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How Evidence-Based Practices Contribute to Community Integration

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ABSTRACT: Since the groundbreaking work of the Robert Wood Johnson Conference in 1998 identifying six evidence-based practices (EBPs) for people with severe mental illness (SMI), the mental health field has moved in the direction of re-examination and redesign of service systems. Surprisingly, one area that has not been fully explicated is the role that EBPs play in promoting community integration. In this paper, we explain how community integration is a unifying concept providing direction and vision for community mental health for people with SMI. As one crucial aspect of the recovery process, community integration clarifies the link between EBPs and recovery. We propose an alternate view, grounded in the empirical literature, to the assertion by Anthony, Rogers, and Farkas [2003, *Community Mental Health Journal, 39*, 101–114] that "EBP research has rarely demonstrated a positive impact on recovery related outcomes."

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INTRODUCTION

Although the concept of evidence-based practice (EBP) is new to the field of mental health, its impact already has been felt widely through federal, state, and local mental health agencies (Hyde, Falls, Morris, & Schoenwald, 2003). As with any new concept, it has been interpreted in many different ways. Some have embraced EBPs with gusto; others have viewed the EBP movement as a threat. One particular perspective has been that EBPs do not promote recovery-oriented outcomes. In this paper, we provide a perspective suggesting quite the opposite, that EBPs are intimately linked to recovery. Our perspective centers on *community integration,* which we see as a unifying concept providing direction and vision in community mental health for people with severe mental illness (SMI).

The paper is divided into five sections. First, we define community integration and explain its relationship to the recovery process, providing a brief historical overview of the emergence of the construct of community integration in community mental health. Second, we discuss the current realities for most people with SMI. Third, we describe the EBP movement. In the final two sections we describe how specific EBPs contribute to community integration and discuss some criticisms of EBP.

DEFINITION OF COMMUNITY INTEGRATION AND ITS RELATIONSHIP TO RECOVERY

Community Integration entails helping consumers to move out of patient roles, treatment centers, segregated housing arrangements, and work enclaves, and enabling them to move toward independence, illness self-management, and normal adult roles in community settings (Carling, 1995; Nelson, Lord, & Ochocka, 2001). Like others with long-term illnesses, individuals with SMI want to manage their own lives and to participate in and contribute to the life of their families and communities. To use an old-fashioned term, community integration implies "normalization" (Wolfensberger & Tullman, 1982), that is, the circumstance in which individuals with disabilities live, work, play, and lead their daily lives without distinction from and with the same opportunities as individuals without disabilities. One way to describe community integration is by stating what it is not: Community integration is *not* immersion in worlds created by and managed by mental

health professionals, such as day treatment programs, sheltered workshops, group homes, and segregated educational programs. These settings are designed specifically to pull consumers into treatment and away from community life. The acid test in determining if community integration is realized is whether consumers are being steered toward a protected setting that is not part of the "regular" community.

Community integration epitomizes the aspirations of the consumer movement and, in our view, constitutes one of the two core elements of the recovery process. Recovery has been defined as both a process and an outcome (Deegan, 1999; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Ralph, 2000). As a construct, it goes beyond community integration by incorporating an individual's self-perceptions and psychological states, such as hope, pursuit of personal goals, self-efficacy, and self-determination. Recovery is an intensely personal journey; it is not a linear progression but consists of periods of growth and setbacks (Strauss, Hafez, Lieberman, & Harding, 1985). Currently, there are no standardized methods for measuring the construct of recovery, although a number of promising approaches have been developed (Ralph, 2000).

We conceptualize community integration as the external, concrete manifestation (viewable to the outside world) of the recovery experience, thus lending itself more easily to empirical measurement. It includes a set of constructs for which objective proxy measures (as well as associated subjective measures) *have* been validated, to a far greater extent than is currently true for the broader construct of recovery. For example, in the area of work, a recovery goal for many consumers is competitive employment that is congruent with personal preferences and is personally satisfying. These three elements—*competitive employment* (Drake, McHugo, Becker, Anthony, & Clark, 1996), *match with personal preferences* (Becker, Drake, Farabaugh, & Bond, 1996), and *job satisfaction* (Resnick & Bond, 2001)—have been operationally defined and measured, although this is not to say that other aspects of community integration in this domain do not warrant more psychometric work.

