Traumatic Brain Injury- Exploring the gaps in unmet needs through Critical Discourse Analysis

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Abstract

Following sustaining a Traumatic Brain Injury (TBI), individuals describe reduced access to adequate services. Research cites barriers to access as funding disparities between localities, disjointed communication from acute to post-acute services, an inadequate workforce, and charities filling the gaps between services. Inadequate services significantly impact the lives of those with TBI and can affect the development of functional gains post-injury.

Research has yet to explore the influence of policy on meeting the needs of those with TBI. The current study aimed to address the social problem of unmet needs within a TBI community by critically appraising relevant recent parliamentary texts. With an added intention of exploring ways clinical psychologists' can engage with the political context of their work. Fairclough's (2001) 5 stage framework for Critical Discourse Analysis (CDA) was utilised to explore the underlying conceptual frameworks within these texts and their impact on how services were operationalised in this community. A critical realist epistemological position was adopted.

A comprehensive historical analysis was undertaken to identify wider discourses that influence this social problem. Seven debate titles from June 2018 to November 2020 were identified for a detailed discursive analysis. These debates were organised following the establishment of the All-Party Parliamentary Group on Acquired Brain Injury (APPG-ABI) in 2017.

The analysis indicated that discursive obstacles to the social problem could be found in systemic barriers, conflicting roles of obligation and action, implicit and explicit prejudice, the power within the personal experience and gendered narratives. These discourses allowed for the generation of new knowledge regarding the networks and

structures that cause inertia in solving this social problem. Networks and structures these identified discourses operated in included, unintegrated care pathways, structures within government operations and the reality of working in NHS settings. Implications for clinical psychologists overcoming these barriers and working in social policy settings were considered.

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1.0 Introduction

1.1 Traumatic Brain Injury (TBI)

TBI is an injury resulting from an external force to the brain, causing transient or permanent neurological dysfunction (McKee & Daneshvar, 2015). TBIs are defined by the severity of the injury; the most common measure to do this is the Glasgow Coma Scale (GCS) score. The GCS focuses on the loss of consciousness duration or the presence of post-traumatic amnesia. These scores are then translated into mild, moderate or severe injuries (Teasdale & Jennett, 1974).

All levels of TBI can be associated with long-term physical, emotional, behavioural, and psychosocial impairments that can permanently affect an individual’s ability to perform routine activities and return to work (Andelic et al., 2010; Andrewes et al., 2014; Daneshvar et al., 2011; Langlois et al., 2006). Most notably, these impairments often reduce health-related quality of life (Polinder et al., 2015; Sigurdardottir et al., 2009; Stocchetti & Zanier, 2016).

Ten million people are affected annually by TBI, it is one of the leading causes of death and disability (UK Medical Research Council, 2022). In the UK, annually, there are 900,000 accident and emergency attendances concerning head injuries, and approximately 1.3 million individuals living with disabilities resulting from these injuries (Yates et al., 2006). This is likely a gross misrepresentation as the vast majority of those with head injuries do not attend medical settings (Parsonage, 2016). TBI has the highest incidence of all common neurological disorders and poses a substantial public health burden (Maas et al., 2022).

Throughout this report, it is important to clarify the shift between terminologies used. TBI sits under the umbrella term Acquired Brain Injury (ABI), ABIs are injuries caused to the brain after birth that cause an alteration in brain function. ABIs can be caused by infection, tumours, strokes or trauma to the head (TBI) (Headway, 2018). At times, the literature in this report is drawn from ABI research. This study is focused on TBI specifically but will draw on relevant material from other conditions where a dearth of TBI information is available.

1.2 Literature Review

A systematic review of the qualitative literature was attempted to identify what is already known about parliamentary stakeholders' influence over NHS services regarding meeting the needs of those with TBI. Due to the nuance of the topic, no relevant papers existed to conduct a systematic review (see the PRISMA flowchart in Appendix 1). The search terms shown in Appendix 1 yielded five published papers. A further hand search was conducted to search the reference lists of the identified papers.

The study considered conducting a systematic review, exploring other relevant stakeholders' perspectives on unmet care needs within a TBI population. However, several key reviews exist in this area (Laurie et al., 2023; Norman et al., 2023). Laurie et al. (2023) conducted a scoping review to identify the main characteristics of ‘appropriate’ access to post-acute (>1 year post-injury) services for adults with ABI. Norman et al. (2023) also conducted a scoping review focusing on the experiences of individuals with ABI and their families interacting with community services. Both these scoping reviews noted that due to the wide-ranging definitions of their search terms and how needs for those with ABI span several fields, a heterogeneous sample is inevitable. Therefore, a more comprehensive systematic review assessing the quality of methodologies is not currently feasible in this body of research.

The current study aimed to look specifically at TBI, but even including ABI, the searches did not produce an amenable body of information to analyse (Misra & Agarwal, 2018). Therefore, a decision was made to utilise the word count available to this thesis assignment by conducting a wider literature review focusing on TBI neurorehabilitation and the influence of policy and practice in perpetuating reported unmet needs in this area.

It is becoming increasingly important to denote searching strategies for wider narrative-style literature reviews (Gasparyan et al., 2011). Following searching the databases highlighted in Appendix 1, the current study turned to Google Scholar, a web-based engine launched in 2004, promoting expanded coverage of scientific information (Gasparyan et al., 2011). This provided a helpful starting point, given that this area of interest was first highlighted through anecdotal experience (Misra., & Agarwal, 2018). Due to this topic spanning several fields, using Google Scholar proved an excellent way to access wider information. Following initial Google Scholar searches, further information was accessed by hand-searching the reference lists of central papers. Other sources of information were grey literature provided by the Supervisor, such as charity reports. Despite the current research looking at documents solely relating to England, due to the limited literature within this area it was decided that supporting research from other countries were to be included in the literature review. This was to offer the reader a more holistic understanding of the issue before narrowing the focus to England, it also highlighted the cross-cultural similarities of how services impact those with TBI.

1.3 Rehabilitation recommendations

The rehabilitation process following TBI can take months or years to re-enable survivors to participate in meaningful lives (Andrewes et al., 2014). This process often requires a wide range of rehabilitation services delivered in both inpatient and outpatient settings. This is typically provided by a multidisciplinary team, compromising professionals such as Neurologists, Physiotherapists, Clinical Nurse Specialists, Occupational Therapists, Clinical Neuropsychologists, and Social Workers (Phillips et al., 2004). The expansive skillset within the team enables the patient to regain as much functioning as possible and improve outcomes beyond those expected from spontaneous recovery (Andelic et al., 2014b; Turner-Stokes et al., 2015)

Many organisations have published clinical practice guidelines (CPGs) to enhance the quality of rehabilitation services offered to individuals with brain injuries. For the UK, the Scottish Intercollegiate Guidelines Network (SIGN) (2013) CPG and the National Institute for Health and Care Excellence (NICE) (2023) CPG. Lee et al. (2019) reviewed recommendations and quality of current CPGs relating to rehabilitation following a TBI. They acknowledged that these CPGs, albeit extensive, do not necessarily translate to routine clinical practice. Adherence to CPGs by clinicians has been low in moderate to severe TBI, as in other patient populations (Gagliardi et al., 2011; Grimshaw et al., 2006). For example, Kerr et al. (2005) found that publication of the SIGN guidelines had little impact on medical management of imaging and hospital discharge for those with head injuries. This suggests that improvements in guideline development and implementation processes are needed to ensure changes in clinical practice. Some researchers note that the key to achieving this is optimising the fit between guideline characteristics and users’ needs and expectations (Eccles et al., 2012; Kastner et al., 2011; Lamontagne et al., 2018). This fits with historical literature suggesting that all stakeholders should be consulted when defining topic guidelines, although exploring other barriers to implementing guidelines is important.

1.4 ‘Reality’ of rehabilitation services

Experiences of rehabilitation services for those with TBI vary depending on certain factors. The literature points to those experiencing services as difficult to access a vast MDT team (Jacob et al., 2020; Ponsford et al., 2021), and some may be unable to access services altogether first-year post-discharge (Collie & Prang, 2013; Foster et al., 2016; Foster et al., 2000; Ta’eed et al., 2013). Others experience services as disjointed, especially transitioning from acute to community care (Dams-O'Connor et al., 2018; Lefebvre & Levert, 2012; Melchiorre, 1998), and some report inabilities to procure appointments, which may be due to service provision or poor staffing levels (Alenljung et al., 2019; Lefebvre et al., 2005; Odumuyiwa et al., 2019).

Norman et al. (2023) conducted a systematic scoping review synthesising research findings on the experiences of individuals with ABIs and their families when interacting with community based services. They concluded that those with a diagnosis of ABI and their families have significant difficulties when interacting with community-based services and often do not receive appropriate access (Abrahamson et al., 2017; Mansfield et al., 2015; Nalder et al., 2012; O’Callaghan et al., 2010; Strandberg., 2009). It is worth noting that most of the papers used within Norman et al.’s (2023) review relate to stroke survivors, so it only broadly applies to TBI.

My anecdotal experience is that the ‘reality’ of these services aligns with the literature. However, there is more acknowledgement of good practice, which tends to vary across regions. It is important to consider service usage to understand the ‘reality’ of rehabilitation services.

Andelic et al. (2021) conducted a European-wide study investigating the use of rehabilitation services. Rehabilitation needs were reported by 90% of individuals (n= 1206), with the most common area of needs being cognitive impairment, followed by physical problems, problems with daily life activities, and psychological difficulties. Despite cognitive problems dominating the need, the physiotherapy provision was most utilised, even though half of the cases did not report physical problems. Contrastingly, they found that psychological services were provided to less than a third of the individuals reporting psychological difficulties- this service provided the lowest coverage of existing needs. Glintborg et al. (2018) supported these findings, stating that clinicians often focused on physical recovery and found a lack of psychological support. It is unclear whether this lack of service is due to resources, absence of understanding amongst staff, or another reason. This further highlights disparities in what rehabilitation is received versus what survivors need, raising the question as to the appropriate allocation of rehabilitation resources. Andelic et al. (2021) primarily focused on the severe end of TBI. However, disparities in acute and post-acute care for all severities of TBI have been noted across many regions and countries (Maas et al., 2022).

While there are excellent examples of rehabilitation services (Chartered Society of Physiotherapy, n.d.) they are not consistently available. Services are often not joined up between acute, residential and home settings, meaning people can easily get lost in the system. This provides another caveat and complexity to rehabilitation services and gives us an idea of their ‘reality’ compared to the CPG recommendations. These differing resources mean services look vastly different across the varying neurological conditions; stroke receives more media coverage and has recently received specific promises made by the government within the NHS Long-Term Health Plan (LTP) (NHS England, 2019). This is even though TBI has the highest incidence of all common neurological disorders (Maas et al., 2022). Despite the higher media presence and explicit targets, a systematic review by (Pindus et al., 2018) reported that families and stroke survivors still feel a sense of abandonment from community-based and primary healthcare services. There is an evident discrepancy between the “reality” of services and CPGs, the limited access to inadequate services creates a notion that TBI needs are less of a priority.

1.5 Impact of inadequate services

There is an evident gap between what CGPs recommend and what Neurorehabilitation services deliver. In addition to services not being fit for purpose, many experience significant difficulties accessing them. Access to services is important following discharge as it is imperative to the maintenance of functional gains and continuation of recovery (Jolliffe et al., 2018; Turner-Stokes et al., 2015; Turner et al., 2011). Without having these needs met, families and individuals with ABI struggle to manage symptoms such as fatigue, pain and emotional and behavioural difficulty (Norman et al., 2023). Shannon et al. (2016) found that stroke survivors did not self-report unmet needs one year post-injury. However, this is the opposite for those with TBIs.

Therefore, it is essential to think about the impact of these challenges on those with TBI and their loved ones. This section will focus on the psychological, physical, social, and wider systemic issues of inadequate services.

1.5.1 Untrustworthy system

The literature points to the system feeling untrustworthy to those with TBI and their families; poor communication experiences often influence this. Harrison et al. (2017) found that most caregivers needed to develop trusting relationships with their local healthcare providers, yet communication between care systems appeared limited, e.g. inpatient facilities to community care. Degeneffe & Bursnall (2015) reported that their participants found the system-level response for those with TBIs as ‘inadequate.’ They reported feeling like the system had a lack of empathy and respect and that the lack of continuity of care led to poor interactions with professionals, which negatively affected their recovery.

Interactions with professionals and providers are imperative to influencing rehabilitation outcomes. Chamberlain (2006) reported that when it came to ‘invisible symptoms’ such as headaches, many reported feeling like professionals treated them with distrust and a lack of empathy. This feeling of distrust extends further than the professional to encompass the service provider. Snell et al. (2017) found that distrust exhibited by providers regarding symptoms, impacted service users’ feelings of integrity and self-esteem. The research highlights that fostering trusting relationships helped counteract the feeling of distrust, as it validated individuals' experiences and had a positive effect on their confidence (Braaf et al., 2019; Brauer et al., 2011; Mueller et al., 2017; Winkler et al., 2011). These papers also recognised that service users valued ongoing treatment with a single provider with whom they had developed a relationship, as there is an assumption that they understand their history. A lack of trust and progress may result in recommendations not being adhered to (Winkler et al., 2011; Laurie et al., 2023). Although, Gill et al. (2012) found that individuals who had trustworthy and reliable staff relationships positively impacted the perception of the provider, even if there is no trust in the provider. Interpersonal qualities were highlighted in Laurie et al. (2023) review paper as being a key factor in influencing access to appropriate services. Qualities such as empathy, sensitivity, honesty, and respect are important for staff interactions (Braaf et al., 2019; Dwyer et al., 2019; Hooson et al., 2013). Although the research highlights a lack of trust within staff, good provider and patient relationships are likely to affect recovery and rehabilitation gains positively.

An influencing factor on whether trust develops can depend on the communication experiences of the TBI survivor and their families. The literature has found that errors in the communication of information and treatment plans can lead to poorer clinical outcomes, medication mistakes, increased dissatisfaction, and inappropriate usage of healthcare resources (Coleman, 2003; Coleman & Berenson, 2004; Greenwald et al., 2007). Those with TBI report that good communication included sharing information across healthcare providers, empathy shown amongst staff, and a good understanding of TBI (Grewal et al., 2024; Tverdal et al., 2018). Specialist knowledge of severe TBI can increase perceived productive interactions with service users (Braaf et al., 2019).

As well as needing trust in the providers, TBI survivors reported the importance of trust in their family; it is then interesting to think about the impact on TBI survivors with caregivers and family members who do not develop trusting relationships with service providers. Does this have a knock-on effect on the individuals’ recovery? Given that research cites that family involvement can improve treatment effectiveness (Eady, 2017; Rasmussen, 2021), it would make sense to assume that families withdrawing from services or being untrusting may affect recovery of their loved ones.

An inability to trust services harms the functional gains a TBI survivor can make; poor communication experiences further compound these difficulties.

1.5.2 Lack of Independence

Inadequate services can affect a TBI survivors' independence. Individuals with TBI reported challenges related to transportation, housing, and interference with employment (Pickelsimer et al., 2007). In terms of housing, many reported facing structural barriers to finding and maintaining housing, i.e., limited housing opportunities within a high-demand market, which generated affordability issues. These factors can then limit an individual with TBI's independence if they have reduced access to suitable, affordable housing.

Many feel a sense of independence when it comes to employment; for those who have sustained a TBI, this can be negatively impacted. If access to rehabilitation is limited, it will likely affect whether someone can return to work and the type of work they can manage (Scaratti et al., 2017). Similarly, for transportation, Krishnan et al. (2018) found that caregivers expressed a need to increase the independence of persons with stroke, in order to decrease the caregiver burden. An example given was using public transportation, many reported that professionals did not teach service users how to use public transportation safely. In ABI cases where public transportation was not suitable, social care services did not explore other transport alternatives (Moore et al., 2019; Odumuyiwa et al., 2019)- demonstrating that without effective services, independence will be negatively affected for those with TBIs.

1.5.3 Caregiver Strain

Without long-term specialist support, the functional gains someone with a TBI can make are limited and can, therefore, place a strain on caregivers. Caregiver strain is negatively impacted by more severe injuries, disabilities that are more functional and complex mental health presentations. Often, these factors mean increased time spent caregiving, which has a negative impact on the carer’s mental health and can result in their own needs becoming unmet (Kjeldgaard et al., 2023). Caregivers of those with TBI can find themselves under a tremendous amount of psychological stress, which is often exacerbated without professional support to cope with the behavioural disturbances or emotional changes seen following TBI (Blake, 2008; Qadeer et al., 2017; Sabella & Suchan, 2019). Even when carers report a high level of preparedness for the role, they felt unprepared for the lack of help and information from the health system to manage their stress (Lieshout et al., 2020).

Conversely, the literature notes that there is an effect between the level of caregiver stress and race in TBI. One study noted that Blacks/Hispanics coped better with stress in their caregiver roles compared to their White counterparts (Sander et al., 2007). It was thought this was due to the cultural difference in social support and the role of community.

Caregivers must navigate this whilst often attending to their feelings of loss, many grieve the person their loved ones were before sustaining their TBI (Bodley-Scott & Riley, 2015). The Dual Process Model of coping with bereavement (Stroebe & Schut, 1999) notes that an individual oscillates between ‘loss orientation’ and restoration activities. Often choosing the restoration activities to avoid thinking about the loss, with a loved one who has sustained a TBI navigating these services can be a source of restoration activities. Restoration and loss orientation are both seen as stressful and burdensome, TBI adds an extra layer of complexity as the individual is not deceased making navigating loss more complex. This adds further strain to caregiver’s role as they try to navigate life after TBI and the dearth of adequate services.

To add further pressure to caregiver roles, studies have pointed towards carers needing specialist education and information about ABI so they can educate their social networks (Odumuyiwa et al., 2019). Without professional support, carers are at risk of burning out, which means those with TBI will continue to have unmet needs.

1.5.4 Psychological Impact of Service Implementation Gaps

After a TBI, it is widely documented that an individual can experience psychological difficulties, such as anxiety, depression, personality changes and anger (Adams & Dahdah, 2016; Kingery et al., 2017; Pickelsimer et al., 2007). These changes can be very challenging for caregivers and those with TBIs to live with, especially the adjustment to their identity pre- to post-injury. The Y shape model (Gracey et al., 2009) focuses on to the threat in an individual’s identity and offers a way to think about potential interventions to resolve the identified discrepancies in an identity pre to post injury. This process of resolving discrepancies can also highlight a period of grief, i.e., navigating the loss of their previous self (Stroebe & Schut, 1999). This can mean that individuals with TBI can often require professional psychological support to manage the emotional and behavioural challenges (Kingery et al., 2017).

Access to psychological support is reported to be the least accessible of the MDT services post-TBI (Andelic et al., 2021; Glintborg et al., 2018); without the proper support, this will have a significant impact on individuals with TBI and their network. Norman et al.’s (2023) review, found that the emotional and mental health needs of patients were not addressed in twenty-seven of the papers, finding services often had a preoccupation with the physical presentation without consideration for the psychological impact of the injuries (Martinsen et al., 2015). There is a crucial need for emotional support to manage the long-term consequences of TBI, yet this is a gap in provision for many.

Maslow (1943, 1954) developed his theory regarding the hierarchy of human needs, arranging the physiological (survival) needs at the bottom, and the more creative and intellectually oriented ‘self-actualization’ needs at the top. Although it is acknowledged that these can be fulfilled in any order (Tay & Diener, 2011), Maslow (1943) purported that the basic needs need to be met before any of the higher needs can be met. Focusing on TBI, the inadequate services impact housing and their finances, which can lead to being unable to afford necessities such as food. Maslow proposed the idea that when basic needs are not met, we lack the capacity to tend to our higher needs, meaning we need to fulfil these before we attend to our psychological needs. For trauma reprocessing (which for many with TBI is a treatment they will benefit from) clinicians note that it is important for individuals to have a good support system and stable environment before embarking on this type of therapy (Chadwick and Billings, 2022). Further highlighting the importance of different services communicating to ensure all needs of those with TBI can be met.

Given the highlighted unmet need from a psychological perspective, it is even more troubling that there is literature suggesting that those with diagnosed ABIs are at greater risk of developing difficulties with their mental health (Bombardier et al., 2010; Koponen et al., 2002; Williams & Evans, 2003). There are also reports of a higher incidence of suicide and suicidal ideation across the TBI cohort (Bahraini et al., 2013; Felde et al., 2006; Madsen et al., 2018). This highlights the consequences and impact on individuals' lives if psychological needs are not addressed, but also the psychological impact of social difficulties.

1.5.5 Community Reintegration Challenges

Many with TBIs can develop difficulties with substance abuse (Felde et al., 2006; Mackelprang et al., 2014; Pickelsimer et al., 2007; Ponsford et al., 2007), and for those with combined mental health difficulties, there is a poorer prognosis (Graham & Cardon, 2008). Individuals with TBIs are highly represented among people experiencing homelessness (Mackelprang et al., 2014; Oddy et al., 2012) and within prison populations (Williams et al., 2010). In addition, those with TBI have also reported limited services to help with social integration (Pickelsimer et al., 2007). These findings suggest there is difficulty reintegrating back into the community post-injury, and the nature of their injury can leave them vulnerable to these consequences.

Injuries to the prefrontal lobe area can create difficulties in managing and regulating anger, which can leave them vulnerable to aggressive acts that may end up in a prison or probation sentences (Shiroma et al., 2012). Impulsivity is regulated in this brain area, meaning they may be drawn to unhelpful coping styles such as substance misuse, to feel quick relief from the distress of not having their psychosocial needs met. Some injuries can present with executive functioning difficulties, meaning planning finances can be hard, and as a result, may mean some individuals violate tenancy agreements and become homeless (Moore et al., 2019; Norman, 2016). The nature of the individuals’ injury leaves them vulnerable to these consequences, highlighting the importance of adequate services to safeguard TBI survivors.

Desistance theories (Farrall & Bowling, 1999; Laub & Sampson, 2001) concern the factors and reasons influencing a person to stop offending. The theory highlights a need for a dynamic, person-centred approach to support offenders; this typically transcends criminal justice institutions. There are key barriers identified in the literature to desisting; these include accommodation difficulties, substance misuse, health issues (mental and physical), employment, education, finances and social relationships, i.e., belonging to social groups (Farrall et al., 2010; Gålnander, 2020). It is, therefore, unsurprising that those with head injuries are stuck in cycles of offending when many of the barriers identified to desisting are barriers they have already faced before committing crimes. This is without the complicating factor of the brain injury itself causing personality and function changes that may give someone a higher predisposition to commit crimes. For individuals without TBIs, moral disengagement (i.e., the level to which an individual feels ethical standards applies to them) decreases over time. However, within a TBI population, the injury is thought to compromise this expected change in moral disengagement, especially within those injuries which affect decision-making brain regions (Schwartz et al., 2020).

As the body of literature highlighting the social and psychological consequences of ABI grows, the impact of rehabilitation packages that are not fit for purpose is damning. With inadequate services, the research highlights a significant negative impact on TBI survivors and their families. As services are aware of these inadequacies, what stops them from implementing CPGs?

1.6 Barriers to implementing rehabilitation services

Laurie et al.'s (2023) review highlighted the importance of a service system being navigable, integrated, and adequate, with equal opportunity to access. The literature reports conflicting experiences. Therefore, it is important to consider the barriers and why, for many, services are often unhelpful. Historically, barriers have focused on an inadequate workforce and logistical challenges; however, more contextually, the 2020 coronavirus pandemic presented a niche barrier. These will be explored further below.

1.6.1 Inadequate Workforce

A barrier to delivering adequate services is the inadequacy of the workforce, specifically the lack of specialist knowledge and training, and professionals' poor communication with service users.

The TBI workforce is limited in their knowledge of the condition and have inadequate training to meet presenting needs (Ballard & Dymond, 2016; Braaf et al., 2019; Brighton et al., 2013; Dams-O'Connor et al., 2018; Holloway et al., 2019; Holloway & Tasker, 2019; Irgens et al., 2020; Moore et al., 2019; Morrow et al., 2020; Norman et al., 2020; O'Callaghan et al., 2010; Odumuyiwa et al., 2019; L. Powell et al., 2020;). For example, the lack of knowledge and training has been especially apparent when accessing support for education needs. Glang et al. (2015) found a lack of training and awareness of TBI among educators, parents and community services meant more children with TBI were not receiving the necessary education support, creating a further learning need. They found that many educators were unaware that those with minor TBIs or concussions might have additional needs.

Mental health services often have a poor understanding of the impact of brain injuries and lack the specialist knowledge to support these individuals (Moore et al., 2019; Odumuyiwa et al., 2019; Ytterberg et al., 2019), in addition they often do not have the provision to support caregivers with their mental health (Tang et al., 2019). Those with TBIs can be seen as having needs too complex to meet eligibility criteria for mental health services (Odumuyiwa et al., 2019). This problem is further compounded as without specialist trained staff TBI services will be able unable to offer comprehensive professional consultation to manage the complexity (Estrella et al., 2021). This can mean they fall between services and experience being passed between services, leaving without the support they need.

Communication of care is a reported barrier to accessing services, including a lack of communication around care plans, transitions and discharge planning (Libeson et al., 2020). Many report having extensive information during their inpatient rehabilitation but that this stops after discharge (Hall et al., 2012; Rusconi & Turner Strokes, 2003), and there is a lack of transparency when navigating organisations to try and find the right services (Graff et al., 2018). A further barrier is that services are inaccessible to those with different cultures and languages. Often, individuals from non-westernised backgrounds report poorer experiences and can feel more isolated and stigmatised (Mbakile-Mahlanza et al., 2015; Simpson et al., 2000). These findings demonstrate the need for a workforce that can implement the CPG service recommendations.

1.6.2 Logistical Barriers

Within the literature, several logistical barriers are reported, namely system processes, from how they interact with each other, how funding is allocated, discrepancies between regional services and how services are utilised.

Often, there are difficulties within this area due to systems working in isolation with poor communication (Estrella et al., 2021). There have been several pushes to help the NHS move towards systems that generate spaces that foster good communication with other services, as highlighted by the NHS England Long Term Health Plan (LTP) (2019), but this remains a challenge for services.

In addition to services not communicating, many have a dearth of services in their locality. Despite the NHS being informed by a lifetime model, i.e. a universal coverage of healthcare for the whole country, there are still stark disparities in what level of community rehabilitation TBI survivors receive. This is likely influenced by the Integrated Care Board (ICB) systems. Recently, the process in which local NHS services are funded moved from Clinical Commissioning Groups (CCGs) to an ICB system, the notable difference being that ICBs will cover a larger area than CCGs. Each region is allocated a budget, which they determine how to spend for the area they are covering.

Funding is distributed using the current national needs-based formula, which uses aggregated data from general practices to determine the needs in that area (NHS England, 2021). NHS England and NHS Improvement (NHSE/I) argue that this methodology enables funding to reflect the ‘fair share’ of NHS resources for each ICB, without destabilising local health economies and reducing health inequalities. Therefore, this might explain the idea of a ‘postcode lottery’; areas with high levels of TBIs may have more of an infrastructure around rehabilitation than those areas with less reported TBI’s. The TBI figures may also impact the funding, as many with head injuries do not attend healthcare services (Parsonage, 2016), suggesting that areas are not receiving their ‘fair share’ of funding.

The funding formula aims to predict service utilisation, yet there is an implementation gap. Service utilisation can vary dependent on demand and specific needs across different demographics. Some studies have attempted to predict TBI service use through various socio-demographics, but these have produced contradictory results. For example, some note a clear sex difference in service utilisation, reporting higher healthcare use among females (Andelic et al., 2014a; Jacob et al., 2020), but other studies found that males received more services (Schumacher et al., 2016), whereas others found no differences (Jourdan et al., 2015; Phillips et al., 2004). It is unclear whether this means women are discriminated against in accessing services or if, clinically they do not need them. Similarly for age, some studies reported that younger individuals with TBI receive more rehabilitation after injuries (Andelic, et al., 2014a; Cnossen et al., 2017; Schumacher et al., 2016), and some reported older people received these services more often (Corrigan et al., 2013; Ta'eed et al., 2015). More frequent service utilisation has been reported among patients with a severe TBI (Andelic et al., 2020; Jacob et al., 2020; Prang et al., 2012), those with a higher degree of trauma symptoms (Jacob et al., 2020) and in those with the more profound disabilities (Andelic et al., 2020). Conversely, needs have been reported to be significantly higher in individuals with milder disability outcomes (Andelic et al., 2014a). Several studies have also found that these unmet needs are exacerbated in cases where individuals and families come from minoritised backgrounds (Greenwood et al., 2016; Sansonetti et al., 2018; Fitts et al., 2019; Mealings et al., 2020). Therefore, there is no uniformity across utilising rehabilitation services in terms of socio-demographic factors.

Another issue perpetuating the 'postcode lottery' is that different regions have differing levels of third-sector support. Charities prop up many NHS services; Clay et al. (2024), in their survey, found that charity leaders estimate charities prop up public services by £2.4 billion a year. There is an argument that whilst charities offer these contracts without state support, public sector services will continue to be underfunded as a need is not presented. However, there is no safeguarding around the charity's funding, and often, when charities close, the services they provide are seldom replaced.

1.6.3 Coronavirus pandemic

In March 2020, the UK employed strict lockdown measures in response to the Coronavirus pandemic (COVID-19), which brought unprecedented societal change. Jia et al. (2020) conducted a cross-sectional study of over 3000 adults in the UK, reporting an increase in psychological morbidity among people with cognitive and physical disabilities. Many brain injury rehabilitation providers stopped offering their typical services during this period. Assessments or other rehabilitation appointments were cancelled face-to-face and, in some circumstances, were rearranged to take place online (Coetzer & Bichard, 2020). Further research has documented the negative impact this reduction in accessing services has caused (Borg et al., 2022; Cotner et al., 2022). It is important to note that this would be accessing services that are already not meeting the needs of these individuals.

Within the brain injury survivor population, adapting to the restrictions was difficult due to the effects of their injuries. This came at a time when services offered limited input when support was needed more than ever. In response to these concerns, Headway, a UK-wide charity, conducted a questionnaire to explore the experiences of lockdown for people living with the long-term effects of brain injury and their relatives (n= 1140) (Tyerman & Headway, 2020). The results highlighted that the restrictions significantly impacted this cohort across various areas of their lives. For those who sustained their brain injury within two years of the restrictions, 42% felt their rehabilitation had been negatively impacted. This is particularly damning as literature often cites that a loss of rehabilitation within the early stages can lead to a lifelong negative impact on an individual's level of disability (Andelic et al., 2012; Tepas et al., 2009). Which also has a knock-on effect on the system that supports the individual.

Although face-to-face appointments were limited during this period, as services began to adapt to the restrictions, facilities to offer remote sessions increased. Tyerman et al. (2021) interviewed 58 people with brain injury to provide feedback on their experiences of remote contact (i.e. video, email and/or telephone) and found mixed reviews. Over half of the respondents reported the sessions as 'effective', and just under half reported as 'less effective'. Moving forward, 62% favoured a balance between in-person and remote contact, whilst a third felt their needs would be best met primarily or entirely through face-to-face contact.

The questionnaire conducted by Tyerman and Headway (2020) also highlighted the emotional impact of the restrictions, with 60% of respondents reporting that the lockdown had a negative impact on their mental health. They cited an increase in frustration, anxiety, loneliness, depression, and a marked fear of the future. This is compared to an earlier study where Headway (2017) found that 28% of respondents had negative feelings about their future compared to 62% within the lockdown period (Tyerman & Headway, 2020). These findings are further supported by Carlacci De Mattia et al. (2023), who asked care coordinators to assess the consequences of the lockdown on 130 individuals with ABI (mostly living in residential care). Although most reported no changes to behaviour or social functioning, 68% reported emotional changes. It is important to recognise these results in the context of the pandemic; literature is beginning to show the negative impact of COVID-19 information on the general population's wellbeing and mental health (Szuster et al., 2022; Wang et al., 2022). Unlike the majority of the population, many within the brain injury community rely on external services to support them to live and enjoy life; 50% reported losing access to vital support that helps them cope with living with a brain injury (Tyerman & Headway, 2020).

