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EXPANDING THE EVIDENCE BASE IN AN ERA OF RECOVERY

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Prior to this decade's focus on evidence based practices, the last decade of the twentieth century witnessed the acceptance of the notion that people with severe mental illnesses could be integrated into and function within the natural community, rather than just the mental health community. Furthermore, recovery from severe mental illnesses was seen as a legitimate vision to guide mental health practice and policy. The vision of recovery from severe mental illnesses was brought to the field by the writings of current and former service recipients, and solidified by the long term research conducted and synthesized by Courtenay Harding and her colleagues. While many definitions of recovery have been suggested, the various definitions are somewhat similar in that they imply the development of new meaning and purpose in life as people grow beyond the catastrophe of severe mental illnesses.

A number of key principles are inherent in the recovery vision. One of the most fundamental recovery principles is the principle of "people first," i.e., people with mental illnesses are people before they are cases, diagnoses, or patients. They are not, as the mental health field has mistakenly emphasized, primarily defined and governed by their symptoms and their diagnoses. Rather, the principle of "people first" assumes that

people with severe mental illnesses primarily direct their own lives like their non-diagnosed brethren. That is, they are influenced by their relationships with others, their own goals, their hopes, dreams, and interests.

While at first blush this people first principle may look benign and straightforward, the adoption of this principle has major implications for how the field of evidence based practices will develop. By incorporating this principle of "people first" into the field of severe mental illnesses, the knowledge base of what constitutes evidence will be expanded dramatically. Behavioral sciences research on the processes that bring about positive changes in all types of people (most of whom typically do not have severe mental illnesses) are now relevant to the evidence based practice initiative in the mental health field.

In this decade the evidence based practice initiative has designated certain practices as evidence based practices (e.g., supported employment, intensive case management) due to their ability to generate positive outcomes in randomized trials. These evidence based practices are described mostly by their program structures (staffing, case load size, etc.). Unfortunately, the evidence based practice initiative has overlooked in

these program descriptions the ingredients of the helping process that occur within each practice and which behavioral sciences research has shown to be related to how people change and grow (relationship variables, skill teaching strategies, hope engendering techniques). I argue that the evidence based practice initiative must be broadened to incorporate these empirically derived helping processes that are fundamental to people's growth and change, and which may underlie most evidence based program structures.

By definition, evidence based practice integrates "...individual clinical expertise with the best available external clinical evidence from systematic research...By best available external clinical evidence we mean clinically relevant research..." (Sackett, 1996, p. 71). With respect to the field of severe mental illnesses, "clinically relevant research" has often been confined to studies in the mental health services research arena. Yet the research literature on how people change and grow, not just people with severe mental illnesses but all types of people, is what is relevant under a "people first" principle. The behavioral science literature, supported at times by mental health services research has identified certain human interactive processes that help people change and grow. These processes include:

- People experiencing a positive relationship with the people providing help;
- People setting their own goals;
- People being taught new skills;
- People encouraged to have positive expectancies and hope for change;
- People developing self awareness about aspects of their own behavior.

I believe that any evidence based practice should incorporate any and all of these evidence based processes into their program structure. Without compromising fidelity to the program model, evidence based practices can promote a positive relationship between providers and recipients, help people set their own goals, teach skills, engender hope for change and promote self awareness. It is these evidence based processes that cut across program labels and which all types of research suggest can add outcome variance to the evidence based practice.

Sackett, D. L. Rosenberg, W. M. C., Muir Gray, J. A., Haynes, R. B. & Richardson, W. S. Evidence based medicine: What it is and what it isn't. (1996) *BMJ*, 312, 71-72