

Illness Management & Recovery Toolkit

Evidence-Based Practices: Shaping Mental Health Services Toward Recovery

This document is part of an evidence-based practice implementation resource kit developed through a contract (no. 280-00-8049) from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) and a grant from The Robert Wood Johnson Foundation (RWJF), and support from the West Family Foundation. These materials are in draft form for use in a pilot study. No one may reproduce, reprint, or distribute this publication for a fee without specific authorization from SAMHSA.

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IMPLEMENTATION RESOURCE KIT USER'S GUIDE

Acknowledgments

We wish to acknowledge the many people who contributed to the development of the materials on Illness Management and Recovery for the Implementing Evidence-Based Practices Project:

Co-leaders of the development team for the Illness Management and Recovery implementation resource kit

Susan Gingerich Kim Mueser

Development team for the Illness Management and Recovery implementation resource kit

Bruce Bird	Lindy Fox	David Kime
Patricia Carty	Kate Hamblen	Bodie Morey
Mary Ellen Copeland	Marvin Herz	Norman Melendez
Pat Corrigan	David Hilton	Thang Pham
Susan Essock	James Jordan	Annette Schaub
Pam Fischer	Samuel Jordan	Nicholas Tarrier

Steering committee, Implementing Evidence-Based Practices Project, Phase I

Charity R. Appell	Howard H. Goldman	William C. Torrey
Barbara J. Burns	Paul Gorman	Laura Van Tosh
Michael J. Cohen	H. Stephen Leff	
Robert E. Drake	Ernest Quimby	

Project manager, Implementing Evidence-Based Practices Project, Phase I

Patricia W. Singer

Foreword

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) is a proud sponsor of this implementation resource kit for teaching illness management and recovery skills. As the federal agency responsible for promoting the quality, availability, and accessibility of services for people with mental illness, CMHS is responsible for identifying treatments for mental illness that work. The materials in this resource kit document the evidence for the effectiveness of illness management techniques and provide detailed materials to help communities to implement these techniques in real world settings. During development of the implementation resource kit, we placed special emphasis on 1) strengthening the consensus building process, 2) expanding the involvement of consumers and families, 3) including practical orientation to issues involving service organization and financing, and 4) insisting on paying careful attention to issues of ethnic and cultural sensitivity and overall cultural competence. We are well pleased with the result.

Many other organizations contributed to developing this implementation resource kit. This broad coalition of researchers, providers, administrators, policy makers, consumers and family members, gives the resource kit its strength and vitality. We are especially appreciative of the support provided by The Robert Wood Johnson Foundation which sponsored the early stages of the Project, when teaching evidence-based illness management and recovery skills was identified as a practice ready for widespread implementation. We agreed with the need to encourage practitioners and consumers to work together to empower people with serious mental illnesses to manage their symptoms and make informed decisions concerning their treatment. Evidence exists for the effectiveness of the individual techniques presented in this resource kit. It is an organized, standardized, and measurable package of proven-effective techniques that is critical for teaching consumers, administrators, and practitioners how to manage serious mental illness and move towards recovery.

This implementation resource kit reflects the current state-of-the-art concerning teaching of evidence-based illness management and recovery skills. It addresses both the "key ingredients" of the clinical model and many practical considerations essential for successful implementation. It also describes the need for each community to adapt the model to its particular needs and characteristics. Careful attention to unique community needs, coupled with fidelity to the key ingredients of the practice, equals successful implementation. The closer the kit user comes to following the implementation resource kit guidance, the more likely the practice will yield good results for consumers.

As mental health services research and evaluation progress, CMHS hopes to support the development of implementation resource kits for additional evidence-based practices, and to refine this and other previously developed resource kits to take new evidence into account. Indeed, evaluation of planned pilot projects for implementing this resource kit and associated implementation strategies will tell us much about how to make improvements in future versions. We hope that this and other evidence-based practice implementation resource kits will be helpful to communities across the nation as they strive to provide the most effective services possible for persons suffering from mental illness.

Introduction

Welcome to the Illness Management and Recovery implementation resource kit. It has been produced by the Implementing Evidence-Based Practices Project as part of an effort to promote treatment practices in community mental health service settings that are known to

be effective in supporting the recovery of adults with severe mental illnesses. The goal: to improve the lives of consumers by increasing the availability of effective mental health services.

The User's Guide begins by providing general information about the Implementing Evidence-Based Practices Project, including the project philosophy and values. This is followed by descriptions of the materials contained in the resource kit and their proposed role in the implementation process. The basic structure of an implementation plan is outlined. Specific suggestions for implementing the practice of Illness Management and Recovery are presented in the Implementation Tips documents. This guide also contains selected references on Illness Management and Recovery and a special populations appendix which provides a review of the literature addressing the range of populations for which this practice has demonstrated efficacy or effectiveness.

If you have any questions or comments about the resource kit materials or the implementation process, please contact Kristine Knoll at the NH-Dartmouth Psychiatric Research (e-mail address: Kristine.M.Knoll@Dartmouth.edu). We look forward to supporting your efforts to improve services to people with severe mental illness. Also, please share your experience in using these materials. Feedback from users will help refine and improve future versions of these implementation materials.

Background

What are "evidence-based practices"?

Evidence-based practices are services for people with severe mental illness (consumers) that have demonstrated positive outcomes in multiple research studies.

Over the past 15 years, researchers in mental health service systems have gathered extensive data to support the effectiveness of several psychosocial and pharmacological treatments. In 1998, the Robert Wood Johnson Foundation convened a consensus panel of researchers, clinicians, administrators, consumers, and family advocates to discuss the research and to determine which practices currently demonstrated a strong evidence base. This project is an offshoot of these efforts.

The six evidence-based practices:

Six practices were identified as currently demonstrating a strong evidence base:

- standardized pharmacological treatment
- illness management and recovery skills
- supported employment
- family psychoeducation
- assertive community treatment
- integrated dual disorders treatment (substance use and mental illness)

Other evidence-based practices for the treatment of persons with severe mental illnesses are being identified and will be promoted as the research evolves. This project is only a beginning attempt to establish models and procedures. This list of identified practices is not intended to be complete or exclusive. There should be many evidence-based practices in the future. Some promising practices being researched currently include peer support programming, supported housing, trauma services, and treatment for people with borderline personality disorder.

What is an implementation resource kit?

An implementation resource kit is a set of materials-written documents, videotapes, PowerPoint presentations, and a website-that support implementation of a particular treatment practice.