The degree to which community integration results in the subjective experience of recovery is an important empirical question. The literature on first person accounts of the experience of mental illness is replete with personal testimonials supporting this linkage (Rogers, 1995; Steele & Berman, 2001). Some empirical studies also suggest that community integration leads to greater self-confidence, hopefulness, self-determination, and other facets of the recovery experience (Bond,

et al., 2001; Carlson, Eichler, Huff, & Rapp, 2003). A national research study also concluded that what we are calling community integration often facilitates recovery (Onken et al., 2002). The opposite process also occurs; spirituality, hopefulness, and self-determination translate into action and lead to greater integration, especially when consumers have supporters who believe in them (Onken et al., 2002). More complete answers to questions regarding mechanisms of change await the development of standardized recovery measures.

Historical Context for the Community Integration Construct

Carling (1995) traces the movement toward community integration to the broader disability and civil rights movements. In the 1960s, the Civil Rights Movement began advocating for the rights of all individuals to have full citizenship in their communities. Similarly, the passage of the Community Mental Health Act of 1963 was based on the optimism that former residents of state psychiatric institutions could find meaningful restoration of their lives back "in the community," with the help of local mental health clinics (Torrey, 2001). The reality fell far short of the intentions of the legislation, in part because of a poorly articulated vision of what that integration would look like (Cutler, Bevilacqua, & McFarland, 2003). The "reform movement" exemplified by the Community Support Program (Turner & TenHoor, 1978) provided an appropriate set of conditions for community *living,* but not necessarily community *integration.* All too often, Community Support Program services replaced the community rather than supporting community integration. For example, prevocational programs were surrogates for real jobs; group homes and mental health center-owned apartments replaced normal tenancy; recreation was dominated by day treatment-sponsored affairs; transportation services were set up by mental health centers. Community integration involves being *of* the community and not just physically located *in* the community.

Another impetus toward community integration derived from the 1999 Supreme Court ruling in Olmstead v. L.C., which underscored the fact that many people with SMI were unnecessarily segregated in institutions when community living would be possible if the proper supports were in place. Similar goals were expressed in the Rehabilitation Act Amendments of 1992, which aimed at assisting individuals with disabilities "to live independently; enjoy self-determination; make choices; contribute to society; pursue meaningful careers; and enjoy full inclusion and integration in the economic, political, social, cultural, and

educational mainstream of American society." Finally, the New Freedom Initiative (2003) echoed these same themes of full citizenship, guaranteeing individuals with mental illness equal access to societal and environmental resources, equal access to options and opportunities, and equal "location of life;" that is, places where people live, work, play, and pray, are the same regardless of the presence of mental illness (Ralph, 2000).

CURRENT REALITIES FOR PEOPLE WITH SMI

Mental health consumers generally have the same aspirations as the rest of the population: meaningful work, decent housing, friendships, health, financial security, and a high quality of life (Carling, 1995; Rogers, Walsh, Masotta, & Danley, 1991; Steinwachs, Kasper, & Skinner, 1992). Many consumers today have achieved better lives than they would have during the era of institutionalization. However, the reality for most consumers is that genuine community integration remains an unrealized promise. Some estimates are that less than one-third are living independently, while about one-third of the homeless population have mental illness (Torrey, 2001). Many have been "transinstitutionalized," from psychiatric hospitals to nursing homes and other supervised residences (Geller, 2000). Among those consumers counted as "living in the community" are many who are leading lonely, isolated, barren lives, often without social or recreational outlets (Carling, 1995; Segal & Aviram, 1978; Wong & Solomon, 2002).

