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Oil and Water or Oil and Vinegar? Evidence-Based Medicine Meets Recovery

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Abstract With the increasing prominence of the notions of "recovery" and "recovery-oriented practice," practitioners, program managers, and system leaders are increasingly asking about the relationship between "evidence-based practices" and recovery. After reviewing the concepts of recovery from mental illness, being in recovery with a mental illness, recovery-oriented care, and evidence-based medicine, the authors argue for a complementary relationship between recovery and evidence-based practices. This relationship is neither simple nor straightforward, but results in a whole that is greater than the sum of its parts through which each element benefits from the influence of the other.

Keywords Evidence-based medicine · Evidence-based practice · Recovery · Self-determination · Choice

With the increasing prominence of the notions of "recovery" and "recovery-oriented practice," practitioners, program managers, and system leaders are increasingly asking about the relationship between "evidence-based practices" and recovery. It seems to some that just as they were beginning to get used to the notion of evidence-based practices in mental health, they began to be pressured to make the services they provide recovery-oriented as well. This has naturally led to such questions as: "Is recovery evidence-based?" or "What is the evidence for recovery-oriented practice?" At the other end of the spectrum, some mental health consumer advocates view the emphasis on evidence-based practices to place a further restriction on their ability to exercise choice in their care. They also are suspicious of scientific claims to offer a privileged access to truth, arguing instead for relying on first-hand experiences as at least an equally valid source of information about the utility of psychiatric interventions.

This article attempts to address these issues by examining several possible relationships that may exist between the emphasis on evidence-based practice and the introduction of the notion of recovery into mental health care. We use as a metaphor for this examination the relationship suggested by a colleague, who asked one of us if the relationship between recovery and evidence-based practice was like that between oil and water; in other words, a relationship between fundamentally different substances or concepts that cannot be blended or integrated. As we responded to him, and as we will argue in the following, we view the relationship between evidence-based practices and recovery to be more like the relationship between oil and vinegar than that between oil and water. Whether raspberry or balsamic-flavored, we believe the two taken together can produce a tasty vinaigrette, dynamically generating a whole that is greater than the sum of its parts.

In order to build this case, we first review briefly the core aspects of recovery and recovery-oriented practice as they have emerged in mental health and then describe some of the key principles of evidence-based medicine. We

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acknowledge that both of these developments have been prominent primarily in English-speaking countries over the last decade, but hope that some of the lessons that we have been learning might also be relevant to other countries into which these concepts are just beginning to be introduced. Following these reviews, we consider several possible relationships between the two concepts, which we conceptualize as follows: (1) the role of evidence within the context of shared decision-making processes; (2) the recovery paradigm as shifting the standard of what are considered to be desirable and meaningful outcomes (i.e., what constitutes "evidence"); and (3) the need to gather evidence on the efficacy of certain newly emerging, recovery-oriented practices. Exploring each of these possibilities will demonstrate how the relationship between recovery and evidence-based practices is far from simple or straightforward, suggesting a more thoughtful approach in which each can inform the work of the other.

Recovery and Recovery-Oriented Practice in Mental Health Care

We focus this brief review on the following three concepts: recovery from serious mental illness, being "in recovery" with a serious mental illness, and recovery-oriented practice. It first is necessary to clarify the differences between the first two concepts—recovering from and being in recovery in relation to a serious mental illness—as it has been our impression that a good deal of the confusion surrounding recent uses of the term recovery in mental health has been due to a confusion between these two distinct concepts. For the purposes of this discussion, we suggest taking the phrase "recovery from" serious mental illness to refer to eradication of the symptoms and amelioration of the deficits caused by the illness. This sense of recovery has been the traditional focus of treatment effectiveness and longitudinal outcome studies and refers to a person getting to a point (i.e., recovering) at which he or she no longer has a mental illness. The notion of being "in recovery," however, comes from a very different source and refers to a very different phenomenon (Jacobson 2001). Developed and promoted initially by the mental health consumer movement, championed by the field of psychiatric rehabilitation, and only recently moving into the mainstream of mental health, this sense of recovery refers to learning how to live a safe, dignified, full, and self-determined life, at times in the face of the enduring symptoms of a serious mental illness. At its most basic, recovery from refers to getting rid of or overcoming a mental illness, while being in recovery refers to reclaiming and living one's life in the face of a mental illness which has not and may not go away (Davidson and Roe 2007). This distinction has important implications for both research and practice, as we explain below.