Specific materials in this resource kit have been developed for each of the key stakeholder groups involved in the implementation effort:

- consumers of mental health services
- family members and other supporters
- practitioners and clinical supervisors
- program leaders of mental health programs
- public mental health authorities

Research has shown that providing practice guidelines to practitioners alone does not change practice. Change is most likely to occur and be sustained if all the major stakeholders in the mental health system are engaged and involved in the process of change. Therefore the materials and guidelines in this implementation resource kit are geared toward five different stakeholder groups. The materials for each specific stakeholder group were either written by representatives of that group or in close collaboration with them.

The resource kit materials are also designed to address three stages of change:

- engaging and motivating for change (why do it)
- developing skills and supports to implement change (how to do it)
- sustaining the change (how to maintain and extend the gains)

What is an implementation package?

An implementation package is a set of implementation materials (the resource kit) combined with complementary training and consultation that support implementation of the evidence-based practice. The resource kit materials are designed to be most effective when used with consultative and training services. As part of the Implementing Evidence-Based Practices Project, EBP implementation centers are being established in various states across the country to provide consultation and training.

How was this implementation resource kit developed?

A team made up of multiple stakeholders developed each resource kit: researchers, clinicians, program managers and administrators, consumers, and family members. Documents oriented toward specific stakeholder groups were either written by the stakeholders or in close collaboration with them. A consensus panel, also comprised of multiple stakeholders, reviewed the materials developed for all of the six implementation resource kits to ensure consistency of presentation and attention to the various perspectives of the different constituencies.

For more information

For a more detailed discussion of the project and the implementation strategies, refer to the enclosed Psychiatric Services articles:

Drake RE, Goldman HH, Leff HS, et al: Implementing evidence-based practices in routine mental health service settings. Psychiatric Services 52:179-182, 2001.

Torrey WC, Drake RE, Dixon L, et al: Implementing evidence-based practices for persons with severe mental illnesses. Psychiatric Services 52:45-50, 2001.

Project Philosophy and Values

The project rests on two philosophical tenets:

First, mental health services for people with severe mental illnesses should have the goal of helping people to develop high-quality, satisfying functional lives. That is, services should aim not just at helping consumers stay out of the hospital and reducing or stabilizing symptoms, but also at helping them to pursue their own personal recovery process. People want services that help them to manage their illnesses and to move ahead with their lives.

Second, consumers and their families have a right to information about effective treatments, and in areas where evidence-based practices exist, consumers and family members have a right to access effective services.

Evidence-based practices are not intended to be exclusive, mandatory, or rigid. Rather, they imply self-knowledge, self-determination, choice, individualization, and recovery.

Defining recovery

There have been many efforts to define the recovery philosophy. The Consumer Advisory Panel for the Implementing Evidence-Based Practices Project drafted the following brief statement. The principles of recovery that informed the development of the implementation resource kit materials are:

- hope
- personal responsibility
- education
- self-advocacy
- support

The cessation of symptoms is not necessarily equal to recovery. Each person develops their own definition of recovery, which many view as a process rather than a destination. It is important to know what is meant by "support." While the support of others is a valuable element in recovery, it does not include solving problems for another person or giving advice.

Empowerment is another critical component to recovery. A person becomes dis-empowered when choices are made for them, even when well-meaning supporters do it. Disempowerment also occurs when assumptions or judgments are made concerning an individual and their choices.

Recovery is most easily achievable when a person and those around them recognize the individual as a whole and complete person regardless of symptoms. One of the most valuable things a person can do for someone with psychiatric symptoms is to listen.

For more information

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How to Use the Resource Kit Materials—An Implementation Plan

Effective implementation of evidence-based practices is best achieved by using the materials with a structured complementary consultative and training program. As part of this project, a number of evidence-based practices implementation centers have been established throughout the country.

A brief description of a basic implementation plan that includes these supports is provided below. See the *Implementation Tips for Mental Health Programs Leaders* and *Implementation Tips for Public Mental Health Authorities* for more detailed suggestions regarding the implementation of *Illness Management and Recovery*.

Consensus building

Build support for change

- identify key stakeholders
- provide information to all stakeholders
- develop consensus regarding a vision for the practice at your agency
- convey a vision and a commitment to all stakeholders

Enthusiasm for the implementation of the evidence-based practice can be generated by communicating how the practice benefits consumers and family members.

Use implementation resource materials:

- Distribute information materials to the key stakeholder groups.
- Hold informational meetings with key stakeholder groups.
- Have opinion leaders within the different stakeholder groups co-host these meetings. Include a viewing of the introductory videotape.
- An introductory PowerPoint presentation can be used to structure the informational meeting.

Developing an implementation plan

An action plan

- identify an agency implementation leader
- establish an implementation steering team that includes representatives from all stakeholder groups

- secure a consultant from an EBP implementation institute
- develop an implementation plan

Responsibilities of the implementation leader and implementation steering team include identifying and utilizing personnel, resources, and processes (administrative support and system changes) needed to support the evidence-based practice; an assessment of training needs; and development of an implementation timeline.

Consultants from EBP implementation centers can work with public mental health authorities and program leaders to inform them about the practice, to evaluate an agency's or system's commitment to change, and to assess current realities of financial incentives, staffing, and structure.

By developing partnerships with community organizations including peer support programs, consumer and family advocacy groups, police, homeless shelters, food banks, department of vocational rehabilitation, and others depending on the specific practice, the implementation leader and the implementation steering team can most effectively develop support for the practice. These groups may contribute to the development of an implementation plan.

Use of implementation resource materials:

- Implementation Tips for Public Mental Health Authorities is designed for individuals at the municipal, county, or state mental health authority.
- Implementation Tips for Mental Health Program Leaders is designed to be shared with the individuals in an agency that make and carry out decisions about the local resources and processes. This includes people who have responsibility for program management, training, policy development, program standards, data management, and funding.

Enacting the implementation

Making it happen

- involve agency personnel at all levels to support the implementation
- host a "kick-off" training where all stakeholders receive information about the practice
- host a comprehensive skills training for agency personnel who will be providing the practice
- arrange opportunities to visit programs that have successfully implemented the practice
- work with an implementation center for off-site support for the practice
- review current agency outcome measures relative to the practice and modify outcome data to monitor the practice. Learn how to make use of outcome measures in clinical practice and supervision
- work with a consultant/trainer to learn how to use the fidelity scale to identify strengths and weaknesses in the implementation effort

Trainers can work with the agency to offer an initial or "kickoff" training for all stakeholders. The trainer can then provide comprehensive skills training for those personnel within the agency who will be providing the practice. The trainers may offer to visit the program at least one day per month for the first six months, then one day every other month for the next six months, for ongoing training, consultation, supervision as needed by the program. The trainer may also be available on a weekly basis for phone consultation.

