Recovery: Expanding the Vision of Evidence-Based Practice

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The New Freedom Commission on Mental Health recommended that evidence-based practice and recovery be central components of mental health reform. There has been ongoing debate about the compatibility of evidence-based practice, a medical-model approach, and recovery, a consumer-centered approach. This paper will explore the two concepts and discuss the ways they can, in fact, be complementary when used as guiding principles for services research. Using recovery principles, researchers can address the limitations of evidence-based practice standards, which include relying too heavily on randomized trials, failing to establish effectiveness for diverse populations, and focusing exclusively on program structure rather than process. Including process variables, particularly consumer-provider relationships, enables researchers to study core program components, in addition to structural components, and to provide a more robust empirical basis for service effectiveness. [Brief Treatment and Crisis Intervention 4:311–321 (2004)]

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In 2002, President Bush created the New Freedom Commission on Mental Health to study the mental health service delivery system for persons with severe mental illness (SMI). A year later, the New Freedom Commission produced its report, Achieving the Promise: Transforming Mental Health Care in America (Department of Health and Human Services [DHHS], 2003), setting out a framework to reform a system that has often been fragmented and inadequate for persons with SMI living in the community. The rarity of federal commissions examining mental health care is an indication of their significance within the policy context. In 1955, a joint commission was instigated by the Senate and the House, and in 1977, President Carter authorized a mental health commission. The recent federal commission reflects the major shifts in the mental health policy arena during the last three decades. The most notable changes have been the National Institute for Mental Health’s implementation of the Community Support Program (CSP); the consumer and family movements’ growing influence in policymaking; the emergence of managed care; the Decade of the Brain’s research focus on mental illness; and the Surgeon General’s report addressing stigma.
and mental health. The report of the New Freedom Commission provides a comprehensive critique of the present system and embodies some of the most progressive and consumer-centered perspectives on mental health services for persons with SMI. As a result, the report has been widely endorsed by the stakeholder community, including the National Alliance for the Mentally Ill (NAMI), the National Mental Health Association, the National Association of State Mental Health Program Directors, and the Bazelon Center for Mental Health Law. The report identified two tasks as central to reforming the mental health system: implementing evidence-based practice (EBP) and promoting recovery for all persons with severe mental illness. Some have viewed these two concepts as antithetical: EBP represents a medical-model approach to treating mental illness, while recovery represents a consumer-centered one. This paper will demonstrate how these two approaches are congruent, and, moreover, how recovery can enhance our understanding and application of EBPs to create broad-based reform within the mental health system.

Evidence-Based Practices

Mental health services research has increased considerably in the last two decades, and as a result, much more is known about the efficacy of services and their effectiveness in the community. Given the limited resources available for mental health services, professionals and advocates argue that funds must be targeted at practices that are known to have improved outcomes. The commission endorsed this viewpoint and addressed the apparent disconnect between mental health research and services for persons with SMI. Specifically, the report addresses the lack of dissemination and implementation of EBPs in the services arena. EBPs are defined by the Institute of Medicine as “the integration of best-researched evidence and clinical expertise with patient values” (Institute of Medicine Committee on Quality of Health Care in America, 2001). Interventions that warrant the EBP label must have shown consistent scientific evidence that they demonstrate improvement in consumer outcomes. The Agency for Healthcare Research and Quality identified three levels of evidence: level A, good research-based evidence, with some expert opinion; level B, fair research-based evidence, with substantial expert opinion; and level C, minimal research-based evidence, with reliance primarily on expert opinion (Institute of Medicine Committee on Quality of Health Care in America, 2001). The American Psychiatric Association has released guidelines that are also based on a combination of expert consensus and research but has set the highest standard for research as meta-analysis of randomized clinical trials, comparing the practice to alternative practices or no intervention (American Psychiatric Association, 1997). The journal Psychiatric Services, in a series of articles on EBPs, has identified a core set of interventions that improve outcomes for persons with SMI. They include assertive community treatment (ACT), family psychoeducation, specific medications for specific conditions, supportive employment, and integrated treatment for co-occurring substance use disorders (Drake, Mueser, & Torrey, 2000).