This period also saw a decrease in acutely unwell individuals seeking medical care. During this period, hospitals and primary care facilities were poised as sources of the COVID-19 virus, fuelling individuals' healthcare avoidance (Czeisler et al., 2020). A retrospective study conducted on over 2000 referrals to a level 1 trauma centre in the north of England reported a 49.6% decrease in TBI referrals during the first national lockdown compared with the prior months (Jayakumar et al., 2020). It is important to interpret these results cautiously as these statistics may not accurately represent regional/national TBI incidence. The decrease may be due to many factors, one being the lockdown measures, which meant significantly fewer people were leaving their homes or engaging in sports/ recreational activities (Lester et al., 2021; Reitzle et al., 2021). The primary reported mechanisms worldwide for sustaining a TBI are falls and road traffic accidents (Dewan et al., 2018; Faul et al., 2010; Peeters et al., 2015), which may have influenced the decrease. The increase in TBI referrals as the restrictions were relaxed further supports this (Abdulazim et al., 2020; ElGhamry et al., 2021; Figueroa et al., 2021); in India, one neurosurgical department saw a 177% increase in head injury admissions post-lockdown (Goyal et al., 2020).

So not only during this period were there reduced services with limited access to them, but this came in a climate of services already not meeting the needs of TBI survivors. In terms of systems recovering from the pandemic, despite the National Health Service (NHS) implementing similar strategies to other countries to clear care backlogs, its path to recovery will be longer than many other countries (Reed et al., 2022). This is due to the large waiting lists pre-pandemic, as a result of the consistently lower public spending on health over the past three decades compared to other large-income countries (Anderson et al., 2021). This means that those who have survived TBIs, will likely be waiting longer for rehabilitation services, which, even when accessed are unlikely to meet their needs fully.

1.7 The effect of policy on service delivery

There are many documented barriers to TBI rehabilitation services, although limited literature looks at policies that can be seen as barriers to care. Ham & Smith (2010) note that policy is a barrier to integrating care systems. However, research has yet to explore the impact of parliamentary texts and operations on creating or overcoming barriers to services.

The controversial Health and Social Care Act (2012) introduced compulsory competition in accessing and commissioning healthcare services. The use of market-like mechanisms was designed to end the ministerial micro-management of the NHS. Instead, ministers can dictate a mandate for what the NHS should achieve, and it is up to the various statutory bodies to enact that mandate. Often, private medical firms were used to manage wait lists and meet the mandate targets. This is a worry for those using these services as research shows that private-sector outsourcing corresponds with significantly increased rates of treatable mortality (Goodair & Reeves, 2022). Ultimately, a policy which aimed to encourage integrated care produced a disjointed service for many, a clear example of how policy can create barriers to care.

Following on from this NHS England (2014) published the five-year forward view and the NHS long-term plan (LTP) (2019), both articulated the need to integrate care to meet the needs of the ever changing population. The LTP specifically names stroke as ‘lagging’ behind on the impact of population health, but there is no mention of ABI or TBI services specifically.

Many policies and parliamentary texts have affected the TBI community over the years, trying to address the unmet needs of this population. The Health Select Committee Report, ‘Head Injury Rehabilitation’ (2001), made over twenty recommendations to address this issue. While significant progress has been made regarding some of the recommendations (mainly about acute care), the ones relating specifically to neurorehabilitation have mostly been left unimplemented. It is astounding to recognise that this document is twenty-three years old, and the recommendations that have not been implemented still have a significant consequences for those with TBIs.

The All-Party Parliamentary Group on Acquired Brain Injury (APPG on ABI) was formed in 2017. With the support of experts, they produced a report on the issues surrounding the provision of neurorehabilitation for those with ABI in the UK. The report was called ‘Time for Change’ (Menon et al., 2018). Interestingly, many of their key recommendations echoed recommendations from the 2001 Head Injury Rehabilitation Report. Since the report, several debates have been held to raise awareness of ABI and lobby for change.

Other key documents that have affected the TBI community are the NHS England (2023) long-term workforce plan, which headlines an additional £2.4 billion in funding and doubles training places for doctors and nurses. This is important given the barrier of staff shortages, as mentioned above, but this report does not detail specialist workforce planning. Therefore, there is no guarantee that there will be an increase in staff with the relevant neurological expertise.

Sustaining a TBI can have a significant impact on an individual's mental health. Therefore, certain policies, such as the Mental Capacity Act (MCA) (2005), will affect these individuals. The MCA is a legal framework that guides an assessment of an individual's decision-making capacity. Moore et al. (2019) highlighted that many professionals conducting these assessments failed to take account of the nuances of ABI, which leaves individuals increasingly vulnerable within the community. Norman (2016) presents a personal case in which access to a mental capacity assessment was not facilitated, despite significant changes in her brother's mental health alongside his TBI and exploitation from those within his community. This was never assessed, and sadly, following other care failings her brother committed suicide.

It is clear that policy and parliamentary processes can significantly affect those with TBI accessing services that can meet their needs; highlighting how the mechanisms within these policies can have adverse consequences for these individuals, therefore, it warrants further investigation. A further detailed policy analysis is available in Section 3.1 and Appendix 2.

1.8 Economic Benefits of adequate TBI rehabilitation services

It is evident that inadequate services negatively impact TBI survivors and their loved ones. In addition, the literature highlights barriers to delivering sufficient services; while policy also plays a role in sustaining unmet needs within TBI. Therefore, it is important to explore the benefits of perpetuating this issue for the state.

Traumatic brain injury (TBI) is a major global health problem and source of disability. In 2017, The Lancet Commission documented that TBI was estimated to remain one of the top three causes of injury-related death and disability up to 2030 (Maas et al., 2017). It is estimated to cost around $400 billion US dollars annually (Maas et al., 2022), demonstrating a substantial public health burden.

A major factor contributing to their level of disability after severe TBI is access to multidisciplinary rehabilitation. This is despite the research that access to MDT rehabilitation proves sustained functional gains (Bonn et al., 2023; Momsen et al., 2012; Turner-Stokes et al., 2015), improved quality of life (Kaurani et al., 2024; Kumar et al., 2017; J. Powell et al., 2002), increased return to work rates (Radford et al., 2018), and a reduced need for long-term care (Königs et al., 2018). One could argue that for each brain injury, this level of treatment is a substantial cost for the state. Nevertheless, several studies have outlined that despite the large initial investment, it produces an overall cost reduction for the state (Oddy & da Silva Ramos, 2013; Turner-Stokes, 2007).

More recently, Turner-Stokes et al. (2019) conducted a cohort analysis from the UK Rehabilitation Outcomes Collaborative national clinical database; the primary outcomes they focused on were reducing dependency and cost-efficiency. They reported a mean episode rehabilitation cost of between £41,235 - £44-235 (95% CI), which was offset within 18.2 months, with a mean net lifetime savings in care costs of between £635,972 - £722,786. They proved that rehabilitation is highly cost-efficient for severely disabled patients with TBI. Lorenz and Doonan (2021) conducted a policy analysis of seven studies (from 2009 to 2019); they explored outcomes and cost savings from access to multidisciplinary rehabilitation. They identified an average lifetime savings of $1.5 million per individual, with costs recouped within 18 months.

Conversely, there is an argument that the predicted lifetime savings are inaccurate due to the reduced life expectancy within this population (Brooks et al., 2015). This study is based on an American cohort, and currently, there is limited mortality information to estimate life expectancy in a UK TBI cohort.

There is a clear argument for cost-efficiency for those with severe ABI/TBIs, but this leaves the question about those with mild to moderate TBIs, as most of the cost-effectiveness research focuses on inpatient specialist rehabilitation rather than community-based rehabilitation. Many with mild to moderate injuries have even more limited access to multidisciplinary rehabilitation (Simpson et al., 2016) often because they do not reach eligibility for their local services. Research suggests that a substantive investment in TBI rehabilitation, across all injury severity, will likely result in a long-term cost saving for the state. Van Velzen et al. (2009) conducted a systematic review of those returning to work following an ABI, and it suggested that only 40% of those who had sustained a moderate to severe ABI returned to work after two years. This highlights a sizeable vocational rehabilitation gap; in the UK, many rehabilitation services are delivered via third-sector charities. It is often reported by charities that their services have to adapt and change in line with the cash flow they receive (Pharoah et al., 2014), making the reliability and longevity of their services unpredictable.

Grigorovich et al. (2017) conducted a case study of one community-based service that provided specialist employment services to those with brain injuries. Results showed that, on average, those accessing the service were 16 years post-injury, furthering the argument for an initial investment in effective person-centred rehabilitation to save money in the long-term. This study also reported that 64% of individuals secured a competitive employment outcome. However, they found it was a short employment tenure (364 days), and job intensity was mostly low (average 3.8 hours a day). Nevertheless, those who secured suitable employment pose a direct conflict with the policies and reports identified in the previous section. The government influences the creation of those documents, which influences the delivery and, consequently, the inadequacy of TBI services. Nevertheless, for the state, there is a clear cost benefit for services to be sufficiently resourced.

On top of the financial gain for the government, there is an ethical argument that finding appropriate, fulfilling work for individuals is important for psychological wellbeing. Many studies report that job satisfaction positively impacts individual wellbeing (Ray, 2022; Rice et al., 1980; Sironi, 2019). Following sustaining a TBI, many cannot return to their pre-injury job, and often, the work they return to is lower pay, fewer hours and involves unskilled work (Simpson et al., 2020; Watkin et al., 2020), which can negatively impact an individuals' level of psychological distress.

The financial argument alone creates a strong argument for stakeholders who can influence funding and designing services to invest in this population. However, from a psychological lens, the government have an imperative moral reason to improve the quality of life for those with TBIs. Considering these arguments for adequate services it does leave the question of why this issue is perpetuates.

1.9 The role of a Clinical Psychologist within social policy

The field of psychology has long seen the value of using academic research to address pressing social issues, and early evidence of these efforts can be traced back to the early 1900s. It became especially prevalent in the 1930s during the rise of the Fascist movement; Krechevsky (1936) speaks about academic psychologists who expressed “great interest in the movement to apply psychology to political problems”. Lewin (1947) argued that conducting academic research for publication is not enough, stressing that academic research should ideally lead to some social action. The profession is, therefore, not static and needs to flex in line with relevant government agendas (Rahim & Cooke, 2019).

Richard et al. (2010) suggest that there has been a shift away from the individual and towards ecological models when considering health promotion as “disappointment over results from experiments and trials in behaviour change has led to calls for interventions and programs addressing not only individual behaviours and their cognitive determinants but also the multiple settings and social contexts that shape behaviours, including large social and cultural dimensions”. This dissatisfaction with the status quo is mirrored by the development of activist-practitioner organisations such as Psychologists for Social Change (Psychologists for Social Change, 2021). It is also partially reflected in the actions of professional bodies such as the British Psychological Society, for example, in creating of the community psychology subdivision in 2010, which outlined psychologists’ role in population health and wellbeing (Community Psychology Section, 2021). Suppose clinical psychology can promote social action in mental health distress and prevention policy; there is an argument that this should extend to other important areas, such as unmet needs within TBI survivors.

Browne et al. (2020) interviewed psychological professionals about their experiences of being involved in politics. They felt that influencing and being part of policy decisions were inherent roles of a clinical psychologist (CP). However, they argued that this mostly does not happen due to resources and the fact that services are often focused on the individual at a micro-level, meaning that the macro-level is not considered. They analysed 37 CP accounts of experiences of macro-level work; they split their findings into two domains: getting there (understanding and undertaking macro-level work) and being there (i.e. experiences of working in this way). Many interviewed spoke of the ethical grey area of taking a ‘plaster approach’, i.e. focusing on the individualised experience of stress. This further promotes the need for CPs to address the impact of the system the individual exists within.

The services CPs work in are increasingly spending time taking the ‘plaster approach’; another way to think about this issue can be seen in Figure 1.

Figure 1

Illustration by Young (2022) summarising Desmond Tutu’s quote

Given the stretched services CPs often work within, this can often leave little time to ‘go upstream’ and think about fixing the bridge, but this is important for meeting needs in the long term. For those with TBI, it is of utmost importance to look at the role of government and policy to understand why those within this cohort keep falling into the river.

Research skills are a core competency of Clinical Psychologist training (British Psychological Society, 2019); one of the key themes in Browne et al.'s (2020) paper discussing psychologists' experiences of macro-level work was the impact of research in this area of work. Research was seen as the vehicle through which policymakers and clinical psychologists communicated. One of the participants said, "… *we're not policy makers ourselves, but the way we put across evidence is really, really important for policy and we have to adapt our language accordingly*". Therefore, suggesting that publishing research can ultimately influence policy making. The power within the role of a CP can be paramount in influencing social policy and solving this current 'plaster approach' within services.

The Power Threat Meaning Framework (PTMF) (Johnstone et al., 2018) was developed as an alternative to psychiatric classification that incorporates social, psychological and biological factors to individual distress. It has four interrelated aspects: the operation of **power** (biological/embodied, coercive, economic, ideological, cultural, and interpersonal), the **threat** that the negative operation of power may pose to the person, group or community, the central role of **meaning** in shaping the operation, experience, and expression of power, threat and our responses to threat, and lastly the learned and evolved **threat responses** to the previous factors that an individual, group or community may need to draw upon to ensure emotional, physical, relational and social survival (Johnstone et al., 2018). This framework underpins many reasons why CPs must be involved in social policy; they are often on the frontline of working with marginalised individuals affected by powers such as the government. For example, of those living with TBIs, many are under economic power as they are reliant on state benefits, which do not always enhance the quality of life in a cost of living crisis. They are under cultural powers, i.e., a lack of understanding of how their condition affects them and can face negative stigma, and they are under the power of policies such as the MCA (2005). This can pose a threat as many are left vulnerable to being exploited due to their injury; this can then affect the way they want to live their lives. As the literature cites, many can turn to unhelpful coping mechanisms to manage, such as substance misuse and gambling (Estrella et al., 2021; Turner et al., 2019). These cycles are likely to survive and be perpetuated within this framework. Therefore, we must collaborate in developing policies and become advocates for those who do not have voices but are unjustly distressed under the power of these operations.

Often, within psychology settings, we are encouraged to rebalance the power and to avoid sitting in a position of expertise without acknowledging other skill sets in the room or in a bid to redress the power (Bostock et al., 2023); this is often done through co-production (Roper et al., 2018). However, in political settings, there is an opportunity to yield this power and sit in a position of expertise, despite the inherent narrative to exist in the grey areas to rebalance power. As well as adapting our positionality, Browne et al.'s (2020) research points to also having to change our language. The research highlighted a need to adapt the language when sharing research to make it accessible to stakeholders within that setting. Some psychological therapies, such as Cognitive Behavioural Therapy (Beck, 1979), have guidelines that encourage the therapist to only ever guide the individual to their answers, rather than sitting in a definitive expert position. These settings will not receive this language; they seek clear, concise and confident messages, however training for CPs in working within political settings is rarely prioritised compared to training in therapeutic models (British Psychological Society., 2019).

This raises further questions about how clinical psychologists can bridge the gap between these two aspects of their roles and positively influence social policy. Overall, there is an argument that the power within our roles can give us the potential to affect change, and with our critical research skills, we can offer a unique perspective on navigating social problems.

1.10 Aims of the study

There is an inherent discrepancy between neurorehabilitation services and meeting the needs of those with TBI. Previous research has focused on investigating this through the lens' of the service user, professionals delivering neurorehabilitation services, and carers of those with TBI. This could be described as taking a bottom-up approach to researching the highlighted problem. Currently, there is no research taking a top-down approach, looking at parliamentary stakeholders who influence how services are funded and created.

Critical discourse analysis (CDA) begins from a perception of a discourse related problem within a part of social life, e.g. problems within the activities of a social practice or a social practice. These problems are often 'needs-based', relating to discursive facets of unmet needs (Fairclough, 2001, p. 236). Cummings et al. (2020) argue that CDA within policy analysis can be used in two ways: addressing or exploring a social issue. This study will draw on the Buse, Mays and Walt (2005) definition of policy, which sees it as "courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health system" (p. 6). In this context, policy can be made within government, by non-government actors, and by organisations external to the health system (Walt & Gilson, 1994) with an impact on health. This definition also includes documents and texts relating to policy development which will be referred to as parliamentary texts in this study.

Therefore, there is a rationale for using CDA to explore discursive factors within parliamentary texts that may influence or perpetuate the unmet needs in this cohort of individuals. With this in mind, the present study aims to attend to the social problem of unmet needs within a TBI population and the role of policy in relation to this aim. It aims to produce new knowledge that can contribute to reducing this illustrated gap in need and, specifically, the impact CPs can have in this area.

Historical consideration of the recent developments around unmet in the TBI populations will seek to establish the context of this policy drive. This will highlight the most relevant and impactful parliamentary texts to consider more in-depth through discursive analysis. This will aim to highlight the key assumptions and contradictions inherent to current, influential policies that pertain to meeting the holistic needs of those with TBI. Often, with TBI, it is discussed within the ABI population rather than individually. The research will endeavour to have a TBI specific lens, but this may be in the context of being discussed under ABI.

1.10.1 Research Questions

To attend to the overarching social problem of unmet needs within TBI neurorehabilitation services, the proposed research will explore the following research questions:

- What are the underlying conceptual frameworks present in the selected parliamentary texts, and how do they interrelate?

- How are these operationalised within the parliamentary texts in relation to action towards meeting the needs of those with TBI?

2.0 Epistemology and Methodology

2.1 Introduction

This chapter clarifies the research design and methodology, including the process of reflexivity and the epistemological position.

Before deciding the methodology for the current study, I joined a neurorehabilitation stakeholder group to think broadly about the local obstacles in meeting the rehabilitation needs in a TBI cohort. The stakeholders worked in the East of England region and included, CPs, physiotherapists, service managers, ICB deputy directors, occupational therapists, and those with lived experience. Echoing many of the themes in the literature, obstacles identified were lack of training and specialist knowledge in the workforce, inequity of resources across neurological conditions, staffing difficulties including burnout, long-term sickness, and high staff turnover. They also reported a heavy reliance on third-sector services that often closed without warning or plans to replace the services they were providing. Many also noted that this had been their experience for many years, feeling that historical changes made little to no impact.

For services to adapt to societal demands, they must be flexible in changing processes and the procedures of how services are accessed and delivered. To achieve this, more resources are often needed, including finances, which ultimately come from the treasury-funded NHS. How resources are distributed can be based on many factors; however, it is widely acknowledged that there are insufficient resources for TBI services. Ultimately some populations appear to be more disadvantaged than others. Those who decide the overall healthcare budget are the government in power, and the local services determine how to spend the budget to meet the needs of their areas.

Therefore, to address the research questions and engage with the problem of unmet needs within a TBI population, Critical Discourse Analysis (CDA) was selected as the most appropriate methodology (Fairclough, 1995). There were several avenues to explore varying influences on unmet needs within neurorehabilitation services, for example, through analysis of interviews with policy decision-makers or psychological therapists, or within the lived experience population. Nevertheless, as a starting point in this untouched area of research, critically analysing parliamentary texts allows for direct investigation of unmet needs at a parliamentary level. Fairclough, (2013) notes that policy is a powerful form of discursive activity that can potentially instigate social change. Social change could shape the context where Clinical Psychologists work, and is therefore integral to creating changes to provide adequate services for survivors of TBI.

2.2 Aims and Objectives

To achieve the aims and research questions outlined in section 1.10.1, the current study aims to use Critical Discourse Analysis (CDA) to attend to the overarching social problem of unmet needs within TBI neurorehabilitation services. It will focus on the underlying conceptual frameworks and how they interrelate, as well as how they are operationalised within texts, relating to action toward meeting the needs of those with TBI. The selected data will be Hansard transcripts of recent Westminster Hall and Common Chambers debates.

2.3 Research design

A Critical Discourse Analysis (CDA) (Fairclough, 1989) design was selected, adopting a critical realist epistemological stance. Analysing parliamentary texts provides insight into how systems promoting health and wellbeing within society are structured. The Clinical Psychologist's role within healthcare settings exposes them to the impacts of policies on individuals and communities, which can put them in a complimentary position to conduct this type of research.

Discourse analysis is a qualitative methodology concerned with conflict (van Dijk, 1997; Foucault, 2000), power dynamics, and meaning construction (Gee, 2014). The literature highlights that research involving the study of discourse and language is highly varied. CDA has similarities with other discursive analysis forms that could have been utilised within the current study. Willig (2001) outlines two prevalent forms, Foucauldian Discourse Analysis (FDA) and Discursive Psychology (DP). DP is similar to CDA as it considers various discursive strategies for specific functions, often relating to social interactions such as conversations and interviews.

FDA and CDA can be used in analysing political texts, as both critique the notions and contractions these can contain. Both methods are interested in the role of power and discourse within the broader context (Weiss & Wodak, 2003). A significant difference is that FDA draws specifically on Foucauldian theories, e.g., the construction of objects and subjectivities within the text. In contrast CDA aims to connect language to the structures and social processes where it is produced and thinks about what this can mean in the real world (Fairclough, 2001). It considers the function a social problem serves for specific groups and why certain discourses are maintained. CDA highlights mechanisms of power within the discourse for emancipation; this means that CDA can take a more explicit position on social change (Fairclough, 2009). These elements of CDA apply to the current study, which aims to consider the impact of parliamentary narratives around unmet needs within a TBI population.

Once the phenomena being investigated is decided, it is suggested that the theoretical assumptions of the study must be explicitly communicated, so that alignment between these and the research questions and the methodology can be demonstrated and thus reduce bias. A Critical Realist position is taken in this study for reasons explored below.

2.4 Epistemological Position

It is essential to locate the current study more explicitly within the CDA paradigm, as many branches have developed from the core work of Fairclough (1989). Discourse Analysis is a broad field containing divergent epistemological positions, with Discursive Psychology at one end of the continuum and Foucauldian Discourse Analysis at the other (Locke & Budds, 2020). The definition of 'discourse' varies across the literature. Discourse has been defined as a social practice whereby individuals draw on psychosocial factors to make sense of significant concepts (Willig, 2000). Dunn and Neumann (2016, pp.18) describe discourse as "a system of meaning production that fixes meaning, however temporarily, and enables actors to make sense of the world and act within it".

2.4.1 Critical Realism

Critical Realism is interested in the influence of language, power, and the effects of these on the 'real world' (Pilgrim, 2019); given these underpinning features, it felt the most suitable position. Alternatively, a Social Constructionist position could have been taken, especially considering that this position is also interest in the power that language has to shape reality. Generally, Social Constructionist positions focus on the various constructions of reality across different accounts and the multiple existing narratives about specific phenomena, and they are less focused on their impact on reality (Willig, 2001). They highlight a fundamental difference between assumptions made about what is assumed to exist and the nature of reality (Willig, 2019). Pilgrim (2019) defines three core assumptions of Critical Realism: ontological realism, epistemological relativism, and the notion of judgemental rationalism. These align with the research questions and methodology of the present study. These will be discussed in further detail.

2.4.2 Ontological Realism

The ontological position of Critical Realism has been described in aligning with the assumption that a material world is assumed to exist beyond our understanding of it. It acknowledges that although individuals' conceptualisations of reality can vary and impact reality, they are perceived to be separate from the material aspects of the world, e.g., objects and events that we experience. Conversely, ontological relativism suggests that multiple realities exist and that "what is experienced as 'real' depends upon the mindset of the person experiencing it and that there is no 'reality' beyond such subjective realities" (Willig, 2016, p. 2).

Given my assumption that parliamentary texts have a tangible impact on health services and the material lives of those who experience them, and my recognition that social structures and the mechanisms governing this relationship are also tangible; this is felt to be the most appropriate grounding for the current study.

2.4.3 Epistemological relativism

Epistemology concerns the nature of knowledge, how we can understand the world around us, the extent of what can be learnt and known, and the validity of knowledge (Willig, 2019). Critical Realism takes a relativist epistemological stance. A relativist position suggests that the world can be construed and discussed from multiple perspectives (Pilgrim, 2019).

Given that this study aims to explore policy and parliamentary discourses for their underpinning theoretical assumptions and contradictions between them, these underpinning ideologies align with this. In order to achieve this endeavour the following assumptions apply: concepts are considered from a range of theoretical standpoints, several theoretical assumptions can present within one text, including conflicting ideas and they are expressed within the language and policy. A relativist epistemological stance posits that knowledge of what exists and how society operates is socially constructed, therefore, research can be used to understand how and why different outlooks arise and gain influence.

Through Critical Realism, epistemological relativism and ontological realism are held in tandem (Pilgrim, 2019). Willig (2016) acknowledges that our understanding of reality may inevitably be a socially constructed, subjective, incomplete representation of that ‘reality’ but that social and material realities can also exist beyond our conceptualisations. Bhaskar’s (1997) concepts of transitive and intransitive aspects of the social world can roughly highlight the distinction between the material world and our individual conceptions of it.

Transitive knowledge is socially constructed and inherently embedded within discourse (e.g., conversations, ideas, opinions, and texts). Intransitive objects are "invariant to our knowledge of them; they are the real things and structures, mechanism and processes, events and possibilities of the world" (Bhaskar, 1997, p. 22, as cited by Joseph & Roberts, 2004). Joseph and Roberts' (2004) share the notion that knowledge in the form of discourse is seen to rely upon the existence of these intransitive aspects but are also responsible for sculpting them within a dialectic process. Constructions of the world can be realised in the sense that they have tangible consequences for individuals through the shaping of practices, organisations, and broader social structures that influence their lives.

The transitive elements in the current research are the theories, language and knowledge, embedded within parliamentary texts and interactions. These influence how the TBI services are operationalised, and consequently, how unmet needs arise, they also influence the focus of our work as healthcare professionals, and the degree to which it is orientated to the health of this population. The impacts of the intransitive aspects of social reality, for example, the work of multidisciplinary professionals within neurorehabilitation services, the interventions they deliver, the resources allocated, how they interact with service users, which services are commissioned, their internal structures, their operating procedures, their location, the amount of funding they receive and so on. There are, real-world implications for the lived experience of individuals with TBI and the quality of life within the ecosystems of their worlds (Bronfenbrenner, 1979).

2.4.4 Judgemental rationalism

Pilgrim (2019., p. 4) states, "Some construal's might be honest and persuasive (e.g., persistent inequalities in health meant the poor will be sicker and die younger than the rich on average) or dishonest and unfounded (e.g., there are no health inequalities only 'health variations' and being health is merely a matter of personal choice).” With this in mind, psychological therapists must move forward with transitive policy elements. An advantage of Critical Realism is that it allows researchers to go beyond the acknowledgment of multiple perspectives and conceptualisations and move towards taking a position as to which of these they believe will have more or less of a disadvantageous impact on individual experience (Pilgrim, 2019). Critical Realists are most interested in making judgements about the accuracy and appropriateness of transitive understandings (Fairclough et al., 2002). This positioning is termed judgemental rationalism.

2.4.5 The researcher’s position

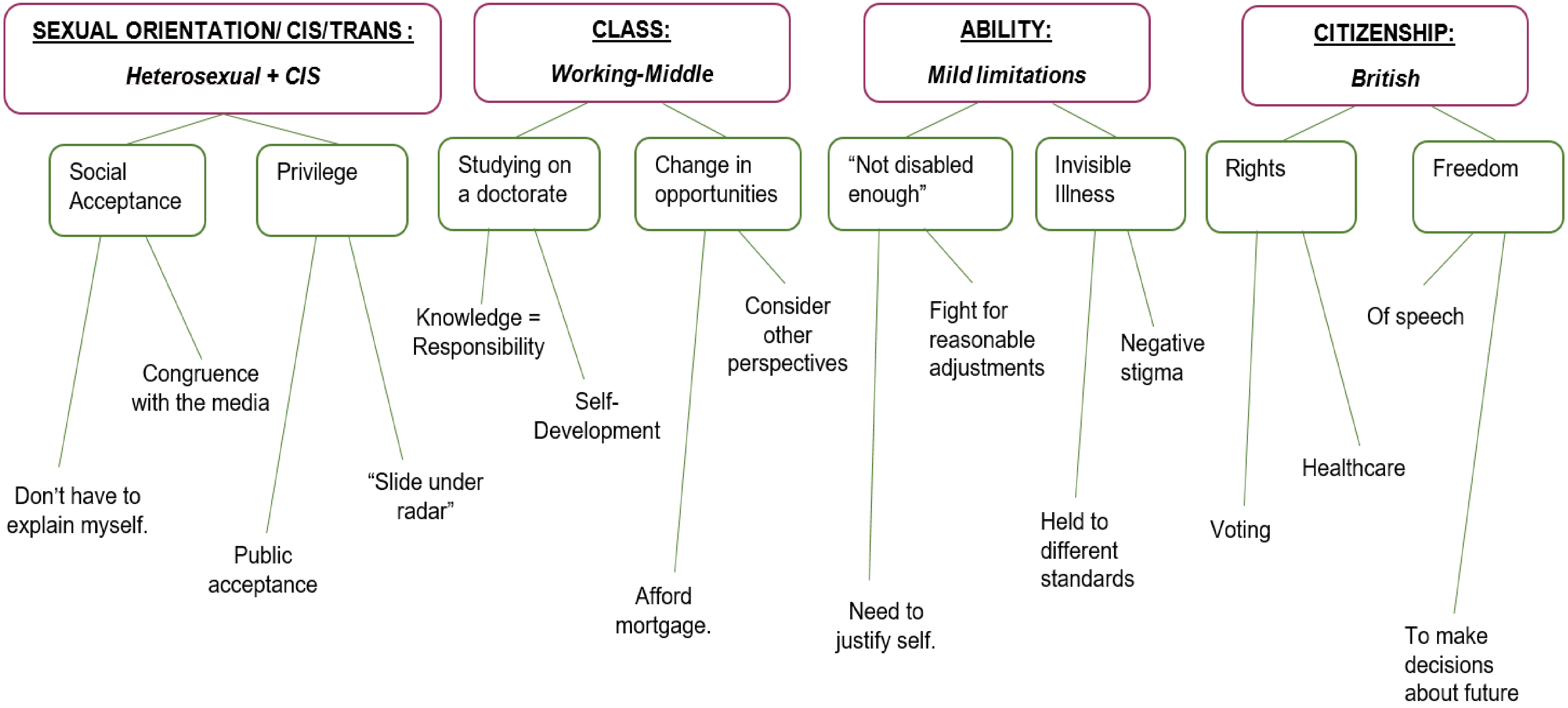
An inescapable factor within CDA is that the researcher is part of the discourse, to make this methodology more rigorous, reflexivity is used throughout. Reflexivity can be defined as an understanding that the researcher is influenced by the analysis as much as they are influencing agents on the research (Probst, 2015). Other definitions of reflexivity often concern integrity and ethics (Pope et al., 2020); for others, it is a reflection or identification of the many intersecting characteristics of a person that present within the research (Galliher et al., 2017). Willig (2001) advocates for reflexivity during the research process, with an acknowledgement that the researcher’s perspective will shape its direction and outcomes.

