

# Policies, guideline implementation and practice change – how can the process be understood?

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**Politics and policy:** It is important to understand why, in the translational continuum from pilot research and randomised controlled efficacy trials to roll-out programmes and routine effectiveness studies, some service innovations are taken up by health service purchasers and providers, while others are not. Why do some innovative interventions or models of care get to the stage of implementation, while others fail to be funded?

*First published online 19 October 2016*

**Key words:** Guideline implementation, routine effectiveness studies, innovative interventions, models of care, health care system.

## Politics and policy

It is important to understand why, in the translational continuum from pilot research and randomised controlled efficacy trials to roll-out programmes and routine effectiveness studies, some service innovations are taken up by health service purchasers and providers, while others are not. Why do some innovative interventions or models of care get to the stage of implementation, while others fail to be funded?

The political and financial organisation of the health care system might be one of the most important variables in this process. The comparison of the British and German health care system may be a good case in point. The centralised organisation and funding of the British National Health Service (NHS) allows the national implementation of evidence-based treatment models and enables the government to intervene directly into processes of service provision and budgeting. These characteristics of the British health care system have facilitated and supported consistent policies in response to criticisms of the asylum and traditional psychiatric care systems with a strict dehospitalisation policy since the 1970s and the stringent implementation of a state-of-the-art community-based mental health care system. However, the centralised funding streams of the NHS make the system vulnerable to budget cutbacks in times of economic crisis. The corporative and decentralised German health care system, on the other hand, requires complicated agreements between service providers and purchasing

organisations such as health insurances not only at the national, but also at the regional level. That state of affairs often leads to the paradox situation that scientific evidence is disregarded in the process of health care reform. In the field of psychiatric care, there are many examples that evidence based psychiatric service models such as home treatment or assertive community treatment (ACT) have not been implemented in Germany although most experts agreed they would be likely to improve mental health care, while other measures such as spa-type care packages or new medications have been implemented and funded over decades without unequivocal evidence. However, the inertia of the German health care organisation also makes the system relatively immune against haphazard and volatile political interventions which may have adverse effects in times of crises. It appears obvious that both types of system have advantages and disadvantages, and it would be worth comparing health care systems with respect to the practical consequences of their characteristics on the implementation of treatment guidelines, the effects of guideline implementation and the reality of service innovation and change.

## Professions and professionalism

It is important to understand why some interventions and service models are well received among professionals, while others fail to find their interest. One important influence might be the education and socialisation of different professional groups and historically established hierarchies in the health care institutions. In Germany, not only medical education in general but also the education of psychiatrists is mainly

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hospital-based, while other important professional groups such as social workers are mainly educated and socialised in non-hospital settings. In the strong hierarchy of the German medical service system, the physician has the overall responsibility regarding the medical-psychiatric treatment process irrespective of his or her limited competencies in the field of psychosocial care. The consequences of such a disbalance between professional education systems on the one hand and professional hierarchies in the treatment process on the other hand have not been sufficiently studied so far. That balance is currently undergoing substantial change characterised by an increased weight of (clinical) management specialists and processes in the routine of health care systems.

Why are global (regional) mental health care budgets implying comprehensive community care packages (integrated with inpatient services) implemented and funded by major purchasers of public-sector health care in some parts of Germany but not in others (König *et al.* 2010)? It is likely that coincidences of human professional relationships contribute to what is implemented in the way of new health care services. In the case of Germany, there are several studies that have evaluated innovative care models. In Hamburg, an ACT-based innovative care model was implemented and evaluated by Lambert *et al.* (2010). Kästner *et al.* (2015), in a quasi-experimental controlled trial of an assertive outreach intervention for people with schizophrenia in Lower Saxony, found that GAF and BPRS values in both patient groups improved significantly, yet the increase in the intervention group receiving the assertive outreach intervention was higher, while patient-rated measures of disability and medication adherence failed to reveal differential change. No differences between assertive outreach and control patients were found in terms of hospital admission or hospital days, and the trial failed to reveal advantages of assertive outreach over usual care with regard to the utilisation of hospital care (Büchtemann *et al.* 2016). There are major health care purchasers (health insurance companies) in some German federal states such as Lower Saxony, Schleswig-Holstein and Thuringia that have shown an interest in agreeing on, funding and implementing regional global budgets for mental health care provision (often with some component of the spectrum of mental health services not included), while others such as major health insurers in Bavaria have not (Deister *et al.* 2004). Why do professionals manage to build alliances with regional authorities and purchasers (funders) of health care in some places and not in others? What is it that sustains alliances that are strong enough to change the way in which mental health care is provided? Could this be due to a combination of factors

such as: (i) personal affiliation and alliances, (ii) evidence-based medicine putting new models and 'technologies' at our disposal and (iii) long-term ethical and social policy convictions of pivotal stakeholders? Also, could such processes in Germany continue to echo the major national, empirical enquiry of mental health care published in 1975 (the *Psychiatrie-Enquête*), which provided an enduring overall service paradigm and lasting (but perhaps insufficient) momentum towards community-oriented care (Lang *et al.* 2015)?

