


**Developing a better way of engaging
rural people with
complex health problems**

*The Lyndon Community's
Clinical Leadership Program*

Presented at the
Outside In Conference, 6-8 May 2009

by
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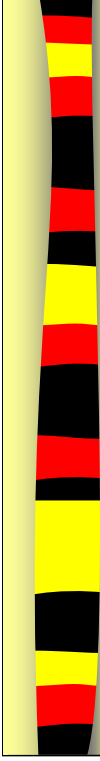


Workshop plan

- Ideally, this is about us learning from you, and you from us, to our mutual benefit. We have 60 minutes!
- First, we will tell you a little about us
- Secondly, we will look at the project philosophy and our evidence base
- Thirdly what this looks like in the field, and the progress so far
- Then, we want to discuss this approach generally and what we can all learn.

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What happened in the workshop was more a loose presentation with questions and discussion along the way. We have no solid feedback yet, but casual discussion after the workshop was positive. We believe the model we presented is quite radical, and may have given participants a fair bit to chew over - and we hope for an ongoing dialogue with at least some participants.




Underpinning beliefs

- *Whilst the determinants of health are complex, and clinical services may be just a small part of health promotion, we can all do better in our clinical work, and big changes often begin with individual change (see Syme, Brady).*
- *We believe this is a new way of doing business, although elements of this model have been used elsewhere. Effectively helping people move towards better health is a generic process, and not disease or discipline specific.*
- *We believe respectful MI approaches can inform service, personal and clinical development, and that real 'clinical leadership' involves leading both clinical services and structural & management changes.*

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Our new approach contrasts with other “clinical leadership” models which seem to constrain the clinician’s role to doing their clinical job, and being better leaders of clinical teams. Our view is that if our health service, particularly community health, needs an overhaul (and most people think so, surely) why not let the clinical service develop from the coal face, where an effective, efficient clinical encounter is the most important component and the role of management and service structure is to optimise this capacity. This model will take time to develop, however, and the current ineffective, inefficient structures are well entrenched - so we need longer funding cycles. It is also important to stress that clinical service delivery is but a small part of health overall, and the determinants of health are complex. Nevertheless, clinical services can, in the end, have a bigger impact than a strict 1:1 approach would suggest, if they can inform and push the development of better health services through a community development approach.




Underpinning beliefs 2

- *We believe that some management structures, single illness funding and treatment, and a preoccupation with process can hinder good services, and that competition between services, short funding cycles and poor outcome data ensures maximum inefficiency and poor outcomes.*
- *We wish to explore the interaction between EBP, CQI and participatory research, where the boundaries between service delivery, community development and research are blurred, and we want to document this - looking at markers such as worker satisfaction and retention, as well as health outcomes. This is difficult.*
- *Maybe we are not able to do what we hope. This needs to be documented, and at the very least, we will all learn and grow. Then others can learn, and avoid the pitfalls.*

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EBP = Evidence Base Practice (including evidence based medicine); CQI = Continuous Quality Improvement. There is good literature on merging CQI and research, and we believe adding evidence based practice principles is also needed. A CQI plus research approach can then merge into a community development approach, where the community is initially the workers and their management team, but then merges into their surrounding community, incorporating consumer and carer views and needs as part of normal business. In small towns, this could have a powerful social influence effect. But, as yet this is all just an idea - we need to collect good outcome data, and maybe it is too ambitious?