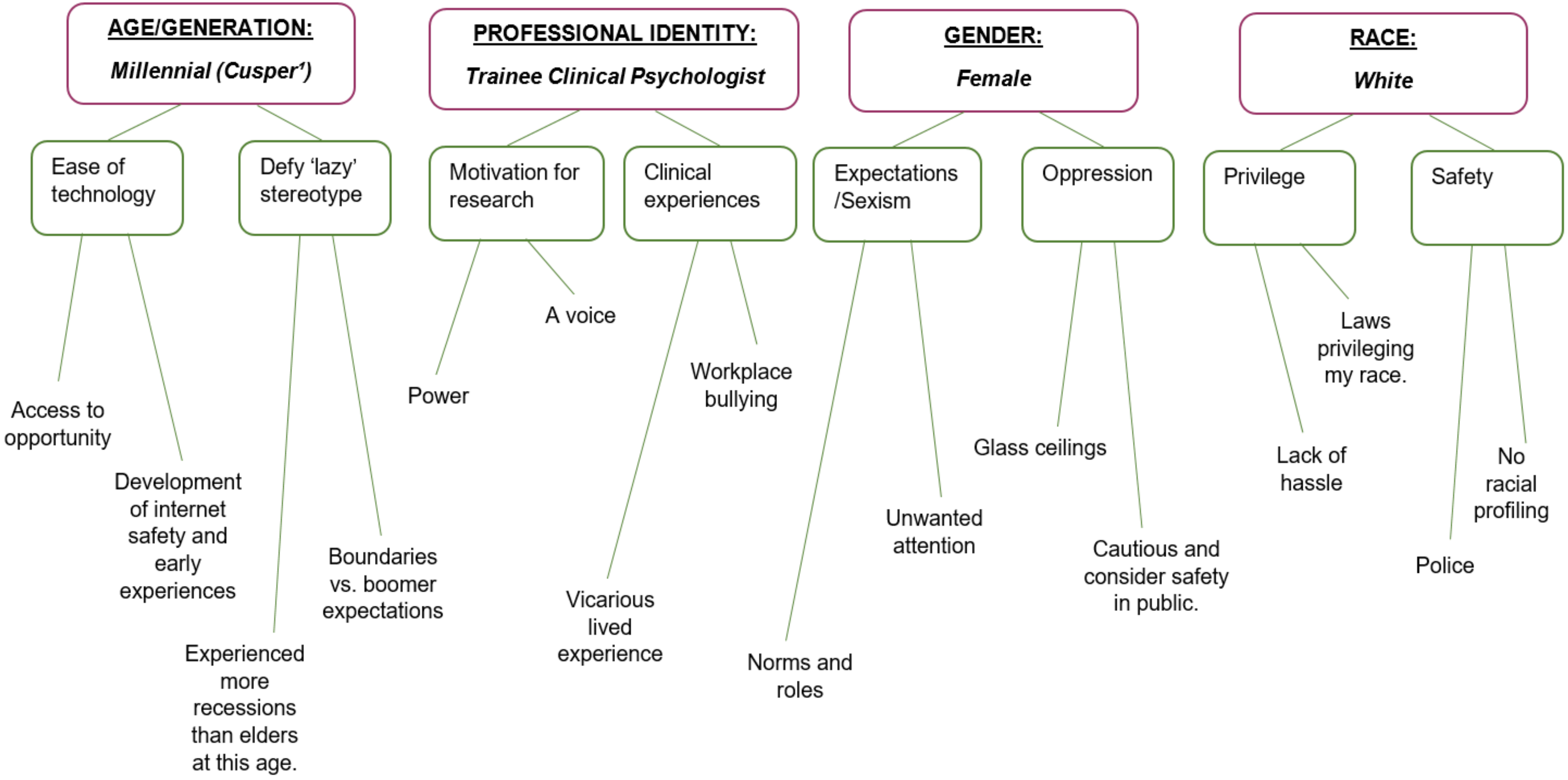
Given the judgemental rationalist position of Critical Realism, a stance can be taken regarding the implications, limitations, and strengths of parliamentary texts while simultaneously allowing the researcher to preserve epistemic humility (Pilgrim, 2019). Rather than diminishing the results of the research as a singular perspective, this reflects the epistemological assumption that all research is a partial representation of reality and fallible. In CDA, the meaning is more specific and is related to the ontological and epistemological framework, which encourages researchers to reflect upon their “positionality… in a variety of sometimes overlapping contexts” (Lynch, 2008, p. 710). Researchers’ reactions and observations are helpful pieces of information and should be treated with the same scrutiny as the data as it reflects transient self-awareness (Kondrat, 1999).

Personal reflexivity concerns values, beliefs, and identities from which the author approaches the research. Jacobson and Mustafa’s (2019) social identity map was used as a starting point to define my positionality. This can be seen in Figure 2. My primary (Tier 1) social characteristics were initially explored. In Tier 2, the positionality map focuses on how social identities affect one’s actions, values, and behaviours. Finally, I identified emotions that connect to the social identity facets (Tier 3). In CDA research, the researcher primarily decides the boundaries between what is judged to be discursive and non-discursive (Jørgensen & Phillips, 2002, chapter 3; Starks & Brown-Trinidad, 2007). Jacobson and Mustafa (2019) stress that the map serves as a starting point for considering a concept as complex as identity and suggest that additional Tier 1 factors can be included to increase the depth of reflexivity.

Figure 2

Researcher's completed Positionality Map





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[1] A slang term referring to individuals born on the edge of a generation. Therefore, they can be a mixed of generations either side of their birth year.

It can be tempting for a researcher to think they can be a neutral facilitator and compartmentalise their identity factors. Galliher et al. (2017) make the point that identity is comprised of many facets, some of which overlap and some conflict. Given the aims of CDA it would be misguided to only focus on the role of intersectionality without considering the influence of power and privilege. The positionality map can be a valuable means of anticipating power and privilege dynamics, impacting the research and, therefore, the researcher impacting the study (Starks & Brown-Trinidad, 2007). Harper (2003) suggests that personal reflexivity should not end with a list of social locations held by the author. It should take it a step further and consider their possible impact on the analysis and, thus, how this will be addressed.

Therefore, it is relevant to acknowledge that my views align with those of the left of the political spectrum. I generally support policies and motions that encourage social equality and work to reduce discrepancies in power, health, and wealth across our population. I hold the position that those with additional needs and, therefore, are less abled are significantly affected by inequalities in privilege and power. These assumptions combine with my professional position as a trainee clinical psychologist, where I hold a compassion-focused position and resist narratives that locate blame on the individuals. This, therefore, informs where I hold the ‘problem’ in terms of what perpetuates unmet needs generally in TBI. In addition, whose responsibility it is to address this, emphasising the need for interventions focused on barriers to implementation and social justice. As a trainee clinical psychologist, it is likely that values and cultural norms will have influenced the choice of research and will likely have a reciprocal effect. This study’s research aims, objectives, and questions were born from clinical observations with the hope of bringing greater attention to this issue. Therefore, an implicit advocacy role was adopted. I critically view neoliberal attitudes that individualise distress, prioritise economic arguments, and locate responsibility for individuals’ societal positions on personal qualities or lack thereof.

These have the potential to influence my receptiveness to examples of these discourses within the text, which could result in the unequal representation of these themes in the analysis. I will be mindful not to start the analysis with a predetermined notion of what specific texts may include. I will also aim to be in tune with examples that go against my expectations or the dominant discourses. In turn, this will hopefully produce a more nuanced account of the texts, avoiding circularity and a further account of the researcher’s pre-existing views (O’Reilly et al., 2021). In the critical reflections section of this report, I will expand upon the steps taken to limit the impact of my pre-existing values on the findings. Within this section, specific examples from the research will be referred to, and personal reflexivity will be necessary to reduce bias within the analysis.

2.5 Method

This section outlines CDA as the most appropriate methodology given the described requirements in section 2.4.

2.5.1 Critical Discourse Analysis

CDA is an explanatory, interpretive, and descriptive process of deconstructing reading (Munro & Beck, 2021). Fairclough et al. (2002) define ‘discourse’ as a positioned way of representing social practices and the material world through text. All forms of linguistic activity are included under the term ‘text’, such as written texts and conversations. For example, in the current study, the text refers to the written transcripts of parliamentary commentary.

Discourses available to society can intrinsically influence our experiences of reality, enabling and constraining the many ways we can see the world. Willig notes, *"…the words we use to describe our experiences play a part in the construction of the meanings we attribute to such experiences*" (2001, p. 56). This process can be considered vulnerable to power; therefore, discourse can be used to construct reality in the interest of certain groups. Within CDA, texts are critically explored for the manifestations of power, dominance, and control operating within them and the role linguistics plays in maintaining them.

CDA goes beyond what can be ascertained from a simple critical reading of the text and brings a socially and politically informed lens to the text, considering its assumptions, terminology, and conceptualisations and their impact, for example, on the ways TBI services are structured.

CDA focuses on mapping the influences that shape the discursive direction of a text and the supremacy of certain themes. CDA suggests this is influenced by the agenda of groups with the most power and influence within society. Nevertheless, this process often remains hidden, and the dominance of certain discourses can be taken as the natural order of things. This seldom means that ideas are sustained despite the detrimental or discriminatory impact on certain groups within society. For the current study, this could mean that the particular ways of understanding meeting unmet needs in a TBI population are perpetuated, despite not being fit for purpose or equitable.

Therefore, a strength of CDA is that it considers the context in which the text was produced and the influencing factors in shaping its discursive features rather than being limited to an isolated analysis of one text. The preconditions include the influence of powerful groups and the specific historical and geographical setting from which the text has emerged. These constrain the discourses available for inclusion within policy, and how the policy will be understood by its reader. CDA refers to extra-linguistic factors, which feel suitable for the current research given its interest in the political structures that result in parliamentary texts influencing how policy is operationalised, for example, through funding and service planning.

Given that CDA was developed with its intended use to critically analyse political and or media discourses, i.e., where the workings of power are most overt, it is a fitting method to use in the current research. It aims to increase transparency within the process, to confirm with the critical aspect of the method, emphasising the ideologies and theoretical constructs that either are unacknowledged aspects of the discourse, or overtly stated (Blommaert, 2008). Drawing attention to the role of discourse in perpetuating social inequalities and to advocate for those oppressed by these structures is an inherent aim of CDA (Weiss & Wodak, 2003). However, although this appears to be a partisan position, it is important to consider that, in some ways, all research is biased by specific lenses and other factors, such as the researchers' interests in the outcome (Harper, 2003).

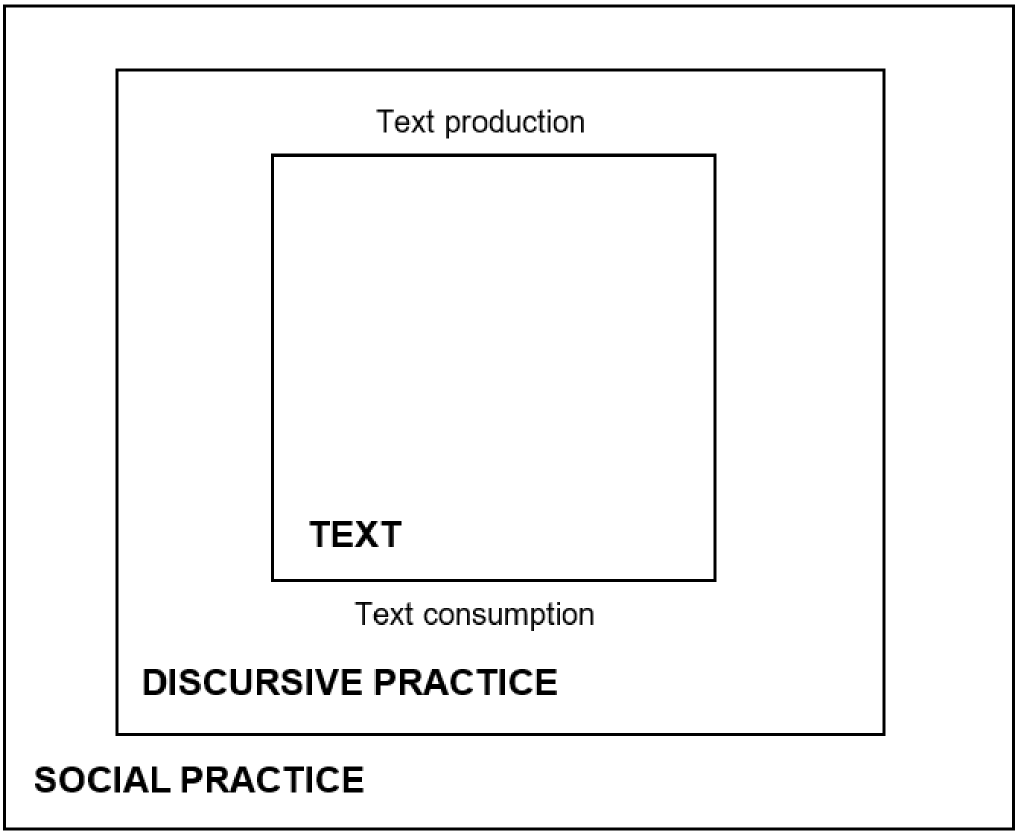
This view aligns with the judgemental rationalist aspect of critical realism, and my own stated aims and values for the research. A crucial role of a clinical psychologist is to support disempowered groups and those who would benefit from population-level action toward alleviating physical and mental distress. Understanding the meanings constructed from parliamentary texts within this topic and how they could reinforce power imbalances is fundamental. With this information, alternatives can be considered that will better serve those with the least power in society; clinical psychologists are well placed to do this in their work settings.

As Willing (2001) explains, discursive approaches to research are more than a structured methodology. Instead, they represent a different way of connecting to language and texts than conventional psychological approaches. These approaches are not typically seen as structured methodological procedures, but rather as theoretical frameworks. Fairclough (1992a) notes that every instance of language is a communicative event consisting of three dimensions; text (speech, writing, visual image- or a combination of these), discursive practice (involving production and consumption of text) and that it is a social practice.

Fairclough's (1992a) three-dimensional Discourse Analysis framework can be seen in Figure 3. The model places the textual analysis in the centre, surrounded by an examination of the discursive practices and social practices, including the interpersonal and historical context. The guiding principle throughout the analysis was to construct a contextual map of emerging discourses through continual re-reading of the data (Henry & Tator, 2007). Alongside the re-reading, the analyst will have the theoretical principles to hand so that findings can be interpreted through this lens alongside the research questions (Wodak, & Meyer, 2001). The analyst will also ask oneself how the interactions between implicit and explicit discourses function ideologically (Fairclough 1992b). As Dunn and Neumann (2016) recommended, a starting point is to revisit the transcript multiple times to generate familiarity and identify macrostructural factors within the margins, coding critical topics raised by speakers can be noted.

Figure 3

Fairclough's three-dimensional model for critical discourse analysis (1992a)



The methodologies available in CDA are not prescriptive and can be selected to fit the research question best (Wodak & Meyer, 2001). To provide rigour in the current study, a framework developed by Fairclough (2001) was utilised (see Table 1). However, the order and form that these stages took in the research were applied flexibly to meet the study's needs.

Table 1

5 Stage Framework for CDA

Stage	Description	Examples of each stage
Stage 1	Focus upon a social problem that has a semiotic aspect	• Introduction • Methods • Historical Analysis
Stage 2	Identify obstacles to the social problem being tackled, You can do this through analysis of: a. The network of practices it is located within b. The relationship of semiosis to other elements within the particular practice (s) concerned c. The discourse (the semiosis itself) by means of: • Structural analysis: the order of discourse • Interactional analysis • Interdiscursive analysis • Linguistic and semiotic analysis	Stage 2a. • Discussion - Section 4.2.1 - Section 4.2.2 - Section 4.2.3 Stage 2b • Discussion - Section 4.1 Stage 2c • Discursive analysis - Section 3.2
Stage 3	Consider whether the social order (network of practices) 'needs' the problem	• Discussion - Section 4.2.4
Stage 4	Identify possible ways past the obstacles	• Discussion - Section 4.3 - Section 4.5
Stage 5	Reflect critically on the analysis	• Discussion - Section 4.6

Note. From 'The discourse of New Labour: Critical Discourse Analysis' by Fairclough, N., 2001, in M. Wetherell, S. Taylor, S. J. Yates, & N. Fairclough (Eds.), *Discourse as Data: A guide for analysis.* Sage.

2.5.2 Strengths and limitations of Critical Discourse Analysis

There are many strengths to CDA, firstly it provides a framework for examining the relationship between discourse and social processes, allowing for a deeper understanding of the social implications of language use. Building on this Cummings et al., (2020), notes a key strength of CDA is its ability to allow for analysis of policy documents whereby it can reveal their inner biases and claims in a systemic, structured way. It can reveal hidden pre-occupations and how they may reflect different discourses: dominant, marginal, oppositional or alternative.

Brookes & Harvey, (2016) argue that contemporary health discourse requires greater critical attention from analysts able to critically examine health information and policy discourse. They acknowledge that most parliamentary communication is Daedalian and from a discourse analysis perspective has received little scrutiny. This is something that CDA allows for and given my position as a trainee clinical psychologist working within the NHS where the government policies and structures decide funding and targets, it is logical and important to explore policy discourse.

A further strength of CDA is the activist nature the method has during the final stage of analysis as there is identification of new discourses, narratives and arguments which can counteract ‘social wrongs’ in current, dominant discourse. This is important given all approaches to CDA have a political commitment to emancipation and, consistent with the goals of Critical Theory, seek to engender social change (Fairclough & Wodak, 1997). Given the service shortcomings for TBI survivors and their carers over the years, this method feels appropriate in exploring the role of language and power, through taking a nuanced top-down approach which has not been done before.

Breeze (2011) notes that although CDA offers a promising paradigm for bridging the gap between real language phenomena and the inner workings of societal power, the method itself and theoretical shortcomings can undermine the conclusions drawn. Similarly to other qualitative methodologies it is subjective and influenced by the analysts' perspectives. This can be mitigated through means of rigour and stating epistemology and ontology (Frantz, 2003). I have detailed my political position and other positions for the reader to hold in mind as they consider findings presented. My influences on analysis have also been further thought about in the critical reflections section.

A widely known criticism of not only discourse analysis but other qualitative methodologies is that as the datasets are vast and rich the researcher must make choices regarding the significance and dominant linguistic features and discourses. The structure of the analysis in this study and process of data coding was meaningfully informed by the work of Araujo et al. (2019), Fairclough (2001), and Gee (2014). However, Krzyżanowski (2016) cautions discourse analysts that in the pursuit of sociolinguistic change they may stray too far into the abstract.

CDA researchers have historically researched the way ideology works through discourse to maintain unequal power structures, this has often been received as quite negative and is thought to produce a deterministic view of society. This is an interesting dichotomy when considering a key function of discourse analysis is to explore the emancipatory discourses in a bid to think about positive change. Conducting this research with a clinical psychology background will help negate this pitfall as a key aspect of clinical psychology research is thinking about the impact of findings and what can be changed or improved. Therefore, this research will think carefully about the impact of the results and what is actionable for the TBI community.

The consequences for empirical research of the theoretical distinction between the discursive and non-discursive remain unclear. When presenting the broader social practices as the background for discursive practices there is a risk that there is no generation of new knowledge or hypotheses about the larger societal structure. It is argued that one source of the problem is that Fairclough's analysis can be limited to single texts. To counter this pitfall Chouliaraki & Fairclough (1999) note that analysing the transformation and reproduction of discourses across a range of texts makes it easier to demonstrate how dynamic discursive practices influence and change the social world. Therefore, the current study has chosen to analyse an intertextual chain of seven texts.

Despite the general use of CDA in education and sociology, policy research employing CDA methodology is sparse but nonetheless, as suggested by Evans-Agnew et al. (2016), represents a promising methodology for policy research. This deficiency may well be due to its inexact approach and criticisms over its methodological shortcomings as expressed by Breeze (2011). I hope to have remedied some of this inexact approach by using Fairclough’s 5-stage model (2001) and the sociolinguistic categories compiled by Araujo et al., (2019) (based on Resende & Ramalho, 2009; Ramalho & Resende, 2011; Halliday & Matthiessen, 2004; Van Leeuwen, 2008) (as seen in Appendix 3).

A further shortcoming of CDA is a theoretically weak understanding of processes of group formation, the subject and agency, including questions regarding subjectification and subjectivity and how much control people have over their language use. Although within Fairclough's theory he acknowledges that discourses take part in constructing social identities and social relations it is still argued to be the weakest element of this theory. This is not helped by the dearth of empirical research into the consumption of texts. Therefore, this study will include ideas around text production and text consumption within its analyses (as seen in Appendix 2).

2.6 Procedure

2.6.1 Sources of data and rationale

Wodak et al. (1999) stresses the importance of the researcher being self-reflective. As no ‘right’ interpretation exists, rather than seeking a ‘truth’, critical discourse analysis takes a non-positivist problem-solving approach (Wodak et al. 1999). By putting analysis in the public arena, CDA aims to challenge existing dominance (Taylor, 2004). Chouliaraki and Fairclough (2010), suggest that the focus of CDA should be on the links between discourse, power and elements of social processes that emerge as research problems through analysis rather than on ‘rigorous methodological protocols’.

With this in mind and due to the constraints of the project, i.e., being a doctoral thesis, the data was chosen through pragmatism. The next steps of research will be discussed in the later stages of this report.

2.6.2 Data Collection and Handling

Suitable texts to answer the research questions were identified via purposive snowball sampling, using my existing knowledge of key policy documents and debates.

Some texts were identified via a systematic search on the government website ‘Hansard’. Hansard is the official report of all parliamentary debates, it details members and their contributions, debates, petitions and divisions, dating back over 200 years (UK Parliament, 2019).

Using the Hansard search function, the term ‘Acquired Brain Injury’ was utilised, selecting the option to find texts across both the House of Commons (HoC) and House of Lords (HoL). This yielded two-hundred and fifty-five references, seven debate titles, three written statements and forty-seven written answers dating from the 09/03/1809 to 14/01/2024 (Date of final search: 13/02/2024). Texts were then identified for mentions of unmet needs, these were highlighted within the debate titles. A secondary search was carried out when reading these references, any key policies and reports referenced within these debates were also included.

Appendix 2 outlines the details of the chosen data sources, it highlights the type of data, author, intended audience and initial thoughts. This document was created to think about the selection of texts, Fairclough (1992a) suggests that texts selected for CDA should demonstrate the existence of ideology and power relationships, meaning that not all texts are eligible for analysis. Fairclough (2013) notes that textually orientated discourse analysis ‘is rather labour intensive’ and can be productively applied to samples of research material rather than large bodies of texts. Therefore with some documents only a selection of data was used as this was most applicable to the research questions asked within this study.

This ideology from Fairclough was followed due to the scarcity of neurorehabilitation CDA literature, subsequently, the final number of texts analysed in this research was seven. As seen in Appendix 2 there were many documents available to explore the research aims and questions, the decision to only look these texts were to ensure the size of the dataset was manageable within the boundaries of the resource available for the research. It was also felt that the series of debates would offer an intertextual chain to see how narratives and discourses developed during the time of the APPG, and would encompass key ideas from the other reports that were not included in the final analyses.

In regards to handling the data, the choice was taken to use NVivo following the guidance from Araujo et al., (2019). I considered using Adobe Acrobat Reader as the highlighting and text functions would allow for figures and tables to be included within the analysis. This is important as they are a key source of semiotic data. As the final texts did not have any tables or figures in, I decided to continue with the choice to use NVivo.

NVivo allows for the creation of nodes in accordance with the selected theoretical approach and research questions. The nodes can be further divided into subcategories called ‘sub nodes’ which may later be grouped into specific folders. Nodes and sub nodes were based on sociolinguistic categories (Araujo et al., 2019). These have been complied for reference into Appendix 3. Araujo et al. (2019) note that not all categories will be relevant to the researcher as such it was noted that the researcher will likely create their own categories and subcategories relevant to the present studies analyses.

2.7 Ethical Considerations

This study did not need ethical approval due to the use of secondary data. Considering the methodological shortcomings outlined earlier in this chapter, it should be noted that my position is explicitly detailed to ensure readers can adjust their lens when reading and critiquing the work.

2.8 Fairclough’s 5 stage model

The following section will outline the analysis process and how this satisfies each of the stages in Fairclough’s 5-stage model (2001).

Focusing on a social problem that has a semiotic aspect is the aim of Stage 1. This goes beyond taking a research question as a starting point; it aligns with CDA’s critical nature and selects an issue with prospective consequences for disempowered social groups. This is represented in the Introduction, Methods, and Historic Analysis sections, whereby the rationale for focusing on the social problem of unmet care needs within a TBI population through consideration of parliamentary commentary is explored.

For example, the introduction section outlines why unmet needs within a TBI population is a current social issue worthy of analysis. This is especially pertinent given that it unequally impacts those who are socially disadvantaged, and there is a reported increasing amount of individuals not receiving support. Yet, the theorised causes of unmet need are considered preventable. Despite the historic political focus on this, unmet needs persist for this cohort.

Having selected this social problem, Stage 2 is to identify the obstacles to it being tackled. This is partially achieved within the Discursive Analysis section, representing stage 2, part c of Fairclough’s model. Rather than representing a straightforward reading of parliamentary texts with a critical lens, this analysis considers explicitly which of the possible pools of discursive themes relating to TBI, prevention, unmet needs, and service delivery are included in the text. It also will consider which are omitted by this way of framing the issue. An additional focus is how conflicting discourses are treated combined in a way that allows a group to achieve dominance over another group. This includes a detailed list of the specific linguistic strategies (see Appendix 3) that make this possible, such as using metaphors or certain modalities that guide the reader to a specific representation or conclusion.

Through this means, the analysis extends to consider the power the text has to make certain options appear natural, taken for granted ways forward in tackling the problem of unmet needs in TBI. Bringing this process to the foreground is how CDA can add new knowledge to inform social change toward meeting the needs of those with TBI.

Following this, the discussion section will appraise the structures and network of practices contribute to the perpetuation of the social problem. This is represented as a combination of Stage 2, part a and b, and stage 3 of Fairclough's model. These aspects of CDA go further than the textual analysis of Stage 2, part c, and is a feature that defines it from other forms of discourse analysis, including Foucauldian Discourse Analysis (FDA). This section sets the problem within its social context rather than considering the text in isolation. Consideration of practices and structures within such institutions, such as the workings of the policy-making process itself, would be relevant to this analysis. This would explore the ideological assumptions that prevail within such organisations and in their wider society. This is also acknowledged in the Historical Analysis section, as the current research extends the analysis beyond the texts selected by locating them within their temporal context.

Stage 3 of Fairclough's model will also be addressed in the Discussion section by assessing the function of who stands to gain from the problem being maintained. For example, primary strategies to equally distribute resources to meet needs within TBI could impact the privileges and freedoms of certain groups and may face opposition. As the current research is limited by being a doctoral thesis, doing each stage of Fairclough's model justice was difficult.

I will then take forward the knowledge generated from Stage 2, Part c in the next section of the Discussion, which addresses the findings' implications. This is related to Stage 4 of Fairclough's model, which identifies possible ways past the obstacles to unmet needs in TBI. Given CDA's key concern with social change and emancipation, researchers are considerate of the new knowledge the analysis generates; for example, its view of power and authority within parliamentary texts could be used to advocate for groups who can be disadvantaged by its specific way of representing the problems. For example, this might include ways that clinical psychologists can advocate through social policy work or contribute alternative discourses around needs being met effectively to resist the effects of policy.

Stage 5 of the model is represented in the critical reflections section within the discussion. Also, within this chapter, critiques of CDA are considered, as are efforts taken to improve the credibility and rigor of the research.

The next section will detail the procedure for the Historical and Discursive Analyses to encourage transparency.

2.8.1 Historical Analysis

The analysis began with an exploration of the historical context of unmet needs within TBI settings and wider population health narratives within UK political texts. A necessary aspect of CDA is researching discourse outside of its context; without this, there is a risk of the texts being analysed through a reductive lens and an incompleteness in thinking about how discourse functions within it (Fairclough, 2013; Fairclough et al., 2002). Looking at the development of the ABI bill as an example, attending to the network of other discourses, events, and social phenomena within that period will help elucidate the preconditions for why this bill was put forward.

Although, an historical analysis is an aspect of all CDA research, there is no defined process for conducting a historical review, so this was developed to fit the research needs (Ward, 2023).

In the present study, the introduction represented an initial historical and contextual exploration. This was further expanded in the Historical Analysis section, where discursive themes relating to unmet needs were tracked in more detail. I achieved this through reading widely across health policies that related to TBI treatment, literature about the historical development of these policies in general (Jørgensen & Phillips, 2002), the recommendations for TBI treatment, and the broader contextual shifts. For example the financial crisis of 2008 and the coronavirus pandemic of 2020.

During this review of the literature, a sense of the unmet needs discourse was developed. Further documents, particularly about contemporary developments in TBI's rehabilitation needs agenda, were identified through a 'snowballing' process whereby texts referenced in relevant parliamentary texts were explored. The NHS Long-Term Health Plan (LTP) was identified as a key document. This was due to its current relevance and scope to influence rehabilitation provision and prevention in the UK.

Documents relating specifically to Scotland, Wales, or Northern Ireland as opposed to the UK in general were not included. Each of these countries would have added a unique policy context, which was beyond the scope of this research to explore in detail. Although some excerpts in the discursive analysis relate to Scottish, Welsh, and Northern Irish experiences, these were included as these spoke to the understanding of unmet needs and added to the consensus of obstacles to the social problem identified, rather than the nuance of country specific structures. Parliamentary texts were considered until the start of 2024 due to the available timeframe for the writing the current study. This informed the selection of texts to be included in the Discursive Analysis section.

2.8.2 Discursive Analysis

After the selection of texts, the discursive analysis was undertaken in line with Fairclough’s Stage 2, Part c. I examined texts for their range of discourses and their relationship to each other regarding the dominance of certain discourses over others (See Appendix 4 for examples of this process). I considered how these discourses were combined and utilised to achieve a certain function; exploring in the analysis any contradicting discourses that gave space for contrary concepts to merge (Willig, 2001). The analysis drew out idiosyncratic ways in which discourses within the text were used to relate to the intended audience for a specific social purpose and the linguistic strategies drawn on to achieve this. The linguistic analysis included examining the sociolinguistic categories highlighted by Araujo et al. (2019) (see Appendix 3 and 4).

3.0 Analysis

3.1 Historical Analysis

A historical analysis will be presented chronologically, focusing on the context and preconditions for relevant policies and parliamentary texts relating to meeting the needs of those with TBI (some of these documents will present with an ABI lens). These specific texts will then be outlined in more detail concerning their notions about unmet needs within this population, the varying conceptualisations of TBI and needs, the new emphasis each document makes, and the actions they endorse. A supporting table with this analysis can be found in Appendix 2. The main features highlighted in the critical texts will then be drawn out. However, each subsequent document had a high degree of commonality with those preceding it.

Several themes will be identified throughout the historical analysis that set the scene for the TBI's unmet needs political agenda. The chronology will begin with the growing independent living movement promoting support for those with disabilities in the 19th and early 20th centuries. The analysis will highlight the movement of dominance for different understandings of disability (including TBI), including social and environmental conceptualisations and those from more individual and biomedical frameworks. Narratives regarding individual versus collective responsibilities for health will be outlined, as well as the influence of interventionist and market-based government policies. The changing rationale for meeting TBI needs, unmet recommendations, and their links to different political pressures will be covered.

These themes are important, given their implications for unmet needs within the TBI cohort. These include varying emphasis on changes to community approaches, social policy, investment in early rehabilitation and primary care, and the provision of treatment both physically and psychologically. Each development within the unmet needs narrative will be explored regarding its relationship to vital historical and political events, including the World Wars, changing economic conditions, crucial publications, the development of different professional groups and neurorehabilitation interventions, and the coronavirus pandemic.

3.1.1 1914-1941- The World Wars

Neurorehabilitation has not always been conceptualised in this term, and in the early 20th century, it was referred to as ‘rehabilitation’. The context of the world wars heavily shaped the development of neurorehabilitation. During this period, a crucial problem was identified: those who had ABIs during battle were often unable to return to service. Further to this, they were heavily impacted both physically and mentally, which also affected their ability to function in society.

During the Second World War (WW2), a pathway to recovery was conceptualised, it detailed a rehabilitation program consisting of two stages (Guttman, 1941). When thinking about developing their ‘rehabilitation’ program, the primary purpose was to get individuals back to work. However, these thoughts were also entwined with an emphasis on the role of the individual in recovery and the value of men still being able to earn a wage with the right job.

A poignant figure at this time was Sir Hugh Cairns, an Australian neurosurgeon living in the UK; alongside his development of ‘rehabilitation centres’, he sought to make a difference in preventing head injuries. He pioneered the work with motorcycle helmet safety (Stone et al., 2016). During WW2, the British army lost two motorcycle riders a week due to accidents. From Sir Hugh's work, in November 1941, the British Army ordered all despatch riders to wear helmets (Stone et al., 2016).