### Guidelines and guideline implementation

From the perspective of scientific evidence, guidelines provide an orientation with regard to state-of-the-art practices in medical treatment. This might be generally appreciated by the novice doctor or nurse because it helps them deal with their lack of professional experience, while for practitioners with long professional experience treatment guidelines might be regarded as restrictions of professional freedom or at least as an element of interference in daily professional routine. Consequently, a non-committal implementation of guidelines may miss the expected effect because it will be applied 'at random' by a majority of professionals. On the other hand, a strictly mandatory guideline implementation process (Morriss, 2015) might lead to a disregard for clinical experience and to hidden resistance among experienced professionals.

It is important to understand the effects of the dissemination and implementation of guidelines by scientific bodies, professional organisations and health service providers. What effects do guideline dissemination and implementation strategies have on process and patient outcomes, i.e., on clinician behaviour and treatment outcome at the patient level? A number of papers have investigated the effects of mental health guidelines being implemented, and the results suggest that: (a) if any effects on provider performance or patient outcome are mostly moderate and temporary; (b) studies with positive outcomes used complex multifaceted strategies or specific psychological methods to implement guidelines; (c) our current knowledge about how guidelines should be implemented is sparse and inconclusive in mental health care; (d) future studies should attempt to employ more rigorous designs; (e) research on guideline implementation strategies should take into account potential barriers to knowledge translation; and (f) randomised controlled trials, controlled clinical trials and before-and-after studies comparing guideline implementation strategies *v.* usual care have not shown consistent positive effects of guideline implementation on provider performance, but a more consistent small to modest positive effect on patient outcomes (Weinmann *et al.* 2007; Giralanda

*et al.* 2013, 2016). This latter finding suggests that guideline implementation strategies may have affected aspects of clinician behaviour that were not measured in controlled trials and that effects on patient outcome may have come about through mechanisms that have hitherto escaped the attention of researchers.

One strategy may be to ask mental health professionals and service users/patients what they consider might bring about clinical change or what aspects of the care package that they provide or receive is relevant for the clinical improvements achieved. Another strategy may be to perform studies that consider the wider context of mental health care systems, and social and political science researchers may be best placed to grasp the wider changes that occur in mental health care as they can address culture and attitudinal changes that shape clinician and health care planners' behaviour. Another way of moving the field forward is described by Fischler *et al.* (2016) who developed an eight-step framework based on project management principles to implement a clinical practice guideline for schizophrenia in a specialist mental health care setting – with the guiding idea of a quality improvement process supported by multi-professional input and commitment.

In order to better understand the overall picture of a changing mental health care sector we need high-quality efficacy research using randomised controlled trials such as those so brilliantly performed in the UK on the one hand (Burns *et al.* 2013; Killaspy *et al.* 2015) because that type of research can guide us and provide the building blocks in moving forward in intervention research. However, we also need large-scale social, political and economic science studies of complex health care systems and of how they achieve reform and innovation in 'real world' settings. Landmark studies that we should refer to in our attempt of moving the field forward have studied ecological and socio-economic phenomena such as the production of public services (Ostrom *et al.* 1978, 2007). To achieve this aim, we are likely to require larger-scale empirical social, political and economic science research consortia and funding mechanisms.

In Germany, the so-called 'Innovationsfonds' (National Innovation Fund) which is currently being implemented and administered nationally by the 'Gemeinsamer Bundesausschuss' (GBA, the body deciding on what is funded in the public-sector and health-insurance-based health service) will fund large-scale service innovation (plus evaluation) and smaller-scale innovative health services research projects with a focus on the implementation and roll-out of innovative treatment strategies and service models (and spending an overall sum of 1.2 billion EUR during 2016–2019). This federal public-health-oriented

programme in Germany is a step towards large-scale translational and implementation research that deserves attention (Riedel-Heller *et al.* 2015). It is to be hoped that such activities and programmes will help the German mental health care system move to a new level of integrated health and mental health care and that the process will not strengthen centrifugal tendencies or trends towards inhomogeneity of care provision, which can be found in social insurance-based health systems. The above national health care innovation and health services-research initiative is a clear example of the international trend towards large-scale implementation research projects that aim at strengthening innovation in the health care systems of high-resource countries (Wensing *et al.* 2012).

Such pragmatic service innovation programmes should be combined with high-quality historical science research on mental health care reforms in Europe that have changed the service systems in countries such as England and Wales, Italy and Germany since the 1960s (Foot, 2015). This type of research (uniting scientists from different fields of historical science, e.g., social policy and health policy history, and different European countries) may help us understand the key concepts and ideas and wider political and cultural influences and trends that contributed to the substantial change brought about in European psychiatric care systems from the 1960s onwards. It is likely that tidal changes in professional opinion have followed wider societal trends at the time, and we are well advised to look out for paradigm change in how society views people with mental illness and how it envisages health care services, their ethics and priorities in a post-modern world. However, in doing so we should consult with historians since, as Stephen Fry put it in *the Guardian*, 'the future's in the past' (Stephen Fry, 2006).

#### Acknowledgements

None.

#### Financial support

None.

#### Conflict of interest

None.

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