Studies of incarceration and victimization further document the grim realities of severe mental illness. Of the 1.1 million individuals held in state and federal prisons in 1995, the one-year prevalence rates were 5% for schizophrenia, 6% for bipolar disorder, and 9% for major depression (SAMHSA, 1997). An estimated 284,000 (16%) of those incarcerated in American prisons and jails on any given day were people with SMI (Ditton, 1999). Consumers are also at great risk of being victims of violence and crime. Between 43 and 81% report some type of victimization over their lifetime (Rosenberg et al., 2001), and one-third report severe physical or sexual assault in the past year (Goodman et al., 2001).

Employment and access to education are also challenges for people with SMI. Over 85% of persons with SMI are unemployed, despite compelling evidence that most want to work (McQuilken et al., 2003) and are capable of working in competitive employment, nearly always preferring competitive employment over sheltered work (Bedell,

Draving, Parrish, Gervey, & Guastadisegni, 1998). Unfortunately, consumer surveys often find that assistance with employment is a major unmet need, largely unrecognized by practitioners (Crane-Ross, Roth, & Lauber, 2000; Noble, Honberg, Hall, & Flynn, 1997), perhaps because they often misjudge consumers as "unmotivated" (Braitman et al., 1995).

Similarly, consumers who have educational aspirations have often been discouraged from pursuing such goals, because they have been seen as "unrealistic" (Shepherd, 1993). As competitive employment goals gradually have become more accepted, it has become increasingly apparent that consumers are profoundly disadvantaged in terms of educational achievements required to pursue meaningful careers (Unger, 1998). Many consumers have had their educational process interrupted by the onset of their illness, often limiting immediate employment prospects to entry-level jobs.

Another area in which community integration is compromised involves substance use disorders, which are estimated to affect as many as 50% of people with mental illness (Regier et al., 1990). Dual diagnosis of SMI and substance use disorder has consistently been associated with many other negative outcomes, including increased relapses and hospitalizations, housing instability and homelessness, incarceration, violence, and economic burden on the family (Drake, et al., 2001).

Four decades after the passage of the Community Mental Health Act, community integration remains an unrealized goal. A recent large national survey again confirmed that consumers are poor, relying on public funding for income; they lack access to affordable, appropriate housing; job discrimination remains a problem; and psychiatric disability is often criminalized (Hall, Graf, Fitzpatrick, Lane, & Birkel, 2003). Compounding this set of problems are others that are related specifically to the mental health services available in most communities. These barriers to community integration include stigmatizing attitudes of practitioners, segregated services, fragmentation of services, and lack of access to services.

Stigmatizing Attitudes

In their contacts with mental health centers, consumers often experience "spirit-breaking" messages reflecting low expectations regarding their potential to realize their dreams (Prince & Prince, 2002). Mirroring prejudices of the general community, many practitioners believe that independent living is beyond the ability of many consumers.

Education of practitioners in the principles of recovery is sorely needed if consumers are to receive respectful, compassionate, and effective rehabilitation services.

Segregated Services

Mental health centers continue to offer contained and controlled services that promote stabilization and caretaking at the cost of integration, self-determination, and empowerment. Emblematic of this problem is the widespread use of day treatment (Parker & Knoll, 1990). Despite the espousal of rehabilitative goals, day treatment does not help people move out of treatment settings and into normal adult roles in the community. In fact, day treatment services can be discontinued and successfully replaced with supported employment and other services that achieve greater involvement in community life (Bond, 2004).

Fragmentation of Services

Nearly everywhere, consumers are faced with a confusing, fragmented system of care in which they must go to different programs or agencies for rehabilitation, mental health, and substance abuse treatment services, typically with little co-ordination between providers (New Freedom Commission on Mental Health, 2003). Research has made it clear that rehabilitation programs cannot be effective in isolation from mental health treatment (Drake, Becker, Bond, & Mueser, 2003; Mueser, Noordsy, Drake, & Fox, 2003).

Access to Services

Several studies have documented the fact that consumers have problems accessing services meeting even *minimal* standards of care (Lehman, Steinwachs, & PORT Co-Investigators, 1998). Access to high quality services is even more tenuous. One recent national survey of 3000 consumers found that few had access to EBPs (Hall et al., 2003). Among those who did receive these services, the majority rated the access as fair or poor.