Similarly to today, Cairns' rehabilitation adopted a multidisciplinary approach with documented roles of physiotherapy, occupational therapists, 'speech trainers', and neurologists; he also spoke about the importance of Psychology. Noting that others before him had not seen the value of psychology within this field, he hoped psychological professionals would offer support beyond measuring intelligence-speaking to an individual's character, values and personality. This era highlights the influence of WW2 and new professional roles, which began to set the scene for the biomedical, psychological, and individualised elements of neurorehabilitation; with an underlying message that men need to be in work to feel a purpose in life.

3.1.2 The Welfare State and Post-war

Following the World Wars there was a period of austerity; under Keynesian economic policy, the UK's welfare state was developed. The policy encouraged individuals to return to employment and increased expenditures for public services (Moth, 2020). Hawksley (2013) categorised this move as a compromise between socialist and capitalist ideals, encompassing elements of collectivist and market principles.

In 1948, the NHS was born; this was a central element of the welfare state. The Beveridge Report (1942) is seen as the founding document of the welfare state. It initially proposed that the welfare state would act as part of the process to manage the 'Giant Evils of disease, want, squalor, idleness, and ignorance' (Beveridge, 1942), starting to develop the notion of social insurance and the ideal of everyone having access to support regardless of your means. Nevertheless, it also poses to responsibilise the individual in their role to alleviate 'society's evils' (Rose & Miller, 1992). The influence of social and responsibilising narratives is seen in contemporary policies relating to the NHS, and parliamentary texts relating to neurorehabilitation are no exception.

The founding of the NHS led to a rise in power and medical professionals in general. This period saw developments in community rehabilitation; this was deemed preferable mainly from an economic and humanistic perspective. Enoch Powell’s water tower speech began the de-institutionalisation of the care of those with mental health difficulties and disabilities in the community and was dubbed the ‘neoliberal dawn’ (Scull, 2021; The Kings Fund, 2014). During this time, the Percy Report (1957) was published, emphasising that mental health should be considered like physical health. It also highlighted that care should be provided in the least intrusive way and with minimal restriction. It is likely that during this time, many with head injuries were misdiagnosed as ‘mentally disabled’ owing to a change in personality or physical disabilities (Linden et al., 2012). Throughout this period, this study will, therefore, consider relevant disability and mental health discourses.

The Mental Health Act (1959) was somewhat applicable to those with TBI, as many may have interacted with this legislation due to their functional changes following injury. This legislation increased opportunities for psychiatrists to take powerful positions of expert mental health practitioners in the community. The profession now included the power to detain those in psychological distress, a move towards role parity with physical health doctors.

The UK appeared to encourage neurorehabilitation provision to turn towards tertiary interventions (including residential facilities) rather than focus on primary community-based interventions; this was influenced by the historical conditions during this period. This occurred alongside a growing assumption that psychological distress can be viewed through a similar lens as physical health problems but with minimal acknowledgement of when they co-occur and the implications that this has for individualising treatment and prevention of further injury.

This period also normalised the propensity for legislation affecting those with brain injuries to include collectivist attitudes to support those who suffer disadvantage and inequality alongside narratives that responsiblise individuals.

3.1.3 The Community Revolution- 1960s

In the 1960s, under the backdrop of deinstitutionalisation, a pivot towards ‘community’ was seen as an alternative to hospitalised treatment (Turner et al., 2015). During this period, Burton and Kagan (2003) noted a dominant bureaucratic stance, which controlled social institutions and pioneered an activist movement that rallied to support the notion of community being an antidote to these social ills. This movement showed allegiance with the marginalised members of society and highlighted the negative impact of individualisation. The evolution of community psychology was developing in the US, and it advocated for change in the social issues that contribute to psychological distress (Trebes, 2016). This movement was vital in highlighting the roles of social determinants in health and the importance of generating spaces for people to thrive (Albee, 1996). However, individuals who left the asylums had minimal resources or capacity to function in a neoliberal environment and fared poorly from this move (Scull, 2021).

Before the 1970s, ‘neuropsychological rehabilitation’ was not an identified treatment, and the term ‘cognitive rehabilitation’ did not exist (Boake, 1991). Developments were being made in the field worldwide around assessment and developing protocols to manage the cognitive effects of brain injury. During this period, it was most likely those with apparent head injuries and soldiers that would be given specialised treatment, and others were subjected to treatment for those with mental health difficulties or other disabilities.

This section highlights how the government leaned into neoliberal ideas and responsibilised individuals in their recovery and care. This impacted the social determinants of health, as many during this time would have become isolated and lonely with reduced access to helpful treatment. However, it also gave rise to the idea that those with 'social ills' can contribute to society and function within the community.

3.1.4 1979-97 – Thatcherism and Neoliberalism

The economic downturn in the 70s and 80s saw reduced popularity of Keynesian economic policy and a rise in alternative ideas. Funding the welfare state and supporting the NHS became increasingly difficult due to changes in the makeup of the UK population (Newton, 2013). During this period, theories attesting to individual freedoms as paramount (Hayek, 1944) were viewed with renewed interest (Cosgrove & Karter, 2018). Following this, neoliberal values were introduced into society; in response, the government intervened by scaling back the welfare state and replacing it with the market to regulate the economy (Rose & Miller, 1992). Increased marketisation was an essential feature of Thatcher's 1979-1997 Conservative Government.

The Black Report (Gray, 1982) highlighted that although the welfare state's creation aimed to reduce health inequalities, several decades after its creation these still persist. However, it posited that this was not the fault of the NHS but rather other social issues such as housing, income, and employment conditions. It made recommendations to address these issues, but due to some stalling from the Secretary of State for Social Services at that time, only limited copies were available. A change of government happened around the time of publication, and the conservatives did not endorse the recommendations, largely due to cost (Jenkin, 2010), thus furthering the neoliberal discourse.

The NHS and Community Care Act was passed in 1990; internal markets were introduced from this act, and it was assumed that efficiency would improve if the NHS were guided under market principles. For example, under the influence of entrepreneurialism and competition (Lewis, 2020). This was marketed as a move that would empower patients by giving them a choice over treatment and being treated more like consumers. The integration of this act was impacted by low funding levels, competition for contracts, increasingly target-driven work rather than care orientated and a push for patient throughput at the lowest cost possible. This likely meant a reduction in person-centred care, meaning the treatment outcomes could have been more effective. None of these qualities aligned well with the TBI agenda, which would require creativity and investment in challenging the broader determinants of TBI and the needs of those with TBI. However, this ideal does not lend itself to an immediate payoff for providers.

In 1996, Barbara Wilson established the Oliver Zangwill Centre for Neuropsychological Rehabilitation (Wilson et al., 2000). Wilson’s rehabilitation approach focused on compensation for cognitive difficulties in daily living (Wilson et al., 1997). This was important at a time when person-centred approaches were not the norm and neurorehabilitation was limited.

As policies reflect a diminished government responsibility in producing social conditions for health equality and wellbeing to thrive, they focus on individuals becoming responsible for managing TBI. The reports/events during this period reinforce the need for better neurorehabilitation for survivors of TBI, with a justified economic argument.

3.1.5 1997-2010- Labour Administrations

Marketisation continued to be embedded, although within a diluted form, during the Labour administration. Moth (2020) characterised this period as one of increased modernisation and centralised control, emphasising target setting and delineating professional roles within mental health services.

In 2001, the Parliamentary Health Select Committee published a report, ‘Head Injury: Rehabilitation’, a document the House of Commons ordered. The report contained over twenty recommendations, highlighting the need for clearer pathways for those with ABI to receive holistic care. It calls to responsibilise the government to plan for different levels of rehabilitation needs and for formal, accurate data collection to inform healthcare planning. It provides an economic argument stating that early investment in rehabilitation will generate an overall long-term saving for the government. This report is a central foundation for those with head injuries to have equitable access to suitable healthcare. However, a reactive discourse was dominant, as no mention of preventative measures was cited within the recommendations.

In 2005 the Mental Capacity Act was passed by government, this legislation was created to empower and protect people who could not make decisions for themselves, i.e., they lack capacity. This helps individuals get the proper support to make decisions in their lives; this legal framework has been challenged as a contravention of the human rights of people with disabilities. This legislation is important but does stray from the free will discourses that permeate British society and democratic practices.

In 2008, the financial crisis highlighted the pressure to prevent TBI and provide suitable rehabilitation to encourage people back into appropriate work. In the same year, the role of social determinants in health and the impact of health inequalities was highlighted by The World Health Organisation (2008). It recommended a 'whole-of-government' approach to address these issues. Although, this was at a time when unemployment rates were at the highest they had been since 1995 (Office for National Statistics., 2018). This also meant a time of squeezing public expenditure, resulting in long service wait times.

This period highlighted the issues faced within this population, but without much action taken. The effects of the financial crisis would stunt rehabilitation progress, i.e. getting back into work. It also presented potentially greater scrutiny over those with TBIs decision-making, and a system that does not always account for the nuances of brain injuries, people risked losing their independence and being further controlled by the government.

3.1.6 2010-2015 – The Coalition Government

In 2010, the NHS Clinical Advisory Group for Major Trauma (Trauma CAG) recommended to the Department of Health the establishment of coordinated care pathways for services in Major Trauma Centres (MTC). Subsequently, twenty-two MTCs were established for adults following significant trauma. As a result of these centres and advances in emergency and acute medicine, survival rates for individuals with ABI have increased by approximately 50%, or 500 individuals per year (Menon et al., 2018). This move did not include reorganising neurorehabilitation services, feeding these reactive neoliberal discourses. This means those who have survived TBI, which previously may not have, are likely being left without adequate follow-up care, as many recommendations from the 2001 Health Committee Report were not actioned.

During the coalition administration, several publications loosely affected those with TBI and likely influenced whether their needs were met. The Marmot Review (Marmot, 2010) highlighted the social gradient of health in the UK, i.e. those from wealth have better health outcomes. Often, those who acquire TBIs are impacted financially and end up reliant on state benefits, especially in the absence of effective neurorehabilitation (Miller, 2024). The review calls for the government to raise the general health and flatten the societal gradient to reduce the economic burden. Within its actions, the White Paper HLHP (Department of Health, 2010) claimed to be the first public health policy to recognise parity of esteem for mental and physical health.

This paper also marked the launch of the new Public Health England, which delineates power from primary care trusts to local authorities. Deferring to local authorities was a response to the health inequalities highlighted by the Marmot review. With a specific budget, it was hoped the local authorities could target the broader health determinants such as crime and employment, further distancing the government's responsibility to society (Gregory et al., 2012). Due to the HLHP's emphasis on individual choices and lifestyle's role in determining health inequality, the interventions often focus on a solution, which is behavioural change. This extends the government's neoliberal attitudes to a local level and into service delivery, with a health emphasis on individualisation. Scott (2015) noted that although HLHP aimed to tackle health inequalities, it held an underlying assumption that local authorities were to move away from ‘nannying.’ Therefore, the policy did not force local authorities to take specific actions to tackle social inequalities. It exists under the justification of choice and a focus on a tailored local approach, as this was in a time of austerity, it is likely to have limited the public health impact of this policy.

Following this, the NHS published a mental and physical health strategy document. The Five Year Forward View (FYFV) (2019) focuses on prevention through a cost-saving lens. There was a heavy emphasis on 'avoidable illnesses', which primarily responsibilised communities, individuals and local services to manage; through this management of 'avoidable illnesses', money could be released to fund more essential things, e.g. new treatments.

During this period under the coalition, the government saw a need to prevent health inequalities to reduce the economic burden. This was a time when social determinants of health were highlighted. However, this was held alongside narratives that responsibilised individuals, communities, the NHS, and local authorities in managing health needs. Underlying neoliberal concepts and narratives further exacerbate that those with worse injuries will get the most support.

3.1.7 2015- 2020 – The Conservative Government

Within the succeeding government, several publications could be seen to address the gap in neurorehabilitation services for those with TBI. In 2015, the National Clinical Audit for Specialist Rehabilitation following Major Injury (NCASRI Project Team & Turner-Stokes, 2019) was commissioned by the Healthcare Quality Improvement Partnership (HQIP). It aimed to determine the scope, provision, quality and efficiency of specialist rehabilitation services across England. In 2019, it produced its final report, which spoke of the increase in recording rates for rehabilitation prescriptions, i.e., over 80% across sites. 40% of participants went to specialist rehabilitation facilities, of the 60% they could follow up, they reported ‘some functional gains,’ suggesting that we only need to rehabilitate those we can make a cost-saving on. The document has a clear lens focused on the cost-saving benefit of this intensive rehabilitation and the amount of time to offset the costs based on what the individual will contribute back to the state through means such as employment- furthering the neoliberal agenda but also maintaining the idea that individuals have to be the most acutely unwell to access timely adequate support.

Further impacting those with TBI, in 2019, the government produced a green paper, Advancing our Health (Department of Health and Social Care, 2019). This document contained language acknowledging the damage caused by health inequalities and the consequent effect on certain individuals and communities.

In 2020, the Exchange Chambers and Calvert Reconnections (2020) conducted detailed research into how brain injury solicitors view the claims and rehabilitation process. Giving a different stakeholder perspective, 97% of solicitors did not believe there were enough residential-based rehabilitation units/ programmes. 71% did not think that the state could provide effective rehabilitation for seriously brain injured patients. This furthers the notion that this cohort of individuals are adversely affected and consequently marginalised. Despite the financial argument, the government believes the responsibility lies with the individual and their family members.

Not only is there over-responsibilising of survivors and family members, but also third-sector charities that do not get support from the government. This responsibilising of third-sector charities is touched upon in the ‘Time for Change’ report by The APPG on ABI (Menon et al., 2018). This document made several recommendations across various areas in which ABI is impacted, i.e., neurorehabilitation, education, criminal justice, sports and concussion, and the welfare system.

This section highlights the ever present neoliberal attitudes and the inequality of healthcare across severity of TBI/ABI. It also repeats the notion of responsibiling the individual, their family members and third sector charities, on which the government relies to fill the gaps of neurorehabilitation. The disparity between third sector charities supporting those with TBI across England means it furthers the inequality of survivors among brain injury due to the discrepancy between third-sector support across regions.

3.1.8 2020- Present

In response to the Coronavirus pandemic, March 2020 saw the first national lockdown mandated by the UK Government. Gill and Lennon (2022) note that during this time, the UK government used fear to promote compliance with subsequent policy. The government did not use fear in the typical way seen in previous health policies; they portrayed a ‘good’ pandemic subject as one who makes ‘moral’ and ‘rational’ decisions to comply with COVID-19 policy. As those with TBI were placed in the ‘vulnerable’ category, this became a frightening time to rely on the ‘good pandemic subject’ to follow the rules and keep them safe. For many, their injuries meant understanding the rules was also difficult, so they became vulnerable to powers of authority. Policy in this era was heavily impactful on those with TBI’s life.

This is catalogued by a time when compared to other countries, the UK’s response was “too little, too late, too flawed” (Scally et al., 2020), and furthered the discourse that those facing social inequalities are not held in the same esteem as those who are not vulnerable or at higher risk. This brings through ideas of eugenics and poses the idea that individuals are sacrificed at the cost of being able to reopen the country. Again, they demonstrate that the government's response is often reactive rather than preventative.

Headway commissioned a crucial report at this time highlighting how the first lockdown affected those with ABI. 57% reported they had missed out on vital rehabilitation, which is known to minimise the long-term effects of brain injury (Tyerman & Headway, 2020). It subsequently led to isolation and confusion for survivors of brain injury.

Following the national lockdown, the UK experienced a significant increase in inflation and a recession. This has been underlined by a cost-of-living crisis, which has further highlighted how inequality matters, and many living with the support of the state were forced into using food banks. They faced tough decisions, such as whether to heat their homes or eat a meal (Trussell Trust., 2021). Those with TBI often face financial difficulties, as many are reliant on state support, which does not amount to what they were earning pre-injury. This can place additional strain on the family and force loved ones into caregiver roles (Miller, 2024). The government increasing the cost of living to rebalance the countries ‘financial books’, speaks to wider neoliberal and economic discourses

In April 2024, The Rt Hon Rishi Sunak delivered a speech on welfare (Department for Health. 2024). His speech alluded to the growing number of individuals who have become ‘economically inactive’ since the pandemic; he wished to remedy this by enabling people to return to work. This aim is underpinned by a view that a meaningful life for British people is to work, as this is a source of ‘dignity’, ‘purpose’ and ‘hope.’ He responsibilises the ‘welfare state,’ stating that it should not only be a source of financial support but should help people ‘overcome whatever barriers they might face to living an independent, fulfilling life.’ Noting that those with ‘potential’ should be supported, with the notion that working creates feelings of contribution and belonging. Within this speech, othering language is used to create a sense of an unfavourable group, e.g., ‘850,000 more people have joined this group due to long-term sickness;’ he goes on further to identify these individuals as being young and with a percentage having depression and anxiety. He describes the situation as ‘economically unsustainable.’ Using the phrase ‘economic inactivity,’ he is not just talking about the unemployed; he is talking about students, full-time unpaid carers, and retired people (who often do not need to work). This language isolates and perpetuates the notion that economic contributions to society justify worth and further invalidates barriers people face to living. While also giving an inaccurate picture of unemployment. This is also catalogued by a time with high NHS waitlists (The Kings Fund., 2024).

This period outlines the disparity between those with additional needs and those without, categorising those in need as unworthy and living meaningless lives without work contributions. These further highlight neoliberal concepts.

3.1.9 Historical Analysis Summary

The Historical Analysis outlines some conditions that led to the current interplay of discourses in recent policy texts about unmet needs within the TBI population. These texts are sometimes viewed as an uneasy blend of priorities and concepts.

Throughout these texts, the collectivist attitude underpinning the NHS is highlighted; there is a clear tone of equality for all with a need to address discrepancies in support, e.g. those recovering from TBI. The plethora of publications raising awareness of the impact of health inequalities further supports this notion. The need to address the gaps in TBI services was also justified in policy through an economic argument for long-term cost reductions for those with adequate rehabilitation.

Conversely, these ideas were combined with policies that responsibilise the individual and locate the ability to change within them or responsibilises their local services. This locates accountability away from the government, whilst other policies restrict independence and create further reliance on the state. There was widespread acknowledgement of the role of health inequalities and the impact of social determinants of health, while there was a retraction of resources for interventions. This further perpetuates that moralistic insinuation of individual responsibility rather than addressing wider issues. Under the coronavirus pandemic, the policies and actions of government reduced the value of those with TBIs lives, exposing them to risks and dangers that may cost them their lives, an act underpinned with eugenic themes. Actions that meant this population was further impacted by social determinants of health, rendering them even more powerless to the state.

This was sometimes characterised by an overreliance on third-sector support and, on other occasions, moralistic insinuations about the government's responsibility to improve the quality of life. In addition, despite policies using narratives that emphasised the importance of addressing broader determinants, the government further distanced itself from responsibility as it represented the dearth of intervention through state provision.

In December 2021, the government committed to developing an ABI strategy to improve services for those with ABI; this is yet to be finalised. This analysis has explored many policies and moments in history that have affected the rehabilitation and lives of those living with TBI, but none of them are specific to them. Therefore, to answer the question in this study, I have chosen to focus on seven debates relating to ABI that took place from June 2018 to June 2020. These transcripts have been sourced from Hansard.

The contradictions inherent to these parliamentary texts and narratives warrant further exploration. To understand the obstacles to effectively meeting the needs of those with TBI and their carers, a close analysis of the rhetorical and discursive means relating to unmet needs, responsibility, and social determinants will be explored. This will be addressed in the discursive analysis section.

3.2 Discursive Analysis

The Discursive Analysis section represents Stage 2 of Fairclough's (2001) 5-stage framework for conducting CDA. Stage 2 focuses on identifying the obstacles to the social problem being tackled. This section relates explicitly to part c, the analysis of semiosis itself (see Table 1). Throughout the text linguistic terminology is used, definitions can be found in Appendix 3.

3.2.1 Selection of the Texts

Seven texts were selected for inclusion in the Discursive Analysis based on the Historical Analysis, which concludes with a focus on the policies that form part of the ABI strategy agenda.

The texts were chosen for several reasons. Firstly, the debates were considered highly informative given that they exemplify the discursive themes highlighted throughout the Historical Analysis section, for example, the economic rationale and neoliberalism. It also gave clear perspectives on a set of stakeholders that have not been explored in previous literature investigating the gaps in neurorehabilitation. This representativeness avoids the risk of selecting a parliamentary text that is an outlier or cherry-picking policy based on a predetermined theory or bias (O'Reilly et al., 2021). It also captures a period that acknowledges these gaps within services, offering an opportunity to think about change and the perceived power to change. There are still no parliamentary texts that are specific to TBI, but as the texts relate to ABI, TBI is therefore considered under this umbrella.

These debates happened after the All-Party Parliamentary Group for Acquired Brain Injury was launched in November 2017. Sir Chris Bryant secured several debates to lobby critical issues in relation to ABI care. The report they curated with the help of other professionals and those with lived experience, 'Time for Change' (Menon et al., 2018), could have been considered for further analysis, but it was felt this may unconsciously present a one-sided view from MPs and Ministers. There was a risk that the finalised statement of the report would not allow for newer discourses and various semiotic factors to be bought to life. It is worth noting that this document was created in collaboration with many stakeholders including those with lived experience; as the study is interested in taking a nuanced top-down view focusing on parliamentary stakeholders, the selected texts would offer the best opportunity to explore this perspective.

Using the debates would allow for different stakeholder voices and to consider how the discourses differ within each text. Given the chronological nature of these debates, variations are likely to be influenced by those in government at the time, demands within society, and influences of constituents, representing different audiences (Fairclough, 2001).

3.2.2 Organisation of texts

The chosen texts span from June 2018 to December 2021. These debates can be seen as an intertextual chain in their own right (Jørgensen & Phillips, 2002). Throughout them, various elements were carried through from previous debates. Therefore, it is logical to analyse the discourses throughout the chain and compare and contrast any nuances they present.

Each debate ranges from one to thirty-two pages, with a total page count of one hundred and thirteen. Five of the seven documents were Common Chambers debates, and the others were Westminster Hall debates. Regarding the most frequent words, ‘need’ and ‘needs’ appear a combined total of two hundred and forty times, rehabilitation appears two hundred and twelve times- with neurorehabilitation appearing thirty-nine times. The final three that featured the most were ‘care,’ ‘time,’ and ‘important,’ each featured over one hundred times. These lexical choices are of interest as they denote how a social actor is represented. In this case, thinking about the NHS, it’s fitting that these words feature the most, but also represent some of the prevalent barriers to meeting the needs of those with TBI.

The debates include a wide variety of topics that loosely follow the areas identified in the Time for Change report (Menon et al., 2018): neurorehabilitation, education, criminal justice, sport-related concussion, and the welfare benefits system. The debates also featured ideas around prevention, the impact of the coronavirus pandemic, and themes of social injustice.

As the debates occurred during the period when the APPG was established, it is likely that the aims of the debates were similar to those of the APPG. These aims were to raise awareness of ABI and seek improvements in support and services for people with ABI and their carers', to provide a voice for people with ABI in parliament, and to raise issues across health, social care, and welfare that affect people living with ABI (The United Kingdom Acquired Brain Injury Forum., n.d.). Thinking about text consumption, it is apparent throughout the debates that they are working to raise awareness, achieved through personal stories and stories shared by their constituents. They also use statistics and reference the 'Time for Change' (Menon et al., 2018) report to meet this aim. On first impressions, it is clear they want a strategy that goes across departments due to the issues spanning health, social care, sport, and welfare.

Initially, the debates are unclear about seeking improvements; they raise awareness of the issues but at times, suggest to the government that they are looking for no further funding. This leaves a question of how services will be improved without additional funding. Most of the themes they speak to would require some additional financial resources, whether that is through training staff or creating more rehabilitation beds.

At times, the debates can use language that may not be accessible to laymen, which may affect the audience's interpretation; this also brings the question about accessibility to the population they are discussing. Some voices sometimes felt more privileged than others, meaning others had to do shorter interventions. MPs talk with such certainty that sometimes the motives behind the interventions are important to consider. Throughout the texts, the ideas of responsibilising the individual and other stakeholders were present, as were framing arguments to fit the wider economic discourse.

Several modalities are present within the texts; these will be considered throughout. Different discourses use different forms of modality (Fairclough 1992b), and the chosen modality will have consequences for the discursive construction of social relations and meaning systems. Five modalities appear present throughout, truth: looking at the affinity to which the speaker commits themselves to their statements, permission: looking at the presuppositions used by the speaker to denote approval or leaving room for allowances to their statement, accountability: the amount to which the speaker calls individuals to responsibility, astute expert: the speaker using language to assume the position of expert, and attestation: the speaker's affinity to which they testify to the truth or genuineness of something.

The truth modality can be seen in the debates' text production; many speak with confident, definite tones throughout. The inclusion of dramatising language can be seen to create an impact and set the tone of the debate.

> *"The damage has been done, and many people who have suffered that brain damage do not know that the reason why they find it terribly difficult to concentrate or to get up in the morning, they suffer from phenomenal fatigue that hits them like a sledgehammer…" (Commons Debate at Westminster Hall 06/02/2020- Chris Bryant, Labour).*

This language begins to set the tone for the sheer impact of this social problem and the importance of overcoming the obstacles so individuals with head injuries can get their needs met. A further notable element of text production is MPs' seamless textual cohesion when making their points—the eloquence from moving between the individual elements of their statements and between each other's' statements.

> *“The hon. Gentleman <u>always</u> makes valuable contributions to our considerations, across a range of subjects, but rarely does he make a contribution that tees me up for the next part of my speech more than that one did.” (Commons Debate at Westminster Hall 02/07/2019- Sir John Hayes, Conservatives).*

It resembles something of a theatrical nature, as there are seamless transitions and an ability to surmise the previous individuals’ point and build upon it to create further impact through repetition or bringing further evidence of the impact felt within this cohort of individuals.

The following sections will consider the discursive content with debates and how they relate across the intertextual chain.

3.2.3 Systemic Barriers

Throughout the debates barriers have been identified to meeting the needs of those with TBI. Most of these barriers are located within systems. Within these documents, the system becomes a social actor, and it is pertinent to explore the varying aspects and identify obstacles to the social problem through the semiosis. Therefore, the following systemic barriers will be examined under the headings below.

3.2.3.1 ‘Postcode Lottery’

During the debate texts, the phrase ‘postcode lottery’ is used to denote the inequity of services across localities and countries within the UK. This phrase activated the semantic field and works interdiscursively to represent an inequitable discourse. The literature points to social determinants of health significantly impacting this cohort of individuals (Douglas, 2020; Dunne et al., 2023; Tyerman & Headway, 2020), but this discourse directly points to medical factors influencing health outcomes. This is highlighted in the following passages:

> *“However, the number of available beds across the UK is inadequate, service provision is variable, and consequently long-term outcomes for brain injury survivors are compromised.” (Commons Chamber Debate 18/06/2018- Paula Sheriff, Labour).*
>
> *“Service provision is variable; consequently, long-term outcomes for brain injury survivors are compromised.” (Commons Chamber Debate 05/09/2019- Julie Cooper, Labour).*

Within these statements, the truth modality is present; the speakers fully commit themselves to their statements regarding the outcomes of variable service provision, i.e., survivors **are** compromised. Later debates call for action from the government; this can be seen in the below passage:

> *“What is the Government’s plan to attract prospective professionals to neurorehabilitation… what are the Government doing to retain the current workforce, especially when service provision is variable across the UK?” (Commons Debate at Westminster Hall 06/02/2020- Sharon Hodgson, Labour).*

This creates a theory of why service provision is variable and notes that this is due to an issue with staffing and retaining trained staff. By the end of the debate this question was not fully addressed by the chair. This brings the accountability modality to light, responsibiling the government and further highlighting inequity for this cohort of individuals. This debate took place under the context of the coronavirus pandemic, when staff shortages were known but also where, some of the workforce died.

Within the post-injury care for these individuals, many will have support from third sector organisations. There have been reports of an overreliance on these services, which are not government funded and can often face uncertainty about their funding streams. Since the debates some of these institutions have had to close due to funding, and with no plan to replace the services they offered their community. This furthers the discourse of a ‘postcode lottery’ and inequitable service provision.

> *“Will my hon. Friend commend the vocational rehabilitation… Momentum Skills in Newcastle? The organisation asked me to pass on its massive support for the “Time for Change” report ...” (Commons Chamber Debate 05/09/2019- Mary Glindon, Labour).*

This charity closed its services at the end of December 2019 as it is no longer financially sustainable. Momentum Skills did not just offer vocational rehabilitation but also community rehabilitation, which included travel training, support with applying for welfare benefits, psychoeducation around head injuries, and opportunities to meet other survivors. Furthering the notion that due to systemic barriers, those with head injuries receive inconsistent services, and are additionally impacted by location.

Interestingly, throughout the debate, MPs call for cross-departmental working to tackle some of these systemic barriers, noting that rehabilitation following a brain injury support from multiple government departments is needed. Throughout the texts MPs illustrate how working at a national level, i.e., people being supported by Major Trauma Centres (MTCs), often presents issues when follow-up care is needed, as national to local services are poorly integrated.

> *“… one thing that was slightly left out of the equation when the major trauma centres network was set up was how to integrate fully neurorehabilitation, good, strong rehabilitation, and the whole pathway from ultra-acute or hyper-acute services all the way through to care in the community and patients returning to their home.” (Commons Debate at Westminster Hall 02/07/2019- Chris Bryant, Labour).*
>
> *“… two years after the introduction of major trauma centres… That does not mean that they are perfect, but some progress has been made since their*

> *inception. Although the majority of rehabilitation care is locally provided, NHS England commissions specialised services for those patients with the most complex levels of need." (Commons Debate at Westminster Hall 06/02/2020- Seema Kennedy, The Parliamentary Under-Secretary of State for Health and Social Care).*

Again, this is further compounded by the 'postcode lottery' discourse as this will affect how the rehabilitation prescription is fulfilled. Interestingly, both passages denote an accountability modality, with the first calling the government to address this pathway and the second alluding to local commissioners to remedy this issue. It highlights that working across the current systems is inherently difficult, an interesting parallel that MPs present when pushing for cross-departmental working; similar to working nationally to locally in the NHS. Working across multiple departments in the government is equally difficult and further perpetuates inequitable service provision.

3.2.3.2 'Pushed pillar to post'

Furthering the notion of systemic barriers to this social problem is the idea that individuals are 'pushed pillar to post' in a bid to get the rehabilitation they need.

> *"The experience of having had a brain injury often includes the sense of being pushed from pillar to post in the health system and in the organisations that the state provides. An element of that is inevitable, because something fundamentally chaotic is being brought into an ordered system…All too often, however, families have to fight for every single bit of support ..." (Commons Debate at Westminster Hall 02/07/2019- Chris Bryant, Labour).*

The difficulty with brain injuries is that they will need support across services, which may be local, regional, or offered by external organisations; this is a confusing practice. It leaves the question of how a person with a brain injury will manage this system. An unclear system leaves the opportunity for social determinants to influence the access to healthcare and ultimately further the social problem of unmet needs. To get support, you have to ‘fight,’ but that becomes tiring being passed pillar to post and ultimately will take away an individual’s resources needed to recover, this is seen in the passage below:

> *“Excessive bureaucracy and form-filling can be a nightmare for many vulnerable claimants, but for someone with an acquired brain injury it can present an insurmountable barrier, leading to sanctions and additional hardship.” (Commons Debate at Westminster Hall 02/07/2019- Julie Cooper, Labour).*

It could be argued that this barrier has been affected by the coronavirus pandemic, although pre- pandemic services were not set up to meet demands, and access barriers still persisted. In order for those with head injuries to have needs met, patients often have to engage with multiple services or have sub-optimal management for some problems (Wade, 2021).