Use of implementation resource materials:

Many agencies find it useful for the implementation leader and agency staff to familiarize themselves with the structure and processes of the practice by visiting an existing program. Before a site visit, the implementation leader and clinical supervisor(s) should review:

- Information for Practitioners and Clinical Supervisors
- Information for Mental Health Program Leaders
- Implementation Tips for Mental Health Program Leaders
- Workbook for Practitioners and Clinical Supervisors
- Materials that support training and clinical supervision
- Workbook for Practitioners and Clinical Supervisors
- Practice demonstration videotapes
- PowerPoint training presentation (available from the West Institute)

Trainers may also serve as consultants to the administrators of the program. This includes demonstrating the usefulness of outcomes data as a clinical feedback tool.

Monitoring and evaluation

Sustaining change: How to maintain and extend the gains

- establish a mechanism for continuous feedback regarding how the practice is being provided in an agency
- publicize outcome improvements from the practice
- use fidelity scales to monitor the practice implementation

Monitoring and evaluation occur in several ways. First, the use of consultants to provide side-by-side, ongoing consultation during the first one to two years of the program is very helpful. Consultants who are experienced in the practice can recognize problems and recommend changes to address them.

Use of implementation resource materials:

It is useful for programs to become comfortable early on with the measures that will be used for monitoring and evaluating the delivery of the practice: outcome measures and the fidelity scale. The information collected can be used not only to identify areas that are problematic, but also to identify areas of excellence. Feedback from these measures may be used to promote and strengthen clinical and programmatic effectiveness.

A Word about Terminology

Terms used in the Implementation Resource Kit materials

The materials were developed by people from a variety of backgrounds and perspectives. During development, it became evident that many different terms are used to describe the key stakeholders. For the sake of clarity and consistency, in most instances common terms are used to identify these groups throughout the implementation resource kits. In some situations more precise, or alternative, terminology is used. For instance, in the Supported Employment implementation resource kit, the term 'employment specialist' is often used rather than "practitioner."

Consumers, clients, people who have experienced psychiatric symptoms

These terms refer to persons who are living with severe mental illness and who use professional mental health services-the consumers of mental health services. The term 'consumer' is most frequently employed in the resource kit materials. In the Integrated Dual Disorders Treatment workbook and in the outcome measures document, the term 'client' is used. The Illness Management and Recovery resource kit uses the term 'people who have experienced psychiatric symptoms'.

Family and other supporters

This terminology refers to families and other people who provide support to a consumer, and recognizes that many consumers have key supporters who are not family members.

Practitioners and clinical supervisors

The term practitioner refers to the people who deliver the evidence-based practice. This is used instead of clinician, case manager, nurse, psychiatrist, therapist, etc. except when referring to a specific kind of role (e.g., the employment specialist in supported employment, or the prescriber in medication management). The term clinical supervisor is used to distinguish between an administrative supervisor and the person supervising the clinical work of the practitioner.

Mental health program leaders

This term is used to describe the person at the mental health provider organization who is trying to put the practice into effect. This term is used instead of program supervisor, operations director, program manager, or program administrator. The term is used because it makes it clear that this person's job is to lead with the support of the agency's administration.

Public mental health authorities

This term is used to describe the people who determine the regulations and funding structures of the public mental health system. We recognize that evidence-based practices are also implemented and overseen in the private sector.

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*Recommended article

Special Populations Appendix

The following is a review of the literature addressing the range of populations for which the components of illness management have demonstrated efficacy or effectiveness, including factors such as age, race, ethnicity, gender, and geographic location.

The core components of illness management are psychoeducation, behavioral tailoring for using medication as prescribed, relapse prevention, and cognitive-behavioral strategies for coping with symptoms. Randomized controlled studies of these components were conducted in settings that included people from a wide range of races and ethnicities, including Caucasians, African Americans, Latinos, Asians, Native Americans and French Canadians. The studies were conducted in the U.S., England, Germany and Canada. Most of the research focuses on individuals with schizophrenia spectrum disorders, with less research addressing major affective disorders.

Studies on the components of illness management have included both male and females, with a higher proportion of males. None of the studies reported the sexual orientation of the participants. The studies included people who came from both urban and rural settings and who received either inpatient or outpatient mental health services. The ages of study participants ranged from 18 to 67, with several studies reporting a mean age of around 40.

There is no evidence suggesting that race, diagnosis, gender, geographic setting, age or inpatient/outpatient status are related to the ability to benefit from the components of illness management.

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INFORMATION FOR PEOPLE WHO HAVE EXPERIENCED PSYCHIATRIC SYMPTOMS

What is the Illness Management and Recovery Program?

- Learning about mental illness & strategies for treatment
- Decreasing symptoms
- Reducing relapses & rehospitalizations
- Making progress toward your goals and toward recovery

What is provided in the Illness Management and Recovery Program?

- You will receive educational handouts, planning sheets, and checklists.
- A practitioner will help you to apply the contents of the handouts to develop your own strategies for managing mental illness and setting and achieving goals.
- You will have opportunities to practice your personalized strategies in the sessions and in your every day life.

What will you learn in the Illness Management and Recovery Program??

The following subjects are covered in educational handouts:

1. Recovery strategies
2. Practical facts about mental illness
3. The stress-vulnerability model and treatment strategies
4. Building social support
5. Reducing relapses
6. Using medication effectively
7. Coping with stress
8. Coping with problems and symptoms
9. Getting your needs met in the mental health system

What is the role of family members and other supporters in this program?

With your permission, family members and other supporters may be involved in reading the educational handouts, attending some sessions, and helping you develop and implement plans for coping with symptoms, reducing relapses and pursuing recovery goals.

INFORMACIÓN PARA PERSONAS QUE HAN EXPERIMENTADO SÍNTOMAS PSIQUIÁTRICOS

¿Qué es el Programa del Manejo de las Enfermedades Mentales y la Recuperación?

El programa del Manejo de las Enfermedades Mentales y la Recuperación consiste en una serie de sesiones semanales en las cuales profesionales de la salud mental, especialmente entrenados, ayudan a las personas que han experimentado síntomas psiquiátricos a desarrollar estrategias personales para enfrentarse con la enfermedad mental y salir adelante con sus vidas. El programa se puede proveer de una manera individual o en grupo, y generalmente dura de 3 a 6 meses.

¿Cuáles son algunos de los beneficios del Programa del Manejo de las Enfermedades Mentales y la Recuperación para las personas que han experimentado síntomas psiquiátricos?

1. Aprendizaje sobre la enfermedad mental y las estrategias para el tratamiento
2. Disminución de los síntomas
3. Reducción de las recaídas y las rehospitalizaciones
4. Progreso hacia las metas personales y hacia la recuperación

¿Qué es lo que se va a enseñar en el Programa del Manejo de las Enfermedades Mentales y la Recuperación?