Summary

What should the response be to this gloomy picture? Despite the great disparity between the ideal of community integration and the current

realities, we have reason to be optimistic. Public support for community integration is strong (even if public budgets do not reflect this support). Within the mental health community we have consensus on what the goals should be, and we have the practices and tools to make these changes possible. Most importantly, we know much more about effective service delivery than at any time in the past. As demonstrated over the past decade, there are several reasons for optimism: (1) Emergence of EBPs, (2) Emerging knowledge base on how to effectively train and consult with agencies to implement and support these practices, (3) Increasing expertise and knowledge based on involving consumers and family members, and (4) Growing understanding of the critical importance of providing mental health, vocational rehabilitation, and substance abuse services by integrated teams of providers.

THE EVIDENCE-BASED PRACTICE MOVEMENT AND COMMUNITY MENTAL HEALTH

Emergence of EBPs

Over the past two decades, we have witnessed amazing strides in the development of effective service models for people with SMI (Drake, Green, Mueser, & Goldman, 2003). Until recently, the mental health field lacked consensus on the identification of specific types of EBP. However, this situation significantly changed in 1998, when a national consensus panel of leading mental health treatment and services researchers, consumers, family advocates, clinicians, and administrators identified six practices for adults with psychiatric disabilities attaining the status of EBP (Mueser, Torrey, Lynde, Singer, & Drake, 2003). These six practices are: (1) supported employment, (2) assertive community treatment (ACT), (3) illness management and recovery, (4) family psychoeducation, (5) integrated dual disorders treatment, and (6) medication management according to protocol. All of these practices aim at increasing community integration and promoting maximum social and economic independence.

EBP in mental health is part of a larger evidence-based medicine movement, which quickly has become a dominating influence in medicine. One Medline search found 12,298 hits to the term “evidence-based medicine” between 1996 and 2003, with only 2 hits for the preceding 4 years (Flaum, 2003). Following the model of evidence-based medicine,

EBPs are founded on the meta-principles of (1) using the best available evidence, (2) individualization, (3) incorporating patients' preferences, and (4) expanding clinical expertise (Drake, Rosenberg, Teague, Bartels, & Torrey, 2003).

Emerging Knowledge Base on How to Effectively Train and Consult with Agencies to Implement and Support these Practices

The National EBP Project is a large-scale project to study and improve strategies for implementing the aforementioned EBPs (Drake, et al., 2001). The first phase of the project was to create toolkits providing practical, hands-on material to enable agencies to implement these practices with high quality. The second phase, now in progress, incorporates systematic consultation and technical assistance to help 55 agencies in 8 states to develop environments that will sustain the practice over time, for example by identifying funding strategies or fostering stakeholder involvement.

One major pitfall in numerous efforts to develop services aimed at increasing community integration has been the failure to implement programs according to the principles defining each EBP (Goldman et al., 2001). In the last decade, we have begun developing management tools to help programs implement practices with "high fidelity," that is, implementing them as intended. Fidelity scales measuring quality of implementation have emerged as one such management tool for establishing and monitoring high-fidelity programs and for successful dissemination of EBPs on a broad scale (Bond, Evans, Salyers, Williams, & Kim, 2000).

Increasing Expertise and Knowledge Based on Involving Consumers and Family Members in Adoption of EBPs

Many different efforts are under way to increase consumer and family involvement in developing, monitoring, and disseminating EBPs and emerging practices. For example, NAMI and other organizations are offering programs where consumers and families serve as *providers* of training (e.g., NAMI's Peer-to-Peer, Family-to-Family, and Provider Education programs) (Burland, 1998). Some sites within the National EBP project have involved consumers and family members as trainers and as members of "leadership teams" directing the implementation of the EBP.

Growing Understanding of the Critical Importance of Providing Mental Integrated Services

One key barrier to community integration is that traditional mental health services have focused narrowly on addressing symptoms and problems, rather than looking at the consumer as a whole person with a variety of treatment and rehabilitation needs. The resulting service systems are then brokered, and the consumer is left to navigate the mental health, vocational, and substance abuse service systems on their own. EBPs address this problem by integrating a range of comprehensive services "under one roof."