Recovery

The commission stated that the ultimate goal for reforming the mental health system was to promote recovery for persons with SMI. This is one of the first times that federal mental health policy has adopted the language of recovery. Rosalyn Carter, a longtime mental health advocate and wife of the ex-president, summed up the most significant difference between the Bush Commission and the Carter Commission by stating that “today, we know that recovery
is possible for every person with a mental illness” (Hogan, 2003). The concept of recovery, as a shaping force in mental health care, fully emerged in the 1990s. The report defines recovery as the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual’s recovery. (DHHS, 2003, p. 5)

Recovery challenges the prevailing view among psychiatrists and the mental health establishment that mental illness is a chronic condition and that treatment focuses solely on symptom management and reduction. The commission takes a more inclusive approach by incorporating symptom management into its definition of recovery but emphasizes that for many, recovery means leading a fulfilling life despite having a disability and symptoms. Nevertheless, the recovery vision represents a significant shift away from the medical-model approach that was dominant in mental health care throughout the twentieth century. Instead, the focus of services moves beyond symptoms and pathology, to the individual, who may have very different treatment goals from those of the clinician.

Recovery, as a mental health concept, essentially arose out of two different strands of mental health advocacy and practice in the 1980s (Anthony, 1993). The first was the psychiatric rehabilitation movement, which drew on theories from physical disability rehabilitation to develop the idea of functionality with a psychiatric disability. Psychiatric rehabilitation brought attention to the fact that mental illness impacted all aspects of a person’s life, and assessing the needs of the consumer based solely on intensity of symptoms was inadequate. The discipline defined recovery in terms of a consumer’s ability to function in the major domains of life: work, housing, relationships, and recreation (Jacobson & Curtis, 2000). This approach has broadened services included in the CSP, the framework that shaped community-based services after deinstitutionalization. Psychiatric rehabilitation programs have particularly focused on the value of community and work for persons with SMI. Therefore, understanding SMI as a psychiatric disability changes how consumers and providers visualize treatment goals: they focus on moving forward while accommodating the consumer’s mental health needs.

The consumer movement was the other major influence that contributed to the concept of recovery. Consumers, who had often been viewed as passive recipients of treatment, began to speak out about the experience of being mentally ill. Influenced by the civil rights movement of the 1960s and the more consumer-centered approach of the CSP, consumers challenged the medical establishment and its portrayal of mental illness as persistent and hopeless. Deegan (2003), a psychologist and consumer, describes recovery as a deeply personal “process” that involves wrestling with the reality of mental illness but also includes finding a new sense of self and feeling of hope, while understanding the limitations of psychiatric disability. This more phenomenological approach to mental illness stresses that recovery is unique to the person; for some it may be striving for a reduction of symptoms through medication, but for others it may be overcoming the effects of poverty, stigma, and marginalization. The language of the consumer movement refocuses services away from sickness and cures, toward improving people’s lives. Jacobson and Curtis (2000) identified the following
concepts as central to recovery: hope, meaning, taking an active role, and choice. Hope involves a belief in the future and seeking to change what is possible. Meaning is intensely personal—for some it may be working at a job or craft, while for others it may be finding a spiritual center. Taking an active role involves taking responsibility for one’s recovery, and choice means being able to choose from a range of possible paths to it. Consumer-based recovery does not necessarily entail collaboration with mental health professionals. Instead, the road to recovery may lie in the support of friends, family, or community.

However, for providers who are participating in the recovery process, the approach speaks directly to the manner in which services are provided. Townsend and Glasser (2003) describe the example of the consumer who wants to be an astronaut. After having two case managers who failed to take his aspirations seriously, the consumer was assigned a case manager who suggested the consumer research what it would take to be an astronaut. On finding the amount of work involved, the consumer decided that being an astronaut was not for him, but he still had a passion for space travel. The case manager then worked with him to find a placement in a company that worked with NASA. Townsend and Glasser (2003) use this story to illustrate what they call the heart and soul of treatment, where providers enter into the dreams and aspirations of the consumers of their service. The challenge for EBP is to capture this process, which, in this case, made the difference between effective case management and ineffective case management.

