VERSITA
EMERGING SCIENCE PUBLISHERS

NAD

Reply

Evidence-based practice – anything goes?

PATRIK KARLSSON & ANDERS BERGMARK

All of the commentaries on our article about the implementation of the Swedish guidelines for substance abuse treatment share disagreeing with our conclusion that the KTP campaign represents a weak way of implementing the guidelines. Unfortunately, it appears that the disagreement is not based on what we write but rather reflects how the commentators themselves look upon the task of establishing evidence-based practice in the substance abuse field. We declare that "we are mainly interested in illuminating to what extent KTP represents a reasonable implementation of the guidelines as they stand" (p. 257), and acknowledge that several components of the KTP campaign can be highly relevant for practitioners. But, since for example several subjects in the "basic course" "neither deal with guideline recommendations nor with more general considerations of EBP" (p. 257), we maintain that KTP is not a reasonable way of implementing the Swedish national guidelines.

Mikael Sandlund is unable to tell whether or not our conclusion is true or false. Instead, his impression is "that the basic course in KTP seems to be constructed to serve the needs of the caring professions. Many staff members working in treatment or nursing homes or on hospital wards in Sweden have none or only short formal education and training in treatment of substance abuse… It is therefore relevant to give basic courses…" (p. 267–268). But we find it very hard to agree with Sandlund that any type of training or education which concerns substance abuse issues, even if the audience is relatively untrained, should be regarded as relevant implementation of national guidelines.

In a similar fashion, the comments by Morten Hesse and Birgitte Thylstrup (from Denmark) are on the wrong track: they discuss the nature of actual practice instead of evaluating if the KTP campaign can be seen as appropriately implementing the Swedish national guidelines as such.

Hesse and Thylstrup argue that "local, individual as well as centralised practices, such as legislation or the development of guidelines, will therefore be fraught with compromises between standards of care and flexibility and responsivity to specific situations" (p. 273). This provides an impression of how practice is shaped. It does not address the relevance of KTP as an implementation effort.

Next in line is Espen Andreas Enoksen from Norway, characterising KTP as follows: "It is rather transcending the 'guidelines for substance abuse treatment' in facing the realities the treatment system deals with. It seems to me that KTP provides reflection, dialogue and a search for local solutions based on the local situation" (p. 270). Again, it may very well be true that KTP stimulates reflection and dialogue, but this is something quite different than implementing guidelines. To some extent,

Enoksen's enthusiasm about the kinds of contribution that KTP may provide to practitioners stands out as somewhat unfounded. Even if KTP may have contributed to reflection, we know nothing about the quality or validity of such reflections. In light of the relative lack of success of earlier attempts to reform treatment practices, it is perhaps wise to refrain from being overly hopeful.

Finally, Kaisa Seppä (from Finland) makes it very clear that her comments do not deal with the relevance of KTP as an implementation of the Swedish guidelines: "Without knowing the details of the Swedish project and its possible shortcomings, I will comment on a general level on evidence-based medicine (EBM) and evidence-based practice (EBP)…and of their implementation in treatment settings" (p. 277).

A point we stress in our article is that the two main "models" of evidence-based practice are confounded in the KTP campaign. This is seen as a minor issue by Sandlund. Seppä claims that the models "do not rule each other out" (p. 278), whereas the Danish commentators take us to task for overlooking "that the failure to choose between the two models represents real dilemmas in social work practice" (p. 273). And yet we maintain that this is rather problematic given the quite different consequences that the two models imply. The models, if their assumptions are taken seriously, point the practitioners to different routes of action.

The failure to differentiate between these models within "Knowledge to Practice" may also lead to increased uncertainty among practitioners about the whole idea of evidence-based practice. This, together with the vague and broad EBP perspective of the campaign – as is evident from the topics covered by the "Basic Course" (http://kunskaptillpraktik.skl.se) – only leads to confusing meanings of EBP. "Knowledge to Practice" indirectly tells practitioners to do two different things at the same time: "they are urged to both follow the guidelines rather strictly… and not to follow them strictly, but instead to treat them as one piece of evidence among others" (Karlsson & Bergmark 2012, 260). This puts the practitioners in a rather awkward situation.

One conclusion which can be drawn from our analysis of the KTP campaign is that, at least in this case, the concept of "evidence-based practice" is both popular and unclear. When almost anything that is done to improve practice in one way or another is called evidence-based practice, the concept risks losing its meaning and contributing to the already loose coupling between different actors in the treatment system.

REFERENCES

Karlsson, P. & Bergmark, A. (2012): Implementing guidelines for substance abuse treatment: a critical discussion of "Knowledge to Practice". Nordic Studies on Alcohol and Drugs 29 (3): 253–266.