HOW SPECIFIC EBPs CONTRIBUTE TO COMMUNITY INTEGRATION

- *Supported employment* helps consumers find meaningful jobs that fit their preferences, promoting the integration of consumers in the competitive job market (Bond, 2004). Supported employment avoids preparatory work activities common in mental heath settings and, instead, moves consumers through a rapid job search and placement process, based on their job preferences. Consumers are provided intensive support in their job search and job placements on a long-term basis, with integration of both vocational and mental health services for better outcomes.
- *Assertive community treatment* is a treatment especially suited for consumers who have not done well in usual mental health services. It has been particularly effective in reducing hospitalizations and homelessness (Bond, Drake, Mueser, & Latimer, 2001). ACT uses a multidisciplinary team approach to case management with shared caseloads and frequent staff meetings, intensive community-based services, and a focus on assistance with daily living skills that helps consumers maximize their independence and level of functioning in the community. ACT has a strong focus on helping consumers attain independent living, following a supported housing approach (Witheridge, 1990), as described below.
- *Illness management and recovery* embodies the principle of self-determination and is based on the value that when consumers are in charge of their own lives and provided the means necessary to make informed choices, they will make better decisions than if they are

directed by medical personnel to "comply" with a treatment plan (Mueser et al., 2002). Through illness management, consumers learn to proactively address illness issues such as symptoms, medications, worries about relapse, and depression, so that they can better pursue recovery goals, such as employment, creative activities, and friendships.

- *Family psychoeducation* is a systematic approach to educating families about mental illness and recovery (Dixon et al., 2001). Family members also have too often been excluded from the recovery process, despite the fact that they are frequently the primary caregivers. Inclusion of family members as part of the treatment team enhances the effectiveness of other EBPs and reduces family burden (McFarlane et al., 2000; Mueser et al., 2002).
- *Integrated dual disorders treatment* uses a stagewise approach to engaging and helping individuals with dual disorders (Drake, Essock et al., 2001). Rather than parallel treatment for mental health and addictions, consumers receive intensive, coordinated community-based mental health and substance abuse treatment on an integrated team. Practitioners ensure access to housing, employment and other services often denied individuals with substance use problems.
- *Medication management according to protocol* is an approach to medication use that stresses informed consumer choice, systematic monitoring of outcomes and side effects, and the use of the atypical antipsychotics as first-line treatments for schizophrenia (Mellman et al., 2001). With active collaboration between prescribers and consumers, medications can play a critical role in community integration by decreasing symptoms and relapse.

In addition to these 6 EBPs, several *emerging practices* are critical to community integration. These are practices that have not yet achieved a sufficient level of research evidence to justify the label of evidence-based practice, but are practices that the best evidence to date suggest contribute to community integration. These include practices that address basic needs that are essential to ensure full participation of consumers in community life. Two such critical practices are *supported housing* and *supported education.*

- *Supported housing,* first defined in the 1980s (Ridgway & Zipple, 1990), is an approach in which consumers rent or lease independent, affordable housing that is integrated into the community (i.e.,

separate from the mental health service agency and no live-in staff). Consumers have access to 24-hour services to avoid crises that might interrupt housing (Rog, 2004). Significantly, the supported housing approach has been identified as a core strategy for realizing the goal of community integration (Wong & Solomon, 2002). The residential research literature for individuals with psychiatric disabilities is enormous, and the supported housing paradigm is widely recognized as the most promising, although much work is still needed in this area (Newman, 2001; Rog, 2004).

- *Supported education* refers to a set of strategies for helping consumers pursue post-secondary education (Mowbray, 2000; Unger, 1998). Like supported employment, supported education provides practical methods for assisting individuals renew their quest to better themselves that may have been lost with the onset of their illness. Although a recent review identified 14 quantitative studies of supported education (Carlson et al., 2003), this literature lacks methodological rigor. These preliminary studies suggest that supported education interventions that focus on *in vivo* assistance while avoiding segregated classroom preparation may ultimately prove to be the most effective strategy.