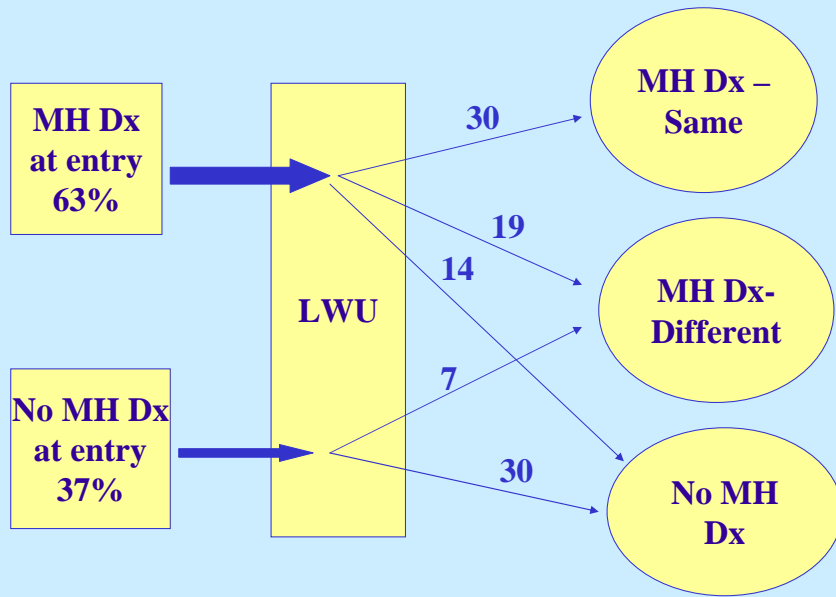
LTC and LWU - a brief history

- Lyndon Therapeutic Community (an NGO with a local Board) started in Canowindra 30 years ago, mostly utilising “traditional” 12 step values
- Lyndon Withdrawal Unit established in the grounds of Bloomfield (psych) Hospital, Orange in 1999
 - # option of 3-4 week stay added to detox program
 - # recently F/T residential staff and nurses and currently 3 Medical Officers (VMO, RMO, D&A physician),
 - # now takes medical, nursing and psychology students
 - # increasingly taking patients with MH issues but not yet clear if this helps much long term (we believe so)

This is what we have found (increasingly?) amongst people presenting to LWU:

NGO = Non Government Organisation

What happens to MH problems in LWU?





Comorbid MH and D&A

This comorbidity is the rule, not the exception

- Based upon “clinical diagnosis” - definitions are difficult but DSM IV/ICD 10 not relevant to primary care
- Many people have had significant contact with health services, for little benefit (cf Martyres)
- Inappropriate Dx, management, medication increases harm (recent increase in opioids, Seroquel, SSRIs and agitation etc)
- We see an essential role for “detox units” as helping stabilise chaos, move towards accurate Dx and Mx plans
- And we now need better specialist psych support - do existing psych services see these people? Can they be helped in 3-4 days? Does acute care inform chronic care?

NGO = Non Government Organisation



The evolution of the CLP

- Outreach clinical service patchily (BH, Bourke) for 5 years
- Increasing evidence of need for a systems approach
- Who gets the right person to the right place at the right time? Maybe the “specialist bit” is the easy part? What do other specialist services do?
- Commonwealth funding from POC 2007
- Good evidence base for engagement and empathy from both D&A and mainstream literature (Balint 1957 and ff)
- Good evidence for MI approach in ALL health care issues
- Strong demand for clinical D&A services, but most people seen have a complex mix of health and other issues
- A background of poor rural services and poor triage capacity, and this continues as the major problem

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MI = Motivational Interviewing. POC = Proceeds of Crime funding, Attorney General's Dept. The literature on the need for good engagement and the role of empathy is solid - but what do most services do with that insight? We believe our service starts immediately by acknowledging that we need to understand the life and needs of each person we work with (initially, patients but later, co workers too), and one option for them is to ignore our priorities and address their own needs. If their concerns do not involve alcohol or other drugs, can we still do some good? Yes, we believe most people come to see us because of concerns re health, theirs or someone else's, so we need to promote health - this is a generic skill. Change also tends to lead to change - so any movement on the health promotion front is worthwhile, even if it's not what the worker wanted for that session. We also need to watch changes in our workers, they are growing too, and this can be hard. We look to their strengths too, and use our clinical skills (respect, engagement, empathy) to help them move along professionally and personally. It is a full time job at first, then it tends to get a bit easier.