> *“In too many instances, families and patients are being pushed from pillar to post when it comes to benefits… Jordan’s father describes dealing with the welfare system as “the most demoralising and depressing experience for us all.” This is a professional family. The initial application for personal independence payment took six months, with interventions from the family’s MP…I cannot emphasise enough the stress this process puts on people with ABI.” (Commons Chamber Debate 05/09/2019- Chris Bryant, Labour).*
>
> *“The final thing that I really want is a coherent, consistent and tidy arrangement of community neurorehabilitation across the whole country, so that whether someone is in Wells, in Winchester or in the middle of Manchester, they and their family or loved ones have the same right to access ongoing community rehabilitation. Otherwise, it just seems terribly unfair. One of the things that so many families have said to me time and again is that they feel as if they are pushed from pillar to post. They hear a story of somebody*

> *getting rehabilitation sorted in one part of the country, and then they find that it is simply not available in their part." (Commons Chamber Debate 24/11/2020 - Chris Bryant, Labour).*

This anecdote shows that despite being an educated professional, the systems of state support are still inaccessible. There is a clear systemic barrier in place from medical systems that affects access to care. Considering governments' overarching discourses previously explored in the historical analyses, this is evidence of responsibilising the individual for their needs and fits with a neoliberal attitude. If individuals cannot access services, this saves money and reduces waitlists. Consequently, for the government it does not wholly fit their economic argument as it will unlikely result in the individuals returning work and paying taxes, conflicting with the tone of Rishi Sunak's 'sick note culture' speech (19th April 2024).

3.2.3.3 A state which is reactive not proactive.

Within systemic barriers, an interdiscursive trend was identified, recognising the advancements in medicine that are allowing more lives to be saved, but at what cost? This denotes a reactive state rather than a proactive state. Throughout the debates, MPs powerfully talk about the value of individuals' lives and how we cannot just quantify that just because someone survives an ABI, this means a job well done.

> *"It is all very well saving someone's life but…good neurorehabilitation in the community, we need to make sure it is available where people live. Otherwise, we are condemning people to a half-life existence when we could restore real quality of life, they might go back to work and be fully independent." (Commons Chamber Debate 05/09/2019- Chris Bryant, Labour).*

This passage denotes an MP speaking to the broader discourses by which the government operates. Initially they take a moral argument, i.e. quality of life, but then talk about returning to work and independence, through this inferring a cost-saving to the government. He utilises ‘we’ language, which insinuates a collective decision to condemn people to a half-existence; this also infers that the government has the power to change this and improve quality of life for this cohort.

Interestingly throughout all the debates the words ‘prevention’ or ‘prevent’ were only used a total of 17 times. Throughout the passages, there was debate about whether preventative measures had been taken in ABI or if more needed to be done- this conflict can be seen in the below passages.

> *“Much has been done to prevent ABI. The hon. Member for Ayr, Carrick and Cumnock (Bill Grant) talked about the benefits of seatbelts and airbags in reducing such damage.” (Commons Chamber Debate 05/09/2019- Julie Cooper, Labour).*

> *“All Governments in these isles need to reflect on that, and on the wider societal impacts of ABI, which require earlier and greater intervention to prevent them from happening at all.”* (*Commons Debate at Westminster Hall 06/02/2020- Neil Gray, Scottish National Party).*

This lack of interest in prevention may be due to the overarching aims of the APPG for ABI to raise awareness. However, this argument could be utilised to speak to the overarching discourses the government operates by, investing in prevention will produce a long-term saving. This idea does fit with the current government’s[2] ideas,

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[2] At the time of writing, the current government refers to the 2015-2024 Conservative Government. On the 4th of July 2024, a General Election took place in the UK. The Labour Party won a landslide victory, with a majority of 174 seats.

as noted in the 2018 Health and Social care policy paper "…prevention is better than cure" (Department of Health and Social Care, 2018).

3.2.3.4 Transivity of the system

Transivity speaks to the notion of the one who does something to whom and in what circumstances. Thinking about systemic barriers and discourses around this, it is important to explore the transivity within this barrier. Historically, Conservative political agendas tend to favour the more affluent in society, which often leads to greater impact of social determinants of health for the less affluent. In the 2019 General Election, the Conservatives promised a 3.1% increase in healthcare funding, which fell short of the 4.1% needed. Consequently, both the health and social care systems remain underfunded (Gardner, 2019). These issues are alluded to throughout the debates and are presented as an additional barrier.

> *"… The latest figures I have seen show that five children in every primary school class in this country will have an acquired brain injury. If we think that figure is bad enough, the figure for poorer constituencies, and for poorer families and areas, will be considerably higher. The research is a bit difficult to be precise about, but a study in Exeter showed that it was 4.3 times higher in poorer areas, and another survey elsewhere found it was three times higher in poorer families." (Commons Chamber Debate 18/06/2018- Chris Bryant, Labour).*

> *"It is a profound source of depression to me as a Labour Member and a socialist that a child from a poorer background is four times more likely to suffer a brain injury before the age of five than a child from a wealthy background. We need to look at all the elements that lead to that, because prevention is far better than cure." (Commons Debate at Westminster Hall 02/07/2019-* Chris Bryant*, Labour).*

Again, this talks about prevention but really highlights the process of who does something to whom and under what circumstances. The agenda of this government disadvantages those affected by social determinants of health. This is especially pertinent given those with lower educational attainment, income levels and those from minorities are associated with higher odds of TBI (Taylor et al., 2024). Furthering the discourse of systemic barriers and failings to meet the needs of those with brain injuries.

Wider neoliberal and economic discourses permeate the postcode lottery discourse, but it presents as its own barrier, as a process that fuels health inequity and perpetuate social determinants. A system that creates responsibility within the individual but also creates a reactive system that does not support their needs after their life has been saved but forever changed. Ironically, conflicting with their wider dominating economic discourse, without investment in accessible services and prevention, the cost-saving for the government is reduced. The issues of morality are also highlighted, which will be further explored next.

3.2.4 Role of obligation and action

A key discourse perpetuating the identified social problem which can cause inertia in response to this issue, is the role of obligation and how action is presented throughout the texts. The themes under this discourse are heavily dominated by the deontic modalities, which denote the level of obligation seen within the semiosis.

3.2.4.1 Moral Obligation

Obligatory statements are seen throughout the language within the texts such as, ‘should,’ ‘must,’ and the term ‘we.’ These statements are often from the perspective of MPs responsibilising the Government using an accountability modality. However, at times, they will take a collective stance and group them within the 'we/us' language. For example:

> *"The onus is on us to enable these individuals to regain their dignity, which they so richly deserve, and to have an active role in our society, which is their society as well." (Commons Chamber Debate 05/09/2019- Bill Grant, Conservatives).*

Although, at times this does leave the question who is us? And therefore, who has the power to create change or take accountability for the stagnant situation. Throughout the intertextual chain MPs hold government accountable to certain moral obligations, however, at times this presents a conflict within the chain. There is a desire for 'everyone' to have their needs met in society, but head injury is often thought about in extremes, i.e., the most severe injuries being thought about first. Again, leaning into that reactive state rather than proactive. Only thinking in extremes doesn't fit the overall agenda and tone of the debates i.e., equitable access for all with head injuries. For example:

> *"… a patient with a significant brain injury will be quickly transferred to a unit that is better equipped to provide specialist emergency care. That can be many miles from the family home. I am sure we can all agree that, if a loved one were involved in an accident or suddenly became seriously ill, we would want to be at their bedside, but for some people, particularly in low-income families that can be a challenge if the patient is transferred to a unit many miles away. That is why I would like to raise the importance of the Headway emergency fund, which provides grants to families to ensure that they can be by the bedside of a loved one in a coma." (Commons Chamber Debate 05/09/2019- Siobhain McDonagh, Labour).*

These services are understandably available to those with the most severe head injuries but therefore privilege those who are sicker and forget about those who are less unwell but have nevertheless suffered a head injury. MTCs are incredible at saving lives; however, they will come at a further financial cost for those on low incomes who may be unable to access the emergency fund or afford travel to their loved ones. These ideals echo wider NHS discourses of needing to become sicker before you can access treatment to become better, often reinforced by long waitlists (The Kings Fund, 2024).

Despite a perceived moral obligation to meet the needs of those with head injuries, there is still a paradox between a reactive system that saves the most sick (who often meet the criteria for post-acute services), and those who have had less severe injuries navigating a ‘postcode lottery’ system. This is despite those in the latter group most likely to give the government ‘the best return on their investment’ thinking about it from an economic argument. However, morally in an idealistic world needs would be met across all severities of brain injury; interestingly this theme illustrated the government going against wider discourses (economic) and leaning more into the smaller discourse of being a reactive state, not proactive.

3.2.4.2 Disguised Action

Within the debates, accountability modalities call individuals to action, often the language then denotes a response to this call, this could be described as disguised action. The notion that the language appears to show something is happening but in reality, this is not the case. For example:

> *“As a Health Minister<u>, I will obviously focus on the health aspects</u> of ABI, but I just want to highlight some of the other areas this touches on one or two of the interventions <u>where its impact is felt</u>, and action is under way. On*

> *education… The Government recently provided some £29 million to support local authorities with ongoing implementation of individual education, health and care plans to meet those needs… On offending behaviour…NHS England's liaison and diversion service has collaborated with the charity Headway… the Ministry of Justice is piloting approaches to improve screening and support for prisoners with ABI…Sport is another area for which there is a growing body of evidence and concern... This is why the Government commissioned an independent review …"* (*Commons Chamber Debate 18/06/2018- Steve Brine, The Parliamentary Under-Secretary of State for Health and Social Care).*

This passage clearly states the intentions of the individual, to discuss health aspects but then goes on discuss other areas where action is underway. This passage was one of the opening interventions for that debate, as to preface that as they specifically discuss health, where there are minimal changes, it lets wider audiences know that this government is taking action. Thinking about the phrase 'where its impact is felt' could be seen to minimise the health aspects of ABI and the present systemic difficulties.

In the above passage, the under-secretary attests to some of the work being done by agencies external to the government. This raises the question, whose job is action, anyway? The debates contains many references as to whose job it is to take action and thus create change. Blaming language is used throughout, and many often take an accountability modality.

> *"Today I spoke to Peter Taylor, the business manager of a charity... He… spoke about the lack of funding and the finger pointing between social services and health commissioners over who should foot the bill for rehabilitation services, with no clear direction over where the money should come from." (Commons Chamber Debate 18/06/2018, Paula Sheriff, Labour).*

> *"…We also need to get individuals and families to volunteer the information to work coaches and those sectors that need it…" (Commons Chamber Debate 18/06/2018- Michelle Donelan, Conservatives).*

> *"What steps are the Government are taking to support charities and other organisations working on treating acquired brain injury." (Commons Chamber Debate 19/02/2019- Bim Afolami, Conservatives).*

> *"Everyone who has an acquired brain injury deserves to receive the best possible care and rehabilitative service." The Minister for Care (Caroline Dinenage) (Commons Chamber debate 19/02/2019).*

All these passages call varying stakeholders to action in some way or another. Interestingly, despite the burden on caregivers highlighted in the 'Time for Change' (Menon et al., 2018) report, individuals and families are responsibilised to volunteer to educate the sectors that 'need it.' It is a privileged position to responsibilise experts by experience to volunteer to fix the issues that in other parts of the debates the government are held to responsibility to fix. Despite some experts seeing co-production as a benefit to their identity (Mayer & McKenzie, 2017), many from marginalised backgrounds report this process as fatiguing and with a significant emotional impact (Winters, 2020). Reeve (2006) specifically speaks to the emotional impact the expectation to constantly educate others on the disability community, they report finding that it creates intolerable pressure whilst trying to exist in a society fuelled by ableism. This furthers the government's notion of responsibilising the individual, as relying on volunteers creates a system of economic gain for the state. Throughout the debates many 'pay thanks' to the work of charities, this is interesting to think about in terms of disguised action and obligation. If charities continue to 'plug the gaps' are there any incentives for a government to take action. The connotation of preference is clear from MPs who talk positively about the work of charities and the impact that this has had on their constituents.

> *"…indeed I pay tribute to the good work of Headway…" (Commons Chamber Debate 05/09/2019- Sir John Hayes, Conservative)*.
>
> *"I have seen for myself how it is able to benefit my constituents and many throughout the UK in other branches of Headway. I thank Headway, its staff, volunteers and those who raise money for it..." (Commons Chamber Debate 05/09/2019- Bill Grant, Conservative).*
>
> *"Charitable organisations such as Headway and the UK Brain Injury Forum, as well as other local and national groups that hon. Members have referred to, are highly valued by those affected… I want to put on the record our appreciation for everything they do." (Commons Chamber Debate 05/09/2019- Seema Kennedy, The Parliamentary Under-Secretary of State for Health and Social Care).*

Some passages call for action and responsibilise the government in their roles. However, many praise the work they do and normalise the circumstances in which they operate- these comments appear more frequently than those responsibilising the government to support charities. Whilst Charities work then 'appears on the record', and may positively impact constituents votes for MPs, it risks normalising 'plugging the gaps.' Clay et al. (2024) reported that charity leaders felt essential public services are at risk due to underfunded contracts and estimate that charities prop up state services by £2.4bn a year. This speaks to the wider neoliberal economic discourses the conservative government operates in line with.

Further in disguised action is the notion of raising awareness and querying whether it does create change. The APPG aims to raise awareness of ABI, but does this translate into action?

> *"First, simply raising awareness is vital, and I hope that the report and this debate have done that…" (Commons Chamber Debate 05/09/2019- Sir John Hayes, Conservatives).*

> *"...That is why it is so important not only that A&E training in the detection of brain injuries is up to date, but that there is strong public awareness of the symptoms, to ensure that help is sought immediately." (Commons Chamber Debate 18/06/2018- Michelle Donelan, Conservatives).*

This passage alludes to the power of raising awareness as an initial step to change, whilst denoting feelings that a single debate and report may have achieved this. Interestingly this is spoken from a permission modality, when typically this MP is seen to speak from the truth modality- does he believe raising awareness is helpful, or is he conforming to the traditions of the system? It is interesting to think about where the stakeholder feels awareness should be raised as they allude to creating widespread public awareness. It also nods to responsibilising the general public to help this population get the immediate support that they need, with a view that awareness will generate this action. This MP is quoted earlier in this section responsibilising loved ones to share information and educate others, attesting again to this accountability modality. In this second statement the language used is a nod to obligation and the accountability modality to garner support or indeed action from the public. However, with no plan on how to execute this idea, it undermines the level of specialist knowledge acknowledged in the literature to understand ABIs.

This first statement could be interpreted as aiming to raise awareness in arenas with the power to change, i.e., government. A Belgian study found that politicians considered citizens as unaware of politics but aware of party initiatives. This study found that politicians overestimate citizens' knowledge (Soontjens, 2021), which leaves the queries of whether the goal is to raise awareness publicly, how this can be achieved, and whether it promotes action or perpetuates the social problem being discussed.

3.2.4.3 Who has got the power?

When exploring disguised action, and analysing these texts the present question is who has the power. The process of transivity presented by ministers is interesting to explore here: the problem is identified, guidelines are developed, local commissioners are held accountable for implementing guidelines, local commissioners have limited resources to meet this target, often they cannot fulfil the impossible task, resulting in no action or little change.

> *"While the majority of rehabilitation care is locally provided, NHS England commissions specialised services for patients with the most complex levels of need. For people who have ABI, neurorehabilitation that is timely and appropriate is an important part of their care... The APPG report was clear that all patients with ABI should benefit from an RP (Rehabilitation prescription)…NHS England's major trauma service, where acute phase rehabilitation begins, sets out that patients should be reviewed by a rehabilitation consultant… to provide an initial formulation…and perform the initial RP… The latest data, from the last quarter of 2018, from the trauma and audit research network shows that the national average rose to a 95% completion rate for RPs… The majority of rehabilitation care is commissioned and managed locally. To support commissioners to plan services for local populations, NHS England has produced a document, Principles and Expectations for Good Adult Rehabilitation, that describes what good*

> *rehabilitation looks like." (Commons Chamber Debate 09/05/2019- Seema Kennedy, The Parliamentary Under-Secretary of State for Health and Social Care).*

This accountability modality is highlighted here, furthering the disguised action and 'passing the book' in terms of responsibility. Local Commissioners are recognised in this passage as having support to implement services via having these guidelines, but this is under the guise of having inadequate resources to meet the predicted demand.

Throughout the debates, many alluded to perceived power between them.

> *"Does the hon. Lady agree that more needs to be done..." (Common Chambers Debate 09/05/2019- Jim Shannon, Democratic Unionist Party).*
>
> *"Does the hon. Gentleman agree that…" (Common Chambers Debate 09/05/2019- Luke Graham, Conservative).*
>
> *"Does the hon. Lady agree that there is…" (Common Chambers Debate 18/06/2018- Jamie Stone, Lib Dem).*
>
> *"Does the hon. Gentleman believe that…" (Commons Debate at Westminster Hall 02/07/2019- David Simpson, Democratic Unionist Party).*

This was noted through their functions of speech, where many interventions would ask their fellow MPs to agree with their statements. This hints at a collective power in sharing the same view, but how is this organised into action?

As well as a collective power, there is an existential assumption that the Ministers or Under-Secretaries have more power than the MPs, although an accountability modality is also present when talking about the parliamentary stakeholders as a collective.

> *"The work of the all-party parliamentary group on acquired brain injury is illustrative of this House doing what it does best: coming together, highlighting a subject, and bringing it to the attention of the wider world and of those who exercise power." (Commons Chamber Debate 05/09/2019, Sir John Hayes, Conservatives).*

> *"I am grateful for the nice comments that the Minister has made, but one of the problems with the guidance is that it does not feel very enforceable, and until the money goes with the guidance, as it were, I think it is unlikely that people will invest in this. It feels sometimes not to use a cliché a bit too Cinderella-like. I just wonder whether there is a means of twisting it into enforceability." (Commons Chamber Debate 24/11/2020- Chris Bryant, Labour).*

While these passages denote language that makes the reader assume that the power lies outside of MPs, this is done by responsibilising those who are seen to have more power. However, as earlier passages show, ministers' responsibilise local commissioners'; therefore, is it about power or how the government wants to appear as taking action. On the surface the government appears to be taking action, however responsibilising a stakeholder with an impossible task is not action in the sense of solving this social problem.

Further to this idea are the propositional assumptions within these passages and throughout the debates. One notably being the power that the prospect of re-election creates in politics; MPs are not in stable jobs, and consciously or unconsciously, that creates an inherent bias in their work. This is even more understandable in the context of the wider government discourses that life's purpose is heavily weighted on employment. For example:

> *“... I got involved in what was known as the Holyrood project. It damn nearly lost me my seat at my second Scottish election because it was a very controversial issue...” (Commons Chamber Debate 05/09/2019- Jamie Stone, Lib Dem).*

This MP felt their chances of re-election were disadvantaged by tackling issues of social justice; this ideal is problematic in exploring the barriers to the current social problem where issues of social injustice have been highlighted. No literature could be found to support that tackling controversial issues negatively affects re-election, although, Tony Blair was re-elected following his controversial 2001 agenda to reform criminal justice. However, regardless of intention behind this intervention, sharing this view ‘on the record’ may further inhibit action, consciously or not.

Given the implicit assumption that the MPs do not have power, and power is limited in local stakeholders, does calling on the modalities of the astute expert and attestation create a way to generate action and change? Nevertheless, despite calls for action through moral obligation, inertia is maintained through the government holding other stakeholders accountable as a source of them ‘taking action’.

3.2.5 Implicit and Explicit Prejudice

3.2.5.1 Societal prejudice vs. MP’s prejudice

Along with the aforementioned systemic barriers, it is important to note the implicit and explicit prejudice within systems and stakeholders. While some societal prejudices are widely acknowledged within the debates, i.e., varied service provision and the welfare system, there is also an apparent prejudice within the society and parliamentary stakeholders.

Throughout the debates, there are nods to ideas that heavily feature prejudice from society and/or MPs, which may present obstacles to the social problem explored.

> *"For example, earlier this year Grace Currie was escorted out of a pub on a Saturday night because the bouncers believed that she was 'too drunk'… The incident must have been extremely upsetting and embarrassing for Grace..." (Common Chambers Debate 18/06/2018- Sharon Hodgson, Labour).*

> *"George was a typical 23-year-old young man with a bright future... As a result of the severity of his injuries and the complexity of his ongoing disabilities, George was eventually awarded significant compensation… A friend introduced George to online gambling, something he had no previous interest in, but he now had the time and the money…The result is that George has lost all his compensation…He is now at least £15,000 in debt and, with no income, has no hope of meeting these liabilities… Research has identified that brain injury survivors are 27% more likely to develop problem gambling or addiction than the general population..." (Common Chambers Debate 09/05/2019- Carolyn Harris, Labour).*

> *"… a degree of prejudice is another thing that sometimes comes with a brain injury. Perhaps the person in front of us in the queue in Morrisons or Sainsbury's or wherever is slurring their words. It is all too easy to get judgmental and think, 'Oh well, they're drunk, and it's only eight o'clock in the morning…" (Commons Debate at Westminster Hall 06/02/2020- Chris Bryant, Labour).*

All passages denote prejudice against ABI survivors, however, how the MPs frame the anecdote is telling of their prejudice. The first and third passages denote a societal prejudice that being drunk is bad and, therefore, is held with negative value presuppositions. While the second passage uses language to blame others for turning to gambling and holds a more positive value presupposition i.e. society is less judgemental of gambling over alcoholism. Although, is this the view of society or the MP presenting it. Nevertheless, this is a broader discourse that needs to be challenged as it is well documented about the causal link between alcoholism and acquiring a brain injury.

3.2.5.2 Prejudice system

MPs decide what they share in their interventions; constituents, and debate briefing documents likely influence them, but the choice is theirs. This brings to question a process of transivity, i.e., the implicit trust that MPs have the constituent's best interest and can represent them accurately. In the case of representing those with head injuries, often the language used is inaccessible at times, and there has to be an implicit trust that MPs will uphold their values and represent them sufficiently to address their social problem. Interestingly, this presents a paradox as the MPs hold other medical professionals accountable for not using accessible language for patients and note the impact that this has.

> *"If the Minister looks only at one specific issue, I am keen she looks at how patients get written to. Some doctors, such as consultants, always write to the patient's GP or other doctor, sometimes in highly technical language…They are writing not to the other doctor, but to the patient and copying that to the doctor. Of course, they have to use language that the patient can understand, but it is about empowering the patient. One message that I have heard more than any other from many patients and families I have talked to is that they feel completely powerless. Lots of other people are making decisions about them, but they do not understand how those decisions have been reached..." (Commons Debate at Westminster Hall 06/02/2020- Chris Bryant, Labour).*

The MPs recognise the importance of patients being involved in their care and understanding this, but these debates could be seen as care for these individuals and therefore, should also be accessible. Again, it shows MPs holding other stakeholders, i.e., medical professionals, accountable to enact change and promote better care for this cohort of individuals. However, it could be seen as a barrier if all stakeholders heed different advice. It creates a further power imbalance and renders individuals powerless. MPs get to choose what is shared in debates and the language used; those with head injuries have to trust that their MP will get this right, but where is the line between power and trust?

3.2.5.3 MP's privilege

Throughout the debate, a notable feature within the semiotic factors is the privilege MPs hold. This is evident in the attestation modality and the potential for power by asserting yourself as an astute expert. This is seen as many MPs attest to features about them that may make others perceive they are in an expert position.

> *"I worked in the NHS as a psychologist for many years, and I was involved in carrying out assessments of people who had acquired brain injuries." (Common Chambers Debate 18/06/2018- Dr Lisa Cameron, Scottish National Party).*

> *"During my 30 years in the fire and rescue service, attending road traffic collisions and cutting the occupants free from crashed vehicles, I saw the trauma at first hand." (Common Chambers Debate 18/06/2018- Bill Grant, Conservatives).*

> *"As a physiotherapist, I have worked with patients with acquired brain injury at various stages of their journey, from intensive care, when it is very much life or death what is going to happen next, to the sub-acute, high-dependency and in-patient settings." (Commons Debate at Westminster Hall 02/07/2019- Ruth Jones, Labour).*

> *"I have been terribly unlucky, by the way, having suffered a severe head injury as a result of a road traffic accident and, like the hon. Member for Rhondda,*

> *contracted bacterial meningitis. We both speak with some authority on this subject." (Common Chambers Debate 09/05/2019- Sir John Hayes, Conservatives).*

These passages denote MPs asserting themselves as being eligible to talk on the subject matter. Does this increase credibility? Aichholzer & Willmann, (2020) note that citizens like politicians to be 'deliberate conscientious,' 'open,' and 'honest.' Potentially stating these facts or sharing the position/lens they bring can create impact and power behind their interventions.

Another area where MP's privilege is explicitly present is during the interventions around travel to see an unwell family member who is potentially being treated in a regional MTC or at a non-local long-term rehabilitation facility. There is conflict among MPs as some acknowledge the barriers and hardships of travelling to loved ones, whilst others make the existential assumption that everyone will travel under these circumstances.

> *"The charity Sue Ryder does an awful lot of work with people who have had brain injuries and other neurological conditions…Sue Ryder is aware of at least 515 people who are placed out of area, a long way from home, which means that all the support systems that they might have through family, friends and so on are simply not available or are extremely expensive because of the travel." (Commons Debate at Westminster Hall 02/07/2019- Chris Bryant, Labour).*

> *"I think the hon. Gentleman made the point that, when it is something as traumatic as neurosurgery, people do not mind travelling. From the northern highlands, it did not really matter to me whether it was Aberdeen, Edinburgh or Glasgow, I just wanted my loved one to get the best possible treatment." (Common Chambers Debate 09/05/2019- Jamie Stone, Liberal Democrats).*

> *"I am still getting over the melanoma being cut out, it is that I, as the patient, wanted to go to the real expert, and I would travel as far as I needed to do that." (Common Chambers Debate 09/05/2019- Chris Bryant, Labour).*

> *"With no paediatric rehabilitation service in Wales, Kyle had to travel to Surrey for treatment. He is grateful for his treatment and his family is working all God's hours to ensure that he gets all the support he needs." (Common Chambers Debate 09/05/2019- Chris Bryant, Labour).*

In the first passage, there is an acknowledgement that travel is too expensive for many, and it may be difficult for some to support their loved ones. As a parallel, the other passages denote MPs talking about themselves and how they would be willing to travel to 'get the best possible treatment' or 'travel' for the right expert. This shows privilege as financially this is an unlikely barrier for them. As we know, those from lower socio-economic backgrounds are more likely to acquire head injuries. These ideals denote that expert care is only available to those with more resources, i.e., seeing an expert. To see an expert, an individual will have to forgo support from their loved ones; loneliness is already well documented in the TBI population (Tyerman & Headway, 2020; Douglas, 2020) and can impact on the rehabilitation of individuals (Hoofien et al., 2001).

There is also a difference presented between adults and children, an acknowledgement that children need important caregivers for rehabilitation. This creates further evaluative assumptions around who does and does not deserve their support network when recovering.

Another aspect of the MPs' privilege seen within the debates is their ability to pick and choose which debates to attend and also leave early. When an MP just wants to 'get something on the record' before they go, can create feelings that the issue is not important or that they have been seen to do their job purely by getting something on the record.

> *"I am sorry that I cannot stay for the whole debate but…" (Common Chambers Debate 09/05/2019- Paula Sheriff, Labour).*

> *"Order. Before the Minister responds, I should say that I appreciate that many want to make interventions because they do not want to stay until the end of the debate.*
> *(Madam Deputy Speaker- Dame Eleanor Laing, Common Chambers Debate 18/06/2018).*

MPs have many competing demands, and the unstable aspect of their job may mean they have to carefully consider where they spend their time. Potentially, the act could be seen as a means of scoring parliamentary points to feature on MP rating websites such as 'They Work for You.' Is getting it on the record enough to overcome this social problem, or does it create an image of unimportance to those who hold power to make changes?

A further MP privilege highlighted within the intertextual chain in the view on employment, this is likely influenced by wider dominant discourses also. Throughout the texts there appears to be a push and pull about a moral obligation to give survivors a good quality of life, but also what a good quality of life means. Within the texts some MPs acknowledge the love for their jobs and having met their career goals being an important milestone for them. Although there also is an impression that without employment, people's lives are without purpose.

> *"...my recovery was sufficient to allow me to fulfil my ambitions, and to allow me to do much of what I would have done anyway...It would not have been easy had I wanted to pursue a number of other careers, but the one I wanted*

> *to pursue was that of a Conservative Member of Parliament—there is nothing more noble." (Commons Debate at Westminster Hall 02/07/2019- Sir John Hayes, Conservative).*

> *"I have mentioned several times in this place the issue of getting disabled people back into work. ...we have a lot of people who have been ill or are partially disabled who have great abilities that they could contribute to the functioning of the United Kingdom and to forging a new and better future for the United Kingdom. It remains a challenge for Governments of all colours to harness those people. If nothing else, it makes them feel that they are contributing to the country, and it makes them feel useful and that they are important. Self-esteem and the esteem of your peers is incredibly important to happiness and to quality of life." (Common Chambers Debate 09/05/2019- Jamie Stone, Liberal Democrats).*

Within the passage there is a clear nod to wider neoliberal discourses that are not being utilised by the government, i.e., finding suitable employment for those whom are disabled. This view is tangled in the idea that employment is a significant contributor to self-esteem and without meaningful work there is a risk that individuals are not important, and this will affect their happiness. Again, this speaks to responsbilising the individual and how they should feel about a matter, for many their work is a small part of themselves and it's their wider interests that fuel their importance and self-worth (Bergman et al., 2020). The reality is that for many they cannot return to work that they previously trained for, as the first passage mentions from a personal experience had they had different career dreams they would not have been achievable. It is a privileged position to be in, to be unable to acknowledge the nuances of an individuals' quality of life that often for many is not around their career.

3.2.6 Power in personal experience

The conscious and unconscious motivations behind speech are often not considered. These motivations are especially interesting to consider in terms of the personal experience's MPs share. This feels like a key conceptual framework to tackle some of the obstacles to the presented social problem.

3.2.6.1 Motivations

The phrase "I have personal experience" activated the semantic field throughout the chain of texts, and it was important to explore the modes of articulation to see how this generated discourse. Some literature shows personal sharing can improve information campaigns, especially around sensitive issues (Walsh et al., 2022). Kreuter et al., (2010) also found that when information is presented to people as a story, they are less likely to feel that they are being manipulated and to counter argue. These may be some of the motivations for sharing personal stories. However, there are other motivations that can be derived from the semiotic features.

> *"I had a serious head injury in my youth…" (Commons Debate at Westminster Hall 06/02/2020- Sir John Hayes, Conservatives).*
>
> *"…I had viral meningitis…" (Commons Debate at Westminster Hall 06/02/2020- Chris Bryant, Labour).*
>
> *"I ... suffered a severe head injury as a result of a road traffic accident and, like the hon. Member for Rhondda…We both speak with some authority on this subject." (Common Chambers Debate 09/05/2019- Sir John Hayes, Conservative).*

These passages present astute expert modalities, suggesting that by sharing these stories, one can assume a position of authority to speak on the subject. It is positive to see representative members from this cohort of individuals speaking on the matter. However, it is important to consider the motivations of MPs around re-election. It is also pertinent to think about the scale of head injuries and the privilege these individuals hold. Further, in the debates, Sir John Hayes noted that he could access the support he needed and that it did not stop him from achieving his career goals in life. This is not the case for many; is sharing this personal experience a way to create impact and authority, or does it alternatively create naivety and become disingenuous? Despite acknowledgements about the discrepancies between recoveries throughout the intertextual chain, some MPs make assumptions that work and worth are solely correlated without room for extraneous variables. Another motivation could be seen as generating impact or creating empathy. There is little evidence to suggest this creates change, but it may be more digestible for the audience. Head injuries are so unique to the individual there needs to be space with narratives to reflect that.

Throughout the debate, MPs are seen to thank each other for sharing their personal stories, and they reiterate them each time. If we assume this is to create impact and empathy, this interestingly does not fit with the wider discourse of neoliberalism, which may hamper change in this area.