Creating an Evidence Base for Recovery

The commission emphasized both concepts, EBP and recovery, but there has been considerable debate as to whether the two approaches are compatible. The question arises whether the phenomenological approach of recovery is in some ways antithetical to scientific research. Many see EBP reflecting the medical-model values of disease management and symptom reduction. Consumers argue that programs based on evidence have tended to ignore consumer feedback, especially in the area of medication and its side effects. There is no doubt that the criticisms leveled by recovery advocates point to important limitations in EBP. However, whether it indicates a fundamental disconnect between the recovery approach and positivist science or just the differences between methodologies within services research is less clear. Instead, these criticisms should help us reconsider how EBP measures improvement and, as a result, which programs are identified for broad implementation. Outcome measures in mental health services research have often reflected the parameters of symptom management, such as relapse, recidivism, length of hospitalization, symptomatology, and number of days employed (Draine, 1997; Ralph, Lambert, & Kidder, 2002). None of these measures give one a sense of the consumer’s quality of life, empowerment, sense of hope, or connection and functioning within the community, which is vital information for evaluating a program from a recovery perspective. There has been empirical research supporting the recovery perspective that has relied more upon qualitative methods and used a broader range of outcome measures to reflect consumer-centered goals. Qualitative studies often give unique insight into the change process and the specific ingredients that bring about change both from the provider and consumer perspectives (Anthony, Rogers, & Farkas, 2003). Although the language of recovery is often at its most powerful in the personal narratives of persons with SMI, recovery advocates have strengthened their message by drawing on empirical studies.
The Well-Being Project (Campbell & Schraiber, 1989) was one of the first large-scale studies to examine what factors promote recovery in the community from a consumer perspective. The study surveyed 331 consumers and found that almost 60% were able to identify an escalation of symptoms and take steps to avert a serious episode. Over half chose strategies that did not involve mental health professionals, such as seeking out friends or using relaxation techniques. A longitudinal study in Vermont followed 262 patients who had been hospitalized for 6 years, then released into the community with supports after they completed a rehabilitation program. The study, which recontacted consumers after 32 years, found that 34% of the participants with schizophrenia made a full recovery in terms of their symptoms and their social functioning (Harding, Brooks, Asloga, & Breier, 1987). Studies on schizophrenia by the World Health Organization conducted in the 1970s and 1980s found that outcomes were better for patients in countries where they received little or no formal psychiatric care (De Girolamo, 1996). Davidson and Strauss (1992) conducted intensive interviews with 66 persons hospitalized for SMI over a period of 3 years. The interviews showed how recovery came out of taking an active role in change, understanding one’s capabilities in respect to change, and using this sense of self as a resource to address stigma. Anthony and colleagues (2003a) argue that this research has marked a paradigm shift toward positive outcomes and is comparable to the increased focus on resilience within psychology. And within EBP, there has now been a move toward being more inclusive of community integration outcome measures such as quality of life, illness self-management, and housing (Drake et al., 2001).

