Is clinical service development simply applied evidence-based medicine? A focus group study

AIMS AND METHOD

Our aim was to determine the role of evidence and other factors in specialist service development in liaison psychiatry. We held two focus groups with liaison psychiatry practitioners working in different services throughout Europe. A topic schedule focused the discussions, which were taped and transcribed. We used content analysis to identify the role of evidence and other factors that had hindered or facilitated service development.

RESULTS

Our content analysis revealed two factors relating to evidence and 25 other barriers and facilitators of service development, which were grouped into national factors and factors related to local services.

CLINICAL IMPLICATIONS

Evidence appears to have some impact on service development but many other factors are influential. Clinical service development cannot be understood simply as emerging in response to research evidence.

Method

We held two 90-min focus groups, each with seven participants. One group was formed from consultant liaison psychiatrists from six European countries, who managed clinical services and were members of the European Association of Consultation Liaison Psychiatry and Psychosomatics (EACLPP). The other group was multidisciplinary, with clinical liaison psychiatry practitioners from the Trent, Yorkshire and Northeast Liaison Network (TYNEL) in the UK. We used focus groups with a topic schedule rather than in-depth interviews, because we wanted interaction between the research participants to lead to a larger pool of factors (Kitzinger, 1994). Informed consent was obtained from all participants.

The groups were audiorecorded and transcribed verbatim. In addition, we took notes during each group. R.R. listened to all the tapes and read the transcripts several times. Themes were identified and then checked to be sure that they had emerged from the data rather than being forced on the data. The transcripts were then re-read for illustrations of the themes. At the end of this process A.H. reviewed and commented on the data analysis and a subsequent version was mailed to the participants for validation.

Results

The themes from the content analysis of the focus groups are presented in Table 1.

First, we asked specifically about the impact evidence has on service development. One group member summarised the consensus about the impact of published evidence:

‘for the question of funding and support by government the evidence is really important because this is what can persuade politicians to put money in, but on a local level it is very seldom that anything other than personal contact and perceived need is important’.

However, there was also recognition that a lack of adequate evidence may act as a barrier to service development at local and national level, with poor or absent evidence being used to prevent development. Evidence through local data collection was generally seen as important to prove demand:
We quickly realised that self harm was presenting equally over the week and managed to present a case of need on the basis of the data collected and moved to a seven day a week service.

National level

We went on to ask, if not evidence then what were the influences on service development. At national level, the policies of governments and national professional associations were seen as influential in service development. It was recognised that if the government agenda did not include liaison psychiatry development then services struggled. Some participants had examples of user-lobbying influencing developments at a national level.

“At the moment our government has put money out for an initiative for chronic fatigue syndrome and that is due to the fact there is a strong patient lobby. The lobby isn’t for consultation liaison psychiatry services.”

Service level

At service level there were three broad themes: internal factors, external factors and reputation.

| Table 1. Barriers and facilitators to liaison psychiatry service development |
|-----------------------------|------------------------|
| **Level**                  | **Broad themes**        | **Specific themes** |
| National                   | Guidelines             | National service frameworks |
|                            | National reports       | Training requirements |
|                            | National professional associations | Recognition of the specialty as important |
|                            | Government policy      | How politicians prioritise evidence |
|                            | User lobbying          | Proximity of the service to the general hospital |
|                            | Political understanding of evidence | Stability of the service in terms of structure, function and management |
|                            | Shortage of doctors    | Whether the service is managed by the general hospital trust or the mental health trust |
| Service                    | Internal factors       | The funding and resources that the service receives |
|                            | External factors       | Links (both formal and informal) to psychiatry and psychology |
|                            | Other liaison psychiatry service providers working in the same general hospital | The need of general hospital patients to receive mental health input |
|                            | Training of professionals in the general hospital to recognise mental health problems and to refer |
| Reputation factors         | Complaints and untoward incidents | Data collection and evidence of effectiveness of interventions |
|                            | Feeling ashamed at the poor quality of psychiatric service provided to the general hospital | Interpersonal relationships between members of the liaison psychiatry team and individuals in the general hospital trust |
|                            | Level of demand of mental health input from general hospital services | Promotion and marketing of the service |
|                            | Quality of service including response times, clarity of advice, being available, good communication | Significant individuals with specific skills, interests or links to general hospital departments |
|                            | Promotion and marketing of the service | Understanding and interest of general hospital staff |

Internal factors

These related to the structure of the service. For example, service development was easier when the liaison psychiatry unit was on general hospital premises, there was stability in the structure and function of the service and there were new funding opportunities. Poor staffing levels, limited local resources and lack of vision by managers of liaison psychiatry services presented barriers.

External factors

External factors such as links with other departments in the general hospital and other psychiatry and psychology departments were considered important. Formal service level agreements helped promote development.

“The head of the department has a contract that they should wherever possible cooperate with other heads of departments for patient care.”

Other providers of equivalent services can be detrimental to service development especially when they are competing for limited resources.

“For example there is a psychologist in the gynaecological oncology service looking after the carcinoma patients and in
the paediatrics department one or two psychologists looking after the patients there. Once we did a survey . . . the longer we went on the more people we discovered, working in different departments, not working together but on different projects, dialysis and all kinds of areas."

Reputation factors
These took up a lot of the discussion time in the focus groups and many participants endorsed the following comment.

'It may take people [liaison psychiatry practitioners] a long time to earn their spurs and I remember when we started in 1989 for the first six months or so we sat around doing almost nothing because they [general hospital staff] didn't have the confidence to do referrals.'

It became apparent from the discussions that marketing and promotion of the service to increase the awareness, interest and the subsequent service demand from other departments were vital but did not always work.

'At our hospital we have a large neurology service that has a vast outpatient service but we do five times as many consultations to the general hospital that doesn't have a neurology department . . . even though the epidemiological data shows there must be great need.'

Individual practitioners in the liaison service with particular skills or contacts seemed to play a crucial role in developing services and in many accounts the service would not have developed without that individual's input.

Discussion
The participants were unanimous that many things were more influential in the development of their services than clinicians' desire to implement evidence-based interventions. At a national level, evidence is incorporated in national service frameworks and government guidelines. These play a role in influencing the shape of services but there are problems; for example the UK National Service Framework for Mental Health supports 24-h access to accident and emergency based services but mentions little about wider general hospital or self-harm services — despite large variation in provision of these latter services (Department of Health, 2003). As trusts become more autonomous, service level internal factors become more important. The most influential factors, however, appear to be local external factors and the reputation of the service, suggesting that service development results from a process of negotiation and marketing that is swayed by the desires of the main stakeholders.

Nationally there is much variation in the provision of healthcare interventions and also variation in provision of whole services — especially specialist services. This inequality of provision has recently been highlighted by the National Institute for Clinical Excellence (NICE) guidance for in vitro fertilisation treatment: although it is recommended that women between 23 and 39 years should be allowed three cycles of treatment, it will take until 2005 to make even one cycle of treatment available for all (National Institute for Clinical Excellence, 2004a).

In the NICE guidelines for eating disorder services, the evidence that is available is mainly of level C quality and there is little evidence about what to do with more severe cases (National Institute for Clinical Excellence, 2004b). In situations like this it is clear that service development will be influenced by factors other than evidence, such as local politics and individual relationships and attitudes.

Our study examines pressures perceived by clinicians developing specialist services in a particular area — psychiatric provision in general hospitals — but the principle of what we have found is widely applicable. That is, a realistic appraisal of all forces impacting on service development is needed if we are to develop more rational service planning and have a clearer idea of how to make evidence fit effectively into that process.

Declaration of interest
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