

Practice-based Research Networks: Opportunities in Family Therapy?

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I would like to continue the discussion of practice-based research networks (PBRNs). I will provide more detail on what I mean by PBRNs and describe some of the features of existing networks. I will argue that research networks could be a valuable tool for family therapists. But, I also point out that the establishment of the mechanisms and culture necessary for PBRNs to function effectively takes considerable commitment from clinicians and their professional organisations. I will also remount my hobbyhorse and give a more specific account of my thoughts about the use of the internet to provide the necessary infrastructure for these networks.

PBRNs evolved originally in the field of medicine, with networks being developed in the field of general practice medicine ('family practice' in the US), over the last fifteen to 20 years. The impetus for the growth of this research model has largely been a range of criticisms of medical research which focuses on specialist tertiary care issues (Alexander & Clancy, 1994; Nutting & Green, 1994). In particular it has been pointed out that the overwhelming majority of people never receive a specialist tertiary intervention, yet most medical research emphasises tertiary level pathology and intervention. In any one month 25% of people have no illness, 50% have an illness but seek no treatment, 24% have an illness and seek usual care, and only 1% will see a specialist or receive tertiary level care (Nutting, 1996). So most research is generally of little relevance to general practitioners because it focuses on pathology and intervention, which does not reflect the reality of general practice patients or how they will be treated (Alexander & Clancy, 1994; Nutting, 1996; Nutting & Green, 1994).

The model emphasises studying health behaviour in the situations where it most often occurs. The premise is that the experience and knowledge of practising clinicians are powerful tools for identifying and framing research questions. The linkage between grass roots knowledge and research methodologies will allow the generation of information that is more immediately able to be used in everyday practice. One aim of PBRNs is to create short feedback loops between clinician-generated questions, research into these questions, and changes in practice (Alexander & Clancy, 1994).

Existing PBRNs focus on health events that reflect the usual selection of primary care populations and the research occurs where people seek care. The PBRNs provide access to information on the experience and care provided by clinicians, and focus on utilising multi-method research designs rather than allowing the method to determine the questions. Further, they involve clinicians in determining the research priorities and interpreting the results and tend to be multidisciplinary in research methods and personnel. PBRNs have been designed to encourage clinicians to develop research into issues that are of interest to them. They emphasise the need for reflective and critical clinical practice, and the network is a vehicle for stimulating, supporting and coordinating this effort. The network is seen as providing a pathway for people and ideas to come together,

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as well as a mechanism for coordinating the diverse range of activities that occur in any research project. PBRNs have been described as most suited for health service research focusing on the effects of 'real world' interventions on 'real world' clients and so evaluating the evidence for practice and the evidence base for health policy. They are also seen as important in promoting a culture of open enquiry amongst clinicians (Alexander & Clancy, 1994).

Although some PBRNs are well established in general practice in the US, the UK and Europe, this model of



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research is more the exception than the rule. This seems to be because of significant difficulties with establishing research networks as well as problems in finding appropriate formulas for funding the projects. Organisation is perhaps the most fundamental issue for the success of a network approach (Green, Hames & Nutting, 1994). PBRNs can be identified as reflecting one of three types of organisational style with somewhat different priorities. Firstly, top-down networks are usually led by professional researchers with an emphasis on the generation of high quality research. Bottom-up networks are developed and led by practitioners in the field and the emphasis is on generating research of relevance to clinical practice. Finally, whole-system networks are generated by different enthusiasts in different parts of the health care system and emphasise the use of multidisciplinary approaches to creating cultural change. In reality a PBRN will have a mix of all of these types, but any research is likely to have a dominant style or agenda which will determine the priorities and focus of the group. Thus PBRNs need a high degree of organisational coherence to enable the competing agendas of the various members to be managed. Essentially any PBRN needs very clear statements about the membership and purpose of the group, as well as clearly identified lines of authority and accountability (Thomas, Griffiths, Kai & O'Dwyer, 2001).

Very early on in the development of a PBRN, participants must have a clear understanding of the governance of the network and the ways in which stated objectives can be reached. So, a PBRN needs the same level of coherent structure as any organisation, but the membership will be from multiple existing organisations and professions. Therefore the group culture and agreed-on processes and structure will take time to mature before any research can be developed. For busy clinicians, this degree of preparation is likely to be either alienating or disempowering, since it is an activity more familiar to professional researchers, bureaucrats, or academics. As a result, existing PBRNs seem mainly to have been established by academic researchers recruiting clinicians

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into collaborations to look at ‘real world’ issues, or by professional associations identifying and promoting research as an important part of clinical practice. Generally PBRNs seem to be coordinated within University settings (van Weel, Smith & Beasley, 2000).

The success of a PBRN also requires that research be undertaken in a way that is appropriate to the stage and

mix of the group. So, in the initial stages, most PBRNs undertake small projects with achievable goals such as descriptive studies. As the network gains in experience, it can undertake more involved methodologies to answer more complex questions (van Weel et al., 2000). PBRNs have been characterised as ‘one of the most fertile areas of

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medical research’ (Nutting & Green, 1994: 335), and they allow for a satisfying synergy between clinical experience and the development of evidence for improvement in health care. This is very much a return to traditional medical research practice prior to the dominance of ‘specialisms’ (Nutting & Green, 1994). But the critical ingredient for the success of PBRNs is that clinicians have to be confident that the demands of the research methodology are compatible with, and relevant to, the demands of routine clinical practice (van Weel et al., 2000). This obviously requires a close cooperation and respect between the researchers and the clinicians. Clinicians must be directly involved in developing the study questions, defining what is meaningful to research and determining which methodology can be used in the context of their daily practice. These are very high standards to achieve and it is likely that many PBRNs will fail because of an inadequate understanding of the critical need to truly involve the clinicians in the decision-making processes.