It is interesting to think of the role of repetition, as mentioned in the below passages.

> *"We are going to be using the broken record technique to ensure that our messages get across and real change happens." (Commons Debate at Westminster Hall 06/02/2020- Liz Twist, Labour).*

> *"I went to John Bercow's book launch last night; in his book, he says of me that I am not shy of repetition. I can assure the Minister that I will not be shy of*

> *repetition. I will not be shy of repetition." (Commons Debate at Westminster Hall 02/07/2019- Chris Bryant, Labour).*

Is this successful in generating cultures of change, or does it limit the material presented in debates? For example, many MPs will start their interventions by thanking services, reiterating the previous points, and then beginning their interventions. If this process is effective in creating impact and change, it is important to consider, but the alternative is that it wastes time and limits the new material that can be explored.

There is even a choice to limit talking about research to give more time to others. This is interesting, given that the services that do not currently meet the needs of those with head injuries, develop their services based on research.

> *"I am just going to skip over to research, and then close, because we have only an hour and I know that a lot of people want to speak." (Commons Chamber Debate 18/06/2018- Steve Brine, The Parliamentary Under-Secretary of State for Health and Social Care).*

In Clinical Psychology, research is critiqued to see the power behind it and how it can influence the services delivered. Interestingly, the system providing services holds research with high impact, as it influences CPGs. However, in this setting there appears to be power in personal experience. Perhaps focusing on personal stories speaks to a wider audience than noting research findings. However, the motivations can be seen as a hindrance and obstacle to solving the social problem. It would be interesting to think about how the debates would function if MPs had job security, but this would mean a non-democratic state, which is not favoured for this social problem.

3.2.7 Gendered Narratives

An unexpected discourse in this material are the gendered narratives present. These are likely influenced by wider societal discourses that were not explored in the historical analyses. For example, there are narratives that head injuries are acquired differently by men and women.

> *"I wish to say a little about the difference between the initial responses to acquired brain injury, whether acquired through a traumatic event such as a road traffic accident indeed… which is why so many young men are affected." (Common Chambers Debate 09/05/2019- Sir John Hayes, Conservative).*

> *"Research… finds that the most common way for women inmates to acquire brain injuries is through domestic violence, 45% of injuries." (Common Chambers Debate 09/05/2019- Chris Bryant, Labour).*

Literature supports that more men are admitted for head injury, 1.5 times more than women (Tyerman & Headway, 2020). However, these figures may be a gross underrepresentation, given the statistics quoted in the passage by Chris Bryant. Interestingly, this is accompanied by a view that men, in particular men within the forces, will not seek help for head injuries.

> *"Perhaps we have thought, 'Well, a little blow to the head is okay; we don't mind and we're not going to worry about that. The right hon. Gentleman is right; perhaps we have been a bit blasé about it, and perhaps even more so in the armed forces, where people want to show that they are tough and can carry on." (Commons Debate at Westminster Hall 06/02/2020- Chris Bryant, Labour).*

Whilst raising awareness to overcome obstacles to this problem, it is important not to perpetuate toxic narratives; this statement is made with the truth modality insinuating it is nothing but fact. This may present a barrier to males seeking support if they perceive it to threaten their masculinity. This is an important barrier to challenge within head injuries as access to services it limited, without shame becoming an obstacle.

Interestingly, thinking about service access, the passage above highlights neglect of identifying head injuries, for women, but also, there is a wider discourse within British society that often creates the idea that women are not equal to men. Within the debates, there were clear differences in the modalities men and women took, with men favouring the truth modality more and women turning more to permission modes.

> *"I know that many Members have been involved in these debates before, so bear with me: as the newbie..." (Commons Debate at Westminster Hall 02/07/2019- Ruth Jones, Labour).*
>
> *"Before closing, I want to ask the Minister a couple of questions. What is being done to ensure that children's services are better developed and that families are not faced with a postcode lottery as to whether their child receives neuro-rehabilitation? Will the Minister commit to a national review of those services, including those for children and young people? Is there an assurance that the number of rehabilitation beds for children and young people will be reviewed? Will the Government commit to ensuring that children as well as adults leave hospital with a rehabilitation prescription? Will the Minister agree to organise meetings between Departments?..." (Commons Debate at Westminster Hall 02/07/2019- Lillian Greenwood, Labour).*

These passages denote modalities different to those seen within male MPs interventions. The use of questions as seen in the second quote leaves room to not present as the expert but rather position the person whom the questions are directed towards as the expert (Rosener, 2011). It fits with the permission modality, and can be seen as a more tolerable way to assert power and expertise. Similar to the first quote which prefaces her intervention with a plea to make an exception for any mistakes she may make. Men were more likely throughout the texts to take the astute expert modality compared to women who tended to lean towards permission modalities. Suggesting that despite how far women’s rights have come this is still a clear difference in power, whether this is implicit or explicit.

There were also interesting dynamics between men and women; for example, when addressing the female under-secretary of state, one male MP used quite forceful language to create pressure that she must be seen to do action. In previous debates male ministers were not addressed in the same pressurising language.

> *“Many people achieve office in this House, but few are more deserving of that opportunity than the Under-Secretary of State for Health and Social Care, my hon. Friend the Member for South Ribble (Seema Kennedy). We are delighted to have her with us today. We will be even more delighted when she answers some of the questions posed by the hon. Member for Rhondda …” (Common Chambers Debate 09/05/2019- Sir John Hayes, Conservative).*
>
> *“We have high hopes of the Minister, who I know wants to end her time in the job by saying just how much she did. [Interruption.] Well, that may be in a number of years, but whenever her time in the job does end, she needs to say, ‘I did so much for those with acquired brain injury’. That needs to be on her record, and we want to ensure that it is, thus our continued advocacy.” (Commons Debate at Westminster Hall 02/07/2019- Sir John Hayes, Conservative).*

The word ‘needs’ in relation to being on ‘her’ record insinuates that to be deemed ‘successful,’ this is what she must achieve. This forceful language is never seen towards males within the selected debates, and there is a value presupposition that further perpetuates broader narratives that women are not equal and need to prove themselves. These interactions to call on women differently within these settings create obstacles to change; this is unhelpful within a wider system where men typically receive better healthcare and have better health outcomes. Women need to be represented in these spaces to advocate for female survivors of head injury, but they also need to be held to the same standards.

Having highlighted the semiotic barriers to meeting the needs of those with ABI/TBI that are endorsed by these chosen debates and the discursive processes that allow for this, the Discussion that follows this section will explore these points further in relation to previous literature.

4.0 Discussion

The discussion section will review these findings in relation to the broader literature on the identified social problem of unmet needs within a TBI population and what is added by the present study. In order to represent Stage 2, part a, and Stage 3 of Fairclough's (2001) model, I will consider the networks and structures that contribute to the inertia of solving this social problem and consider if it is of interest or benefit to different stakeholders if this problem continues. Following this, I will identify the ways past the obstacles and relate these to the implications for clinical psychology and the roles of clinical psychologists, thus addressing Stage 4. In line with Stage 5 of Fairclough's (2001) model, the discussion will end with a critical review of the analysis.

4.1 Relating the findings to the literature.

The current study aimed to address the social problem of unmet needs within a TBI population, this focus was selected to represent Stage 1 of Fairclough’s (2001) model of CDA (as seen in Table 1). The research explored the underlying conceptual frameworks within the selected parliamentary texts and how these are operationalised concerning the action toward this social problem to achieve this aim. This research hoped to produce new knowledge for relevant stakeholders to draw upon in understanding the problem and develop ideas towards solving some of the obstacles for this social problem. More specifically, it further highlighted that unmet needs persist in this area but also that historic recognition had not translated into action at a level felt by TBI survivors. The potential explanations for this are summarised below in reference to existing literature and theory.

Within the systemic barriers discourses identified, there were apparent conflicts compared to the wider discourses the government operates by. Both ‘Pushed Pillar to Post’ and ‘A state which is reactive, not proactive’ highlight a need for earlier intervention; this would likely mean a financial investment in services to optimise the functional gains a survivor of TBI can make. The fact that the state is not proactive means that this cycle of insufficient resources continues even though this is in direct conflict with the broader economic discourse operating within these settings. The greater the functional gains, the more likely an individual returns to work and thus pays taxes (Bonn et al., 2023; Momsen et al., 2012; Turner-Stokes et al., 2015). This means that a heavy initial investment would produce a cost-saving in line with the widely accepted economic discourses of the government (Maas et al., 2022).

The identified processes of transivity are widely supported in the literature; the conditions of being left without effective rehabilitation can leave individuals open to being impacted more by social determinants of health. This runs across several of the identified discourses, i.e., gendered narratives, disguised action, and prejudice systems. An apparent systemic failure can be traced to an underfunded NHS; Degeneffe and Bursnall's (2015) participants reported that they found the system-level response for those with TBIs inadequate. They further reported feeling like the system lacked empathy and respect, and inadequate continuity of care led to poor interactions with professionals. This is unsurprising given the reported high staff absence levels, burnout, and low morale in the NHS (Clarkson et al., 2023; Oliver, 2024; Wise, 2022); all this pressure for staff culminates in increasingly causing harm to patients (Jones et al., 2022; 2024). This is important to acknowledge as pre-pandemic literature identifies that individuals working in brain injury rehabilitation find it difficult due to the complex and unpredictable nature of injuries (Murray et al., 2019). The impact of limited funding and resources was the most stressful aspect of their roles. However, they also experienced high levels of work-related stress and are reliant on supervision structures to manage this. This paper did not mention whether a lack of training or specialist knowledge contributed to the impact of working in this area. However, pre-pandemic, it was a difficult place to work without accounting for further cuts in resources and staffing.

Within the systemic barriers discourses identified, there is an acknowledgement that services are inequitable, which fits with the broader literature (Jacob et al., 2020; Ponsford et al., 2021). Specifically, the 'Postcode Lottery' discourse recognises service inequitably and, acknowledges that services that do operate are not always meeting the needs due to the lack of specialist-trained professionals. This is also recognised widely in the literature (Ballard & Dymond, 2016; Holloway et al., 2019; Holloway & Tasker, 2019; Irgens et al., 2020; Moore et al., 2019; Morrow et al., 2020; Norman et al., 2020; O'Callaghan et al., 2010; Odumuyiwa et al., 2019; L. Powell et al., 2020). It is essential to locate this lack of specialist training within context; during the intertextual chain of parliamentary texts, the coronavirus pandemic happened. This global pandemic categorised a time when staff died, and services became even more limited- especially for those with TBI (Tyerman & Headway, 2020). So not only was there a dearth of specially trained staff pre-pandemic, but there were also likely further losses due to the virus. The World Health Organisation (2021) estimated that between 80,000 and 180,000 health and care workers could have died from COVID-19 between January 2020 and May 2021.

So, what does this mean for a stretched system post-pandemic? The London School of Economics, with The Lancet, commissioned a report on the future of the NHS post-pandemic (Anderson et al., 2021). This compared recovery across countries; interestingly, this noted that life expectancy has slowed in the UK, and the UK fairs poorly compared to other high-income countries regarding health outcomes. One reason for this was the UK's consistently lower healthcare spending than most high-income countries, and would need a funding increase of at least 4% to begin to address this. Different sources have reported that the UK’s path to recovery may be longer than many other countries (Reed et al., 2022). It is creating yet another barrier to meeting the needs of those with head injuries as we continue to work reactively rather than proactively.

The findings of this study identified that there appears to be a moral obligation for those in power to act. This was apparent through the accountability modalities, which can influence service delivery. Interestingly, despite clear underfunding for the past decade (Gardner, 2019), the minister responsibilises local commissioners for insufficient ABI services throughout all the parliamentary texts. This has meant an increase in waitlists, with wait times unfairly felt in areas of deprivation (The Kings Fund, 2024). In mental health services (another area those with TBI may need access to), in response to demand and service pressures, 15/33 trusts had raised treatment thresholds and some reduced provision in their area (Department of Health & Social Care et al., 2023), creating further access barriers and perpetuating a reactive state. These ideals conflict with the government’s broader neoliberal discourses as mainly focusing on severe head injury does not create the cost-saving they could generate by offering effective services for those with mild to moderate head injuries.

Since 2013, the privatisation of the NHS in England has increased; this is problematic as other literature notes that using private suppliers can negatively impact services and increase rates of treatable mortality (Goodair & Reeves, 2022). Continuing to praise services may be an obstacle to change as it gives the government an argument to refrain from funding additional services. Meanwhile charities continue to plug the gaps in services with minimal support to keep their services open. In light of the cost of living crisis, the government has pledged support for charities through one-off grants, although nothing is ongoing and definite (Department for Culture, Media and Sport. & The Rt Hon Stuart Andrew. 2023). Nevertheless, throughout the parliamentary texts, MPs continuously thank charities for their work, as if their appreciation is enough to negate the barriers that people with TBI face when these services unexpectedly close.

Interestingly, according to a survey by The National Council for Voluntary Organisations (NCVO), almost half of their respondents felt that the government should do more to support small charities. This was in the context of a quarter of them relying on them once a week for reasons, such as ‘they had nowhere else to turn to’ because ‘public services were insufficient.’ Many noted that if these services were to close, it would hurt their community (Mercadante, 2024). With services being privatised or closing without contingency plans to replace the resources, there is another barrier to solving this social problem. These contextual factors were not highlighted within the texts but rather an appreciation and overemphasis of thanks to charities- a fundamental framework creating obstacles to change.

There are nods to the MP's privilege and motivations behind their words throughout the analysis; as it is an elected role, it does entail a degree of job insecurity. Does this create bias around re-election agendas? Baker et al. (2020) noted that since 2015, there has been a significant decline in those standing for office within constituencies; this may highlight the pressure of job instability. MPs also face an additional challenge of retaining the support of their voters- who are intrinsically influenced by their actions and opinions. For example, individuals who disagreed with their representative's stance on Brexit were three percentage points less likely to vote for them. If they agreed, it only increased percentage points by 0.53 (Hanretty, 2021). This may influence MPs' actions and their stances, as they stand to lose a lot without their seat, as evidenced in some of the texts, i.e., one MP believed working on social justice issues meant he almost lost his seat, whilst others appeared for debates but left early. Within this juggling act to remain in their seat and thus in power, where is the voice of TBI survivors?

Within the prejudice system, it was highlighted the role of advocating for survivors of TBI whilst operating in an inaccessible system. Throughout the intertextual chain, information suggests that other parts of the system that TBI navigate are equally inaccessible due to the language used, i.e., GP letters. Many documents support services to use accessible language or develop 'easy read' alternatives, including NHS policies for some trusts (NHS England., 2016; 2018; Sheffield Health and Social Care Trust. 2021). In terms of literature supporting the importance of accessible language, most is rooted in research on learning disabilities (Terras et al., 2021). This is core training for Clinical Psychologists (The British Psychological Society., 2019). However, the language used within debates and the complexity of interventions can sometimes be challenging for a professional to access. This further denotes the power impressed on this population and that they must implicitly trust that their best interests will be accurately represented.

Within the prejudice discourses, there were views shared that were negative around alcoholism; this was both from members of parliament but also extended to the general public. These views can be seen to perpetuate the obstacles to this social problem; the negative stigma associated with alcoholism and the languages used to discuss it can affect the care received Redpath et al. (2010) found that if an individual was to blame for their injury, qualified healthcare professionals have more prejudicial attitudes than those entering the profession, with increased prejudicial attitudes related to a decrease in intended helping behaviour, which has the potential to impact an individual's recovery negatively. There is a causal link demonstrating that the younger the TBI is acquired, the greater the likelihood of developing alcohol use disorders later in life (Corrigan et al., 2013; Dams-O’Connor et al., 2013; McKinlay et al., 2010; Weil et al., 2019). Although dependent on the chosen coping mechanism, there is a conflict where survivors are seen to be positioned as victims, e.g. gambling, rather than positioned as wholly responsible for their health, e.g. drugs and alcohol.

Furthering this prejudice system is again a notion of being passed pillar to post when needing services whilst using substances. The Mental Welfare Commission (2022) found that mental health teams and substance misuse teams appear to work exclusively rather than in tandem. These individuals reported that the services blamed each other and, in the end, experienced poor treatment from both. It notes a widespread discernment regarding being assessed by mental health teams, with an expectation that without being substance-free, they cannot access these services- which is not in keeping with guidelines. Wrapped within this complexity is a greater predisposition to use substances, but also to be judged if their injuries make them appear like they are using substances. The texts shared survivors' stories of being denied entry to places for being ‘too drunk’ when their speech difficulties were a result of their injuries. This makes the general negative stigma around alcoholism in society even more challenging to navigate as a survivor of brain injury. Those with TBI have historically faced many assumptions about their condition, often due to the invisible nature of it. This is especially seen within the welfare benefit application process (Knight & Anderson., 2017). This suggests a need for wider awareness of brain injury and the nuances of how it can present.

MPs' privilege, at times, can create blind spots, leaving concerns about how they can connect with this population. It is worth noting that several MPs had injuries themselves and others with family member experience. However, this still did not stop them from being able to see their blind spots, for example, when talking about being able to travel without financial repercussions. In response to individuals being sent to rehabilitation facilities miles from home, there were mixed responses from MPs about it being unjust. For many, financially, being reliant on state support would not make this accessible (Miller., 2024). Travelling for rehabilitation was seen as more acceptable for adult head injuries than for a child. This was interesting given that families can also positively impact treatment effectiveness (Eady, 2017; Rasmussen, 2021); it is therefore essential to consider the location of rehabilitation. Individuals rehabilitating miles from home can exacerbate the impact of social determinants of health and harm treatment outcomes (Salas et al., 2020).

This speaks to the wider issues of the blind spot MPs may have regarding their privilege; a reduced ability to access their Theory of Mind (Baron-Cohen et al., 1985; Premack & Woodruff., 1978) may present further obstacles to meeting the needs of the survivors of TBI. “Theory of Mind refers to the ability to attribute mental states to oneself and others, understanding that others have beliefs, desires, intentions, and perspectives that are different from one’s own” (Ruhl, 2023). Poor theory of mind may run the risk of alienating connections with this community, for example, Rishi Sunak’s statement about growing up with Sky TV enabling him to connect with constituents impacted by the cost of living crisis, despite his estimated personal fortune of £651 million (Morton., 2024); leaving concerns that some MPs cannot connect with their constituents political interests.

The current study looked into the role of using personal experiences in the debate and the motivations MPs may have behind this semiotic factor. At points favouring personal experience over research, this is interesting as NHS (2023) notes that research evidence will inform commissioning decisions to improve experience outcomes. NICE Guidance (2024) are evidence-based recommendations for health and care in England and Wales to help professionals promote good health and enhance the quality of care and services. As NHS professionals, this is what they will be most interested in, and typically, more powerful papers feature a higher impact in the research world. However, in this setting, it has been forgone. This leaves the question of whether personal experiences raise more awareness than facts and could offer ideas to overcome obstacles to the social problem. Literature is limited in this area, but in terms of bridging political gaps between parties, facts fostered mutual respect; however, opponents were seen to respect moral beliefs when they are supported by personal experience and not fact (Kubin et al., 2021). This is important, considering that the APPG is a cross-party structure that must gain buy-in across the political spectrum. Nevertheless, there remains to be more literature on the effects of these techniques on creating action, and we are still trying to understand motivations.

An unexpected finding from this research was that gendered narratives add to the obstacles of solving the social problem. The gendered stereotype of men not seeking help does not fit with some emerging current literature. However, at another points in history, it was very much the case (Galdas., 2009). Some studies are now finding that many men will now seek help for mental health (Stevelink et al., 2019); Mind

(2019) reported that since 2009, men are three times more likely to see a therapist and are as equally willing as females to seek support from their GP. They also found that the number of men saying nothing would put them off finding help if they were feeling low has decreased by almost a fifth since 2009. Although the research is more limited on physical health, it notes that men prefer to seek help for these problems (Britt et al., 2020). Although similar to what was noted in the results, a barrier to seeking help is the preference to handle their problems independently. This may mean it takes them longer to seek help for their difficulties (Mind, 2019). Perpetuating a narrative that men do not seek help will present an obstacle to solving the social problem, and actually conflicts with the reality of society.

Within the findings, there was an acknowledgement that the domestic abuse rates contribute to inaccurate numbers of ABI/TBI. This fits with a recent report by BrainKind (2024). Despite women living longer than men, they spend 25% more of their lives in debilitating health compared to males (Benenden Health, 2023). Manual (*The Men's Health Gap* | *Manual*, n.d.) found that in most countries, men are more likely to face higher health risks, but this is not the trend in the UK. They found the largest female health gap in the G20 and the 12th largest globally. This also translates into brain injury services; following TBI, women have poorer outcomes (Mikolić et al., 2021) and are less represented in research trials (Gupte et al., 2019). Suggesting a further barrier to solving the social problem.

The research also highlighted how women are treated differently from men within the debate process and how men and women operated different modalities. Women favoured permission-based modalities, and males sat comfortably within astute expert modalities. Research shows that women politicians are held to different standards from men, and the media tends to focus more on females' appearance and personal lives. Does this mean that women’s perspectives are fairly represented in political settings, given that male MPs are only more likely to represent women’s interests when their re-election is at risk (Höhmann & Nugent. 2022)? Women tend to receive more negative viability coverage than their male counterparts (Van der Pas & Aaldering, 2020). Generally, in societies, men are believed to possess agentic qualities, such as being aggressive and ambitious, whereas women are thought to embody communal qualities, such as being affectionate and emotional (Eagly & Karau, 2002; Prentice & Carranza, 2002). Women need to be represented and held in equal power in these spaces to overcome the barriers women already face in healthcare.

4.2 Networks and structures that contribute to inertia

Through identifying the obstacles to the social problem being tackled (Stage 2 of Fairclough’s framework), it is critical to look beyond policy discourses to consider the broader contextual factors that maintain the problem (Fairclough, 2001). This section will consider the network of practices within these parliamentary texts (Stage 2, part a). It will also consider Stage 3 of the model, i.e., whether the social order ‘needs’ to retain the status quo regarding the inertia of meeting the needs of those with TBI.

As highlighted by this research, several networks and structures contribute to the inertia of meeting the needs of this population. These are primarily present within the role of obligation and action discourses identified. These will be discussed in further detail below.

4.2.1 Unintegrated Care Pathways

The first structure contributing to inertia is the unintegrated care pathways between local and national services and the ICBs' role in commissioning local services. Many who have sustained a TBI will be admitted to an MTC; during their admission, a consultant should complete an RP. RPs are informed by NICE guidelines, which denote what specialist services are needed depending on the injury. The 2015 Rehabilitation Code (Rehabilitation Working Party., 2015) is a legal process that helps ensure access to appropriate rehabilitation is given. However, several issues have been highlighted with the RP process; despite RPs being completed for most patients, most did not receive a copy of the document, and often, the recommendations were unmet. Other shortfalls included a lack of consultants and beds (NCASRI Project Team & Turner-Stokes, 2019). This highlights the difficulties of onward care from national services and could account for individuals not receiving the support they need. It is also important to recognise that this process is for those with the most complex needs, which does not account for the difficulties navigating between national, regional and local systems for those with mild to moderate injuries (Norman et al., 2023). NCASRI Project Team and Turner-Stokes (2019) highlighted the need for better integration, as current arrangements for commissioning and provision of rehabilitation medicine input “are haphazard and continue to vary widely across the country”. This speaks to the discourses highlighted in this research within systemic barriers and the systems that cause further inertia in solving the obstacles to this social problem.

Further compounding the unintegrated pathway systemic issues is the ICB system spoken about in section 1.6.2. Despite a funding formula that 'reflects' local healthcare needs (NHS England., n.d.), the NHS remains underfunded (Gardner, 2019), presenting an impossible job for local commissioners. Further barriers for TBI survivors with this system is that nearly all TBI estimates are undercounts (National Academies of Sciences et al., 2022); this can be due to many reasons: ABI/TBIs from domestic abuse often do not present in medical settings (BrainKind, 2024), and the recognition and misdiagnosis of TBI (Xun et al., 2023).

In theory, the ICBs and funding allocation system should help overcome barriers to this social problem, but these systems cause inertia. Historic difficulties with services cross-working, local data collection issues, and general underfunding over the last decade (Gardner, 2019) mean these systems cannot effectively address the social problem.

4.2.2 Structures within Government

The structures within the government have also been identified as systems that cause inertia in solving this social problem. APPGs can span different parliamentary terms with different parties who promote different agendas. Concerning the APPG structure, its informal nature and unfunded status often mean meetings and processes can be slower and more complex to organise due to limited resources. The fluidity in which MPs can change roles can impact the progress of APPGs; Sir Chris Bryant (Labour) shared in a Commons Chamber Debate on the NHS, "... *I have chaired an APPG on acquired brain injury, and it was often difficult to get it going, because all the Conservatives on it kept on being made Ministers—they then got sacked and then they were made Ministers again. One of them, the right hon. Member for Plymouth, Moor View (Johnny Mercer), may be about to become Defence Secretary—I have co-operated with him on this subject for a very long time... Keeping APPGs going is sometimes problematic, because the people who are most interested sometimes get other jobs that mean that they cannot take part. But there is no reason why someone cannot continue the work without being in an APPG.*" (Hansard, 19th July 2023, Column 973). This highlights the difficulties with the APPG structure and how it can contribute as a system of inertia. The role of an

APPG can be seen as a mechanism to build networks and connect with relevant stakeholders interested in the topic. However, if the issue is vital to the individual (MP), why do they leave when a better role comes along, rather than continue the work alongside new opportunities?

Currently, there are more APPGs than MPs (Bryant, 2022). This questions the motives behind those establishing and joining APPGs and why many abandon APPG responsibilities. Given the noted lack of resources allocated to the APPGs, this could be an adequate reason. However, it has been highlighted that APPGs can sustain funds from external sources such as charities and private lobby firms (whose clientele is often unknown). The government acknowledged that APPGs backed by unknown private lobby firms could leave possibilities for bias; in response, they launched an inquiry into APPGs (Committee on Standards, 2022). They created new guidance stating that groups receiving £12,500 or more in financial and material support must publish an annual income and expenditure statement. This was to reduce the risk of improper access and influence by paid lobbyists, commercial entities, or hostile states (Committee on Standards, 2022).

It is an important system as often APPGs can give rise to voices that may otherwise not be heard in parliament, but the loose guidelines can be used manipulatively. Sir Chris Bryant notes that when an Annual General Meeting comes along for an APPG, these are poorly attended, and he wondered if the group is sincerely an APPG or just a “personal campaign or money-making venture masquerading as a parliamentary affair” (Bryant., 2022). His claims are not entirely unfounded, as MPs have a history of scandal regarding financial affairs. The 2009 MPs Scandal highlighted that many MPs used the expense system to compensate themselves for forgone salary increases (Pattie & Johnston., 2012). APPGs are time-consuming, but they must have the freedom to operate. However, this lack of policing can create opportunities for bias and scandal.

Despite the issues with APPGs and how they may contribute as a structure of inertia, perhaps they also do not, as the government has committed to developing an ABI strategy. Although, a strategy is non-binding and is not policy, it is seen as a way of effecting it (Public Administration Select Committee, 2010). More research is needed to denote how much of a strategy is enacted; the purpose of a strategy is to think about the issue's uncertainty, dynamics, and complexity. It is a way to ensure that the whole government (cross-department/party) identifies and acts effectively on the issue (British Ecological Society, 2017). However, for the ABI strategy in particular, there are still barriers within this process, as highlighted by Sir Chris: *"...In November 2021, Boris Johnson and the right hon. Member for Bromsgrove (Sir Sajid Javid) appointed me to co-chair a programme board to create a national strategy on acquired brain injury. This issue matters in every single one of our constituencies, and I am afraid we are still failing. Despite the months that have passed, it has not been possible to put the strategy together for a whole series of reasons, including churn of ministers and the fact that the Government are not able to put a single penny into it—not even enough money to check how many people suffer a brain injury every year. This is a cross-party issue. How can we ensure that later this year—regardless of who forms the Government—we end up with a national strategy for acquired brain injury…"* (Hansard, 23rd May 2024, Column 1056). Further highlighting structures within the government are causing inertia in solving this social problem.

4.2.3 Reality of working in these settings

A significant factor contributing to inertia in these settings is the challenging reality for professionals. There is a shortage of experts in working with TBI patients due to limited training opportunities and funding (Ballard & Dymond, 2016; Holloway et al., 2019; Holloway & Tasker, 2019; Irgens et al., 2020; Moore et al., 2019; Morrow et al., 2020; Norman et al., 2020; O'Callaghan et al., 2010; Odumuyiwa et al., 2019; L. Powell et al., 2020). NHS pay bands do not adequately recognize specialist expertise, often requiring professionals to self-fund their training without financial rewards.

Clinical psychologists, for instance, must complete a demanding qualification in clinical neuropsychology (QiCN) after their doctorate, often while juggling full-time jobs and personal commitments (The British Psychological Society, n.d.). This period is typically high-stress and low in wellbeing (Jones & Thompson, 2017; Peters, 2023). Without this qualification, many remain stuck in lower pay bands longer than peers in other specialities.

Job security is another issue, as many neurorehabilitation roles are in the third sector, which depends on external funding. Recent closures, such as the Icanho rehabilitation centre due to financial pressures (King, 2024) and Momentum Skills mentioned, highlight the instability. This reliance on charities and personal resources for further training creates a barrier to attracting and retaining specialized professionals, perpetuating inertia in addressing this social issue.

4.2.4 Does society 'need' the problem?

Following this exploration of structure and networks that create inertia to the social problem, we explore if society needs the problem. Depending on the lens the problem is viewed from, it produces different answers. Considering the goals of the wider government discourses, i.e., neoliberalism, economic growth, and responsibilising the individual, it could be seen as a needed problem. Whilst charities continue to plug the gaps in neurorehabilitation settings, this fits with the economic ideals of the wider government, as it encourages functional gains which may result in employment and a financial gain for the government without a cost to the public purse. Working is of enormous importance to the current government and has been illustrated as the purpose in life.

During the coronavirus pandemic, the government operated under a eugenics discourse; the development of MTCs creates a conflict with this discourse as a greater survival rate following major trauma is seen. Typically, those surviving have greater rehabilitation needs and limits to the functional gains made, which comes at a cost to the government (Oddy & da Silva Ramos, 2013; Turner-Stokes, 2007; Turner-Stokes et al., 2019). However, the MTC development speaks to the reactive state of the government and goes against their ideal of people returning to employment. A broader discourse at influence here is that Britain wants to be powerful, and people out of work hampers the country's wealth. Brexit (Britain exiting the European Union) was a means to capitalise on Britain entering the single market to retain and build its wealth (Hope, 2024). However, the reality of Brexit is 290,000 fewer jobs in London alone, with two million job losses nationwide, mainly in the financial and construction sectors (Hope, 2024).

Despite the areas where it does and does not fit government ideologies, society does not morally need this problem. With the correct support and investment, barriers to this social problem could be overcome, benefiting individuals and the wider society.

4.3 Implications and Recommendations for Clinical Psychology: Overcoming the Barriers

This section will consider the findings in relation to the broader implications for clinical psychology and make relevant recommendations.

4.3.1 Clinical Psychology in Social Policy

Often, as clinical psychologists, service remits force us to work at the micro level of systems (Bronfenbrenner, 1979), when often, without addressing issues in the macro-level systems, individual distress persists. Figure 1 illustrates the importance of macro-systems, i.e. without looking upstream at why people are falling in; we are providing a ‘plaster’ approach (Browne et al., 2020). This research offers a method to ‘look upstream’ and highlight the importance of our roles in policy. Pulling people out of the river offers a unique viewpoint that many in power will not have. Identifying the discursive obstacles can provide a ‘manual’ of how to be heard at that level, i.e. economic arguments, different modalities and the power of personal stories vs. research. Perpetuating the economic argument can be problematic, but as a start to change, being heard in these settings allows us to advocate for our clients. Research may provide a starting point for thinking critically about these spaces before entering them. To achieve social justice, we must feel brave enough to share these spaces and speak from accountability modes to provide more than a 'plaster' for our clients.