The standards of evidence required for EBP can be problematic when applied to recovery-oriented services. Randomized clinical trials, widely considered to be the highest level of evidence, are often not feasible or possible for practices that promote recovery—part of the reason being that these services are relatively new in their implementation and have not yet been subject to more rigorous studies. In response, the commission identified emerging best practices, which are defined as “treatments and services that are promising but less thoroughly documented than evidence-based practices” (p. 68). These include consumer-operated services, wraparound services, jail diversion and community reentry programs, and multifamily group therapies. Anthony (2003a) points out that much of the basis for psychiatric rehabilitation practice has come from research employing correlational and quasi-experimental designs. Furthermore, findings from controlled studies that do not replicate clinical settings are often limited in establishing effectiveness, in comparison with findings from quasi-experimental studies in clinical settings. In applying model treatments within child mental health services, Mckay (in press) found that real-world issues (such as the diverse needs of children and limitations in provider skills) that jeopardized outcomes had not been included in the experimental setting. She argues that these real-world issues must be addressed when developing innovative treatments (Mckay, in press). In addition, randomization is not always the optimal research design. In the case of consumer-provided services, the consumer’s commitment to receiving such services plays an important role in determining the service outcome. Consumers randomly assigned to these services, who would not have chosen consumer-provided services, tend to have high dropout rates. Corrigan and Salzer (2003) promote the use of preference as an important design component in researching treatment effectiveness. The issue of preference is an essential consideration for consumer-provided services. Solomon (2004)
concludes that “the level of evidence [for consumer-provided services] is limited by virtue of a lack of research and by not very rigorous research due to this methodology being antithetical to this service element” (p. 21). Therefore, when considering how empirical studies support recovery-oriented services, applying certain types and levels of scientific evidence is not always appropriate.

The Importance of Process

As the Townsend and Glasser (2003) story illustrates, recovery’s heart and soul is located in the process of change and healing, which cannot be reduced to the structural components of services or their outcomes. These social and psychological factors tend to go unstudied, and as a result contribute to the “error variance” in clinical effectiveness research (Hohmann, 1999). ACT (assertive community treatment), an EBP, has been studied extensively and manualized to ensure that the program is replicated successfully. But the manuals give no guidance in terms of process, or how the providers actually interact with the consumers in the ACT service environment. Anthony (2003b) argues that process factors may actually determine outcomes more than the structure of services. How providers relate to consumers, whether they treat them with respect and care, is key to promoting recovery for the consumer. Whereas in clinical and counseling psychology, great emphasis has been placed on the power of the relationship in determining service outcomes, community mental health continues to focus more on service models and techniques (Anthony, 2003a). Psychotherapy research has directly studied clinical relationships and nonspecific effects, or factors that contribute to change but are not considered to be the critical ingredients of the intervention (Kazdin, 2002). The nonspecific effects of interventions such as ACT may well be generated by the quality of the consumer/provider relationships.

A vital part in building successful clinical relationships is the provider’s ability to communicate and connect with a diversity of consumers. The literature suggests that taking account of cultural differences is not an EBP itself but should be a key component in determining whether any practice can be deemed to be evidence based (Carpinello, Rosenberg, Stone, Schwager, & Felton, 2002; Goldman et al., 2001). The commission (DHHS, 2003) states that cultural competence is “essential to ensure . . . renewed hope for recovery among ethnic and racial minorities.” However, EBPs have often failed to establish the effectiveness of interventions for racial, ethnic, and cultural minorities. The majority of research that has been used to establish EBPs has not included adequate numbers of racial or ethnic minorities to allow for evaluation of differential impacts on specific groups (DHHS, 1999; Drake et al., 2001). Therefore, by focusing on process within EBP, research can examine consumer/provider relationships and the factors—including cultural difference—that influence them.

Another important insight for EBP has arisen out of the tension between recovery and symptom management approaches. Psychiatrists have responded to criticisms from recovery advocates by suggesting that focusing on issues of self and empowerment are worthless when a person’s illness is such that she is subject to acute psychotic symptoms (Peyser, 2001). What this exchange has highlighted for researchers is the importance of stage of recovery in determining service effectiveness. Frese, Stanley, Kress, and Vogel-Scibilia (2001) point out that advocates on both sides tend to represent consumers at a diversity of stages of illness, and therefore have very different agendas. The consumer perspective has often been articulated by consumers well into their recovery. These consumers are also responding
to many decades of abuse and silencing and are therefore reluctant to cede decision-making power about services to the scientific community. In contrast, the NAMI (2003), which tends to represent family members with severely disabled relatives, has argued that mental illness is a brain disorder and has advocated for EBPs, specifically endorsing ACT, supported employment, and illness self-management. While agreeing that a medical approach, which communicates “biology as destiny,” is countertherapeutic for consumers, Frese and his colleagues (2001) argue that persons who are very disabled by illness may benefit from evidence-based psychiatric interventions. However, as the person improves and symptoms decrease, then consumers should have more control over their treatments, and services should address a broad range of their concerns, from housing to social supports. In focusing on degree of disability, these researchers are attempting to integrate the two perspectives into a continuum of care for persons with SMI. Again, recovery can inform EBP, demonstrating that interventions are more effective when they are tailored to the consumer’s recovery stage.