CLP continued

- Turf wars in rural towns, too many fly-in fly-out agencies - can good clinical D&A/MH services help change the management of all health problems to a consistent health promoting model?
- If all workers will not effectively address alcohol use - what about health? Doesn't alcohol use effect everything? Is it just our (specialist) job? Does MH just get "done" by MH workers?
- Need for qualitative (staff views) and quantitative (health outcome) data on change/progress
- Use the workers' strengths, attention to detail (each client, each worker, each manager, each community)
- Work on our own (LWU/LTC) situation, too. Are we modeling a good (efficient, effective, evidence based) service (hint: no, but we are trying and evolving too)?

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Many small towns (though not all) seem to have adequate numbers of workers, but often no coherent approach. Can we help change this? Can we evolve a health promoting approach that all workers can work with as a minimum. And will this make any difference - we need to collect the right data. We need to respect each workers strengths and weaknesses, too. And we need our organisation to become that which we wish to model and promote - a mature, open, evidence based, health promoting organisation. This is not easy, even for a smallish NGO!



Just to show where we visit, and the fact that our area is bigger than Tasmania (though our population is smaller). Each town seems to be unique in existing services and in service needs, and we need to stick to good principles whilst being flexible and adaptive.



ARM on the plane out of Menindee, with the Darling just flooding into the Menindee Lakes system in the background, Feb 2008. Clever photography by LB.



We take these as given:

- Most people prefer health to illness and we have a duty and a right to ask about common risk factors
- Health has complex determinants but simple clinical interventions can have big effects, too
- Even small towns have health workers but they are often not effective and efficient
- We do not always need a specific worker for each problem when there are generic skills that help in many problems
- An increase in chronic complex problems demands a model that helps us work efficiently. Emphasising engagement whilst avoiding harms from bad advice and inappropriate medication is a good start
- Population health, health promotion (harm reduction) and motivational interviewing give us a good model
- Management structures should optimise the capacity of clinical staff to work, be happy, be efficient

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This is all self explanatory, but we have references supporting these views if they are needed. We particularly believe that current training of health workers still focuses too much upon brief curative interventions (the magic bullet) at the expense of teaching and supporting effective approaches to chronic, complex problems, which tend to be learned in the field - or not. It is important to note that a specialist model, and the funding of specific limited services (eg a cannabis clinic, a cardiology service) may militate against the evolution of an efficient and effective chronic care service, and may reflect the need of funding bodies for clean lines of accountability whilst squandering limited resources.



What has happened so far?

At LWU:

- Slowly, a more evidence based clinical model: clinical incident review, student training, screening tools, EPC items
- All staff at the Lyndon Community have undergone training in evidence based practice (ADCA) and recently 4 days MH training
- Weekly EBP sessions - up to 20 people
- 3 medical staff inc rural Australia's 1st D&A RMO
- Partnerships with Maari Ma, Aboriginal Medical Services and the Greater Western Area Health Service
- Support and training for Aboriginal health trainees

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EPC = (Medicare) Extended Primary Care billing items. All slow and steady. Currently, our staff are being interviewed re their responses to this new approach, and that will inform our next moves. It has not been easy, and some people want to stick to the old ways, but we respect their needs whilst still trying to change ourselves.



What has happened so far 2?

Regionally:


- Monthly clinics for Marri Ma and Aboriginal Medical Services
 - with the implication that we are accepted and effective?
- Beginning of more regular outreach to support workers, support their change and confidence, set up triage system
- Gathering feedback from workers and a recognition that change is stressful, but needed
- Recently, lead agency in the Murdi Paarki D&A intervention and opportunity to expand
- Probably little impact on GPs, local or regional (except at Maari Ma, with 2 new chronic care GPs), though contacts are increasing and networks beginning

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Pretty clear - the next stage has begun even before the funding is secure because the timing is right for the other partners. We are having some discussion with GPs, but it is too early to say how this approach will effect them. We need to know if this approach promotes health, but that is a few years away, probably.



