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Editorial

Capacity building in burns and mental health care

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ABSTRACT

Delivery of safe quality care in health is augmented by better research capacity building. This can include financial investment in research and system development, and, mostly notably, human capacity to undertake research. Establishing capacity to undertake research warrants attention to a range of activities to build and sustain health professions' impact on health outcomes. This editorial reflects on burns and mental health care to identify challenges for capacity building. These challenges range from resource restrictions, organisational culture and identification of enablers to assess broader health impact. Strategies to promote capacity building for practice include harmonisation of international standards, financial resourcing to build research capacity in low and middle-income countries, effectively implemented and monitored training, any involvement of multiple perspectives in design and delivery.

1. Introduction

'Capacity building' is a term that entered mainstream health rhetoric as a process by which individuals and institutions develop their skills and their abilities, with reference to skills in health research to improve health outcomes [1–3]. The term has since evolved and received numerous redefinitions and relabelling, as well as being applied to different spheres of health. Key to most definitions, however, is the emphasis on capacity building as being a long-term exercise that entails the application at multiple organisational levels [4] and an enabling environment that encourages translation of skills and knowledge into practice [5]. This knowledge translation, or knowledge mobilisation, describes the bridging of the gap that exists between research (capacity building) and practice (and presumably better health outcomes) [6] and recognises the reality that capacity building does not necessarily translate into improved outcomes without appropriate, context-specific strategies that enable a change in clinical practice [7].

The development of strategies that build knowledge and therefore the capacity to provide health outcomes are redundant without successfully translating such knowledge into clinical practice. There are numerous examples of where research has resulted in a marked change in clinical practice and better health outcomes. One need only consider fluoridation of drinking water, tobacco regulation, alcohol consumption in pregnancy, and seat belt laws. Yet, history is littered with examples of concrete scientific evidence that has not resulted in a change to clinical practice, either through lack of knowledge translation or lack of policy change to support new practice [8,9]. As an example, one Australian study found that the provision of appropriate care for 22 conditions ranged between 32–86%, indicating a large degree of clinical practice was not based on evidenced-based best practice brought about by capacity building research [10]. The need for both skills development and translation into practice highlights the inextricable link between capacity building and knowledge translation [2].

Research capacity building has become synonymous with the tertiary education sector as more health professions are linked to university education [11]. Not only is this environment well equipped to undertake research for capacity building, but it is also in a key position to teach and train emerging health professionals in new knowledge and skills through undergraduate and graduate courses, thereby aiding knowledge translation in the clinical setting [12].

Building capacity in the clinical setting is less straightforward. Despite being recognised as an important educational standard across all health professions, there is still a need to develop research-capable as well as clinically-capable graduates [13]. Although health staff 'promote health and make decisions that build on the capacity inherent in individuals and communities' (p. 28) [14], translating this into capacity building comes from the development of a research culture within the clinical setting with staff who are informed consumers of research [15].

1.1. *What does good capacity building look like?*

Knowing what capacity building should look like starts with intentional action being taken to improve outcomes for patients, deliberate attempts to marry experience-based learning with the acquisition of new learning from outside of the organisation and its current resources and capabilities [2]. This intentional action is more likely where there already exists a strong interest in that area and where opportunities are promoted [16]. Enabling individuals to act as educators in clinical settings where possible, rotating staff between areas to aid knowledge, and discussing capacity building and knowledge translating projects as part of team meetings, are but a few suggestions for capacity building in the clinical environment [2]. Knibbs et al. [17] pointed to the benefits of designing solutions drawn from clinical experience that use language that is amenable to action as a means of facilitating capacity building and knowledge translation in the clinical setting. A separate study found six themes for successful capacity building, being respectful relationships between those involved, increased knowledge and experience as key outcomes of capacity building involvement, being able to participate in all states of the research, a sense of making a genuine contribution to public health action, sustained support for research opportunities, and effective management of challenges [18].