Recovery from Serious Mental Illness

Recovery from serious mental illness is not a new concept. As long as there has been a concept of mental illness, there have been people who have recovered from it; historical examples include Percival, Judge Schreber, and Clifford Beers. Some people are fortunate to recover fully from a first and only episode of mental illness, while for others recovering from the disorder may take place over a longer period of time. While the lineage of this insight can be traced back to Bleuler, at least since the 1970s we have documented, in fact, that many people, between 25 and 65% of a given sample of people diagnosed with a serious mental illness, will experience significant improvements in their condition over time resulting in a good outcome ranging from only mild impairment to full recovery—at times even after many years of profound suffering and disability. (e.g., Davidson et al. 2005; Davidson and McGlashan 1997; Jobe and Harrow 2005; McGlashan 1988; WHO 1979). Recovery in this sense, as we noted above, refers to the absence of symptoms, signs, and functional impairments; people who recover no longer have a mental illness.

We know relatively little about this form of recovery and about the extent to which it is promoted by existing treatments. For example, despite the initial fanfare accompanying the release of a second generation of anti-psychotic medications, two recent large, multi-site, randomized, double-blind studies offer persuasive evidence that these medications are no more effective than their predecessors (Jones et al. 2006; Lieberman et al. 2005). It remains the case that only about 70% of people diagnosed with schizophrenia will experience a decrease in symptoms in response to medication and that this decrease will be limited primarily to the domain of positive symptoms. The majority of the disability associated with mental illness, however, appears to be due to the hidden impacts of negative symptoms and neurocognitive deficits (Davidson and McGlashan 1997). While both first and second generation medications tend to be associated with improvements in psychotic symptoms, it also remains unclear the degree to which these gains make significant differences in the actual day-to-day lives of people with schizophrenia. The surprisingly high rates of medication discontinuation and switching in the two large-scale medication studies mentioned above (e.g., 74% over an 18-month period in the CATIE study) suggest that whatever the perceived benefits of these medications may be they often are outweighed by their serious side effects.

Cognitive approaches have shown promise in augmenting medication and in addressing the neurocognitive deficits that medications do not affect. Adding cognitive

behavioral therapy to medication, for example, may increase the rate of reduction of positive symptoms from 41 to 59% and appears to produce results which are sustained over time (Kingdon and Turkington 2005; Zimmermann et al. 2005). A meta-analysis of seventeen RCTs of cognitive remediation, training, or rehabilitation—which involve the person's participation in exercises which aim to improve neuro-cognitive functioning (e.g., memory, learning, attention, executive functioning)—found positive findings in fourteen studies, with small-to-moderate effects for improvements in neuropsychological performance and cognitive functioning (Twamley et al. 2003). While all of these findings show promise, few studies have included an assessment of real world functioning and further study is required to assess the degree to which these gains generalize to everyday life tasks.

Thus, while people may be experiencing improvements in their condition over time, some to the point of recovering fully from it, these improvements cannot be attributed directly to existing treatments. First of all, we know that only one-third of individuals with serious mental illnesses receive any specialty mental health care (DHHS 1999) and that among those who do receive care, most people do not receive evidence-based practices. Secondly, even among those individuals who are fortunate to receive evidence-based treatments, these treatments demonstrate only small to moderate effects. An example is provided by the case of Family Psychoeducation (FP), which represents one of the few evidence-based practices for which the real world impact of the intervention has been estimated. A recent Cochrane meta-analysis that included 43 randomized and quasi-randomized controlled trials found evidence that FP reduces hospital admission, encourages medication adherence, and improves general social functioning and levels of expressed emotion within the family. The authors of this review noted, however, that intervention effects across these studies tended to be moderate, with the primary benefit of FP being that it reduces the risk of relapse. In this case, they suggested that the data accounted for prevention of one relapse per year for every eight families participating in the intervention (Pharoah et al. 2006).