Los siguientes temas son cubiertos en las hojas educativas:

1. Estrategias para la Recuperación
2. Hechos Prácticos sobre la Enfermedad Mental
3. El Modelo sobre la Vulnerabilidad al Estrés y Estrategias para el Tratamiento
4. Creando Apoyo Social
5. Reduciendo las Recaídas
6. Usando las Medicinas Eficazmente
7. Enfrentándose al Estrés
8. Enfrentándose a los Problemas y a los Síntomas
9. Consiguiendo que sus Necesidades sean Satisfechas en el Sistema de la Salud Mental.

¿Cómo pueden ayudar los miembros de la familia y otros grupos de apoyo?

Con el permiso de la persona que ha experimentado los síntomas psiquiátricos, usted puede ayudar de la siguiente manera:

- Leyendo las hojas educativas usadas en el programa
- Asistiendo a algunas sesiones con los profesionales de la medicina y la persona que ha experimentado los síntomas psiquiátricos
- Revisando las hojas educativas con la persona que ha experimentado los síntomas psiquiátricos
- Ayudando a la persona a desarrollar e implementar planes para enfrentarse a los síntomas, reduciendo las recaídas, y buscando metas hacia la recuperación.

INFORMATION FOR FAMILIES AND OTHER SUPPORTERS

What is the Illness Management and Recovery Program?

The Illness Management and Recovery Program consists of a series of weekly sessions in which specially trained mental health practitioners help people who have experienced psychiatric symptoms develop personal strategies for coping with mental illness and moving forward in their lives. The program can be provided in an individual or group format, and generally lasts between 3 to 6 months.

What are some of the benefits of the Illness Management and Recovery Program for people who have experienced psychiatric symptoms?

- Learning about mental illness and strategies for treatment
- Decreasing symptoms
- Reducing relapses and rehospitalizations
- Making progress toward goals and recovery

What will be taught in the Illness Management and Recovery Program?

The following subjects are covered in educational handouts:

1. Recovery Strategies
2. Practical Facts About Mental Illness
3. The Stress-Vulnerability Model and Treatment Strategies
4. Building Social Support
5. Reducing Relapses
6. Using Medication Effectively
7. Coping with Stress
8. Coping with Problems and Symptoms
9. Getting Your Needs Met in the Mental Health System

How can family members and other supporters help?

With the permission of the person who has experienced psychiatric symptoms, you can help by:

- Reading the educational handouts used in the program
- Attending some sessions with the practitioner and the person who has experienced psychiatric symptoms
- Reviewing the educational handouts with the person
- Helping the person develop and implement plans for coping with symptoms, reducing relapses, and pursuing recovery goals

INFORMACIÓN PARA LOS MIEMBROS DE LA FAMILIA Y OTROS GRUPOS DE APOYO

¿Qué es el Programa del Manejo de las Enfermedades Mentales y la Recuperación?

El programa del Manejo de las Enfermedades Mentales y la Recuperación consiste en una serie de sesiones semanales en las cuales profesionales de la salud mental, especialmente entrenados, ayudan a las personas que han experimentado síntomas psiquiátricos a desarrollar estrategias personales para enfrentarse con la enfermedad mental y salir adelante con sus vidas. El programa se puede proveer de una manera individual o en grupo, y generalmente dura de 3 a 6 meses.

¿Cuáles son algunos de los beneficios del Programa del Manejo de las Enfermedades Mentales y la Recuperación para las personas que han experimentado síntomas psiquiátricos?

- Aprendizaje sobre la enfermedad mental y las estrategias para el tratamiento
- Disminución de los síntomas
- Reducción de las recaídas y las rehospitalizaciones
- Progreso hacia las metas personales y hacia la recuperación

¿Qué es lo que se va a enseñar en el Programa del Manejo de las Enfermedades Mentales y la Recuperación?

Los siguientes temas son cubiertos en las hojas educativas:

1. Estrategias para la Recuperación
2. Hechos Prácticos sobre la Enfermedad Mental
3. El Modelo sobre la Vulnerabilidad al Estrés y Estrategias para el Tratamiento
4. Creando Apoyo Social
5. Reduciendo las Recaídas
6. Usando las Medicinas Eficazmente
7. Enfrentándose al Estrés
8. Enfrentándose a los Problemas y a los Síntomas
9. Consiguiendo que sus Necesidades sean Satisfechas en el Sistema de la Salud Mental.

¿Cómo pueden ayudar los miembros de la familia y otros grupos de apoyo?

Con el permiso de la persona que ha experimentado los síntomas psiquiátricos, usted puede ayudar de la siguiente manera:

- Leyendo las hojas educativas usadas en el programa
- Asistiendo a algunas sesiones con los profesionales de la medicina y la persona que ha experimentado los síntomas psiquiátricos
- Revisando las hojas educativas con la persona que ha experimentado los síntomas psiquiátricos
- Ayudando a la persona a desarrollar e implementar planes para enfrentarse a los síntomas, reduciendo las recaídas, y buscando metas hacia la recuperación.

INFORMATION FOR PRACTITIONERS AND CLINICAL SUPERVISORS

What is the Illness Management and Recovery Program?

The Illness Management and Recovery Program consists of a series of weekly sessions in which mental health practitioners help people who have experienced psychiatric symptoms develop personal strategies for coping with mental illness and moving forward in their lives. The program can be provided in individual or group formats and generally lasts between 3 to 6 months.

With the permission of the person who has experienced psychiatric symptoms, family members and other supporters may be asked to read the educational handouts, attend some sessions, and help the person develop and implement plans for coping with symptoms, reducing relapses, and pursuing recovery goals.

How do practitioners benefit from the Illness Management and Recovery Program?

Practitioners benefit by:

- Learning a comprehensive, step-by-step approach to helping people gain skills in managing mental illness
- Saving time by receiving ready-to-use materials for conducting sessions
- Gaining skills in using motivational strategies, cognitive behavioral strategies, and educational strategies
- Experiencing increased job satisfaction from seeing improved outcomes, such as people reducing relapses and hospitalizations and making progress in their goals for recovery

How does the program compare to what is currently offered at community mental health centers?

This program pulls together the main components of effective illness management programs and provides a comprehensive, structured, step-by-step approach. It provides materials that have a recovery orientation and are user friendly both for practitioners and for persons who have experienced psychiatric symptoms. The program also heavily emphasizes helping people put knowledge into practice in their every day life.

What will people learn in the Illness Management and Recovery Program?

The following subjects are covered in educational handouts:

1. Recovery Strategies
2. Practical Facts About Mental Illness
3. The Stress-Vulnerability Model and Treatment Strategies
4. Building Social Support
5. Reducing Relapses
6. Using Medication Effectively
7. Coping with Stress
8. Coping with Problems and Symptoms
9. Getting Your Needs Met in the Mental Health System

What resource materials do practitioners receive as part of the Illness Management and Recovery Program?