1.2. *Key challenges to capacity building*

One study cited most challenges to capacity building as stemming from the institutional context [8], something that is further supported in the literature. To summarise, capacity building can be impeded at the individual level (skills and time), the organisational level (commitment, resources, culture) and the systemic level (policymaking, targeted solutions). Resource restrictions have been noted as a lack of time to undertake capacity building activities or implementation [11,16,19] including mentoring [20] and a lack of funding or sustained funding to undertake research [11,16,18,19,21]. It is noted, however, that increased funding has limited benefit if increased capacity building research skills are not also realised [16,22].

Challenges within the culture of an organisation or between organisations can include assimilating new research findings into existing routines [2], developing a supportive and enabling environment [4,23], barriers in communication due to language or culture [8] and competing or unsustained organisational commitments and priorities [8,21]. Organisational commitment is also found to be more limited in remote areas [19] and developing nations where a research culture and research funding are restricted [18]. Effective monitoring and evaluation, as well as developing agreement on what approaches work best [4] and developing more targeted, less ad hoc solutions [16] have also been highlighted as challenges.

This lack of big picture focus is further compounded by a reduced capacity for health professionals and researchers to gauge the importance of the policy impact, thereby losing opportunities to effectively play the political game of policymaking [8]. Finally, a tendency among health professionals to pathologise issues, to the neglect of examining wider social determinants of health [21] led capacity building away from a greater focus on structural interventions [8].

1.3. *Capacity building in burns and mental health care*

The importance of mental health considerations for critical care burns patients is crucial for on-going care, recovery and follow-up and is well established [24]. The consequence of untreated or undertreated mental health issues is more than simply a burden of disease. Mental health also has flow on effects of economic and social loss as well as physical health [25]. Well targeted capacity building and complementary knowledge translation could have the capacity to reduce mortality, shorten hospital stays, improve quality of life, enhance return to work options, minimise psychological impacts of a burns injury and provide overall improved health outcomes for this patient group.

Capacity building is increasingly acknowledged as fundamental to improving mental health services and systems of care and in particular within low and middle-income countries [22,26]. Low and middle-income nations offer a unique set of challenges, where follow up and rehabilitation options are limited, and cost can be prohibitive to patients requiring treatment [3,27,28]. These nations benefit from capacity building actions that centre less on the need for equipment, which is often unattainable, and more on knowledge creation, dissemination and innovation using locally sourced materials [29].

Higher income nations have considerably more scope for research, resources and technological advancements in this area [28]. However, research has revealed limitations to capacity building amongst developed nations too, such as understaffing, with key health professionals being employed across more than one department, which ultimately impact on functioning [30]. The mandating of optimal staffing levels achieves not only better patient care [31,32] but also creates more time for protocol development, capacity building, and coordination between key institutions and their referral networks [33].

Addressing such challenges to capacity building is found in appropriate and targeted strategies. Strategies can be grouped in three ways: adopting international standards of care; delivering and monitoring effective training programs; and use of multiple perspectives to inform research and analysis. One of the key areas identified in the literature in regards to capacity building is the need to start with internationally agreed standards [27,28]. Agreed treatment protocols allow for consistency and make transferring this knowledge to other staff and other nations much more practical [29]. Without such agreed standards, the necessary training remains problematic, as does a proper evaluation of whether approaches to burns care are working and delivering long-term improvements in care [27]. Indeed, this view is supported in the literature, with burn prevention strategies attributed to decreasing burn-related mortality and morbidity after standards for trauma management were implemented [34]. Consistent standards then lead to the establishment of more effective, specifically designed and locally owned training programs that can be more easily delivered across organisations and across countries [27,35]. Effective monitoring and evaluation of the training is also necessary to ensure continuous quality improvement and knowledge translation.

Capacity building in burns care benefits from the adoption of multiple perspectives as the involvement of consumers and their caregivers in the development of policy and planning in health care can strengthen the health care system [26]. The burn survivor can be valuable in guiding capacity building as their perspective is a unique one and critical throughout burns recovery and rehabilitation. Making the patient's voice heard opens a broader range of psychosocial outcomes post burn injury. Kool et al. [36] point out the need to emphasise the value of mental health needs that impact survivors' quality of life. While morbidity is of prime importance, the perspective of the patient must aim to incorporate the return to baseline function and long-term quality of life [37]. Therefore, capacity building is enhanced by health care providers gaining burn survivors' perspectives and ensuring that appropriate mental health services are built around their unique and challenging needs.

