

## COMMENTS, CRITIQUE, AND INSPIRATION

### THE MEDIUM, THE MESSAGE, AND EVIDENCE-BASED PRACTICE

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Marshal McLuhan, the media guru of the 1960s, famously observed “we shape our tools, and thereafter our tools shape us” (McLuhan, 1994, p. ix). Tools influence the way we think and behave, “we become what we behold” (McLuhan, 1994, p. 19). We extend ourselves through the tools we use but inevitably we also lose something in the process. For example, the invention of the automobile has greatly extended our mobility but it has also changed village life and led to pollution. In medicine, an over-reliance on diagnostic tests has been blamed for a loss of basic clinical skills (Bordage, 1995) and in nursing, an overextension of the scientific may lead to a diminishment of the humanistic. This paper considers McLuhan’s proposition that our tools shape us in relation to mental health care and the tools derived from evidence based practice (EBP).

### THE NATURE OF EVIDENCE BASED PRACTICE

McLuhan (1994, p. 5) proposed that “every age has its favourite model of perception and knowledge that it is inclined to prescribe for everybody and everything.” In health care the current dominant, if not entirely favoured, model is embodied in the term “evidence based practice.” It has been described as “ubiquitous” (Tanenbaum, 2005, p.163), the “mantra of the moment” (Jennings & Loan, 2001, p. 121), a “core value” (King, Lloyd, & Meehan, 2007, p. 7), and promoted as a concept that “should

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apply to all of health care” (Craig & Smyth, p. xvii). The definition derived from evidence based medicine has been extended to practice in general. Evidence based practice is widely defined as the “conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett et al., 1996, p. 71). Various definitions extend the scope of evidenced based practice to include consideration of clinical experience, resources, and patients’ preferences, but all emphasise research as the preferred basis for decision making (Jennings & Loan, 2001; McKenna, 2003).

Evidence based practice (EBP) subsumes the tools of research, information, library technology, meta-analysis, and synthesis to produce guidelines and guidance for practitioners. If EBP is a tool in itself, then it is for marketing and persuasion. To say that a practice is “evidence based implies that aforementioned tools have been applied and that a practice has been found to work. That is, it works not only under rigorous and controlled conditions (efficacy) but in the real world as well (effectiveness).

Evidence-based practice is predicated on the idea that some evidence is better than others (Tanenbaum, 2003). Randomised controlled trials are acknowledged as the gold standard, and the meta-analysis or synthesis of findings from a number of trials the pinnacle of the evidence hierarchy. Research designs with less control and replicability are generally perceived as providing weaker evidence. Expert opinion is considered the lowest level of evidence for practice and knowledge derived from trial and error, tradition, and authority is dismissed as no better than old wives’ tales (Zauszniewski & Suresky, 2004). The most useful evidence for practice will be derived from research that minimises bias, maximises generalisability, reflects characteristics of the practice setting where it is to be implemented (e.g., public mental health services), and provides evidence of effectiveness in diverse populations (Shumway & Sentell, 2004).

Staff and service users have been found to be interested in research and research findings (Cleary et al., 2006). Service users and families have also been found to be enthusiastic about programs and practices deemed to be “evidence based” (Scheyett, McCarthy, & Rausch, 2006). However, EBP is not merely a laudable interest in generating more and better research and enhancing research consumption. It has become a social movement that seeks to promote a particular style of working (Crawford, Brown, Anthony, & Hicks, 2002). It is a result of complex historical, social, and political forces (Lines, 2001). As a discourse, it promotes a particular view of knowledge and practice and furthers the interests of particular groups (Mitchell, 1999; Milton, 2007).

With varying degrees of success, proponents attempt to reconcile EBP with other discourses, such as recovery (Deane et al., 2006; Farkas, Gagne, Anthony, & Chamberlin, 2005; Torrey et al., 2005), accommodate qualitative evidence (Stickley & Phillips, 2005), and service user participation (Adams & Drake, 2006; Cook, Toprac, & Shore, 2004). Proponents claim that the spirit of EBP is not slavish adherence to guidelines and rules (McKenna, 2003). Nevertheless, mental health professionals continue to appear resistant to the evidence based package (Crawford et al., 2002; Deane et al., 2006). The reasons, in part, are assumptions about how EBP should be used as a tool and the imposition of the tools of research into the arena of practice.