1. A Practitioners' Guide, with practical tips for teaching people about mental illness and helping them develop strategies for each of the 9 topic areas
2. Educational handouts, checklists, and planning sheets for each of the 9 topic areas
3. A short introductory video
4. Informational brochures
5. A fidelity scale to measure whether the program is being implemented as designed
6. Outcome measures to assess whether the program is having a positive impact on participants

INFORMATION FOR MENTAL HEALTH PROGRAM LEADERS

What is the Illness Management and Recovery Program?

The Illness Management and Recovery Program consists of a series of weekly sessions where practitioners help people who have experienced psychiatric symptoms to develop personal strategies for coping with mental illness and moving forward in their lives. This is a model for people who have experienced symptoms of schizophrenia, bipolar disorder, or depression. It is appropriate for people at various stages of the recovery process. The program can be provided in an individual or group format and generally lasts between three to six months.

Practitioners for Illness Management and Recovery can come from a wide range of clinical backgrounds, including but not restricted to the following: social work, occupational therapy, counseling, case management, nursing, and psychology. All practitioners providing the program will need training and ongoing supervision.

Is the Illness Management and Recovery Program an evidence-based practice?

The Illness Management and Recovery Program is based on research which has shown that people who have experienced psychiatric symptoms can show improvements in:

- Knowledge about mental illness
- Reducing relapses and rehospitalizations
- Coping more effectively and reducing distress from symptoms
- Using medications more effectively

What is the role of family members and other supporters in this program?

With the person's permission, family members and other supporters may participate in one of more of the following ways:

- Read the educational handouts used in sessions
- Participate in selected sessions
- Assist in developing relapse prevention plans
- Participate in homework assignments
- Help the person pursue their recovery goals

What are the benefits for Community Mental Health Centers that provide the Illness Management and Recovery Program?

Mental Health Centers are under increasing pressure to provide interventions that have demonstrated positive outcomes for people who have experienced psychiatric symptoms. But it is often very time-consuming to locate and evaluate the research and to find user friendly, step-by-step materials that can be used implement and measure the outcomes of the intervention. The Illness Management and Recovery Program makes it possible to provide an evidence-based practice in a comprehensive and easy-to-use format.

What is provided in the Illness Management and Recovery Program?

- Educational Handouts for Illness Management and Recovery, written for people who have experienced psychiatric symptoms. These handouts contain practical information, summaries,

check lists, and planning sheets for nine topic areas, as listed in the following section of this brochure.

- The Practitioner's Guide for Illness Management and Recovery, which provides practical suggestions for each handout, including how to help people develop and practice coping strategies, how to help people develop and pursue recovery goals, and tips for responding to problems that may arise during sessions.
- A fifteen minute introductory video.
- Informational brochures for people who have experienced psychiatric symptoms, family members and practitioners.
- A fidelity scale to measure whether the program is being implemented as designed.
- Outcome measures to assess whether the program is having a positive impact on participants.

What topic areas are covered in the program?

Educational handouts are provided for the following nine topics:

- Recovery strategies
- Practical facts about mental illness
- The stress-vulnerability model and treatment strategies
- Building social support
- Reducing relapses
- Using medication effectively
- Coping with stress
- Coping with problems and symptoms
- Getting your needs met in the mental health system

INFORMATION FOR PUBLIC MENTAL HEALTH AUTHORITIES

Evidence-Based Practices

Mental Health Authorities are under increasing pressure to provide interventions that have demonstrated positive outcomes for people who have experienced psychiatric symptoms. This is often easier said than done. Many agencies are finding it overwhelming to locate and evaluate the research, find user-friendly materials to implement the intervention, locate training opportunities for staff, plan organizational change and set up the programs themselves.

To help implement effective treatment programs, the Robert Wood Johnson Foundation and the Substance Abuse and Mental Health Services Administration (SAMHSA) jointly provided funding for a project to identify and implement interventions that are supported by research evidence, i.e., “Evidence-Based Practices.”

The Illness Management and Recovery Program is an Evidence-Based Practice.

The Illness Management and Recovery Program is based on research which has shown that by learning more about managing mental illness, people who have experienced psychiatric symptoms can take important steps toward recovery. Specifically, there is evidence that people can:

- Learn more about mental illness.
- Reduce relapses and rehospitalizations.
- Reduce distress from symptoms.
- Use medications more consistently.

The Illness Management and Recovery Program provides a structured approach for practitioners to help people move toward recovery.

The program consists of a series of weekly sessions where practitioners help people who have experienced psychiatric symptoms to develop personalized strategies for managing mental illness and achieving personal goals. The program can be provided in an individual or group format, and generally lasts between three to six months. It is designed for people who have experienced the symptoms of schizophrenia, bipolar disorder, and major depression.

The content of the sessions focuses on the following nine topic areas:

- Recovery strategies
- Practical facts about schizophrenia, bipolar disorder and major depression
- The stress-vulnerability model and treatment strategies
- Building social support
- Using medication effectively
- Reducing relapses
- Coping with stress
- Coping with problems and symptoms
- Getting your needs met in the mental health system

The Illness Management and Recovery Program provides materials to guide practitioners step-by-step.

The Illness Management and Recovery Program incorporates the main components of effective illness management programs and provides materials that are user-friendly both for practitioners and for people who have experienced psychiatric symptoms. The following components are included:

- Educational Handouts for Illness Management and Recovery, written for people who have experienced psychiatric symptoms. They contain practical information, summaries, check lists, and planning sheets for each of the nine topics listed above.
- The Practitioner's Guide for Illness Management and Recovery, which provides practical suggestions for each handout, including how to help people develop and practice strategies, how to help people develop and pursue recovery goals, and tips for responding to problems that may arise during sessions.
- A fifteen minute video to introduce the program.
- Brochures written for people who have experienced psychiatric symptoms, for family members, and for practitioners.
- Fidelity scales to measure faithfulness of program implementation.
- Outcome measures to assess the impact of the program.

IMPLEMENTATION TIPS FOR MENTAL HEALTH PROGRAM LEADERS

Implementation Tips for Mental Health Program Leaders

This document is designed to help mental health program leaders who are seeking to implement the Illness Management and Recovery Program at their clinical site. This program is the result of consolidating the main components of effective illness management programs which emphasize helping people who have experienced psychiatric symptoms to develop strategies for managing their own illness. It is a comprehensive, structured, and step-by-step program, which provides ready-to-use materials.

Over the years we have seen different program leaders who have successfully put effective illness management programs into effect in routine mental healthcare settings. In this document, we offer you ideas that we have gathered from these mental health program leaders.