Discussion in Wilcannia - these are usually booked in before and after a clinic, so we can “value add” to the process, rather than the clinic just doing the 1:1 role. Sometimes “training” is opportunistic, too, when people discuss a pressing problem.




What does this mean?

We have learnt about what does not work:

- Just providing a clinician does little - a well informed, supported structure and a clear philosophy is needed
- Training alone does little - knowledge is not practice change
- Change is not always desired, in staff or patients
- Change is confronting - people change at different rates, and need ongoing support
- Co operation in and between services is not a given - some people love their silo - small certainties vs. big uncertainty
- “Self evident” need for practice (as in personal) change is not always evident to others
- Patient centred and MI approaches do not appeal to all - need to understand the workers assumptions and beliefs
- Many people still want D&A and MH problems to just go away

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Again, self explanatory, but covering some VERY BIG issues. In addressing these big issues, what approach other than iterative action research is likely to be effective? This approach is not always appealing to funding bodies because you cannot define ahead of time exactly what you are going to do, or to achieve. Some trust is needed. Good researcher support is essential, so the right data is gathered to inform practice change. In the end, if all workers become researchers, their practice may be better and their job satisfaction may improve. And the BIG issue - why do so many workers feel they have no role in D&A?



What does work - primary workers


NB This is based upon work in rural NSW in D&A/MH - but there are lessons for all services

- We must respect and support our workers. We cannot squander them. We do not need scores of specialist workers dropping in, we need competent generalists (AND all specialist workers always doing generic health promotion as well)
- Recognise that primary care workers, working 1:1, and with groups and communities, can begin, and help, the process of change to more healthy people and communities
- We must focus upon engagement, not setting up barriers and hurdles. This may not be in typical "health" settings. Change is a process - this includes people changing to trust us
- Engagement in an empathic, health promoting environment is a potent tool. Contrast "nothing works in amphet use" to the evidence - everything works!



What does work - specialists

- Specialist services can promote engagement, through staff education, training, support, as well 1:1 clinical work. This is community development within the service - contrast with the “cargo cult” and “crumbs from the master’s table” models
- Avoid staff induced harms - bad advice (cf Balint 1957!), rapid Dx, fobbing off, expensive and dangerous medications - and the missed opportunity to do some good
- We must respect and develop the skills of local workers. Specialist services can erode confidence and undermine local workers - then fly out. Or support ongoing change
- Most useful training occurs on the job - we must build this in to time/funding/service structures. Look at the details of each interaction, practice, system; aim for a consistent approach
- We need data that informs reflective practice, not data that meets a political or management need



What does work - systems

- Improve each aspect of work - do our structures support and encourage reflection and expertise? Or do we keep reorganising for the perfect structure, whilst the world keeps changing?
- We need evidence based policy and systems, not just practice. Systems usually resist change. How to do it?
- Integrate MH, D&A, physical health from the start. Primary care MH is not specialist MH (cf Kates, Hickie), nor is primary care D&A, diabetes etc. This causes funding stream headaches
- Integrating data collection, CQI and research - this then becomes community development. Our project seeks to lead from the front and let the management system develop to support good practice
- How to be flexible and responsive, whilst still being accountable and monitoring good health outcomes?



[l, top] Menindee from the air, [l, bottom] Wilcannia hospital, [r, top] view from the dining area, of the Darling River, and [r, bottom] ARM with Wilcannia staff.




BTW, a recent press release

The Rudd government is preparing to implement an ambitious health reform agenda including:

- more emphasis on prevention across the whole health system and the primary and ambulatory health system in particular
- enhancing the role of the primary and ambulatory health system and increasing the number of health professionals providing primary and ambulatory health care
- providing information and support to consumers to help them make better decisions re their health and health care and to manage their own care
- workforce development to improve capacity and capability in preventive health
- implementation of new service delivery models to make best use of available health professionals which will mean redesigning some roles and introducing new ones

And this is where to find us.



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