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Evidence-based practices suffer without recovery focus

(*EDITOR'S NOTE: The following column was written by William A. Anthony, Ph.D., director of the Center for Psychiatric Rehabilitation at Boston University. It originally appeared in the newsletter* Mental Health Weekly, *a sister publication of* Behavioral Health Accreditation & Accountability Alert.)

The concept of evidence-based practice is developing rapidly. It needs to be emphasized, however, that mental health system planners' interest in incorporating evidence-based practices into their system planning efforts is occurring concurrently with the concept of recovery-oriented system planning. Unfortunately, from a recovery perspective, much of what is important to people's recovery has not been uncovered by current evidence-based practices.

Like the emperor who had no clothes, are we fooling ourselves as a field into thinking we have covered much of what is important?

Our service delivery system over most of the last century has been built on the mistaken assumption that people with severe mental illnesses do not recover, and in contrast typically deteriorate over time. Service systems and interventions have been designed to stave off this deterioration, and more recently, to maintain people in the community. As a result, much of the existing published evidence-based practice research was conceived without an understanding of the recovery vision and/or was implemented prior to the emergence of the recovery vision.

Thus, the system planning implications of current published evidence-based practice research are deficient in speaking to a system built on a recovery philosophy and mission.

For example, consumer outcomes reported as impacted in journal articles are often not the outcomes that most closely define recovery. The outcome variables often reported as positively impacted in randomized clinical trials are variations on hospital relapse, or inpatient hospitalization, or symptomatology, or becoming employed. Typically these include variables such as recidivism, length of hospital stay, days spent in the community, ratings of psychiatric symptoms or days employed.

In a recovery era these outcomes may be less important than measures that are more related to people's goals or experienced progress. Measures related to people's experience of progress (e.g., empowerment, well-being, physical health, recovery of meaningful roles) rather than relapse have become more relevant to questions of recovery. Simple counts of employment (yes or no) or hospitalization (yes or no) are an enormous conceptual distance from what might be considered to be recovery outcomes.

In addition, subjective outcomes seem to be considered as less important outcomes in current evidence-based practice research. Yet, recovery assumptions and data suggest that there is no one path to recovery, and that goals and processes that are indicative of recovery for one person may be different for another person.

Evidence-based practice research published to date has rarely found an impact on qualitative measures of outcome that may be gathered through interview and narrative. When evidence-based practices are promulgated for replication without taking subjective measures into account, possible important philosophical elements of a practice may be omitted because they are not empirically linked to the traditional outcomes reported.

For example, having people with psychiatric disabilities design and administer programs may be important because these tasks inculcate a set of program values that include self-determination and respect. These values may alter the nature of a person's experience in the program in ways that are critical to recovery and therefore may be an important component of a "best practice," but may not be picked up unless subjective measures are included.

In summary, currently published evidence-based practice research has infrequently demonstrated a positive impact on recovery-related process and

outcomes (e.g., having choices, feeling respected, positive changes in meaningful work, self-esteem, empowerment, etc.). The parade to implement evidence-based practice in recovery-oriented systems may wish to "rest in place" until the emperor is more completely dressed.

The notion of evidence-based practice and the vision of recovery-oriented services can work well together. However, if evidence-based practice research is to immediately inform our development of recovery-based services, then the concept of evidence-based practice must be broadened to include "encouraging and promising but not yet confirming" evidence-based practices.

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