Implications for Mental Health Systems

The implementation of EBPs and recovery-oriented services requires profound change at the system level. Despite the progress made in services research to establish EBPs, clinical interventions still tend to rely heavily upon tradition, clinician preference, practice wisdom, and marketing practices (Drake et al., 2001). The Institute of Medicine report stated that there was on average a 15- to 20-year delay between research findings on effectiveness and their translation to routine clinical practice (Institute of Medicine Committee on Quality of Health Care in America, 2001). The findings of the Schizophrenia Patient Outcomes Research Team in its PORT study found that usual practice conforms to EBP less than 50% of the time in the area of psychopharmacology, and less than 10% in the area of psychosocial interventions (Lehman & Steinwachs, 1998). The issue remains why there is such a lag between research findings and practice. Many have pointed out the numerous intervening factors operating on the system level that determine services other than research findings; these include financing, policy, laws, and cultural norms (Goldman et al., 2001; Hogan, 2003; Minkoff & Cline, 2003). It is naïve to think that facilitating communications between researchers and clinicians about EBPs, which often require restructuring services, is sufficient to bring about change. The missing piece, therefore, in linking science and service, is the systems intervention necessary to ensure the implementation of EBPs. Minkoff and Cline (2003) argue that implementation should focus specifically on systems management such as strategic planning, management science, and quality improvement.

The commission identifies fragmentation of the U.S. community mental health system as a major barrier to systems intervention and ultimately mental health reform. EBPs such as ACT and supported employment provide services that cut across traditionally separate service domains, such as vocational rehabilitation, housing, and mental health. Recovery requires that services reflect and support the consumer as an individual. A system that has traditionally divided itself according to the different needs of persons with SMI, mental health, financial assistance, housing, and physical health is seriously challenged by a demand to treat consumers holistically. Some of the demands for a recovery-oriented system speak directly to the care provided by mental health professionals, but much of it addresses larger issues of how social service systems are structured in the United States. After deinstitutionalization, the CSP laid out a network of
essential services to support persons with SMI in community, but these services emphasized minimizing symptoms and their consequences. Anthony (1993), in setting out standards for a recovery-oriented service system, stresses the importance of keeping consistent consumer outcomes across all services, which reinforces the idea of individual needs defining services.

The fragmentation of the mental health system from a recovery perspective is evidence of a system that does not reflect how mental illness and recovery involve all aspects of people's lives, or more simply expressed, does not reflect their humanity. Although research into the direct impact of fragmentation on client outcomes is hard to establish, there is no doubt that lack of coordination and inappropriate or inadequate services have a deleterious effect on quality (Anthony, 2000). Recovery is pushing systems, as well as providers, to see beyond the diagnostic and categorical services, to treating the individual consumer and his/her multiple needs. The vision of Anthony and other recovery advocates is of an external system that reflects the internal reality of its consumers (Jacobson & Greenley, 2001). However, efforts at integrating service systems without focusing on content and quality of services have not always improved outcomes at the consumer level. The Robert Wood Johnson ACCESS program provided technical assistance and funding to nine sites to implement mental health systems integration strategies. Again, although system integration was increased, the study found no additional improvement for consumer outcomes benefiting from systems integration and technical support when compared with the control group (Rosenheck et al., 2002). Similarly, an $80 million project was implemented in Fort Bragg, North Carolina, to test the effectiveness of a more continuous care system for children with mental health and substance abuse disorders. The study found no difference between the demonstration and comparison sites in terms of clinical outcomes (Bickman, 1996). Systems integration, therefore, appears to be a necessary condition for improving services for persons with SMI, but not a sufficient condition. The implementation of EBPs has reinforced the need for systems integration, but recovery reminds us that the content and quality of service delivery is also a vital part in improving service outcomes for consumers.