Leading the implementation

The Illness Management and Recovery Program is more likely to be successfully implemented if a specific identified person is responsible for leading the implementation. The identified leader is more likely to succeed if he or she has the backing of senior administrators and the respect of on-line staff. We recommend a person-centered management approach, such as the one articulated by Charles Rapp and his colleagues (see Appendix). This approach encourages practitioners to focus on goals set by the person, to use person-centered outcome data to guide ongoing management decisions, and to see leadership as an ongoing learning experience. Progress and success are measured by person-centered outcomes rather than by process measures such as hours of therapy or day treatment.

The implementation leader's job is to assist the agency in identifying and overcoming obstacles to successful implementation. This may include advocating for funding, rallying the support of the Executive Director or other key leaders, or bringing in consultants when needed.

Many authors have written about the process of leading change in healthcare. Please see the Appendix for references on this topic.

The task of implementing the Illness Management and Recovery Program can be broken into three phases:

1. building momentum for change
2. making the change
3. maintaining and extending the gains.

Building momentum for change

Programs have found the following strategies to be helpful:

- Work to get early buy-in from key leaders at the clinical site. Titled leaders and informal leaders are both important. They can help you with the rest of the process.
- Get the agency CEO to visibly articulate support for the Illness Management and Recovery Program.
- Work with your local NAMI and consumer groups to build consensus for change among key stakeholders.
- Bring in outside speakers to inspire the staff. Speakers tend to be more successful if they have credibility to the practitioners. Practitioners indicate that presenter credibility is increased if the presenter is a practitioner, demonstrates that he or she understands the population, expresses an acceptable value set, and/or is well-known in the field.

- Bring in people who have experienced psychiatric symptoms to talk about their experiences with learning to manage their illness and how it has helped them to move forward in recovery. This strategy works best if people have received services from local programs or from programs similar to your own.
- Connect your practitioners with professionals who have similar roles. Case managers tend to listen to case managers, physicians to physicians, and so on.
- Educate practitioners about studies that demonstrate the effectiveness of the components of the Illness Management and Recovery Program. See the article, “Illness Management and Recovery for Severe Mental Illness: A Review of the Research,” by Kim Mueser, et al, listed in the Appendix.
- Organize retreats to predispose practitioners to implement the Illness Management and Recovery Program. Retreats can be used to educate practitioners, to help them appreciate the importance of the Illness Management and Recovery Program, and to engage them in planning the implementation.
- Place the Illness Management and Recovery Program in the context of the larger recovery paradigm across the agency. Articulate how the Illness Management and Recovery Program will assist the agency in fulfilling its mission, that is, assisting people in their recovery process.
- Anticipate the impact of the change on operations and other programming.

Making the change

The goal of the implementation leader is to redesign the process of care so that it becomes natural and easy for practitioners to provide Illness Management and Recovery Program on a regular basis. It will be helpful to anticipate the following issues:

Time frame

Generally, it takes about a year for practitioners to feel comfortable and confident providing the Illness Management and Recovery Program.

Staff qualifications

Academic credentials are less important than being able to develop a collaborative relationship with people who have experienced psychiatric symptoms. Practitioners who are flexible and optimistic about the recovery process tend to be very good at providing illness management programs.

Staff responsibilities

The Illness Management and Recovery Program is a comprehensive model which assists staff members, especially case managers, in fulfilling current job responsibilities effectively. To implement the program on an individual basis, practitioners need to be able to schedule weekly sessions of 45 to 60 minutes, for three to six months (depending on how much time the person needs to cover the nine topic areas). To implement the program on a group basis, practitioners need to be able to schedule weekly group sessions of 45 to 60 minutes with six to eight people in each group. The groups last from 3 to 6 months (depending on how much time the group members need to cover the nine topic areas).

Training

Practitioners will need knowledge about the symptoms and treatment recommendations for schizophrenia, bipolar disorder and major depression. They will need training in the core values of Illness Management and Recovery and training in its teaching principles, which include developing a collaborative relationship with people who have experienced psychiatric symptoms, teaching basic facts about mental illness, using motivation-based techniques, and using basic cognitive behavioral techniques.

Supervision and support

Weekly group supervision is recommended. Supervision should include regular validation of participant strengths and practitioner strengths. In supervision, practitioners will benefit from discussing possible solutions for difficulties they may be encountering in sessions.

Clinical team meeting

Practitioners providing the Illness Management and Recovery Program are part of the clinical team and should attend the clinical team meetings.

Equipment

Because of the extensive educational handouts required to conduct sessions, practitioners need to have access to file cabinets, xeroxing, and shelf space.

Paperwork

Practitioners will need to complete a “Strengths and Knowledge Inventory” for each person and complete an Illness Management and Recovery Progress Note for each session. They will also need to document the person’s goals and progress toward goals at least once a month and to administer review questions at the end of each of the nine topic areas covered in the educational handouts. Other paperwork may be required by the funding sources and local regulations.

Tracking people’s goals

Practitioners will assist people in identifying recovery goals. Together they will assess progress towards these goals at least once a month.

Policies and procedures

Relevant policies and procedures should be reviewed and revised to support the implementation of the Illness Management and Recovery Program.

Maintaining and extending the gains

- Put in place a process that lets staff know how many people are participating in the program and the extent to which they are accomplishing their goals.
- Visibly recognize staff members who have made the Illness Management and Recovery Program a success in your agency. Consider revising job performance reviews to include an assessment of skills in providing the Illness Management and Recovery Program.
- Find ways to tell each other success stories. Consider devoting a portion of each clinical meeting to sharing good news. This could include feedback and anecdotes from participants, family members, and employers.
- Sponsor events to celebrate achievements made by participants in the Illness Management and Recovery Program. Provide an opportunity for people to talk about what they have learned and accomplished.
- Become a training site to stay fresh and interested and help pass on your knowledge and experience to others.

The following publications are excellent resources on program management:

Batalden, PB, Stoltz, PK: A framework for the continual improvement of healthcare: Building and applying professional and improvement knowledge to test changes in daily work. The Joint Commission Journal on Quality Improvement. 19:10, 424-445, 1993.

Gowdy, E., & Rapp, C.A. (1989). Managerial behavior: The common denominators of successful community based programs. Psychosocial Rehabilitation Journal, 13(2), 31-51.

Nelson EC, Batalden, PB, Ryer, JC (Eds.): Joint Commission Clinical Improvement Action Guide. Oakbrook Terrace, Illinois, 1998.

Rapp CA: Client-centered performance management for rehabilitation and mental health services. Rehabilitation and Mental Health Service Delivery.

Rapp, C.A. (1993). Client-centered performance management and the inverted hierarchy. In (Eds.) Flexer, R. & Solomon, P., Community and social support for people with severe mental disabilities. Andover Publishing Co.