The literature identifies that there is the need for a clear way forward for research capacity building of clinical staff [11] and strategies for better engagement [38]. Such strategies, as identified in the Health Compass review, include formal mechanisms for collaboration, shared planning and decision-making, engagement with stakeholders, and setting goals jointly [39]. These sorts of participatory strategies have been found to offer opportunities for wider discussion, enhanced sense of empowerment by participants and more innovative solutions than that which could be achieved individually. Furthermore, participation by those designed to benefit from it, namely patients, helps create meaning and context as their experiences and values are incorporated into capacity building and knowledge translation [21].

Like burns care, mental health issues are particularly neglected in low and middle-income countries [40]. There is also the issue of 'brain drain' from developing countries as health professionals and researchers move to developed nations for enhanced opportunities [22]. This lack of capacity building activity has been further exacerbated by limited research that focuses on the issue of mental health in these developing countries, largely due to a lack of time, funding and trained staff [22]. With these disparities noted, the result internationally has been an intensification of international policy discourse on global mental health [25] and a slew of capacity building initiatives aimed at enhancing mental health interventions. These initiatives have focused very much on building capacity through financial aid (in the case of low and middle-income countries), as well as having the right people – multidisciplinary teams and stakeholders including patients – involved in the process of resource design and implementation for capacity building.

2. Conclusion

The study of capacity building and overview of strategies has pinpointed the need to ensure, where possible, that guidelines and practices are internationally standardised, as well as ensuring that multi perspectives of integral stakeholders – including health care professionals and patients – are incorporated in capacity building endeavours. The result of multiple perspectives is the production of research that better reflects the context, the end users and the location. So, while standards might best be harmonised internationally, each needs to be implemented with an understanding of the local realities, be they financial, social or something else entirely. In addition, capacity programs that are designed to meet the necessary mental health and burns care standards must emphasise the need for the training of appropriate professionals that provides adequate time spent scoping and planning. This training is also best commenced at the earliest point in the health career continuum. University programs that develop health professionals for advanced practice roles, support capacity building and empower staff for practice change and quality care will help to imbed capacity building into the health sector from the outset. From such measures will come a culture that, if aligned and mentored by health academics, should perpetuate a self-sustaining cycle of capacity building and implementation of evidence-based best practice. Research capacity building therefore requires collaborative research within, for, and by practice.

Declaration of interests

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Michelle Cleary*
College of Health and Medicine, University of Tasmania, Sydney, NSW, Australia

Sancia West
College of Health and Medicine, University of Tasmania, Sydney, NSW, Australia

Josef Haik[a,b,c]
[a]*Department of Plastic and Reconstructive Surgery, Sheba Medical Center, and Sackler Faculty of Medicine, Tel Aviv University, Israel*

[b]*College of Health and Medicine, University of Tasmania, Sydney, NSW, Australia*

[c]*University of Notre Dame, Western Australia,Australia*

Melanie Greenwood
College of Health and Medicine, University of Tasmania, Hobart, Tasmania, Australia

Therese Toohey
Rachel Kornhaber
College of Health and Medicine, University of Tasmania, Sydney, NSW, Australia

* *Corresponding author at*: School of Nursing, University of Tasmania, Lilyfield, Locked Bag 5052, Alexandria, NSW, Australia.
E-mail addresses: Michelle.Cleary@utas.edu.au (M. Cleary)
Sancia.West@utas.edu.au (S. West)
Josef.Haik@sheba.health.gov.il (J. Haik)
melanie.greenwood@utas.edu.au (M. Greenwood)
Therese.Toohey@utas.edu.au (T. Toohey)
Rachel.Kornhaber@utas.edu.au (R. Kornhaber).

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