"Recovery" in the sense of the remission of all symptoms and deficits therefore can not be attributed directly to our existing treatments and remains poorly understood. Although a host of factors have been suggested as contributing to recovery, from a shorter duration of untreated psychosis (e.g., Marshall and Rathbone 2006; Perkins et al. 2005) to the more supportive social networks or nutritional/dietary habits of developing countries (e.g., Christensen and Christensen 1988; Gupta 1992; Hopper and Wanderling 2000; Peet 2004), we have made little progress in accounting for the heterogeneity in outcome that has been established for well over a 100 years.

Being in Recovery

During these same 30 years, however, there have been dramatic developments in the consumer and family movements in mental health, and along with these developments the emergence of the second form of recovery described above. This notion of being "in recovery" refers to a process rather than to an outcome (e.g., Anthony 1993; Bellack 2006; Deegan 1988; Jacobson 2001; Spaniol and Koehler 1994). This sense of recovery was borrowed by the consumer movement from their peers in the addiction self-help community, who considered themselves to be "in recovery" as long as they were making active efforts to manage their sobriety and rebuild a meaningful life in the wake of their addiction. What appears to have been most appealing about this notion to people with serious mental illnesses was that their peers with addictions had been reclaiming their lives and the responsibility for making their own decisions even without first being cured of what they considered to be a life-long condition. As there also is not yet a cure for serious mental illnesses, people with these conditions argued in a similar vein that they should be able to reclaim their lives and autonomy without first having to be cured from mental illness.

This notion of being in recovery therefore does not have as much to do with a person's level or degree of symptoms, deficits, or pathology as much as it does with how the person is managing his or her life in the presence of an enduring illness—or perhaps how the person is managing an enduring illness in the context of his or her ongoing life. This form of recovery thus represents a personal, social, and political reality as much as it does a medical one, as it is significantly impacted by who the person is, the nature and density of his or her social support network and milieu, and the rights and responsibilities accorded or denied to the person by virtue of the society in which he or she lives (e.g., through stigma and discrimination; Davidson 2006). While this form of recovery has been identified and developed primarily by the consumer movement, it has been defined in various ways by people in recovery, the U.S. government, psychiatric rehabilitation practitioners, and researchers (DHHS 2003, 2005, 2007; Onken et al. 2007). Where all authorities seem to agree is that this form of recovery involves the person's self-determined pursuit of a meaningful life in the communities of his or her choice in the face of an enduring impairment.

Recovery-Oriented Practice

Several factors have been identified as appearing to be essential to this form of being in recovery—as they may also be to persons' efforts to manage other prolonged health conditions—which have yet to be investigated as

components of the active treatments described above. As listed, for example, in the SAMHSA (Substance Abuse and Mental Health Services Administration of the U.S. Government) consensus definition of recovery, these factors include hope, dignity, respect, choice, social support, involvement in meaningful activities, and having a sense of meaning and purpose in one's life (DHHS 2007). Care which is oriented to promoting this form of recovery has, as a result, been defined as person-centered, strengths-based, collaborative, and empowering. Consistent with the goals of self-determination and enabling people to pursue meaningful lives in the community despite the lack of a cure for their condition, advances in psychiatric rehabilitation focus on enhancing functioning and supporting people in taking part in routine adult roles in the community such as employment, education, and socialization. Supported housing that offers a high degree of consumer choice has been highly effective in enabling people to obtain and maintain safe and affordable independent housing with community-based support (Tsemberis et al. 2004). Other rehabilitative strategies such as supported employment and assertive community treatment also appear to demonstrate greater impact than the active treatments reviewed above.

