The “Buzz” About Evidence-Based Practice in Psychiatric-Mental Health Nursing

Interest in the implementation of evidence-based practice (EBP)—considered the “gold standard” in changing practice—has continued to grow. Typically, EBP is reflected in our professional codes, standards of practice, and organizational mission, and managers/leaders, academians, researchers, and policy makers are actively promoting EBP to improve consumer outcomes and facilitate staff accountability. So what are the implications for clinical nurses, and how implementable is EBP in everyday practice?

EBP involves the integration of the current best available research evidence with clinical expertise and patient values to facilitate clinical decision making (Roe & Whyte-Marshall, 2012; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). Custom, authority, expert opinion, and ritual are no longer acceptable or defensible for clinical decision making, and there is an expectation that the latest research evidence will inform practice (Rice, 2008b). Further, the values and preferences of patients must also be taken into account. When viewed this way, EBP can be seen as a clinical strategy for problem solving, with an emphasis on identifying the best available research evidence and integrating this so that clinicians can have “confidence that they are providing the highest care to meet the needs of patients and their families” (Roe & Whyte-Marshall, 2012, p. 177).

Developing skills and expertise for searching the literature for current evidence is important, as is framing the search question. For clinical nurses, however, finding the time to appraise the evidence can be challenging, and specialist skills may be required to evaluate the evidence. Approximately 2 decades ago (1995), it was estimated that medical practitioners would need to read 17 articles per day to remain up-to-date with all the “evidence” in their specialty (Davidoff, Haynes, Sackett, & Smith, 1995), so one can only imagine how many articles practitioners need to read nowadays given the explosion of the information age. Generally, many nurses have trouble finding time to read lengthy articles and reports, irrespective of setting.

Clinical nurses may consider themselves poorly positioned to lead and manage change, especially if their setting cannot support innovations that may be costly and require additional resources (Cleary, Walter, Hunt, Clancy, & Horsfall, 2008). It is therefore unsurprising that many nurses are somewhat cynical and fatigued by discussions about EBP. It is important, however, that standards, various codes, workplace policies, and protocols are reviewed and updated regularly, and these should reflect the best available evidence.

There are a range of EBP resources for busy clinical nurses working in mental health; Rice (2008a, 2008b, 2008c, 2010, 2011) provides an informative series of articles. Organizations such as the Cochrane Collaboration (http://www.cochrane.org), or more specifically the Cochrane Schizophrenia group, provide EBP knowledge bases, as their work focuses on the preparation, publication, and maintenance of systematic reviews relevant to clinicians. The reality is that the quality of the evidence...
varies considerably, and many systematic reviews conclude with a statement about the absence of evidence to determine the effectiveness of the intervention at the time. Although many practices have been extensively researched with high-quality, randomized clinical trials—and good outcomes have been achieved in controlled conditions—the practical realities of the real world may preclude widespread implementation beyond the trial (Cleary et al., 2008). This is due to constraints such as organizational resources, workforce issues, staff education and training, and funds.

There are also many psychiatric mental health (PMH) care issues that are inadequately researched or defined, and due to ethical aspects, these topics do not lend themselves to randomized clinical trials, the gold standard for evidence. In such instances, discussion among clinicians and other relevant individuals on the recommended interventions, potential risks and benefits, and various alternatives to achieve the best outcome in relation to the EBP outcome is important (Rice, 2011). There are a range of clinical guidelines that evaluate the evidence and provide best practice for mental health (e.g., National Institute for Clinical Excellence [NICE], which provides evidence-based guidelines on a variety of topics including mental health [http://www.nice.org.uk]).

Finally, although it is encouraging to see that the evidence base for effective treatments and interventions is growing in PMH and guidelines are being developed, further work is still required. Largely, how can this evidence be implemented in real world contexts, given that much research is conducted in settings with selected samples that may not translate to everyday clinical situations at a local level (Barwick et al., 2012; Cleary et al., 2008)? The next iterative process mainly involves synthesis, contextualization, and adaptation, with the aim of moving the best available evidence into practice (MacDermid & Graham, 2009). Thus, “translational medicine” and “knowledge translation” seem to be the new buzz topics for PMH nurses.

REFERENCES

Michelle Cleary, PhD, RN
Associate Professor
School of Nursing & Midwifery
University of Western Sydney
Sydney, Australia

The author has disclosed no potential conflicts of interest, financial or otherwise.
doi:10.3928/02793695-20140127-01