-house continuing professional development for members of the team. As part of their training, clinical psychologists develop skills in teaching other professionals and often have experience of teaching unqualified staff, relatives and carers as well as undertaking psycho-educational work with patients.

Research
Clinical neuropsychologists are trained in a wide range of research methods and statistical analysis techniques. As such they can make an important contribution to the establishment of active research programmes within clinical services. This is often best achieved through collaboration with colleagues within academic/research institutions.

The report of the House of Commons health select committee’s inquiry into head injury rehabilitation (2001) recommended that the Department of Health allocates more of the R&D budget to research into traumatic brain injury rehabilitation (para. 41). Clinical neuropsychologists are well equipped to be at the forefront of research in brain injury rehabilitation.

References


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