This research serves as an important reminder of the difficulties of accessing psychological therapies for those with TBI. Andelic (2021) noted that in ABI care, many needed support with cognitive and emotional difficulties but were unable to access suitable interventions. Menon (2022) also recognises that despite over 90% of TBIs being categorised as ‘mild’, over half do not fully recover by six months post-injury. He attributes this to a need for interventions focusing on mental health and post-traumatic stress disorders. It is important for CPs to recognise this, as they can influence change at different levels, including service commissioning; conducting audits will likely show the deficit in care in this area.

This research highlighted how Clinical Psychologists can inform policy within a TBI setting but also across other issues affecting the profession, and the individuals we seek to support. With this research CPs can start conversations with commissioners to reflect the funding formula difficulties and seek solutions to properly funding their services. CPs can also begin service development projects to counteract some of the issues those with TBI face when accessing services as highlighted within the research and previous literature. For example, a project developing communications with other TBI services to minimise being ‘pushed pillar to post’, creating close relationships with charities and embedding their work into NHS services may also safeguard them from being closed. Alternatively, being able to research the impact of closed services and being able to find solutions to absorb the lost services so patient impact is minimised. CPs research skills are invaluable in being able to connect and influence policy, in addition to their knowledge of populations affected by certain social policies.

4.3.2 Changes to services

The research points to some changes that could be made to services to help overcome the barriers to this social problem and the nuances it brings. Firstly, changing the service remits to a lifespan service would mean individuals have access to an MDT service for life. This framework exists across other health conditions, including cleft lip and/or palate (CLP) and burns. Within these services, there is an acknowledgement that as individuals reach different transitions, they may need support from different professionals. For example, every child born with CL/P in the UK is automatically referred to a multidisciplinary network, from which they are placed on a pathway of appointments, interventions, monitoring and surgery (Hodgkinson et al., 2005). The treatment continues throughout childhood and often into early adulthood, allowing adults to re-access services if needed (McWilliams et al., 2024).

Changing services to ‘lifespan’ services following injury would allow for the correct support throughout someone’s life and the difficult transitions they may have to navigate. One study found that many with TBI reported that early rehabilitation was helpful, however, they found it challenging to access ongoing services (Leftkovits et al., 2021). A lifespan service offers an opportunity for a community psychology pathway where survivors and their loved ones can experience the psychological benefit of peer support. Hughes et al. (2020) found limited evidence for the psychosocial effectiveness of peer support groups of ABI. However, there were benefits of participating in a peer support group, i.e., being connected, interacting with others, and providing and receiving support. It may also provide an opportunity to reduce the risks of loneliness and other social determinants of health (Salas et al., 2020). This pathway also promotes ways for charities to work with NHS services, creating safety within charities' operations. CPs can work towards this aim by writing business cases and applying for external funding to trial these community approaches. This will offer an opportunity to generate data and provide further evidence for business cases.

This research also highlights several areas of stigma that those with ABI/TBI face, for example, substance misuse, gambling and gender. This creates unique opportunities for services and Clinical Psychologists to address and educate the public about these issues. For example, finding ways to co-work with addiction services to overcome an obstacle highlighted by the research and avoid perpetuating the cycle of clients feeling 'pushed pillar to post' when trying to access services (The Mental Welfare Commission, 2022). Services should prioritise fostering ways to work across services, for example, through consultation, joint formulation or professionals meetings. This could be facilitated through the specific research expertise that Clinical Psychologists offer.

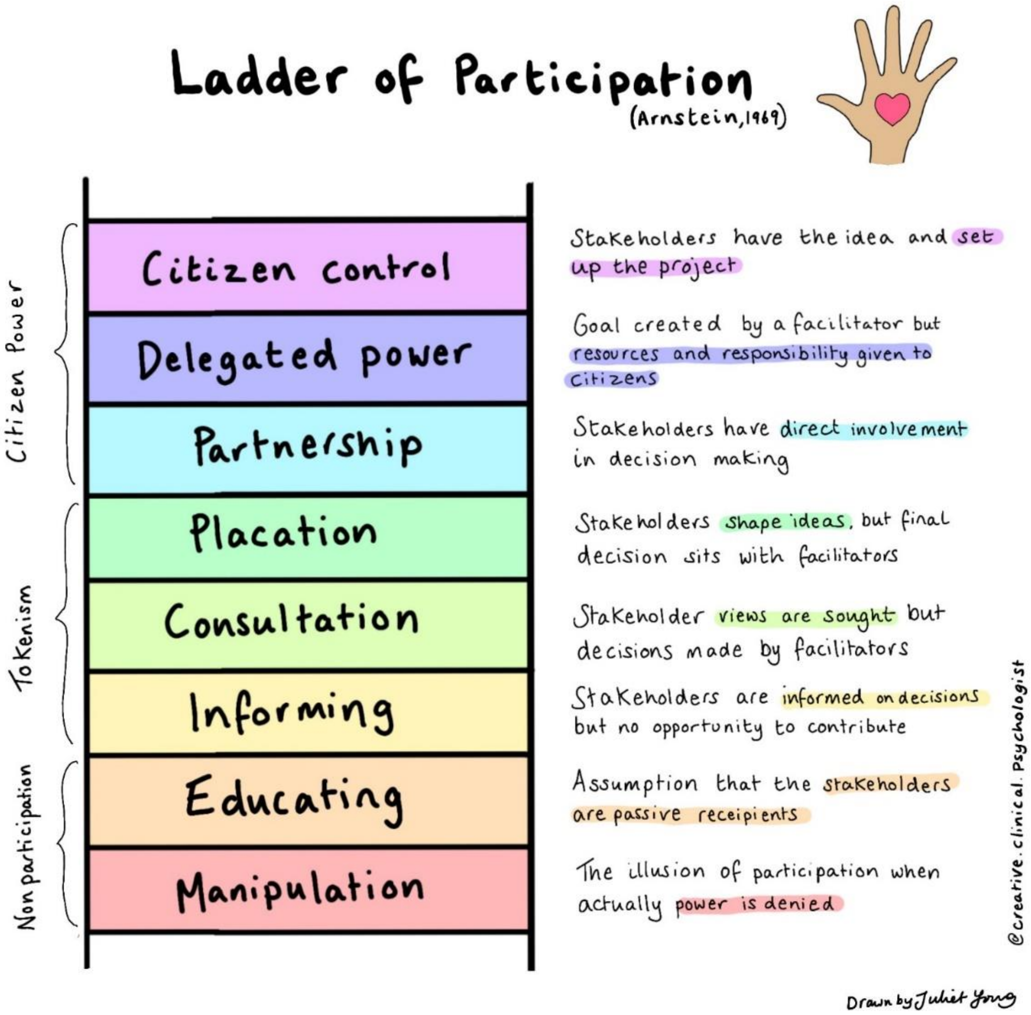
It also highlights the gender bias present within TBI services; services would benefit from finding ways to address this and encourage equitable access to care. Another area to focus on for services is reaching the domestic violence community to account for undiagnosed head injuries. Clinical Neuropsychologists could assess these individuals and help them access any necessary services. It would also offer an opportunity to collect accurate data on the TBI population, which could translate into adequate funding from ICBs.

4.3.3 Highlighting the ideals of co-production

The research highlights accessibility as an obstacle; the language used in CP settings and the documents shared with patients can be inaccessible, which has inherent power. Co-producing an understanding with the service user can be a powerful intervention in its own right, often seen at the formulation stage of therapy (Lewis-Morton et al., 2017). This research has highlighted the role of power in the development of services and how often co-production is not considered. Figure 4 highlights the importance of co-production.

Figure 4

Ladder of Participation (Arnstein,1969) illustrated by Dr Juliet Young (@creativeclinicalpsychologist).



This is a helpful model for thinking about participation levels and whether participation is tokenistic; in this case, it is helpful to overcome some of the obstacles presented by the social problem as patient choice within their care positively impacts their outcomes (Ogden et al., 2009). In structures such as the government or the NHS, higher levels are unlikely to be achieved within these systems. Despite the references to the ‘involvement’ of those with lived experience in contributing to the ‘Time for Change’ Report (Menon et al., 2018) and stories shared within the debate, it feels best placed within the tokenism part of this model. Even if total citizen power cannot be given, it is important to consider co-production in all settings affecting this social problem and redress the power by giving those with TBIs and their networks opportunities to make service decisions.

Overall, the findings suggest that clinical psychology can positively impact the obstacles to the social problem. These include writing grant applications and business cases, co-producing written materials and service decisions, finding a voice in social policy, raising awareness and challenging stigma about addictions, and finding effective ways to work across settings. All these recommendations will positively impact 'looking up the stream' and effect real change.

4.4 Strengths and Limitations

CDA, like many other qualitative methodologies, is often critiqued for its inability to contribute to understanding a concept in a reliable, credible and trustworthy manner (Gee, 2014). A strength of this research is that it demystifies the CDA approach and offers a replicable methodology. Whilst being respectful to the CDA framework, this approach offers standardised elements of the process, i.e. utilising the sociolinguistic categories (as seen in Appendix 3) and reporting explicitly how each section of the research relates to Fairclough’s 5-stage model (2001) (as seen in Table 1). However, there is no single method for CDA as it is an approach, but being explicit about my methodology and increasing replicability gives opportunities for others to access this approach.

A further strength of this research is that this is the first time parliamentary texts have been utilised to explore the parliamentary stakeholder lens in the social problem of unmet needs within TBI. Taking a top-down approach has allowed a light to be shone on stakeholders that are not always considered in so much depth. Using CDA also meant a unique opportunity to see power structures affecting this population, producing actionable recommendations for CPs and other stakeholders.

Despite the methodology's strengths, as aforementioned in section 3.5.2, it also presents limitations. To add rigour to the methodology presenting these findings to a focus group of relevant stakeholders (parliamentary, neurorehabilitation professionals, TBI survivors and their loved ones) could have created an opportunity for co-production of actionable recommendations. Nevertheless, it is crucial to recognise that this is a professional doctorate, and further research can move these findings forward.

A further limitation was that the discursive analysis was conducted solely by myself, although, this is quite typical in CDA (Meyer, 2001). Given the standardised sociolinguistic categories (Appendix 3), this could have presented an opportunity for another coder to test for inter-rater reliability; as an alternative, supervision was utilised to think about these categories and how I understood the themes from the coded transcripts. A second coder may have increased the power of the study. However, it may also have taken away from the attitude of the CDA framework; further thought about the lenses/position of the second coder would have needed to be considered (Jacobson & Mustafa., 2019).

A final limitation is that the research question focuses on TBI, but due to the limitations of the parliamentary text, the analysis had to look at TBI through ABI. Other neurological conditions have historically been cherry-picked to think about individually from a government/NHS perspective, e.g., Stroke from within the LTP (NHS England., 2019). Unfortunately, this was not achievable with this research due to the limited parliamentary texts that were solely related to TBI.

4.5 Future Research and Dissemination

Now that the obstacles to the social problems have been identified, future research can take several avenues. Initially, research should focus on consulting relevant stakeholders such as MPs, Service Managers, ICB commissioners, those with TBI, TBI caregivers, MDT specialists, charity managers, and other relevant parties to discuss these discourses and consider how they might use their power to overcome some of the highlighted barriers.

During the analysis of this study, Manley et al. (2023) published their research. They invited a diverse range of TBI stakeholders from East Kent to participate in a three-hour workshop. The purpose was to collaboratively find better ways to ‘optimise rehabilitation potential and return to a meaningful life, maximising their quality, participation and independence’. This six-stage process was well received and was quoted as ‘co-production’ (Langley et al., 2022) despite not including survivors of TBI. It would be beneficial to conduct this workshop nationally, including survivors of TBI, their families, and caregivers; this would allow us to move beyond tokenism in participation and towards citizen power (see Figure 4). However, this time, with a focus on the powers to create change, the barriers to the social problems identified in this research and creating actionable outcomes. This will also contribute towards mitigating the effect of networks that cause inertia.

Investigating these networks that cause inertia would be pertinent for future research. An ideal place to start is by investigating the current data collection systems that influence the allocation of funds to ICBs. Despite some of the service inadequacies relating to an overall lack of funding for the NHS (Gardner, 2019), incorrect data is also being used to predict need. Domestic violence charities offer an opportunity to collect data on head trauma that has not been attended to medically;

this will help curate accurate data on TBI incidence. Auditing this process may mean funding is allocated more proportionately and meets the aims of the ICB system, i.e., to reduce health inequalities (NHS England., n.d.).

Regarding dissemination, I plan to attend some conferences next year following my maternity leave- such as events held by the World Federation of Neurorehabilitation, UKABIF, and local and national Headway groups. There are also plans to disseminate this amongst relevant stakeholders, such as those within the APPG and local MDT specialists in neurorehabilitation. Utilising connections at UKABIF will help determine further helpful spaces to disseminate the findings. Regarding funding these dissemination plans, I will apply for grants like those offered by the National Institute for Health and Care Research (NIHR).

My thesis will also be available via the Essex University open access Research Repository. I hope to be able to publish a rapid review in Advances in Clinical Neuroscience and Rehabilitation (ANCR), as well as a more substantive paper in the Frontier in Rehabilitation journal. Regarding the implications for clinical psychologists' engaging with the political context of their work, I aim to publish this aspect of my findings in The Psychologist. As a barrier identified in the results, I will publish an accessible, easy read version of my results through organisations such as Headway and UKABIF.

4.6 Critical Reflections

This section will include critical reflections on the analysis in line with Stage 5 of Fairclough (2001). One of CDA’s main criticisms is that its ideological position defines it; this is about its critical stance on social hierarchies and power, focusing and favouring those who are seen to suffer in relation to this, and therefore has a heavy focus on political action (Meyer, 2001; Titscher, 2000). Furthermore, due to the text selection within CDA, there are arguments that this is a biased process and, therefore, will bias the interpretation of the texts to confirm a predetermined standpoint (Widdowson, 1995). In response to these criticisms, Fairclough (1996) notes that CDA makes its standpoint explicit from the outset of analysis, unlike other methodologies where assumptions and biases are presented but are not acknowledged.

Pilgrim (2019, p. 4) said researchers should be “cautious about our knowledge at times because it is partial and fallible; we don’t understand and may never understand much of what is real.” With this in mind, the current study will proceed in line with epistemic humility. The following comments will focus on steps taken to add quality to the research, focusing on credibility and rigour (Spencer & Ritchie, 2012). There was limited literature on this topic to guide this research. Norman et al. (2023) was a key review influencing the development of the social problem, but most of their papers related to stroke survivors’ experiences rather than TBI. Andelic et al. (2012; 2020; 2021) provided further sources relating to the economic benefits of rehabilitation and service utilisation specifically for TBI. However, most of these focused on moderate-severe injuries, leaving a gap in information for mild TBIs.

Credibility in research can be referred to as the defensibility and plausibility of the claims made within the study. The Historical Analyses of the recent development of parliamentary texts and discourses that have impacted those with TBI were conducted (see Appendix 2 for examples of this process); this allowed me to select parliamentary texts that best represented these discourses and the social obstacle being investigated. This meant I could broaden the focus rather than focusing on an isolated narrative based on a predetermined bias (O'Reilly et al., 2021; Widdowson, 1995).

Once the parliamentary texts were chosen, the discursive analysis went through several stages. It involved familiarising myself with the texts by reading them multiple times to become familiar with the emphasised points and themes. Following this, the texts were coded according to the main sociolinguistic categories in CDA (Araujo et al., 2019) (see Appendices 3 & 4 for examples of the process). This method allowed for a standardised process of discourses to be identified rather than representing spurious or manufactured ideas. Supervision was used to facilitate this process; the additional perspective helped deepen the analysis and add a different lens to identify areas of apparent bias or poorly evidenced discourses. These attempts to improve my credibility and add rigour to my research were anchored within the personal reflexivity highlighted in the researcher's position section of the epistemology and methodology section. I will further outline how my assumptions and values may have influenced the research outcome and how personal reflexivity was used to mitigate this impact on its credibility.

An area of the analysis that required particular attention to reflection was the topic of implicit and explicit privilege within the parliamentary texts. As I previously stated, I hold critical views about right-wing politics and believe that they perpetuate and further inequalities in health amongst the most vulnerable. I aimed to consider the mechanisms that maintain power imbalances and the vested interests that parliamentary stakeholders might have in minimising the existence and impact of social factors. I also considered the workings of power. I had not expected within the texts an acknowledgement of their privilege and the mechanisms of government that contribute to the obstacles of meeting those with TBIs' needs. I anticipated furthering neoliberal ideas and responsibilising narratives. However, by maintaining awareness of my biases, I noted that they were acknowledged and how they disadvantaged and excluded certain groups.

The hardest part of this project for me was embodying and learning the methodology. Throughout the analysis, I had to adapt and take a different position whilst acknowledging my positionality and how this may influence the results. Throughout, I noticed that one particular MP featured heavily in these parliamentary texts, which irritated me; I used supervision to explore my biases around this and control for it in the results. These biases mainly were around their privilege and my perception that they could not see this, compounded by the truth modality in which they spoke. This is a shift from my positionality, i.e., as a trainee clinical psychologist, a crucial part of our clinical work is to guide others to understandings that fit them- rather than sitting in a position of expertise. I reflected that this is likely influenced by the role of an MP, as there is pressure from job instability. The fluid roles must create pressure to speak with affinity to create stability. Thinking in this way helped me understand the role of ‘getting things on the record’, but within this, I can also recognise the impact this can have on creating change.

As I am not a linguist, understanding the terms seen in Appendix 3 and being able to identify their operations within the texts meant the coding process was time-intensive. Prior to engaging in the research, I read several key chapters from the books Methods of Critical Discourse Analysis (Wodak & Meyer, 2001) and Discourse as Data: A Guide for Analysis (Wetherell et al., 2001). Following this, I met with Dr Ewen Speed for a consultation to consolidate my social problem, and he further directed me to read Discourse Analysis as a theory and method (Jørgensen & Phillips, 2002) to broaden my understanding of CDA. I tried to look for external training, but unfortunately, due to time constraints, none fit my timeline. I spent many hours (70+) reading published CDA works and thinking about their methodologies.

In addition, rigour was demonstrated through the research process documentation (see Appendix 1, 2, 3 and 4). A criticism of CDA is that it does not have a fixed methodological process; rigour was shown in this research by selecting a robust structure to conduct CDA (Fairclough, 2001). Huckin (1997) describes CDA as a “democratic approach which takes an ethical stance on social issues with the aim of transforming society - an approach or attitude…” When the researcher is new to the CDA process, the analysis can have the potential to lack rigour and structure. When reading published words of CDA, I often felt unable to replicate their methodology. I was keen to make this different in my research. Therefore, the stage process outlined by Fairclough (2001) (as seen in Table 2) was utilised, as well as the main sociolinguistic categories in CDA, as seen in Appendix 3. The combination of these frameworks offers a more standardised approach to CDA. However, it is flexible enough to maintain the 'attitude' of CDA (Huckin, 1997), creating an accessible, structured approach for future researchers.

5.0 Conclusion

Over the last couple of decades, it has been made apparent that TBI services are not fit for purpose and do not meet the needs of survivors and loved ones. Researchers have conducted studies to investigate the barriers to this problem and its consequent impact on this cohort (Laurie et al., 2023; Norman et al., 2021). Currently, there is no research investigating parliamentary stakeholders’ role in this problem. This perspective is crucial because they directly influence policy, which can impact the NHS budget and thus affect service delivery. Despite this wide acknowledgement of inadequate services, measurements taken to meet the needs of this community have yet to be forthcoming.

Therefore, the current study aimed to facilitate new understandings of the structural and discursive barriers to unmet needs in TBI. Through exploring the underlying conceptual frameworks in the selected parliamentary texts and their impact on action or perpetuation of inertia in this area.

A critical realism position was adopted for the current research, this position allowed the researcher to take an explicit stance regarding the implications, limitations, and strengths of the texts, whilst maintaining epistemic humility (Pilgrim, 2019). Therefore, within the analysis multiple perspectives were able to be considered rather than diminishing the results to a singular viewpoint. For example, the multiple perspectives were seen in the exploration of different modalities and how they influenced the results.

Discursive analysis indicated that different positionings of stakeholders and systems denote responsibility or dismissal of responsibility when calling to meet the needs of those with TBI. These were further compounded by systemic barriers but left the question of who has the power to enact change. Despite the explicit acknowledgement of obligation to this community, unmet needs within TBI were further conceptualised in the disguised action of parliamentary figures. In addition, there was evident wider discourses influencing the obstacles to solving this social problem; for example, neoliberalism demonstrated through the emphasis on employment being a fundamental purpose in life.

These findings were discussed regarding their relationship to other prominent structures and networks of practices that could be interested in maintaining inertia regarding unmet needs in TBI. Networks and structures identified as barriers to change included unintegrated care pathways between national and local NHS services, structures within government, and the reality of working in NHS settings, i.e., expert staff shortages, charities plugging the gaps whilst also being decommissioned, and recognition of expertise.

This study highlighted the role CPs can take in engaging with social policy; for governments to be able to improve the lives of the public, they need policies and interventions to be based on an in-depth understanding of human behaviour to stop the persistence of certain social issues (British Psychological Society, 2019b). A perspective that clinical psychologists can offer with their training. Although often within training programs, this top-down approach is not emphasised, and treatment is instead seen as the primary role of clinical psychologists, noted as the ‘plaster approach’ throughout this research (British Psychological Society, 2019a). In the case of this social problem, instead of individual intervention, we need to consider the wider macro systems and ‘go up the river and see why people keep falling in’ (see Figure 1). The implications for clinical psychology in overcoming these barriers were considered at various micro and macro levels, initially concerning individual work with clients in a neurorehabilitation setting, engaging with service development, and working at a policy level to help influence and contribute to overcoming this social problem.

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7.0 Appendices

7.1 Appendix 1

MEDLINE with Full Text, ebook Collection (EBSCOhost), APA PsycArticles, APA PsycInfo, CINAHL Complete, were searched on June 14, 2024. These databases were selected as they would yield quality peer-reviewed papers within relevant fields. Search terms were influenced by a previous reviews of experiences of individuals with acquired brain injury and their families accessing and interacting with services (Laurie et al., 2023; Norman et al., 2021). Table 2 denotes the search terms used.

Table 2

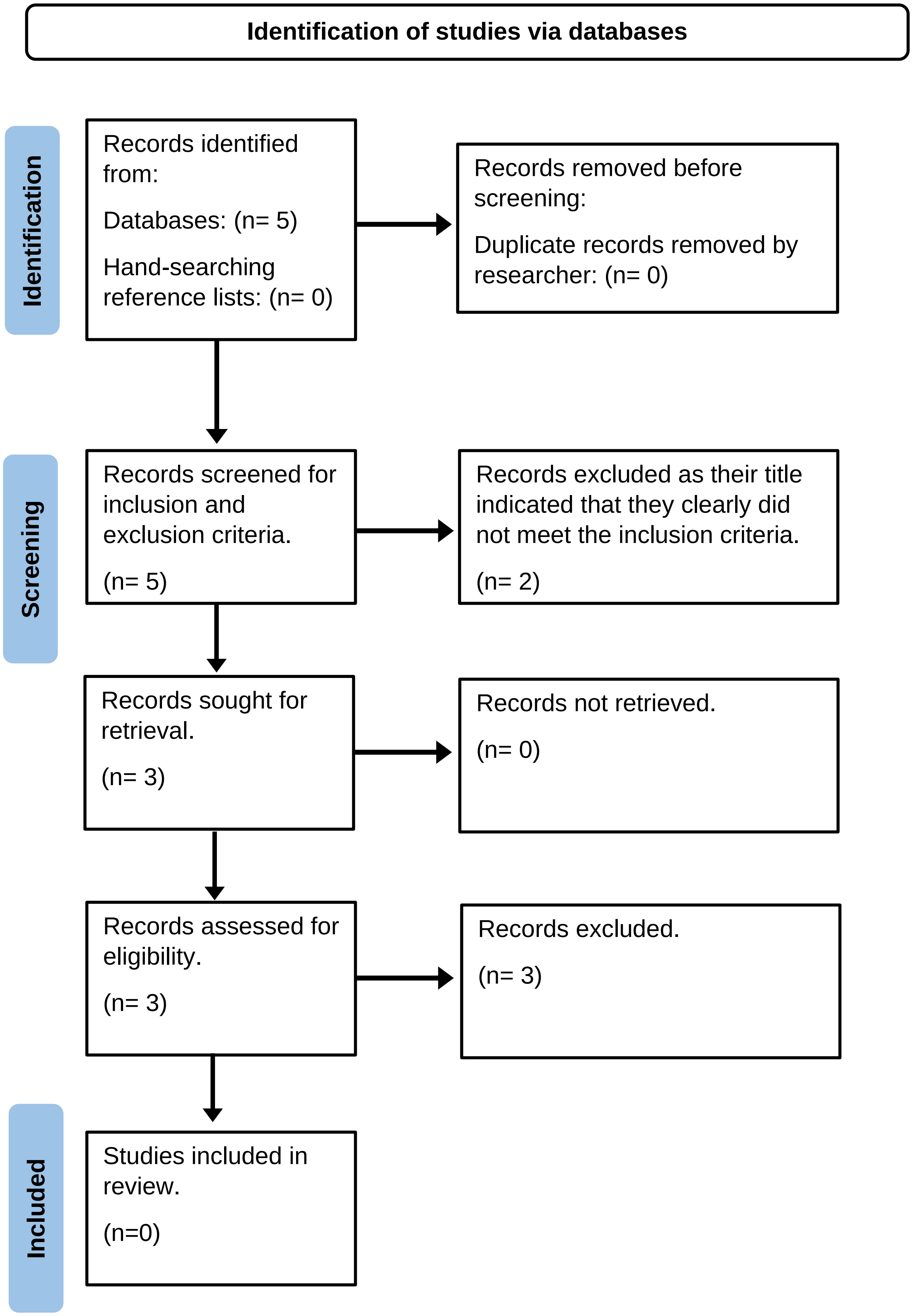
Table of search criteria.

Search terms	**Concept 1: Parliamentary Stakeholder**	**Concept 2: Influence**	**Concept 3: Healthcare/ Service delivery**	**Concept 4: Population**
	Politicians OR MPs OR Member of Parliament OR Minister OR Parliamentary figure OR political leaders OR elected candidates	adequat* OR satis* OR impact OR influence OR dissatis* OR insuffici* OR inadequa*	Service delivery OR neurorehab* OR rehabilitation OR NHS OR National Health Service OR healthcare OR community services	Traumatic Brain Injury OR TBI OR Brain Injury
Databases	MEDLINE Ultimate, ebook Collection (EBSCOhost), APA PsycArticles, APA PsycInfo, CINAHL Ultimate			
Inclusion	Published in the last 20 years (2004-2024); published in academic, peer-reviewed journals; Written in English; Human subjects of all ages; compromising of people in political employment, concerning parliamentary figures influence on TBI service delivery/implementation			
Exclusion	Doesn’t refer to TBI; non full text papers; papers from outside of the United Kingdom			

Given the search's heterogeneity, it was impossible to develop a search strategy based on keywords that would yield research from different disciplines. Most studies were attempted to be identified by hand searching, predominantly through searching reference lists of published papers and reviews. Figure 5 presents a flow diagram of the study identification process.

Figure 5

PRISMA Flowchart.



7.2 Appendix 2

Historical Overview of Policy Text Developments

Table of Needs Themes

Key
Initial reflections on the documents highlighted in green.
Selected texts for discursive analysis highlighted in yellow.