Rapp, C. A. (1998). The Strengths Model: Case Management with People Suffering from Severe and Persistent Mental Illness. Chapter 8 – Supported Case Management Context: Creating the Conditions for Effectiveness. New York: Oxford University Press.

Supervisor's Tool Box. (1997). Lawrence, KS: The University of Kansas School of Social Welfare.

The following article focuses on the evidence for the Illness Management and Recovery intervention:

Mueser, K.T.; Corrigan, P.W.; Hilton, D.; Tanzman, B.; Schaub, A.; Gingerich, S.; Essock, S.M.; Tarrier, N.; Morey, B.; Vogel-Scibilia, S.; and Herz, M.I. Illness management and recovery: A review of the research. Psychiatric Services, in press.

IMPLEMENTATION TIPS FOR PUBLIC MENTAL HEALTH AUTHORITIES

Implementation Tips for Public Mental Health Authorities

The Evidenced-Based Practices Project presents public mental health authorities with a unique opportunity to improve clinical services for adults with severe mental illness. Service system research has evolved to a point where it can identify a cluster of practices that demonstrate a consistent, positive impact on the lives of people who have experienced psychiatric symptoms. The Illness Management and Recovery Program represents one of those evidence-based practices.

This document is for public mental health authorities who are planning to implement the Illness Management and Recovery Program—a series of weekly sessions in which practitioners help people who have experienced psychiatric symptoms develop strategies for managing mental illness and achieve personal goals. The program can be provided in an individual or group format and generally lasts between three to six months. It is designed for persons with schizophrenia, schizoaffective disorder, bipolar disorder, and major depression.

Building a Consensus for Change

To implement the Illness Management and Recovery Program, the public mental health authority must assemble all of the stakeholders: people who have experienced psychiatric symptoms, family members and other supporters, practitioners, related state/public organizations, and provider groups.

From the beginning, the public mental health authority needs to be an active part of this group as they discuss the goals of illness management and recovery, identify the benefits they expect, and determine the best methods for implementing it in the service system. For the implementation to succeed, the public mental health authority must articulate the vision of illness management and recovery and develop momentum around that vision.

Making the Change

With a vision firmly in place, the process of intervention in the service system can begin. Careful planning will go a long way to ensure a successful outcome. A pilot or demonstration site may be used to manage the inevitable problems that will arise and will give all the stakeholders the opportunity to see that this intervention works. The public mental health authority is responsible for creating incentives within the system. Attention to the alignment of these incentives is vital to the success of the implementation of the Illness Management and Recovery Program.

Sustaining the Change

Sustaining the project should be central in the initial planning stage. There are too many examples of excellent initiatives that began positively and had the enthusiastic support of participants, but then floundered because of a failure to address the critical issue of the ongoing project maintenance. The public mental health authority can use strategies (rules and contracts) to address the issue of program maintenance and can ensure that the Illness Management and Recovery Program will continue to grow and develop.

It is important to help agencies find solutions when problems arise in implementing the Illness Management and Recovery Program. It is also important to collect good data on the programs that are implemented. Site visits, fidelity measures, and outcome data are extremely useful to ensure quality services over time.

Strategies for Public Mental Health Authorities

- Articulate the vision of illness management and recovery, which is based on people with psychiatric symptoms developing their own strategies for managing mental illness and developing plans for achieving personal goals. It is a collaborative approach that stresses the person's individual experience with psychiatric symptoms and his or her individual goals.
- Articulate the benefits of illness management and recovery, which includes people who have experienced psychiatric symptoms being able to reduce relapses and to move forward in recovery.
- Involve as many people as possible in planning for implementation and maintenance. The more stakeholders involved, the more comprehensive the plans can be. Anticipate funding needs. For some agencies that have already instituted a psychoeducational program, implementing the Illness Management and Recovery Program will involve staff training and the introduction of structured curriculum and specific techniques. For agencies that do not have a psychoeducational program, more changes in organization, staffing and funding will be necessary.
- Make efforts to ensure that services are reimbursed at a realistic rate. Implementing the program should not be experienced as a financial loss for an agency.
- Monitor fidelity of program implementation. If the program is not being implemented as designed, the outcomes will not be as positive.
- Monitor outcomes. Use the outcome measures to demonstrate that people who have experienced psychiatric symptoms are benefiting. Publicize these benefits.
- Continue to meet regularly with the stakeholder group. A suggested schedule would be approximately once a month for the first year, once every two months for the second year, and quarterly for the third year. These group meetings should focus on progress being made in implementing the Illness Management and Recovery Program (for example, how many people have access to the program?) and how to solve problems in implementation (for example, how can the achievement of people's goals be better documented?).
- Visit sites that are implementing illness management and recovery. Talk to practitioners and people that are participating in the program. Ask to see the materials that are being used.
- Identify programs that are doing a particularly good job of implementing the program. Give them public recognition.

For more information

Mueser, K.; Corrigan, P.; Hilton, D.; Tanzman, B.; Schaub, A.; Gingerich, S.; Copeland, M.E., Essock, S., Tarrrier, N.; Morey, B.; Vogel-Scibilia, S.; and Herz, M. Illness management and recovery: A review of the research. Psychiatric Services, in press.

ILLNESS MANAGEMENT AND RECOVERY FIDELITY SCALE

This document is intended to help guide you in administering the Illness Management and Recovery (IMR) Fidelity Scale. In this document you will find the following:

Introduction: This gives an overview of IMR and a who/what/how of the scale, plus a checklist of suggestions for before, during, and after the fidelity assessment that should lead to the collection of high quality data, positive interactions with respondents, and an efficient data collection process.

Protocol: The protocol explains how to rate each item. In particular, it provides:

- A definition and rationale for each fidelity item. These items have been derived from controlled research on illness management.
- A list of data sources most appropriate for each fidelity item (e.g., chart review, program leader, clinician/practitioner and consumer interviews). When it is appropriate, a set of probe questions is provided to help you elicit the critical information needed to score the fidelity item. These probe questions were specifically generated to help you collect information from respondents that is relatively free from bias such as social desirability.
- Decision rules will facilitate the correct scoring of each item. As you collect information from various sources, these rules will help you determine the specific rating to give for each item.

Cover sheet: This form obtains background information on the study site. The data are not used in determining fidelity, but to provide important information for classifying programs, such as size and duration of program, type of parent organization, and community characteristics.

Score sheet: The score sheet provides instructions for scoring, including how to handle missing data and which cut-off scores to use for full, moderate, and inadequate implementation.

Progress note: This is a sample of a progress note form recommended by the IMR Implementation Resource Kit developers (Susan Gingerich and Kim Mueser) for use or adaptation in the implementation of IMR. The progress note is an important data source in IMR fidelity assessment. Each site implementing the IMR practices should be encouraged to adopt a similar style of progress note as a part of its daily practice in order to facilitate fidelity assessments.

