Study Leave Visit to Spinal Injuries Units in Perth and Sydney, Australia

Background to Visit:

I am part of a special interest group for psychologist's working in Spinal Injuries Units in the UK. Last Autumn our group were contacted by a similar group in Australia who requested greater liaison with British colleagues.

At the time the psychologists working in Perth were beginning to introduce goal planning meetings and working on their own form of needs assessment checklist to use with patients during rehabilitation.

It is probably worth pointing out here what goal planning is and how it is used in rehabilitation of spinal cord injured people. Goal planning and keyworking provide an individualised patient centred approach to rehabilitation, establishing clear targets and goals for each patient and assessing how effectively these goals and targets have been achieved. Keyworkers act as advocates for the patient enabling each patient to lead their own rehabilitation and reach their full potential whilst they are in hospital. Goal planning and keyworking is an approach used in a number of Spinal Injuries Units in the UK. The Oswestry service has been employing it since 1994 and had a well developed service at the time of contact from the Perth Unit.

The psychologist in Perth also had much in common with myself as we had both been in post for 8 years and it seemed the Units were about the same size (35 beds in Perth). Both Units took acute and rehabilitation patients direct from hospitals which received them following injury. The Perth Unit, like ourselves, also took patients with no neurological deficits. It seemed that we had a lot to share.

It was hoped that by visiting the Perth Unit I could assist them with the development of goal planning and keyworking and at the same time look at other aspects of the psychological service we had in common but which may have been less of a focus for me. This included working with those with chronic pain, reviewing my neuropsychological assessment service and looking at their specialist sexual counselling fertility service which was multidisciplinary. Finally it would be useful just to compare their service with ours and to look at how different disciplines operated, whether they were able to provide the same range of services or whether indeed they worked in the same way we do.

What I was able to contribute in Perth:

I was able to meet with all of the staff at the Perth Unit known as the George Bedbrooke Unit, to look at the way they worked as a team and also as individual disciplines.

Within the first two days of my ten day visit I met with the team drawn from different disciplines who were responsible for the introduction of goal planning and keyworking in their rehabilitation service (the core group).

Over the course of my stay we reviewed their pilot version of the needs assessment checklist, made comparisons with that used in Oswestry and provided them with computer software looking at how our information from the checklist was summarised and analysed.

I had videoed administrations of the checklist and a goal setting meeting with two patients from our Unit and I reviewed these with their core team. There were some discussion about the objectivity of the checklist, especially in regard to the verbal independence of patients. Following meetings with core group I set up some training events for them whilst I was there, including a keyworker training workshop. This is a framework that I have used in Oswestry to train more than 60 members of staff. I also carried out a checklist administration with one of their patients which was videoed for use in training and gave a presentation on the use of goal planning and keyworking in our unit which was also videoed. This presentation included information about how we audit our service and how patients and staff view goal planning and keyworking. I also provided written material for these presentations and training events and included my package for keyworker training. I encouraged the psychologist and her core group of workers to start their own training which I regard as an essential pre-cursor to the successful introduction of goal planning and keyworking to a rehabilitation service. I also met separately with medical staff, most notably the physician who was a Rehabilitation Specialist at the Unit, to try and encourage him to get medical colleagues to join the goal planning process so that it could be truly multidisciplinary (please see attached letter).

Through these various interventions I believe I was successful in demonstrating the benefits that we have experienced with goal planning and keyworking in Oswestry and encouraged the Perth Unit to take up this approach and use it systematically. The psychologist working with me was planning to extend the use of this system of rehabilitation to other groups in the hospital such as those with head injuries and rheumatological problems.

What I was able to gain from my experience in Perth:

I was able to attend ward meetings with five different consultants providing a service to the spinal unit and to contrast this with the Oswestry approach. I also had the opportunity to visit the occupational therapy and physiotherapy facilities and to see how spinal patients were treated there and what resources were available compared to Oswestry. I had meetings with individual staff and different disciplines to compare and contrast their practice with others. I met with the social worker, the nurse specialist who looked after the educational needs of patients and also the nurse specialist who was in charge of the training needs of staff. For example I contrasted the practice of the role of resettlement in our Unit with that achieved in Perth. The Oswestry service has a multidisciplinary team of 3 people who resettle our patients. In Perth there was no such role - the job was achieved partly by a social worker and an occupational therapist and nurses already based in the community.