CRITICISMS OF EVIDENCE-BASED PRACTICES

The criticisms of the EBP movement have been strong and widespread (Essock et al., 2003). They have included many valid and thoughtful critiques exposing deficiencies in the basic conceptualization as well as criticisms of specific EBPs.

Regarding the basic conceptualization, one key issue is how EBPs are identified in the first place. We should be vigilant to the danger that the process for selecting which practices are "official" EBPs can become politicized (Mueser, submitted). It is beyond the scope of this paper to examine the complex issues concerning the methods and criteria for identifying EBPs (Beutler, 2000). However, differentiating between "evidence-based" and "emerging" practices centers primarily on the rigor of the research designs used to evaluate effectiveness. In fact, even among the EBPs identified by the RWJ conference there are differing levels of empirical support; three practices (supported employment, ACT, and family psychoeducation) have strong and convincing evidence for effectiveness, whereas the evidence is weaker for the remaining three. In our view, however, it is not helpful to dilute the

concept of EBP to include any "best practice," if that latter term is broadened to clinical opinion or popular practices that have not been exposed to rigorous empirical study (Hughes & Weinstein, 1997). Our reasoning is simply that if popular practices did in fact promote community integration, then we would not expect to find the dismal realities for consumers described above.

Another valid concern is the relationship of EBPs to the consumer movement and particularly to consumer-run alternatives (Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Tracy, 2003). Given that consumer-run services do not have a strong empirical base, some consumers fear that the hard-won financial support for consumer-run programs obtained over the past decade will erode with the growth of the EBP movement. Consumers often mention peer support as a critical factor facilitating their recovery (Onken et al., 2002). We agree with Tracy (2003) that consumer-run services and evidence-based services are complementary. Funding for both should be given high priority, while professionally-led practices lacking an evidence base should be called on to justify their continued funding. An analysis of where dollars are spent for mental health services would help clarify this discussion.

Regarding criticisms of specific practices, ACT has been a lightening rod for criticism, having been characterized as paternalistic and coercive (Dennis & Monahan, 1996; Fisher & Ahern, 2000; Gomory, 2001; Williamson, 2002). If being closely associated with the medical model means that ACT is paternalistic and coercive, then certainly ACT stands guilty as accused. However, as noted above, evidence-based medicine provides an entirely different vision for health care. Moreover, numerous reviews suggest that ACT increases stable community living and that ACT consumers are more satisfied with ACT services than are consumers receiving traditional case management services. Some studies also have found improved quality of life for ACT consumers (Bond, Drake et al., 2001).

The oft-repeated criticisms regarding coercion on ACT teams have been largely anecdotal; only a few studies have directly surveyed ACT consumers regarding their perceptions of services (Williamson, 2002). Some of the criticisms of ACT may be more correctly characterized as criticisms of poorly implemented ACT teams (McGrew, Wilson, & Bond, 2002). However, it should also be acknowledged that some ACT teams, especially those specializing in homelessness, jail diversion, or co-occurring substance use, have extensively used legal mechanisms such as outpatient commitment and representative payeeship (Gold Award,

2001). Legal mechanisms are perceived as coercive among consumers who are non-adherent to treatment, though apparently not by consumers who are actively participating in treatment (Elbogen, Swanson, & Swartz, 2003). Clearly, these issues need to be brought out in the open and studied carefully (Compton et al., 2003; Dennis & Monahan, 1996; Rain, Steadman, & Robbins, 2003).

In addition to many thoughtful and valid criticisms of EBPs, there are also some criticisms that are based on misconceptions or distortions of the empirical literature. One of the most troubling is the oft-repeated insinuation that EBPs have been developed without an understanding of recovery, or worse, that the goals of EBPs might be indifferent, or even antithetic, to recovery (Anthony, Rogers, & Farkas, 2003). In our view, arguments asserting this position distort the EBP literature while defining recovery in vague, unattainable terms, which *no* research to date could have measured.