Supported Employment (SE) programs help individuals to find jobs of their choice in integrated work settings that pay minimum wage or higher and offer 'on the job' training and support when requested by the worker (as opposed to offering training and then 'placing' people in jobs). SE tailors placements to individual capabilities and interests, offers time-unlimited vocational support, and may include collaboration with a person's supervisors and coworkers (Bond et al. 2001a). A recent meta-analysis of 11 RCTs examined the efficacy of SE for people with schizophrenia. In the 5 investigations that compared this approach to conventional rehabilitation services, over half (51%) of participants receiving SE worked competitively versus less than twenty percent (18%) of those in the comparison groups (weighted mean effect size was large, = 0.79). Overall, those receiving SE were about four times more likely than control participants to obtain competitive work (Bond et al. 2001a). When quasi-experimental studies of converting day treatment to SE are included, between 40 and 60% of participants enrolled in SE obtained competitive employment compared to less than 20% of those not enrolled in SE, resulting in a large unweighted effect size of .85 (Becker et al. 2007).

Since its inception, Assertive Community Treatment (ACT) has focused on in vivo skills training and community support and has aimed to improve quality of life by delivering services in the community around the clock, 7 days per week. A Cochrane review found that those receiving high-fidelity ACT were significantly more likely to remain in contact with services and less likely to be admitted to the hospital (Marshall and Lockwood 2000). In addition, a more recent literature review of 25 RCTs concluded that ACT significantly increased housing stability and moderately improved symptoms and quality of life (Bond et al. 2001b). As a service delivery modality which can also incorporate other interventions such as SE, cognitive behavioral therapy, and the emerging and promising practice of peer support (Davidson et al. 2006; Solomon 2004), ACT remains one of the most effective services currently available for people with serious mental illnesses. Most recently, additional modifications to ACT have been proposed to enhance its potential to be a more recovery-oriented practice, stressing the importance of such issues as self-determination, choice, and empowerment (e.g., Salyers and Tsemberis 2007).

In summary, then, recovery-oriented practices identify and incorporate a person's own goals, interests, and strengths in the effort to support the person's own efforts to manage his or her condition while pursuing a meaningful life in the community. Those interventions that aim to support the person in managing the illness appear to have a more robust evidence base than those that aim to reduce or eliminate the illness and its effects. We now will turn to see how this might or might not relate to an emphasis on evidence-based practice in mental health.

Evidence-Based Practice in Mental Health

Evidence-based practices in mental health derive from the general movement toward evidence-based medicine in general health care (Sackett et al. 1996). The evidence-based practices movement assumes that mental health programs and practitioners have an ethical obligation to offer the most effective treatments available to people with mental illnesses (IOM 2001; National Advisory Mental Health Council Behavioral Science Workgroup 1999; DHHS 1999, 2003) and asserts that effectiveness is to be established and confirmed by scientific evaluation. What this means and how to implement the concept have been debated extensively (Drake et al. 2003, 2005).

Evidence-Based Medicine Builds on Basic Health Care Values

The history and philosophy of medicine recognize a variety of basic values as the foundation for ethical and effective practice (Culver and Gert 1982). These include treating patients and their families with respect, being truthful in providing patients and families with accurate information, and first avoiding harm and then attempting to be helpful to people in distress. Chief among the values of modern

medicine also is the principle of autonomy: people have a fundamental right to make decisions about their own bodies. Evidence-based medicine fully endorses these and other basic health care values.

Sharing the scientific evidence collaboratively is the sine qua non. Without knowing the evidence, practitioners cannot be certain that they are avoiding harm and doing their best to help their patients. Without understanding the evidence, people cannot be truly informed and thus cannot make informed choices and decisions about their care. Only in exceptional situations are coercion, involuntary treatment, or other contradictions to these basic health care values considered morally justified. For example, the person who is in a delirium or coma due to a stroke and is not competent to understand his or her current medical needs may require intervention prior to being able to provide informed consent. In this situation, relying on next-of-kin, a court-appointed guardian, or medical urgency is considered morally justified.

The situation is the same in psychiatry. A person who is seen by a psychiatrist for treatment of depression has a right to receive full information about the illness, to understand the available treatments and their expected outcomes and potential side effects, to make an informed choice, and to give consent regarding treatment. The person's rights may be overlooked only in specific circumstances, such as when he or she presents an immediate life-threatening risk to self or others. In such extreme situations, state laws typically provide for a process of substitutive decision-making, for example, by a panel of doctors and lawyers, to protect the person and/or the threatened victim(s).