Several states have taken the initiative in applying the recovery approach within their mental health systems. The efforts have ranged from including the concept of recovery in their mission statements to trying to shape all their services according to recovery principles. In 1993, the Ohio Department of Mental Health (ODMH) began a series of dialogues with providers, consumers, and family members to explore the mental health recovery process. The subsequent report identified four stages, ranging from unaware/dependent to aware/independent (Hodge, Townsend, Hyde, & Hogan, 2003). The stages provided a framework for implementing recovery practices, which included clinical care, peer and family support, facilitation of employment, empowerment, stigma reduction, community involvement, access to resources, and education (Jacobson & Greenley, 2001). The ODMH then reinforced this process by offering grants to localities in order to establish comprehensive recovery centers, which offer peer support, assistance to case managers, education, and social and recreational activities. Grants were also given to agencies that adopted the recovery management plan, which allows consumers to develop their recovery process in collaboration with the provider. The Ohio recovery model is an example of tailoring a recovery vision to the specific needs of consumers and implementing change through financial incentives.

Recovery and EBP have to be compatible with existing funding systems to be successfully
implemented. Managed care, with its demand for accountability, is clearly a major impetus for EBP, and as a result, there is growing pressure on providers to measure their services, in terms of both quality and outcomes (Dziegielewski & Roberts, 2004). Some have argued that there is also the potential for increased continuity of care with managed Medicaid funds (Mechanic, 2003), providing opportunities for recovery-oriented systems integration. States, including California, Massachusetts, New York, and Washington, have actually written recovery principles into their contracts with managed care organizations (Jacobson & Curtis, 2000). These principles require that organizations contract with providers who pursue recovery-oriented services, including consumer-operated services, and that consumers have an advisory role on managed care organization boards.

The support of key policymakers has been vital to bringing the recovery approach into the mainstream. The National Association of State Mental Health Program Directors in the late 1990s took on recovery-oriented mental health care as one of its major policy priorities. With funding from the Substance Abuse and Mental Health Services Administration, it established the National Technical Assistance Center, whose mission includes “fostering consumer recovery and independence through consumer-centered services” (National Association of State Mental Health Program Directors, 2003). Through conferences, meetings, and publications, the center promotes networking and information exchange about how to create recovery-oriented systems. The center has also initiated a research project to develop a set of performance indicators related to recovery. With the collaboration of several state mental health agencies, the project seeks to “devis[e] a core set of systems-level indicators that measure critical elements and processes of a recovery-facilitating environment” and integrate them into a multistate report card to assess mental health systems (Onken, Dumont, Ridgeway, Dornan, & Ralph, 2002). Probably the most significant aspect of the work that has been done to implement recovery-oriented systems is that it has always begun by asking consumers what they need from the mental health system. The recovery approach not only determines the end goal of mental health reform, but also shapes the process.

**Conclusion**

The significance of the New Freedom Commission on Mental Health is still being debated among policy analysts. Both of the previous commissions were precursors to important mental health legislation, but the fact that President Bush required that the commission be “budget neutral” in its recommendations indicates to some that the report is powerless to bring about real change. Probably the most important aspect of the commission is the government’s acknowledgement of the need to simultaneously implement EBP and recovery in order to reform the mental health system. The simultaneous endorsement of these two concepts, previously seen as antithetical, allows for a new way of thinking about how research can inform services. EBP has systematically defined the structure of effective services, but recovery gives us insight into their core, where real change is effected. Recovery advocates have challenged researchers to incorporate a more consumer-centered approach to empirical study. This approach includes expanding the aspects of services chosen for study, methodologies, outcomes measures, and standards of evidence. Recovery requires research on a micro, mezzo, and macro level to determine the system, organization, program structure, and elements that are both necessary and sufficient to activate and sustain the recovery process.
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