What would recovery look like without community integration? In some contexts, recovery and community integration are different ways of talking about the same thing. We agree with Anthony et al. (2003) that EBP research should measure "...meaningful roles in society (e.g., valued work, decent housing, membership in a community, enrollment in school)" (p. 105), but these are precisely what we mean by community integration. The notion that "Simple dichotomous counts of employment or hospitalization are an enormous conceptual distance from what might be described as recovery outcomes" (p. 105) may leave the impression that EBP studies are reductionistic, whereas "recovery-oriented" studies use richer measures. If we use Anthony et al.'s standard of avoiding simple counts, then one could equally question some of the widely-cited findings of one of the seminal recovery studies (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987). In fact, competitive employment rates and other such indicators *do* tell us a great deal about the recovery vision of a mental health center, resonating strongly in the attitudes of practitioners, consumers, and family members (Gowdy, Carlson, & Rapp, 2003). It is profoundly short-sighted to disparage such simple indicators.

Anthony et al. (2003) make a second point regarding the importance of qualitative methods. We wholeheartedly agree that these are vital to the advancement of the field and should be included to give a full picture of outcome. In fact, many excellent qualitative studies have been conducted on EBPs (e.g., Alverson, Alverson, & Drake, 2000; Angell, 2003; Gowdy et al., 2003).

Anthony et al. (2003) also state that "EBP research has rarely demonstrated a positive impact on recovery related outcomes," citing examples of recovery-oriented measures such as quality of life, self-esteem, empowerment, satisfaction, and well being (p. 106). We do not agree: Many studies *have* shown EBPs to positively impact these areas. More to the point, however, is the fact that it is generally hard to show strong experimental effects for these kinds of self-report measures *regardless* of what intervention is being studied. In our opinion, the problem rests more with the difficulty measuring subjective outcomes than with the intervention being measured. To our knowledge, there is no corpus of non-EBP research showing experimental effects for any of these measures, nor do Anthony et al. (2003) offer such evidence.

DISCUSSION

Community integration is a unifying, standardized, and measurable set of concepts for the assessment of EBPs. It provides a focus to link our scientific methods to our value system and capture the essential goal of EBPs in way that may sidestep what we believe to be a false dichotomy between EBPs and recovery. The purported lack of direct evidence that EBPs promote recovery can be largely attributed to the lack of standardized measures of recovery. To the extent that recovery has been measured at all in existing studies, it refers to measures such as functioning in satisfying adult roles, quality of life, and self-esteem. As valid and more precise measures of recovery are developed, they should be included in evaluations of evidence-based and emerging practices.

Each of the aforementioned EBPs and emerging practices goes beyond maintaining consumers "in the community," but strives toward truly integrating them into the economic, political, and social spheres of society. Not all areas of community life are adequately covered by the established EBPs. *Social* integration, involving reciprocal relationships between consumers and others in society, has not been adequately achieved (Angell, 2003; Prince & Prince, 2002). Certainly, more work also is needed in the areas of jail diversion, treatment for medical conditions, and treatment for trauma and co-occurring post-traumatic stress disorder.

Consumer choice and self-determination also are fundamental characteristics of EBP. In contrast to traditional vocational approaches,

supported employment facilitates real choices in employment. ACT teams enable individuals to find safe, affordable housing in the community. Integrated dual disorders treatment uses motivational strategies to respect the individual's goals and stage of recovery. All of the EBPs focus on consumers' personal goals as the starting point for intervention.

Beyond the debate regarding which practices should be deemed evidence-based is our assumption that *widespread acceptance of a reasonable set of EBPs is far superior than having no evidence-based framework at all, even if the list is incomplete.* It is clear that EBPs will evolve over time as we learn more. In the meantime, an evidence-based framework has helped to clarify and organize planning at the federal, state, and local levels. By defining what does work, it has made the continuation of unproven service models less easy to maintain. Judging from its rapid acceptance in medicine, it seems unlikely that the EBP tidal wave will recede in mental health, despite outspoken critics.

Practices emphasizing community integration have consistently proven to be more effective than clinic-based, segregated approaches, whether we are discussing employment, academic attainment, residential alternatives, or skills training. Community integration is part of the fabric of EBP.

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