One issue that is not very much explored in relation to PBRNs is the use of the internet and various web-based tools to manage the organisational aspects of the network. A number of web tools have been specifically developed to enable individuals within groups and organisations to function at a distance from each other and dispersed from any central or coordinating unit. Many of these tools are focused on the facilitation of collaborative work practice in the development of project plans and documents. The tools include functions such as group diaries or calendars, bulletin boards, real-time discussion forums, online meetings, document sharing and tracking, collaborative development and sharing of relational databases, and many more. These tools are often used by international multi-centre research teams to coordinate the research effort but with little application of the technology to empower grass roots development of research networking. Yet a range of very low cost options exist for this type of operation. As an example, I set up a Yahoo group just the other day —

located at http://au.groups.yahoo.com/group/ANZJFT_PBRN-forum/. If you point your browser there, you can explore the options that are available for free. I would argue that, although the tools available are very basic, they can nonetheless form the basis for a coordinated and structured PBRN. Yahoo group tools include membership management options, a multi-threaded message board, a real-time discussion facility, file sharing which would enable a basic form of document tracking and collaborative development, a basic flat file database, and a simple facility for quickly checking opinions and views from members. Obviously this type of option would not suit a completely functional research network effort — for that, true document sharing and collaborative development of complex relational databases needs to happen. But Open Source tools are available which implement these options. This means that the main part of the infrastructure of a fully functional internet-based research network can be established at no cost. The only real expense is a host for the server-based software necessary to make the whole thing run.

Clearly the internet has potential for use in the development of dispersed research communities involving networks of clinicians and other researchers. These communities could easily use the web tools available to identify common research interests, form research teams and sub-teams, plan studies, design and develop data collection databases, collect or transfer data into a central repository, and produce group-based papers and documentation. The main obstacle would seem to be familiarity and comfort with computer based tools and the difficulties in establishing hierarchies within a medium that naturally inclines to flattened structure.

All of this is very general, but I think that it has a direct relevance to family therapy, particularly as we can observe a powerful agenda for data collection and outcomes assessment in Australia at the moment. Yet very little of this actually involves the clinicians who end up collecting data and being impacted on by the changes in policy that are formulated. This research agenda is also strongly based in the reductionist methods that drive the medical model of research, which is at odds with the systemic and narrative framework of much of family therapy practice. A good foil to the existing thrust is family therapist PBRNs. The philosophy and purpose of PBRNs are very much attuned to the family therapy climate. Practice-based research invites multi-disciplinary research using methods marginalised by mainstream research, such as descriptive, qualitative, and narrative, to be included and valued. PBRNs also require clinicians to be thoughtful and reflective about their practice, which is very much a part of the standard family therapy team. The valuing of a bottom-up and system wide approach to the development of research also seems to fit within family therapy frameworks in encouraging the input of the values and philosophy of the clinicians and the possibility for including the clients as members of a research network.

But the development of PBRNs is a lengthy and relatively cumbersome process. This is a key area in which professional associations need to take leadership. Successful PBRNs have been based around professional associations, not only encouraging members to become involved in research but actively developing and supporting the establishment of research networks. This requires not only an intellectual commitment to research but a financial commitment to building the infrastructure necessary for research to happen and to the nurturing of teams of clinician researchers to form the basis of the networks. Obviously this type of commitment will be difficult for family therapy in Australia without a strong and financially stable professional association.

To some degree I am writing about this issue in ignorance of what may already be happening in family therapy in Australia and New Zealand. It would be really good to know whether family therapists are currently involved in using PBRNs. If they are, what are the teams working on and where? Also, difficulties are inherent in building and maintaining PBRNs, so it would be good to know how family therapy clinicians are finding the process. Even if no PBRNs involving family therapists have been established, it would be really good to know about the level of interest in setting them up. If PBRNs exist, do clinicians and family therapy teams out there, who are not involved in research, want to be? This is one reason that I set up the ANZJFT_PBRN-forum — Research in Practice, at the Yahoo address above. If you have something to say about this issue, if you want to tell about your PBRN, or if you want to explore with other clinicians how to establish a PBRN, then please visit the site and leave a message, complete one of the polls, develop a poll of your own, or join as a member.

Ultimately, it seems to me, successful PBRNs rely on communication, and if you can let me and other family therapists know your thoughts, there is every possibility that it will lead to the development of something bigger.

References

- Alexander, G. & Clancy, C., 1994. Practice-based Research: Laboratories for Health Care Reform, *Journal of Family Practice*, 38, 4: 428–431.
- Green, L., Hames, C. & Nutting, P., 1994. Potential of Practice-based Research Networks: Experience from ASPN, *Journal of Family Practice*, 38, 4: 400–407.
- Nutting, P., 1996. Practice-based Research Networks: Building the Infrastructure of Primary Care Research, *Journal of Family Practice*, 42, 2: 199–204.
- Nutting, P. & Green, L., 1994. Practice-based Research Networks: Reuniting Practice and Research around the Problems most of the People have most of the Time, *Journal of Family Practice*, 38, 4: 335–337.
- Thomas, P., Griffiths, F., Kai, J. & O'Dwyer, A., 2001. Networks for Research in Primary Health Care, *British Medical Journal*, 322: 588–590.
- van Weel, C., Smith, H. & Beasley, J. W., 2000. Family Practice Research Networks: Experiences from 3 Countries, *Journal of Family Practice*, 49, 10: 938–943. 