Psychiatric Bulletin (2005), **29**, 259–261

original papers

RACHEL RUDDY AND ALLAN HOUSE

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 we 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.

The link between evidence and service development is poorly understood. Naylor (1995) outlined the limitations of evidence-based medicine and pointed out that in many areas of medicine there is not, and in some cases is unlikely to be, clear evidence for interventions. This means that even with the current drive to provide evidence-based guidelines in all areas of medicine, the lack of evidence will often mean that other factors must be influencing decisions about service development (Woolf *et al*, 1999).

In this study we aim to determine the factors that influence service development using the example of liaison psychiatry services. We chose this area because liaison psychiatry is a specialist service that operates in both general and mental health hospital trusts and is not a government priority area, and therefore may be representative of other small specialist services. Also, despite two College reports (Royal College of Psychiatrists & British Association of Accident and Emergency Medicine, 1996; Royal College of Physicians & Royal College of Psychiatrists, 2003) recommending standard structures for liaison psychiatry services, and government directives aimed at reducing inequality in service provision (Secretary of State for Health, 1998), little change has been observed in the past decade and there remains a wide diversity in service provision (Mayou *et al*, 1990; Howe *et al*, 2003; Ruddy & House, 2003). A recent meta-review of interventions in liaison psychiatry shows that there is little high quality systematic review evidence for effective interventions (Ruddy & House, further details available from author). This prompts questions about what factors are influential in changing service provision in liaison psychiatry.

Our overall aim was to determine the role of evidence and other factors in specialist service development in liaison psychiatry.

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 audiotaped 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:

https://doi.org/10.1192/pb.29.7.259 Published online by Cambridge University Press

original papers

Table 1. Barriers and facilitators to liaison psychiatry service development

Level	Broad themes	Specific themes
National	Guidelines	National service frameworks
	National reports	
	National professional associations	Training requirements
		Recognition of the specialty as important
	Government policy	
	User lobbying	
	Political understanding of evidence	How politicians prioritise evidence
	Shortage of doctors	
Service	Internal factors	Proximity of the service to the general hospital
		Stability of the service in terms of structure, function and management
		Staffing levels, inappropriate staffing, high staff turnover
		Whether the service is managed by the general hospital trust or the mental health trust
		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

> '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.

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

https://doi.org/10.1192/pb.29.7.259 Published online by Cambridge University Press

original papers

> 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

Priorities and Needs Research and Development funding from Leeds Mental Health Trust sponsored the study.

Acknowledgements

We thank members of TYNEL (Trent, Yorkshire and Northeast Liaison Network) and EACLPP (European Association of Consultation Liaison Psychiatry and Psychosomatics) for participating in the focus groups.

References

DEPARTMENT OF HEALTH (2003) *National Service Framework for Mental Health*. London: Department of Health.

HOWE, A., HENDRY, J. & POTOKAR, J. (2003) A survey of liaison psychiatry services in the south-west of England. *Psychiatric Bulletin*, **27**, 90–92.

KITZINGER, J. (1994) The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health and Illness*, **16**, 103–121.

MAYOU, R., ANDERSON, H., FEINMANN, C., *et al* (1990) The present state of consultation and liaison psychiatry. *Psychiatric Bulletin*, **14**, 321–325.

NAYLOR, D. C. (1995) Grey zones of clinical practice. *Lancet*, **345**, 841–842.

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (2004a) *Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders*. CG9. London: National Institute for Clinical Excellence.

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (2004b) *Fertility: Assessment and Treatment for People with Fertility Problems*. CG11. London: National Institute for Clinical Excellence.

ROYAL COLLEGE OF PHYSICIANS & ROYAL COLLEGE OF PSYCHIATRISTS (2003) *The Psychological Care of Medical Patients: A Practice Guide* (2nd edn). Council Report CR108. London: Royal College of Physicians & Royal College of Psychiatrists.

ROYAL COLLEGE OF PSYCHIATRISTS & BRITISH ASSOCIATION OF ACCIDENT AND EMERGENCY MEDICINE (1996) *Psychiatric Services to Accident and Emergency Departments*. Council Report: CR43. London: Royal College of Psychiatrists & British Association of Accident and Emergency Medicine.

RUDDY, R. A. & HOUSE, A. H. (2003) A standard liaison psychiatry service structure? A study of the liaison psychiatry services within six strategic health authorities. *Psychiatric Bulletin*, **27**, 457–460.

SECRETARY OF STATE FOR HEALTH (1998) *A First Class Service: Quality in the New NHS*. London: Stationery Office.

WOOLF, S. H., GROL, R., HUTCHINSON, A., *et al* (1999) Clinical guidelines: potential benefits, limitations, and harms of clinical guidelines. *BMJ*, **318**, 527–530.

***Rachel Ruddy** Academic Specialist Registrar and Honorary Lecturer in Psychiatry, Academic Unit of Psychiatry and Behavioural Sciences, University of Leeds, Leeds LS2 9JT, **Allan House** Professor of Liaison Psychiatry and Head of the Academic Unit of Psychiatry and Behavioural Sciences, University of Leeds

https://doi.org/10.1192/pb.29.7.259 Published online by Cambridge University Press