Evidence-Based Medicine Assumes that Scientific Evidence is Often Complicated, Hierarchical, Ambiguous, and Limited

Critics of evidence-based medicine point out that researchers often disagree about the scientific evidence, that the evidence is often limited to specific types of disorders or settings, and that there is no strong evidence to inform many common clinical decisions. These legitimate concerns have been considered extensively in the evidence-based medicine literature, resulting in consensus that the available scientific evidence has many limitations and must be used judiciously and in conjunction with other important considerations (Guyatt and Rennie 2002).

The gold standard for scientific evidence regarding treatment is the systematic review of several double-blind randomized controlled trials. In practice, however, randomized controlled trials are rare and systematic reviews are even more rare. Even when available, randomized controlled trials are usually conducted under constrained research conditions, such as using university research settings, highly selected patients, highly trained clinicians, carefully monitored treatments, and other special conditions. In other words, research trials often do not include typical settings (such as rural clinics), minority groups (such as Americans of Hispanic origin), clinical populations (such as persons with multiple previous episodes or serious co-morbidities), practicing clinicians (such as those with large case loads), or other features of routine practice. Thus, the available scientific evidence always has serious limitations. One way in which evidence-based medicine responds to these concerns is by considering various types and levels of evidence within a loosely conceived hierarchy. For example, in the absence of randomized controlled trials, quasi-experimental studies are to be considered, though they have less inferential validity.

Some clinical decisions can be guided by higher-level, more reliable, and more extensive evidence than others, but there are always limitations to the quality of the evidence in general and to the applicability of the evidence to specific people and situations (Whitley 2007). At the same time, some useful and relevant evidence is almost always available. In the typical clinical situation, the available evidence, even if strong, does not match the current patient perfectly. For example, several randomized clinical trials show the effectiveness of a particular intervention, but the current patient differs from the patients in those trials. How do the clinician and patient use the evidence in this situation? This is one area in which clinical experience and understanding the effects of physiological variation, co-occurring illnesses, treatments, and other factors are critical. For example, a competent physician has to know that older patients, those of Asian heritage, or those with impaired liver function may be vulnerable to certain side effects and may require smaller dosages of some medications.

Evidence-Based Medicine Recognizes that Factors Other than Scientific Evidence are Also Critically Important in Medical Decisions

A second way in which evidence-based medicine deals with the limitations of evidence is to assume that scientific evidence is only one important component of decision-making (Guyatt and Rennie 2002). Additional components include the person's own values, goals, and preferences; his or her interest in being an active participant in decision-making; his or her cultural context and local support system; and the local resources. All of these factors must be weighed in decisions. In fact, these other factors often override the scientific evidence, especially in situations where the evidence is weak (O'Connor et al. 2007).

Without access to accurate and understandable scientific information, patients and practitioners are likely to be influenced by misinformation from the press and internet, the prejudices of their families or social contacts, the biases of vested interest groups (e.g., marketing from industry), or the idiosyncratic opinions of local providers. With access to accurate information, people can and do make choices that are highly differentiated. That is, their treatment choices often differ from what their providers might recommend, from what their peers choose, and from what they would choose in the absence of such information (Wennberg 1988, 1991). Because situations, information, and preferences are complicated, people often report that decision aids help them to clarify their understanding of the information, their values, and their preferences (O'Connor et al. 2007).

This emphasis on accurate information and shared decision-making requires a fundamental shift away from the traditional model of medical authority in which the physician decides what is the best treatment and tells the patient what to do. Shared decision-making suggests that the patient and clinician consider information about reasonable and available treatments and their likely effects (both benefits and side effects), share their expertise and perspectives, discuss alternatives, and arrive at plans that both can endorse (Deegan and Drake 2006). Most medical decisions today involve complicated trade-offs that should be weighed and considered carefully in this manner (O'Connor et al. 2007).

A critical implication of the emphasis on patient preferences and shared decision-making is that it affords a different view of outcomes as well as of treatments. For example, many people value functional status and quality of life as much or more than they value symptom control and certainly more than they value physiologic measures. For example, people with mental illnesses often value working, avoiding medication side effects, and improving quality of life more than they value complete symptom control (Deegan 2007).