Date	**Policy Text**	**Brief Description**	**Target audience**	**Text**		**Rationale for reform in this area**	**How 'need' is conceptualised (how defined, metaphors, legitimised, presuppositions- what is assumed beforehand)**	**Power- who's voices are privileged? Which biases are present- what is being ignored? What stereotypes are presented in the text?**	**Changes from previous policy texts**
				Consumption **How do readers interpret?**	**Production**				
15/06/2018	House of Commons (HoC) Library- Debate Pack ABI	Briefing prepared ahead of general debate on ABI in HoC chamber 18/06/2018	Our job is to provide a range of research and information services for MPs and MPs' staff. Our work helps MPs scrutinise	Feels well referenced with a variety of sources. Wide variety of topics covered possibly under Head injury rehab, sport	HoC library prepares quickly after announcement of parliamentary business- intended to provide a quick summary or overview of the issue	To have an **overall life cost saving**	Lack of sufficient rehabilitation services- **dependent on locality** Young offenders- need better screening, support and	Focus on rehabilitation prescriptions- but these only available to severe cases. Does have the voices of other organisations and survivors.	

			legislation, prepare for debates, develop policies and support their constituents.	related injury and offenders. Feels impartial due to wide variety of sources and voices	being debated and identify relevant briefings and useful documents. We are a team of researchers, statisticians, librarians, indexers, communications and customer service professionals, working together to provide an impartial and trusted service.		raised awareness. Need for **communication and coordination** between services. Need to save important relationships. Better understanding of brain injury across all stakeholders and impact	Headways voice is privileged- think this is a good thing- does this privilege head injury over other ABI's. HRH Prince Harry Brian Injury ID card scheme **privileged.** Big focus on sport related concussion	
18/06/2018	Commons Chamber Debate	Debate about gaps in provision and 'hidden epidemic of ABI'	DWP on the bench in the debate as hopes certain points will be heard	Formal and hard to follow at times. Hard to know motive behind comments. Vast reaching in terms of	Likely most statements were produced prior to debate. Comments may be from constituents rather than MP themselves.	Call for **prevention work** for criminals with ABI Call for review of benefits assessment service	Need for more **funding** for carers and relatives of ABI survivors. Need for inquiry into **current services and gaps.** Need in education for	MP's expressing gratuities to government but also praising themselves for their work. **Power-** "ladies first" Personal affinity to the	More mention about prevention of ABI More focus on neurorehabilitation Themes of blames between departments

				covering the scope of ABI and impact of gaps in services. Some voices felt more privileged than others			children with ABI to be better supported. “Neurorehabilitation is therefore one of the most cost-effective services the NHS provides…” Need for beds. Need for raising awareness amongst key stakeholders e.g., teachers- but also within the public. Need for cross-departmental working. Idea of “finger pointing between social services and health commissioners over who should foot the bill for	topic- reason behind bringing this? Minister will support APPG inquiry- **privileged** voice but does speak to many issues. John Hayes- seems to have punchy summaries in most debates. Use of quotes to make impact of point.	

							rehabilitation services”		
09/2018	Time For Change Report	All-Party Parliamentary Group on Acquired Brain Injury Report- Highlights gaps within after care for ABI and makes recommendations to address these	Government and relevant department Other key stakeholders around this issue	Comprehensive report, easily read and accessible language Economically focused Highlights clearly where changes are needed	Produced with help from all relevant stakeholders and pulled together by anaesthetic consultant- vast stakeholders covering each topic. Well referenced document- mixture of images and figures to illustrate points	Pointing out to the government that there is a **long-term cost saving** to be made	Need conceptualised by lack of funding. Need to combat long-term effects of ABI e.g., behavioural, cognitive, educational and social/relationship issues. Need for beds and rehabilitation prescriptions	Asking government for promises to have reliable stats and have **cross departmental** working on this issue. Survivors’ voices privileged. **Disempowered areas of UK-** as some areas have sparse access to neurorehabilitation services. MTC’s incentivised to use rehab prescriptions but no other environments. Also, GP and patient do not get copies. Case study to bring personal element	“Non antagonistic” plea to government for change in this area Focused more with survivors’ voices rather than MP’s personal experiences. Focus on disparity between areas in UK

January 2019	The Lancet, Neurology, Correspondence piece- “Time for change in acquired brain injury”	Summarises the recommendations from the ‘time for change report’. It follows on from the Lancet 2018 commission on TBI.	Researchers Medical professional Policy makers	Scholarly medical language e.g., sequelae Discourses include economical argument, neoliberalism, Inadequate healthcare professional knowledge … but policy makers are having outputs	Typically, correspondence is not peer reviewed in the lancet as often does not feature original research. Have to declare any competing interests	Believes making these changes will bring about a **long-term cost saving** and ‘could have a substantial individual, societal and financial benefits. Early neurorehabilitation is cost effective but can also minimise residual disability- meaning more people back in work and paying taxes	“Rapidly growing public health problem”. “Leave survivors with a considerable burden of physical, cognitive, psychosocial sequelae. Describes **resources as patchy** and **inadequate** and implementation of past recommendations as poor	Policy makers voices **privileged** as they are assigned to collate the ideas of professionals, patient support organisations and patients. Large emphasis on professionals being educated about nuances of brain injury- biased in that many providers to do not have ‘expertise’- stereotype. The good work that happens is being ignored. Also biases findings of one report- did they look at historic	Focus on idea that not only cost saving for government but that they have a financial obligation to help

								research to support? Written without references so nothing to back up factual claims. Leaves no room for interpretation "implementation of past recommendations is poor"	
05/09/2019	Commons Chamber Debate	Debate following APPG report and calling for government to action recommendations	Government and within this the relevant departments Present at debate is Under-secretary of Health and Social Care	At times formal, hard to know real agenda. Covered lots of aspects of the gaps for those with ABI. Seems that those with power didn't have much to make changes	Voices of local ABI organisations to get support through parliamentarians and their power	Call for change in 2001 and not all the recommendations have been met- want further **reform.** Give people real quality of life with good neurorehabilitation not half existence. Needs to be **cross departmental working.** RTC- Helmet guidance to reduce head	Want government to guarantee full neurorehabilitation as needed. Talk of prevention of ABI via seatbelt restriction enforcement Need for more specialist staff and for services to have a full task force. Need to get **sufficient benefits**- less	**Power** in talking at this level- influenced other MPs to visit head injury organisations. Talks of **social justice** i.e., likelihood of sustaining a head injury increases with level of poverty. Recognition that with hidden disabilities its **bureaucracy**	Emphasis on cross departmental working Changes seen within rehabilitation prescriptions. Talks of bodies in charge in sport and making poor decisions First time spoken about department responses from time for change report

						injuries- talk of **prevention.** Government needs to connect a local approach to a national one. Raise and **maintain awareness** about **prevention** of ABI. Need for people to be back in work “to forge a new and better future for the United Kingdom”	stressful system. Need **“a political miracle”.** Need for recommendations to be ‘enacted in full’- head injury rates increase. Need to reduce **misdiagnosis.** Young men mostly affected by RTC ABI- stereotype. Need support as **vulnerable**- e.g., gambling addictions. Need for better **recognition** of ABI. Need for long term support closer to people’s homes.	**fighting** to get needs met. Those with authorities within sport are putting players **lives at risk** concerning football. **Power** in that some areas have been long term support than others- **‘lottery’.** Some departments taken more active role in responding to report recommendation- some responses are not seen as sufficient. Those who bring personal stories why are they there for the issue	

01/07/2019	Research Briefing- Prior to debate on 02/07/2019	Summary of key points from 09/05/2019 debate on ABI to prepare for 02/07/2019 debate on ABI	Policymakers and other relevant stakeholders (healthcare professionals, organisations,	Doesn’t appear balanced and impartial. Doesn’t feel like holistic enough to capture needs of ABI cohort	Around 800 words and 2 pages of text for each briefing Gov.uk website “UK Parliament produces impartial analysis and research on a variety of topics… that affect the UK like the economy, health and security”.	Priorities appear to be raising awareness (e.g., add to code of practice for SEN), **further investment** in services, screening for prisoners and updating benefits assessments. Have higher completion rates for rehab prescriptions. “Ensure that those who have sustained brain injuries are guaranteed full neurorehabilitation as needed”. Screening for domestic abuse victims	Assumed need within rehabilitation prescriptions and the power audits hold- no data on how many of these prescriptions were filled fully or partially. Need screening for women of domestic abuse to **“rescue their future and prevent crime”.** Blame on NHS England and how they use funding and on MTC’s on completion of rehab prescriptions. Written as “key points” so assumed no other knowledge is known beforehand.	Prime ministers voice privileged but also shows power i.e., will debate invitation to work with Chris Bryant because of their history… seems unprofessional and biased. Ignored **prevention** within the briefing and only focuses on certain cohorts of people within ABI population	Less focus on prevention more focus on awareness Lens for neurorehabilitation but also heavy lens on criminals, education system and welfare system Focus on women sustaining ABI from domestic abuse

02/07/2019	Commons Debate at Westminster Hall	To debate specific elements of ABI and what is needed within the strategy to support this cohort of people and their carers effectively	Targeting certain divisions such as ministry of defence, department for work and pensions (DWP), department of education, ministry of justice, the home office are named. Health minister is within debate also. Public gallery- likely with pertinent stakeholders in	At times focused on thanking people for work which detracts from need and purpose of debate Hard sometimes to see through the name dropping and whether contribution is for further votes or not	Third sector organisations such as Headway, constituents, survivors of brain injury and carers likely have made contributions to MPs prior to debate. Produced with a view to enact change	DWP needs to be better able to pick up how injuries affect day to day life. ABI affects **employability** in young adults- support in this area. Need for speech therapists- shortage within this field- (Chris assumes do not feel valued within teams) Know about impact of brain damage acquired through alcoholism and pregnancy. For families to not have to “fight” for every element of support for survivors of brain injury Significant overall **cost**	Need is really thought about through personal stories and services that can affect them e.g., invisible illness and DWP assessor. Liken fatigue in the brain to a Duracell battery. “Vicious cycle of depression and anxiety affecting recharging of the battery”. References television show to bring need to light- mother father son. Supposed sharing would help and make people courageous. Accused of “being drunk”- stigma	Chris Bryant breaks debate rules to name public gallery member and bring issue to light or to affect responses- uses power for good? Chris Bryant name drops important people- is this part of **responsibilising**? Talks of several ways can acquire brain injury e.g., “more dramatic and traumatic injuries...” **Social Justice** themes- child from poorer background 4x more likely to have brain injury- important for	_More talk of employability and how ABI affects this. Shortages of experienced professionals- shifting blame? Bringing more relevant cultural references to highlight impact of ABI. Talks again on prevention

						saving for government if effective rehab is provided at the beginning. These recommendation for changes are not new- all in 2001 health committee report…	Need for **prevention.** "**Pushed from pillar to post** in the health system". "Fundamentally chaotic being brought into ordered system". Need for more child rehab centres/pathways. Approx 330 beds short	Labour manifesto. **Financial gain** for government but **"moral imperative"** too Those who speak always add personal element/story- to add impact to their point? Or the only reason they are at the debate? "We are going to be using the broken record technique to make sure our messages get across and real change happens". **Power** of MP's commending work of others	
19/02/2019	Commons Chamber Debate	Questions posed to the minister for	Audience primarily governme	Formal, third person	Pre-prepared statements	"Everyone who has an ABI **deserves** to	Defined through	Headway voice is **privileged.**	Heavy monetary need focus

		care (Caroline Dineage) around ABI support	nt officials which can affect spending. In some respects, for MPs about their constituent voices being heard. So, audience also constituent and headway	can be confusing. Tokenistic and non-committal, talks around money but not specifically for ABI	by ministers bringing views of constituents. Some sound prepared beforehand but responses won't have been. Think about party's speakers are from and values and ideas underpinning statements.	receive the best possible care and rehabilitation service". Ultimately this reform is left to ICB's in terms of how funding achieves/addresses this. Reform through developing technology to support people- through NIHR grants	numbers i.e., 1.3 million. Need through supporting third sector organisations. **Monetary need** Need to be 'attractive' in a bid to secure funding. Need for **ministerial power** i.e., talking with her = more likelihood of change? Assumption that young people with brain injury need more innovative technology treatments. Need in terms of research	Stereotypes that mostly young people get brain injuries from excessive alcohol consumption. Minister for care voice privileged as "one whom has answers". **Power** in terms of formal ways to address people "hon friend or hon lady"	but blame shifting between local services and government control over this. Focus on the role of research in supporting those with ABI
05/02/2020	House of Commons Library- Debate Pack	Briefing prepared ahead of general	Our job is to provide a range of research	Feels well referenced with a	HoC library prepares quickly after announceme	Affecting 1.3 million people in UK and correct	Need for more neurorehabilitation health professionals	Chris Bryant will lead the debate.	Focus on reform within education and

	ABI	debate on ABI in HoC chamber 06/02/2020	and information services for MPs and MPs' staff. Our work helps MPs scrutinise legislation, prepare for debates, develop policies and support their constituents.	variety of sources. Wide variety of topics covered possibly under Head injury rehab, sport related injury and offenders. Feels impartial due to wide variety of sources and voices	nt of parliamentary business- intended to provide a quick summary or overview of the issue being debated and identify relevant briefings and useful documents. We are a team of researchers, statisticians, librarians, indexers, communications and customer service professionals, working together to provide an impartial and trusted service.	neurorehabilitation could have huge **long-term cost saving** for government	(physiotherapists, OT's, SALT, nurses, neuropsychologists and educational psychologists) to deliver services. Need for better guidelines for children returning to school post injury. **Shared responsibility and cooperation** across government departments Need for more beds. **Reform** benefits assessment system Better detection as symptoms can often overlap with other conditions	**Power** in clinical audit for governments to track change and make decisions. **Privilege** for sport and ABI, Education, welfare and criminal justice system- less emphasis on prevention and TBI or specific types of ABI Privileges experiences of younger generation- is this purposeful for government and tax ideas? **Neoliberalism** Power within DWP- takes advantage of ABI presentation	benefits system. Power within audits Focus on younger people' does this appeal to government as "next generation" idea that they are worth investing in over older generations

								and denies benefits. PMQ's asked across several departments e.g., defence, justice education, - clever in lead up to debate	
06/02/2020	Commons Debate at Westminster Hall	Debate around current gaps and need for those with ABI and their carers	Government department that can effect change in line with ABI strategy	Talks of language mistakes but often the language used within debates is inaccessible to the average reader **add discourse here**	Statements likely to be pre-prepared by ministers informed by constituents	View that "the government want to wash their hands of it"- in relation to advice around concussion safety in sport Call to government to set up a **cross departmental body** to look at the issue rather than thinking of each within different silos	Need for ABI support with children, prisoners, **Raise awareness** amongst key stakeholders. **Raise awareness** in certain environments e.g., schools and sports. Need for rehabilitation prescriptions Need for **prevention** plans. Need for **improved communicatio**	Social Justice- children from poorer backgrounds are 4x more likely to get a head injury Don't talk to Stroke as feel this is well managed Idea of being "blasé" about a knock to the head- must appear tough (stiff upper lip Britain) Trajectory of child head injury, no support, becomes repeated offender	Talks of communication and how to be more accessible for those with ABI Bigger emphasis on raising awareness and cross departmental working

							n between medical professionals and ABI survivors. Carers do not know “whose door to knock on or whose to knock down”- in relation to following thinking behind decisions about their loved ones MOJ- Screen new prisoners for ABI DWP assessors to have full understanding of ABI and impact Beds and professionals to fulfil rehab prescriptions Short term needs fulfilled- long term is questionable	Praise government for major trauma centres Talks of **prejudice** around brain injury **Power** within language e.g., vegetative state also road traffic accident (all accidents are preventable) **Power** of research **Power** in minister “I will certainly take forward the idea of a real, collaborative cross-Whitehall group to discuss this”. Chris Bryant- “I will not shy of repetition”-	

								calls out minister	
24/11/2020	Commons Chamber Debate ABI + Covid 19	Talking about impact of covid on ABI services and thinking more widely about need for ABI strategy	Audience primarily government officials which can affect spending. In some respects for MP's about their constituent voices being heard. So audience also constituent and headway	That there is a need for services to resume and a negative impact from covid on this cohort. Lots of 'brown nosing' and formal language that detracts from point of debate	Pre-prepared statements by ministers bringing views of constituents. Some sound prepared beforehand but responses won't have been Think about parties speakers are from and values and ideas underpinning statements	Chris reason for rationale is "I want people to **live independently** and have **freedom** that we would all want for every individual". During covid some were sent home with large expensive care packages as rehab not available- might not have even needed that care if the right specialist care was there- **not cost effective** Government talks about guidance but without money can be seen as "a bit too Cinderella like"	Need for rehab centres to be reinstated after covid To get support families "are **pushed pillar to post".** Need for ministers across education, defence, work and pensions, health and social care, housing and treasury to develop single coherent ABI plan Need services back up and running and strategy as head injuries at this point had not slowed down "fatigue that brings despair	Lots of thanking each other for doing their jobs Currently access to rehab is patchy and **unfair** across England. Those with brain injuries discharged early as needed beds for covid patients- affects their outcomes Those from poorer backgrounds likely to have worse outcomes around head injury Chris asks to give way- interrupt- did not give way	Focus on the impact of COVID and how this has exacerbated the difficulties that those with ABI face. Brings into question the morality of government with disadvantaging these individuals

							and an inability to feel like living” **Postcode lottery**		
16/06/2021	Acquired Brain Injury Bill	“A Bill to make provision about meeting the needs of adults and children with an acquired brain injury, and for connected purposes”	HoC and stakeholders relevant to examine, discuss and amend it Then House of Lords as must pass both before receiving royal assent and becoming law	Sounds formal Outlines important areas Feels like it gives government lots of power to decide strategy, which may mean not all areas are covered	Written by MP Chris Bryant- guide for MP’s writing Bills and what they should include	Priority for government not really mentioned here as MP’s are asking of government to develop strategy. MP’s rationale is that there is a gap and it needs filling- also houses the economic argument	Need for a strategy Talks about need for **prevention** of ABI. Research into societal, congenital, medical and environmental causes of ABI Better trained staff Will require parliament to pay out any expenditure incurred under or by virtue of the act	Consent of Lords and Commons- **power** Leaves secretary of state to decide the strategy- but encourages consultation	Specifically calls for an ABI strategy which includes prevention, research and finances
09/11/2021	Acquired Brain Injury Bill- Explanatory notes	Notes prepared to assist the reader of the Acquired Brain Injury Bill	Those reading and debating the Bill	Likely to need further background to debate topic	Not endorsed by parliament- created by Chris Bryant MP- published by	Want government to provide research to evaluate and improve	Need as defined through improving the provision of services available	Talks about the **power** the bill will have. Need for **financial provisions**	Clearly asking for financial backing to make the strategy feasible

		introduced to HoC on 16/06/2021, and to inform debate on it		Helpful to distinguish powers Bill will have	authority of the HoC To be read alongside the Bill	assessment tools	Need for government to provide statutory guidance on how to implement strategy	depending on strategy decided. Talks about where Bill will be applicable across UK **Power** within benefits assessors- need to be aware of brain injury and presentation of this	
03/12/2021	Commons Chamber Debate	Brief word about no need for legislation for ABI strategy as house supports already	Government in power, constituent and those with vested ABI interest	Interpret Bryant as having power to ‘force’ government Reader might feel like a pointless statement Might also feel like just saying something so record in the archives	Pre-prepared statement	Need of strategy and strategy backing but not to the extent of legislation	Need spoken of in terms of strategy not legislation	Also, ministerial power- “I was incredibly generous”- meant to be humorous but likely consumed as ignorant and self-righteous (is it generosity when social justice is concerned?)- ABI need reduced to a Christmas gift to an MP- think about connotations	Want backing of strategy so does not have to go down the legislation route

								of gifts- gifts insinuate something you don’t need but should be thankful for? **Power**	

7.3 Appendix 3

Summary of the main Sociolinguistic Categories in CDA

Social Functions of language	Analytical Categories	Analytical Subcategories	What to analyse?	How to analyse?
Ways of acting or (inter)acting in discourse (Actional meaning)	**Genre structure (genre)**	Rhetorical movements	Things that the text does (contextualising the topic; introducing the participants)	Verify how the text is structured in terms of the actions that it takes
		Language	Language styles that "situate" a text in a context	Assess characteristic elements of a given document (manner of address; type of sentence construction, etc.)
		Form and formatting	The wording style that characterises the text	Examine the line and paragraph divisions, section divisions, pre-textual elements, post-textual elements, and graphic elements that accompany the text
	Intertexuality	Articulation of different voices	Direct and indirect "references" that are present in the text and the relationship between voices-distance/ difference from what has been said	Identify the use of quotation marks, *verba dicendi*

	Functions of speech	Demanding, offering, asking, affirming	The text's objectives (generic speech functions may turn into more specific types)	Map verbs and the actions that they connote
	Textual cohesion		The logical nexus established between clauses (and between paragraphs, if possible): casuality, conditionality, correction* or contradiction, emphasis or mitigation, distancing…)	Map connectors (conjunctions, etc.)
Ways of representing in discourse (Representational Meaning)	**Interdiscursivity** (Identifying the discourses and their models of articulation)	Enumeration	The order of the enumerations to identify the priority level and/or the distancing of some terms	Observe the order of terms' appearance and the distance from the central idea of the sentence
		Repetition (and synonyms and near synonyms)	Terms that have similar meaning (or refer to terms present in the text) that appear more than once in a text	Observe repeated words, synonyms, near-synonyms and derived words
		Activated semantic field	The associations between a word or expression and the meaning fields.	Examine the most frequent or most important words in the selected excerpts
	The representation of social actors	Mode of reference	The words employed to represent the social actors referred to in the text and their connotations	Map nouns used to refer to the social actors

		Mode of representation	Strategies for representing actors (individual/ group; opposition between us and them; personalisation, assimilation, functionalisation, aggregation etc.)	Map nouns used to represent the social actors
	The words' meanings	Textual patterns of co-occurrence or collocation (analysis of context)	How ideas (represented in words that precede or succeed the key term) are associated with the term or issue being analysed	Examine the text adjacent to the keywords. It is important to identify the order of enumeration and repetitions of associate/ proximity of terms
		Lexical Choices	The ways a given topic or actor is represented	Examine the most frequent words
	Processes of transivity	Relational, verbal, mental, behavioural, material and existential	The type of experience or event represented in the text and the connection between "the one who does something, to whom, and in what circumstances"	Examine verbal elements, their subjects and predicates
Ways of being in discourse (identification meaning)	**Metaphors** (make it possible to know something in terms of something else; highlight some aspects and mask others)	Conceptual metaphors	Whether concepts are structured in terms of others	Identify relational verbs or words that cause strangeness when immediately associated. For example: Time is money. You

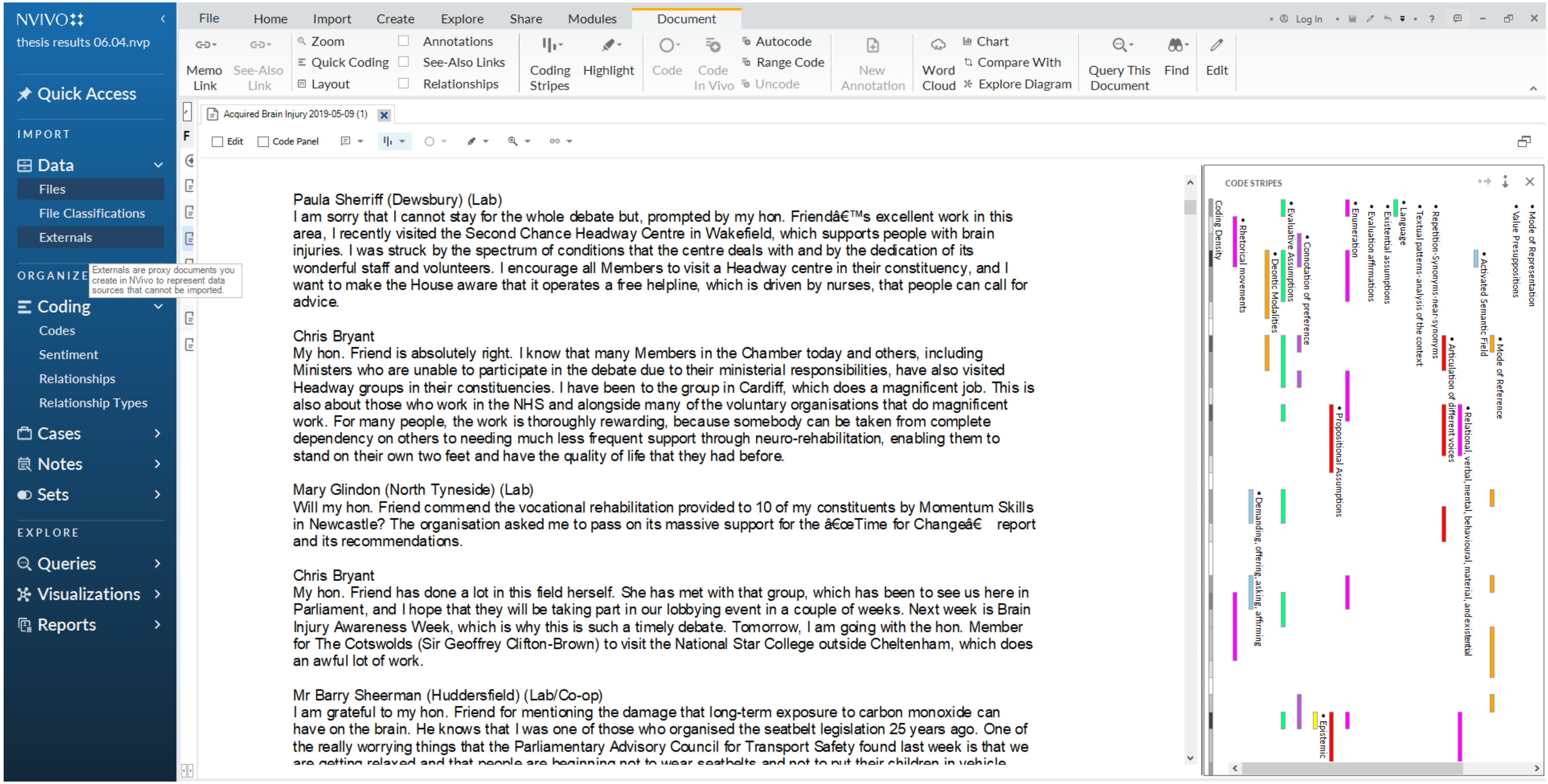
				are wasting my time.
		Orientational metaphors	Spatial-orientation representations and how they reflect physical and cultural experiences	Identify words with spatial references (up, down, etc.) For example I am feeling down
		Ontological metaphors	Strategies for the “materialisation” of experiences and abstract phenomena	For example: Nipping evil in the bud. (Evil is abstract, so it does not have a bud)
	Evaluation (reveals judgements present in the text)	Evaluation affirmations	What elements the text represents as being positive or negative, necessary or disposable	Examine adjectives, adverbs, and exclamation point usage
		Connotation of preference	The subjective marks that express affinity or approval (or the lack thereof)	Identify mental verbs related to affection (to like, to admire, to love, to detest etc.)
		Evaluative assumptions (linked to value presuppositions)	Passages where values are inserted via implicit content, which is revealed by tacit significations bearing value judgement	Identify implicit, assumed and unexpressed judgement manifested in the text
	Modality (relativizes the representation of discourses via emphasis or attenuation)	Epistemic modality (it reveals truths linked to the existential assumptions)	The level of confidence expressed concerning the genuineness of an affirmation	Examine verbs (may [be]), modal adjuncts (certainly, possibly, rarely), adverbial groups (without doubt, with frequency),

				and expressions that denote confidence (it is certain, it is possible)
		Deontic modalities (they reveal obligation) (linked to the propositional assumptions	The level of obligation or permission expressed in the text	Examine verbs (necessity) [may/should], modal adjuncts (necessarily, mandatorily, indispensably) and expressions that denotes obligation (it is necessary/ urgent)
	Presuppositions (implied text related propositions, related to shared meanings, which ward off questioning)	Existential assumptions (they assume something is true)	Elements in the text that represent something as undoubtedly true	Analyse affirmative sentences, adjective clauses
		Propositional assumptions (they assume how things are or how they may be)	Elements that represent how a phenomenon is presented or realised, assuming that as the best or even only way to understand reality	
		Value presuppositions (they differentiate good from bad)	Elements that denote judgement (positive or negative)	

Note. Produced by Lopes re & Aimeida Camo, 2019, based on Resende & Ramalho, 2009; Ramalho & Resende, 2011; Halliday & Matthiessen, 2004; Van Leeuwen, 2008.

7.4 Appendix 4

Worked examples of the NVivo coding process



Paula Sherriff (Dewsbury) (Lab)
I am sorry that I cannot stay for the whole debate but, prompted by my hon. Friendâ€™s excellent work in this area, I recently visited the Second Chance Headway Centre in Wakefield, which supports people with brain injuries. I was struck by the spectrum of conditions that the centre deals with and by the dedication of its wonderful staff and volunteers. I encourage all Members to visit a Headway centre in their constituency, and I want to make the House aware that it operates a free helpline, which is driven by nurses, that people can call for advice.

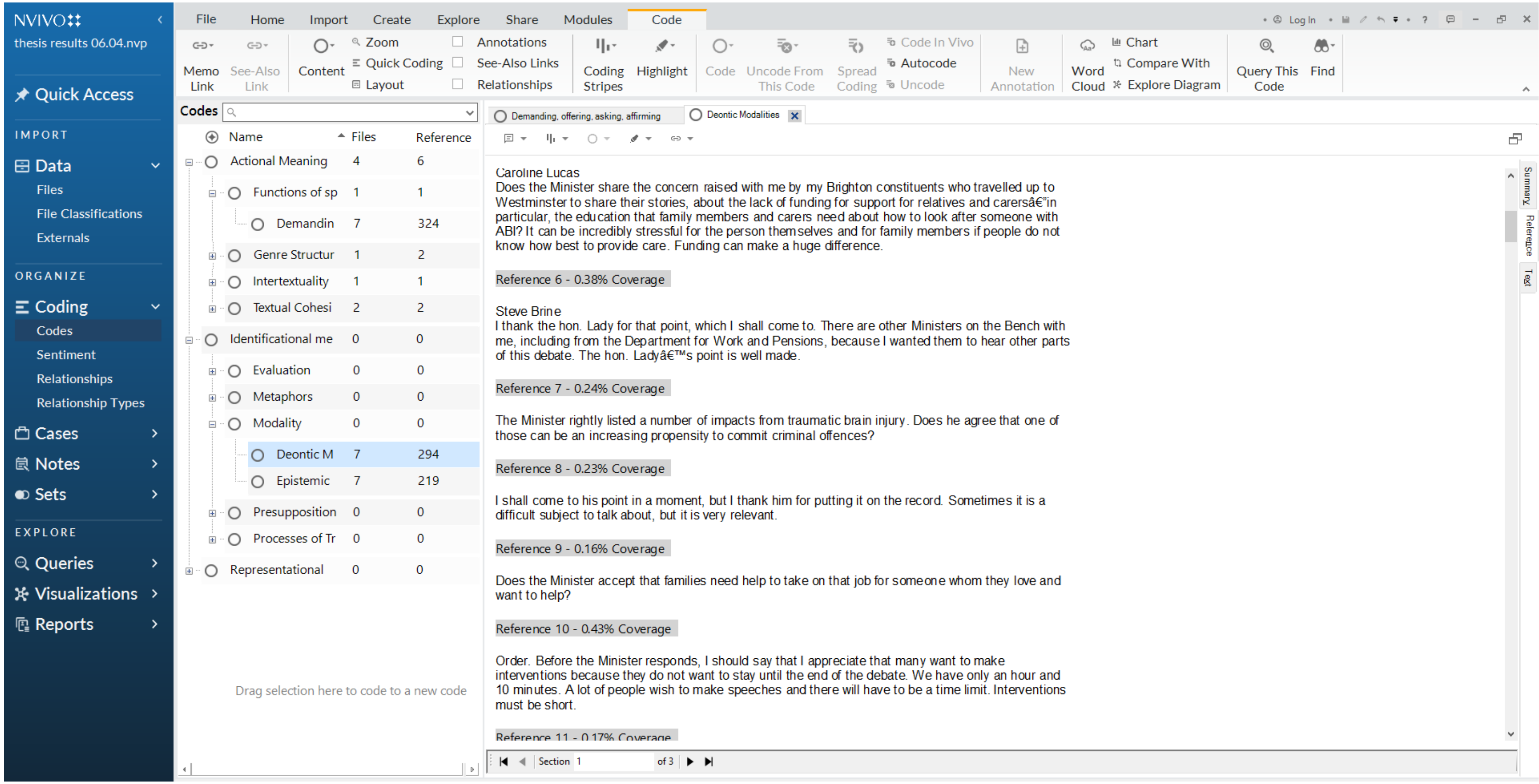
Chris Bryant
My hon. Friend is absolutely right. I know that many Members in the Chamber today and others, including Ministers who are unable to participate in the debate due to their ministerial responsibilities, have also visited Headway groups in their constituencies. I have been to the group in Cardiff, which does a magnificent job. This is also about those who work in the NHS and alongside many of the voluntary organisations that do magnificent work. For many people, the work is thoroughly rewarding, because somebody can be taken from complete dependency on others to needing much less frequent support through neuro-rehabilitation, enabling them to stand on their own two feet and have the quality of life that they had before.

Mary Glindon (North Tyneside) (Lab)
Will my hon. Friend commend the vocational rehabilitation provided to 10 of my constituents by Momentum Skills in Newcastle? The organisation asked me to pass on its massive support for the â€œTime for Changeâ€ report and its recommendations.

Chris Bryant
My hon. Friend has done a lot in this field herself. She has met with that group, which has been to see us here in Parliament, and I hope that they will be taking part in our lobbying event in a couple of weeks. Next week is Brain Injury Awareness Week, which is why this is such a timely debate. Tomorrow, I am going with the hon. Member for The Cotswolds (Sir Geoffrey Clifton-Brown) to visit the National Star College outside Cheltenham, which does an awful lot of work.

Mr Barry Sheerman (Huddersfield) (Lab/Co-op)
I am grateful to my hon. Friend for mentioning the damage that long-term exposure to carbon monoxide can have on the brain. He knows that I was one of those who organised the seatbelt legislation 25 years ago. One of the really worrying things that the Parliamentary Advisory Council for Transport Safety found last week is that we are getting relaxed and that people are beginning not to wear seatbelts and not to put their children in vehicle

List of references relating to the code ‘Deontic Modalities’.



Name	Files	Reference
Actional Meaning	4	6
Functions of sp	1	1
Demandin	7	324
Genre Structur	1	2
Intertextuality	1	1
Textual Cohesi	2	2
Identificational me	0	0
Evaluation	0	0
Metaphors	0	0
Modality	0	0
Deontic M	7	294
Epistemic	7	219
Presupposition	0	0
Processes of Tr	0	0
Representational	0	0

Caroline Lucas
Does the Minister share the concern raised with me by my Brighton constituents who travelled up to Westminster to share their stories, about the lack of funding for support for relatives and carersâ€”in particular, the education that family members and carers need about how to look after someone with ABI? It can be incredibly stressful for the person themselves and for family members if people do not know how best to provide care. Funding can make a huge difference.

Reference 6 - 0.38% Coverage

Steve Brine
I thank the hon. Lady for that point, which I shall come to. There are other Ministers on the Bench with me, including from the Department for Work and Pensions, because I wanted them to hear other parts of this debate. The hon. Ladyâ€™s point is well made.

Reference 7 - 0.24% Coverage

The Minister rightly listed a number of impacts from traumatic brain injury. Does he agree that one of those can be an increasing propensity to commit criminal offences?

Reference 8 - 0.23% Coverage

I shall come to his point in a moment, but I thank him for putting it on the record. Sometimes it is a difficult subject to talk about, but it is very relevant.

Reference 9 - 0.16% Coverage

Does the Minister accept that families need help to take on that job for someone whom they love and want to help?

Reference 10 - 0.43% Coverage

Order. Before the Minister responds, I should say that I appreciate that many want to make interventions because they do not want to stay until the end of the debate. We have only an hour and 10 minutes. A lot of people wish to make speeches and there will have to be a time limit. Interventions must be short.

Reference 11 - 0.17% Coverage