The difficulties arose when patients lived outside the immediate Perth area as the service provided for the needs of the whole of Western Australia which is a very large geographical area with a sparse population outside the centre of Perth. In the remote areas it was interesting to see how services could be provided locally with no professionals perhaps being available for many miles. Due to the problems posed by distance patients requiring ongoing care were often discharged to an interim care facility in the grounds of a hospital known as the The Quad Centre which is very different from our Transhouse. I was able to attend and observe in action two multidisciplinary services which do not have a parallel in Oswestry. Firstly the sexual counselling/fertility service which included people from all disciplines and was open to all patients who were at the Unit. Secondly there was a multidisciplinary chronic pain service and I attended one of their clinic meetings and saw how chronic pain problems could be managed by the whole team approach.

From within the psychology service at the hospital but outside the service provided to the spinal unit I was able to draw on the expertise of a specialist neuropsychologist with more than 20 years experience. This will be of great assistance in my role at Oswestry in dealing with groups of patients who have had head as well as spinal injuries. I was also able to look at the way the psychology profession has developed in Australia compared to the British system. There was less professional autonomy in Australia with the psychologist being part of a rehabilitation medicine department managed by medical staff. However they were well resourced in terms of equipment and technology and had a very close liaison with the University of Western Australia whose campus was very nearby.

What benefits I can bring back to the Oswestry Service:

Helping to get a new set of people started in using keyworking and goal planning was useful in seeing what problems occur in systems when you try to create change in practice. This experience will feed back into our service and how we maintain our goal planning and keyworking, hopefully at the highest level. In Perth, in particular, it was useful to have staff 's critical evaluation of the needs assessment checklist and how this should be best administered. In Perth there was a greater general awareness among staff of the principles of research methodology and validity of measures.

The knowledge I was able to gain in working directly with the Specialist Neuropsychologist will be very valuable in my work with head injured patients at our spinal unit including access to some test materials which are not available to me in the UK.

The information I gained from the psychologist in Perth who worked routinely with chronic pain patients could also be applied to my work with spinal patients with pain problems. Of particular value was some new methods of helping patients cope with the pain sensation as well as learning about how to live with pain.

The approach of the team running the sexuality counselling service was of great interest to me and led me to decide to conduct a survey of patient satisfaction with this aspect of our service in Oswestry. Hopefully this may lead on to change and improvement in the service we offer.

Visit to the Prince Henry Hospital, Sydney:

In addition to the two weeks I spent in Perth I was also able to make a two day visit to one of the Sydney Spinal Units at the Prince Henry Hospital which is positioned overlooking the historically significant Botany Bay. The Unit there was smaller than our own, only 25 beds and only served those patients in rehabilitation, the acute patients were treated at another hospital. The Unit was part of a larger rehabilitation hospital which was being run down with possible plans to redevelop the site. The facilities in this hospital had been under threat and were in a state of flux as the service had moved sites within the hospital recently and was likely to move again. This meant the spinal unit was housed in an area of the hospital not designed to meet their needs and the physical environment left a lot to be desired, patients for example had to be bused to their therapy area.

The input from the psychology service was also significantly smaller than in Oswestry and Perth Unit. It was difficult to plan a service and its development because of the uncertainty about the future of the unit. There was really only a chance to offer a consultant referral service for individual patients and there had been no chance to influence the service at the systems level. The psychologist did not have enough input to be a fully integrated member of the team. It was helpful and also daunting to see this service and look at how it might be open to improvement. This helped me reflect on some of the positive comparisons that could be made with the Oswestry service and also some of the difficulties faced by those working in less glamorous areas of rehabilitation.

Conclusions:

It was a broadening experience to be able to compare my work practice and situation with colleagues in Australia. It was beneficial to my personal professional development to be able to offer the Perth unit the training in the use of goal planning and keyworking and to draw on my 5 years experience of using this approach in Oswestry.

It was also helpful to look at work with a colleague in similar circumstances and to be able to use her strengths in other areas such as the management of chronic pain and sexual counselling for those with spinal cord injuries. I hope this experience will improve my own practice in these areas. It was also useful to have an overview of the profession of psychology in Australia and to compare it to the development of that in the UK.

21 September 1999