One common misconception regarding evidence-based practice in the mental health field is that it prescribes a standard, invariant approach for all people. As the foregoing discussion makes clear, the philosophy of evidence-based medicine is that the available evidence is just one factor in the decision-making process. A treatment with the strongest evidence may not be the optimal treatment for a particular individual, who may have specific risk factors that preclude the treatment, for whom the treatment may not be available or affordable in a given situation, or who may have a different preference. Consider the example of clozapine. This drug is an evidence-based alternative for patients with schizophrenia who do not respond well to other antipsychotic medications (Lehman et al. 2004). However, many factors might exclude clozapine as the treatment of choice for a particular person. The person may have a history of medical problems that would make clozapine especially dangerous; the person may prefer not to have weekly blood monitoring; the person may choose to avoid the characteristic side effects of clozapine, such as severe sedation and metabolic risks; or clozapine may not be available or affordable for a variety of reasons. All of these factors could override a decision to try clozapine. In shared decision-making, they would be considered carefully and weighed against potential benefits by the patient and the physician.

This cursory overview of the guiding principles of recovery-oriented practice and evidence-based medicine—both of which assume that people have a right to make informed decisions about their own care—would seem to suggest that the two are quite compatible. Why, then, do questions persist about the relationship between the two? If they mix well enough to produce a tasty vinaigrette, as we have tried to show, what is all the fuss about? We next consider three ways in which the two approaches may appear to be in conflict, but we believe actually produce a creative and useful tension.

Three Possible Relationships Between Recovery and Evidence-Based Practice

Is Recovery Evidence-Based?

We consider this question separately in relation to each of the two forms of recovery described above. In terms of recovery *from* serious mental illnesses, the answer is yes, as we have known at least since the time of Bleuler that people at times experience complete remissions from psychosis and that others often experience improvements in symptoms and functioning over time. These findings have now been confirmed consistently and repeatedly over the last 30 years through a series of rigorous longitudinal studies in which a significant portion of any given sample of people with serious mental illnesses were found to experience at least partial, and many up to full, recovery over time (Davidson et al. 2005). We do not yet know why or how this comes about, as this form of recovery typically occurs over a longer period of time and does not appear to be a direct result of the treatments we currently offer for the disorder. But, yes, there is definitely an evidence base that has established that many people will recover over time, despite the fact that this form of recovery does not seem to be attributable to the evidence-based practices we deploy.

In relation to being in recovery, there is a robust evidence base that many, if not most, people can figure out how to live with and manage the disorder over time (Davidson et al. 2005). At the same time, this question may

be considered irrelevant to the issue at hand, as what is primarily at stake in the notion of being in recovery is not a medical or scientific condition but the person's need for, and right to, finding a way to live a meaningful life in the face of the illness. Unless, until, and only for as long as a person poses a serious and imminent risk to self or others, is gravely disabled, or is deemed to lack the capacity to be in charge of his or her life by a judge, people with serious mental illnesses retain the human, civil, and legal right to self-determination. This is not a question of evidence, but a question of statute. Some mental health practitioners may at first be uncomfortable with this idea, due to the common perception that people with mental illnesses demonstrate poor judgment. On this score, however, there is no compelling evidence. The evidence that exists, in fact, suggests that the vast majority of people with serious mental illnesses—despite whatever cognitive deficits they may experience—nonetheless remain legally competent to make their own informed choices and typically do so on a par with people who do not have mental illnesses (Stroup et al. 2005; Roe et al. 2001).

What the introduction of recovery adds to evidence-based practice is thus twofold. One, it instills a sense of humility in the face of the evidence that exists, highlighting for us the fact that many people do in fact recover from mental illnesses, and many more find ways to live meaningful lives in the face of enduring illnesses, with or without help from mental health services. This fact—which has been pointed out by the consumer movement consistently over the last 30 years—may initially appear discouraging, but should encourage us instead to be hopeful that in future generations we will discover new and more effective ways to help people manage and/or overcome these illnesses. In this respect, the work is just beginning. Two, the introduction of recovery helps to move psychiatry closer to the mainstream of contemporary medical practice, in which evidence-based medicine has become the expectation rather than the exception. This is because recovery reinforces the point that patients are partners in the treatment and rehabilitation enterprise, as they retain the right to make their own informed choices based on, or despite, the evidence—just as is true in other branches of medicine.