## **EVIDENCE-BASED PRACTICE AS A PRACTICE TOOL**

Some mental health programmes are considered to have been researched sufficiently to warrant being called evidence based practices (e.g., collaborative psychopharmacology, assertive community treatment, family psychoeducation, supported employment, illness management and recovery skills, and integrated dual disorders treatment) (Mueser et al., 2003). According to Drake et al. (2001, p. 188), services need to adhere to specific programmatic or fidelity standards to produce good outcomes. That is, to the extent that it is possible, clinical practice should replicate the conditions of the research although this is rarely achievable (or desirable). A characteristic of evidence based practices are that they are they are standardized, replicable, and effective (Drake et al., 2001). When an intervention has been shown to be effective for a specific problem, it ought to be implemented whenever that problem is present (King, Lloyd, & Meehan, 2007). A difficulty is that real-world problems are seldom as specific and circumscribed as research problems.

The concept of EBP has generated considerable controversy that is summarised elsewhere (Beecham, 2004; Healy, 2003; Milton, 2007; Mitchell, 1999; Tanenbaum, 2005). One criticism is that clinical practice does not and should not operate the same way as research. Practice should be informed, but not dictated, by research. This is particularly so in the messy areas of public mental health services. Randomised controlled trials tend to suit interventions that can be readily manualized, and administered quickly for conditions that are easily operationalized. By their nature, public mental health services tend to involve people with complex needs, multiple problems, and uncertain diagnosis. The emphasis of gold standard research is to generate knowledge that can be

generalised about people, diseases, and treatments, whereas practice is concerned with specific individuals in particular contexts.

Good research design attempts to minimise the background noise of context. However, in mental health nursing practice this context is crucial. For example, a person who has a depressed mood may have reasonable concerns about losing a job, foreclosure on a mortgage, and an impending acrimonious divorce. In a randomised controlled trial of an antidepressant or brief intervention the only outcome likely to be considered is a rating of mood on a depression scale. Random allocation to treatment groups and a sufficient sample size will help ensure that people's personal circumstances do not confound the results. In practice, however addressing the person's specific concerns in some way will be (or ought to be) central to any help offered.

A view of the individual as a subject with a problem reducible to a pithy diagnostic label and quantified on a symptom rating scale does, of course, serve the interests of pharmaceutical companies very well. Interestingly, the effectiveness of antidepressants has been called into question in recent years, with most antidepressants being shown to be not much better than placebos in controlled trials (Kirsch et al., 2002; Parker, Anderson, & Haddad, 2003). Some have suggested that the marketing tail (of the pharmaceutical industry) has effectively wagged the dog (led the practitioner) and called for a return to medicine based evidence (Heerdink et al., 2004). However, antidepressant use is not declining. Evidence based practice is used selectively, and effectiveness and efficacy are routinely conflated to further the interests of diagnosticians and drug companies.

If the control, manipulation, and certainty of randomised trials are highly valued it is understandable that practitioners might value and import standardised questionnaires, structured interventions, or observations from research to practice. The proliferation in practice of these standardised tests, scales and so called outcomes measures inevitably has an impact on how practice and people are viewed. As Hagen (2007, p. 113) points out in relation to the famous and popular Beck's Depression Inventory (Beck et al., 1961), these scales "reflect a subtle yet important reification of an abstract concept (depression) which has largely been socially constructed, and remains quite idiosyncratic and elusive." These tools (which all reduce a person's experience to pre-determined, decontextualized categories) create an illusion of certainty and control. However, they do not make assessment or nursing practice more evidence based. The quantification of symptoms may become valued more highly than the person's own account of their problems. With overzealous use, practitioners may lose the capacity to engage

with people, appraise how they feel, ask the right questions, and sit with uncertainty.

Evidence based practice encompasses a drive to not only improve practice but to prescribe, standardize, and regulate it. This is, in part, to palliate the anxiety associated with the reality of uncertainty in practice (Franks, 2004; Lakeman, 2006). Saarni and Gylling (2004) suggest that EBP with an agenda of reducing variation and uncertainty in (medical) practice is more of a political/social movement than a scientific endeavor. There has been a proliferation of guidelines related to practice that tend to be orientated around disorder categories (see for example the National Institute for Health and Clinical Excellence in the United Kingdom [<http://www.nice.org.uk/>]). Rarely have nurses been involved in formulating such guidelines; rarer still has been any reference in the guidelines to nursing, nursing theory, or the values associated with nursing (Barker & Buchanan-Barker, 2005).