Are Evidence-Based Practices Recovery-Oriented?

While the field has yet to come to a consensus on what precisely comprises recovery-oriented care, for the sake of this discussion we will suggest, as we did above, that recovery-oriented practices are distinguished by being person-centered, strengths-based, collaborative, and empowering. Given this definition, there are two possible answers to the question above as well.

A first possibility would be to examine each evidence-based practice individually and assess the degree to which it was consistent with the principles of recovery-oriented care. Tools are beginning to appear that could be used for this purpose (e.g., O'Connell et al. 2005), asking such questions as to what degree does this practice invite and honor people's own choices and preferences, to what degree does this practice elicit, identify, and build on people's strengths, to what degree does this practice focus on enabling people to participate in naturally occurring community activities as opposed to remaining within the confines of the mental health system, etc. In this way, different practices would fare better or worse in terms of recovery orientation. We might even suggest that certain of the evidence-based practices described above, such as ACT, SE, and supported housing, are effective in part precisely because they are recovery-oriented. These, and other similar, approaches may work because, when delivered correctly, they emphasize people choosing their own goals, taking responsibility for managing their own condition, pursuing their own dreams, etc.

Using this approach, supported employment, for example, would score high by virtue of its built-in focus on people's own interests and choices, and by virtue of its aim to help people to attain their own goals related to competitive jobs in the community. Similarly, supported housing that offers people a high degree of choice can be considered to enhance recovery not only because it enables people to secure a home of their own but also because it has been found to increase their sense of mastery as well as reduce psychiatric symptoms (Greenwood et al. 2005). ACT, on the other hand, might be vulnerable to criticism for using coercion and for historically emphasizing symptom reduction and avoidance of hospitalization over a person's own goals (although this may now be changing). Finally, in other cases, such as that of psychopharmacology, the presence or absence of a recovery orientation would be found in how the treatment was delivered rather than in the treatment per se (e.g., Deegan 2007; Noordsy et al. 2000).

A second approach is to raise the question of what counts as evidence in the studies that have led to a particular practice being included in the list of practices that are "evidence-based." In this respect, very few studies have used outcome measures that are recovery-oriented, settling typically (as we saw above) for such measures as reduction in symptoms, increases in neuropsychological performance, or reductions in hospitalizations, with little reference to the degree to which these changes made a difference in a person's day-to-day life. Extrapolations of course can be made, such as it is better on the whole to remain out of the hospital or to have fewer symptoms, but these indicators speak only to minimizing illness and

deficit and do not address maximizing the person's opportunities for a meaningful life. But the two processes of minimizing illness and maximizing life may not be the same (Davidson et al. 2009). In fact, for some people taking risks to move ahead in their lives, such as returning to school or taking a job, may temporarily increase their level of symptoms and may even precipitate a hospitalization. In the longer term, however, these were indicators of progress rather than dysfunction. When viewed from this perspective, an entirely different domain of outcomes becomes important, centering on the issues of self-agency and self-efficacy. In this respect, research has only begun to address the processes of developing hope, taking control of one's treatment and recovery, and defining and pursuing one's personal goals.

With this shift from symptom reduction to personal growth, the introduction of recovery raises the bar related to what can be considered a 'good enough' outcome in mental health. With recovery, we can no longer focus solely on reducing symptoms and suffering, which remain nonetheless worthy goals as well. But we need to complement this focus with one on the process of developing self-agency in enhancing functioning, pursuing and achieving meaningful life goals, and, in the words of the New Freedom Commission on Mental Health, "living, working, learning, and participating fully in the community" (DHHS 2003). This poses a significant challenge both to mental health practice and to research, in that assessing such outcomes may turn out to be nearly as difficult as promoting them. This, however, is one of the two main challenges posed to mental health by the introduction of concepts of recovery, the other one, mentioned above, being that of respecting individuals with serious mental illnesses as partners in the treatment and rehabilitative enterprise.