In the interests of reducing the possibility of liability and getting on in the workplace, practitioners adhere to guidelines or stick to treatments that have met the gold standard test (Franks, 2004). They also acquiesce to completing so called standardised outcome measures (Lakeman, 2004), which are, in turn, used for case mix determination (Eagar, Trauer, & Mellsop, 2005) and the funding of health services based on diagnostic groups (France, 2003). In some places only particular narrowly-defined evidenced based practices for specific diagnosis are publicly funded (Tanenbaum, 2005). Under the guise of EBP, practitioners of all kinds can be reduced to gatekeepers, data-collectors, and guideline followers, and the patient to a standardized case to be managed rather than a person to be known and engaged with.

Torrey et al. (2005) suggest that EBP can be concerned with such concepts as “recovery,” “choice,” “consumer preferences,” and “shared decision making.” Good practice might encompass all of these things, but EBP itself stresses knowledge generation and dissemination. It is good that people who use mental health services are treated respectfully and preferences for care are honoured. However, stating this is more an appeal to values, philosophy, and ethics rather than to EBP. Questions about good or right behaviour are better addressed using other tools. Lobotomy in various forms was for many years practiced on people and achieved similar results to the long-term use of conventional anti-psychotics. It lost favour not because it lacked an evidence base, but because of ethical concerns. Being evidence based does not confer goodness to a practice.

Medication for all things psychiatric is also said to be evidence based (Drake et al., 2001). Drugs tend to reduce “symptoms” of mental illness,

but some people don't see their experiences as symptoms or want them reduced. For example, the Hearing Voices Network advocates an acceptance of voice hearing and typically rejects the view that it should be viewed as a symptom of illness. Clearly values underpin the judgment that hearing voices or other symptoms of mental illness are bad or pathological. Offering people choices and informing them fully of the implications of those choices is good practice, but this is not the same as EBP. Evidence based practice is not sufficient for good practice and good practice is often more than EBP.

## WHAT THIS MEANS FOR NURSING

Evidence-based practice should not be the tail that wags the dog of nursing practice. Nursing has a long history of theorising and philosophising about care and valuing different knowledges. Yet, more often than not, EBP guidelines are bereft of any reference to theory, philosophy, or ethics. Indeed, one would be hard pressed to find any reference to nursing in guidelines, as EBP is based on conceptions of treatment based on diagnosis not care. Crowe (2006) reminds us that the focus of nursing should be on the patient's experience not on the psychiatric diagnosis. The values associated with nursing—care, compassion, and concern—need to be championed today as loudly as ever before (Barker & Buchanan-Barker, 2005). EBP will be barren indeed if the emphasis is not placed on judicious use of research and guided by good judgment, common sense, and sound values.

Just as the mobile phone has radically altered the way people relate to each other, so do the technologies and tools derived from research and embodied in the EBP movement stand to alter the way mental health care is construed and undertaken. Research into improving mental health, enhancing research consumership, and discarding practices that don't work ought to be promoted. However this does not mean that anything derived from research is necessarily good. The moment that tools no longer serve their purpose they should be discarded. Tools developed for research purposes do not necessarily serve a useful purpose in the provision of clinical practice; indeed, they may inhibit understanding and exploration.

It is reasonable to be skeptical of and resist moves to standardise practice. In undermining ritual institutional mental health practice that does not serve people's recovery, care must be taken not to replace it with other rituals that diminish the professional agency of nurses and cast them as mere tools themselves. A rejection of homogenised care is not a rejection of the fundamental tenets of EBP but an acknowledgment

that people are unique and the tools chosen to assist in or account for care need to be chosen with this in mind. Schwartz and Wiggins (2005, p. 414) reminds us that “it is critically important for clinicians to realize that practice guidelines and algorithms and evidence-based practices are all perhaps best for the ‘average patient’ but not necessarily even applicable to the person who is in front of you.”

McLuhan (1994, p. 19) proposed that the conventional response to thinking about tools, that is, ‘it is how they are used’ is “the numb stance of the technological idiot.” The tools that we choose, derived from research or otherwise, both extend and diminish ourselves. They not only help us meet our goals but shape them as well. According to Maslow (1966, p. 15) “. . . if the only tool you have is a hammer [it is tempting] to treat everything as if it were a nail.” We face a choice: Is our principal tool our own self and do we dictate our goals and purposes or are we principally instrumental to the work of others? Both stances require a consideration of the nature of social movements that effect us and a reflection on the tools we use.

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