Are Recovery-Oriented Practices Evidence-Based?

Finally, there are two answers to this last question as well. First, to the degree that recovery-oriented practice refers to a collaborative approach involving shared decision-making between the person and the practitioner, the answer is both yes and, once again, that the question is not relevant. Data have shown that shared decision-making is a more effective approach to care than a traditional authoritarian one (Priebe et al. 2007), and in this sense the answer to the question is yes. To the degree that the question is posed to challenge the person's active role in determining his or her own care, however, we have made the point above that this is a question of right not of evidence. Even if we did not already have evidence of its effectiveness, it remains a cornerstone of a democratic society that each adult is free to make his or her own choices unless there are clear and compelling reasons for that freedom to be curtailed. Emergency commitments are obviously an example of the latter, as is when a judge determines that a person needs to be conserved. But in all other circumstances, people with mental illnesses remain in control of their "own person, free from all restraint or interference of others, unless by clear and unquestioned authority of law" (as determined by the United States Supreme Court in *Union Pacific Railway Co. v. Botsford*). The introduction of psychiatric advance directives as a new tool for recovery-oriented practice aims to enable people to retain these rights even when they have become acutely or temporarily disabled, delineating beforehand the person's preferences should such situations occur.

The second answer to the question of whether recovery-oriented practices are evidence-based may be the least satisfactory, as it is "not yet." Because of the relative newness of the concept of recovery and its application to practice, the field has not yet accumulated an adequate evidence base to speak to the effectiveness of certain recovery-oriented practices. We are taking recovery-oriented in this sense to refer not to the overall principles of self-determination, strengths-based, etc., as we did above, but to specific concrete practices that are currently emerging in the field. We do have a solid evidence base for supported housing and supported employment, as we noted above, but other developments such as peer support and peer-run programs and businesses are only now beginning to be studied in rigorous ways. Thus far, the evidence for peer support, for example, shows that people in recovery can provide mental health services at least as effectively as people who are not in recovery (or who have not disclosed that history) (e.g., Davidson et al. 2007). What has yet to be determined are the ways in which peer support may have a value added component deriving specifically from the provider's personal history of recovery and his or her use of that history within the relationship (Dixon et al. 1994; Solomon 2004). On this matter, as is in relation to other uniquely recovery-oriented practices (such as recovery mentors or coaches, peer-run respite programs, social cooperatives, recovery centers) much remains to be learned.

As recovery-oriented practices emerge and proliferate, an emphasis on evidence-based practices will be essential in preventing the mental health field from going down yet another blind alley. Recovery advocates should in this way welcome, rather than reject, a focus on evidence, as they have nothing to lose and everything to gain in showing that this new approach to care is at least as effective, if not more so, than the approach which preceded it. As long as evidence-based practice incorporates and honors the active role of the person as a partner in a collaborative health care enterprise, recovery advocates will surely want people with serious mental illnesses to be able to make informed

choices on their own behalf. How can such choices be made in the absence of evidence? Integrating the emphasis on evidence with recovery might require a broader definition of what constitutes evidence, to include, for example, first-hand experiences. Although evidence-based medicine recognizes a hierarchy of evidence, it has not thus far included first-hand accounts. But it is possible, of course, to do so (e.g., Flanagan et al. 2007).

Conclusion

As we hope is by now evident from the discussion above, the relationship between recovery and evidence-based medicine is neither contradictory nor mutually exclusive. It is neither straightforward nor one-directional. There are many possible relationships between the two value bases and sets of principles, and through several of these relationships we think both recovery and evidence-based practices can benefit. Stated simply, we need both to listen to people in recovery about their needs, preferences, values, and choices and also to find out which interventions are most effective in helping them to achieve the kinds of lives they wish to lead. While involving people in recovery in research through adoption of a participatory paradigm may be one particularly promising strategy for accomplishing these goals (Wallcraft et al. 2009), the development of respectful and collaborative relationships between health care practitioners and individuals with mental illnesses is the best way to ensure the delivery of evidence-based medicine over the long term. This is the vinaigrette which can be produced when each brings out and builds on the best in the other.

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