Introduction

What Is Illness Management and Recovery?

Illness Management and Recovery (IMR) is an evidence-based psychiatric rehabilitation practice. The primary aim of IMR is to empower consumers with severe mental illness (SMI) to manage their illness, find their own goals for recovery, and make informed decisions about their treatment by teaching them the necessary knowledge and skills. IMR involves a variety of interventions designed to help consumers improve their ability to overcome the debilitating effects of their illness on social and role functioning. Evidence supporting the effectiveness of illness management is available in studies focusing on the specific interventions as well as those evaluating comprehensive intervention packages.

The core evidence-based components of illness management are psychoeducation, behavioral tailoring for medication, relapse prevention training, and coping skills training. Psychoeducation provides the basic information about the nature of specific psychiatric disorders and the principles of treatment. Behavioral tailoring helps consumers manage daily medication regimes by teaching them strategies that make taking medication a part of their daily routine. Relapse prevention training teaches consumers to identify triggers of past relapses and early warning signs of an impending

relapse, and helps them develop plans for preventing relapse. Coping skills training involves identifying people's current coping strategies for dealing with persistent psychiatric symptoms and either increasing their use of these strategies or teaching new strategies. To effectively teach these components and to ensure that knowledge is put into practice, practitioners use a variety of techniques including motivational, educational and cognitive-behavioral strategies. Throughout the IMR program, practitioners help people to set and achieve their personal goals.

Overview of the Scale

The IMR Fidelity Scale contains 13 items that have been developed to measure the adequacy of implementation of IMR programs. Each item on the scale is rated on a 5-point behaviorally-anchored rating scale ranging from 1 ("Not implemented") to 5 ("Fully implemented"). The standards used for establishing the anchors for the "Fully implemented" ratings were determined through a variety of expert sources as well as empirical research.

What is Rated

The scale is rated on current behavior and activities, not planned or intended behavior. For example, in order to get full credit for Item 3 ("Comprehensiveness of Curriculum"), it is not enough that the program is currently developing a curriculum.

How the Rating Is Done

The fidelity assessment is conducted through a site visit. It requires a minimum of 4 hours to complete, although a longer period of assessment will offer more opportunity to collect information and hence should result in a more valid assessment. The data collection procedures include chart review, review of educational handouts, and semi-structured interviews with the IMR program leader, IMR practitioners, and IMR consumers. When feasible, fidelity assessors should observe one or more IMR sessions (either live or a videotaped session).

The IMR fidelity assessment is primarily based on documentation in progress notes. Consequently, if these notes do not exist or are not easily available, the fidelity assessment will take a very different course. The goal is to examine the charts and 5 most recent progress notes of IMR sessions for each of 5 IMR consumers (preferably ones who have received IMR training for several months) for each of 3 IMR practitioners. If a practitioner has fewer than 5 IMR consumers, then use the charts and progress notes for all IMR consumers for that practitioner. If the site has more than 3 IMR practitioners, then the program leader should select 3 IMR practitioners for review. The fidelity assessors should aim to interview at least 3 consumers (one each per practitioner) for whom progress notes available.

The ideal is that the consumers chosen for review are randomly selected. It is also possible that the progress notes will not be integrated into the consumer charts (although this is optimal). In any situation, both the charts and the progress notes should be reviewed.

Who Does the Ratings

Fidelity assessments should be administered by individuals who have experience and training in interviewing and data collection procedures (including chart reviews). In addition, interviewers need to have an understanding of the nature and critical ingredients of IMR. We strongly recommend that all fidelity assessments be conducted by at least two assessors.

IMR Fidelity Assessor Checklist

Before the Fidelity Site Visit:

- Establish a contact person at the program. The fidelity visit is coordinated by the site IMR program leader (or equivalent), with whom you arrange your visit. The program leader should communicate beforehand the purpose and scope of your assessment to the IMR practitioners. Schedule your visit when key staff are available and ideally when you can observe an IMR session. Exercise common courtesy in scheduling well in advance, respecting the competing time demands on practitioners, etc.
- Create a timeline for the fidelity assessment. Fidelity assessments require careful coordination and good communication, particularly if there are multiple assessors. For instance, the timeline might include a note to make reminder calls to the program site to confirm interview dates and times.
- Establish a shared understanding with the site being assessed. It is essential that the fidelity assessment team communicates to the each site the goals of the fidelity assessment. Assessors should also inform sites about who will see the report, whether the program site will receive this information, and exactly what information will be provided. The most successful fidelity assessments are those in which there is a shared goal among the assessors and the program site to understand how the program is progressing according to evidence-based principles. If administrators or line staff fear that they will lose funding or look bad if they don't score well, then the accuracy of the data may be compromised. It is particularly important that fidelity assessors explain during a baseline interview that the goal is to obtain an initial picture of the program, and that high fidelity is not expected when a program is just starting.
- Indicate what you will need from respondents during your fidelity visit. In addition to the purpose of the assessment, briefly describe what information you will need, who you will need to speak with, and how long each interview or visit will take to complete. The first step is to determine which practitioners are providing IMR training and which consumers are receiving IMR. The site visit will go more smoothly if the contact person can assemble the following information beforehand:
 - List of names of IMR practitioners
 - Roster of IMR consumers assigned to each practitioner
 - A copy of agency brochure
 - A copy of IMR program mission statement
 - Copies of curriculum and educational handouts
 - Total number of consumers served by the IMR program in the previous year
 - Number of consumers who dropped out of the IMR program in the previous year
 - Charts and progress notesThe goal is to examine the charts along with the 5 most recent progress notes for IMR sessions for each of 5 IMR consumers (preferably ones who have received IMR training for several months) for each of 3 IMR practitioners. (See Appendix for sample progress note.)

During Your Fidelity Site Visit:

Overview: The general strategy in conducting program fidelity assessments is to obtain data from as many sources as possible. When all these data sources converge, then one can be more confident in the validity of the ratings. However, experience suggests that the sources often disagree. A review of progress notes should precede practitioner and consumer interviews. If the IMR interventions are well documented in progress notes, and the fidelity assessor is convinced that practitioners both understand the forms and have completed them conscientiously (by querying the practitioners and the program leader), then these progress notes can be used as the primary source for making ratings on

the fidelity scale. If the information from different sources is not in agreement, (for example, if the program leader indicates a higher rate of use of a particular technique than is documented in the records), then ask the program leader to help you understand the discrepancy. The results from a chart or progress note review can be overruled if other data (e.g., team leader interview, internal statistics) refute it.

The first step in the fidelity assessment is an interview with the IMR program leader. The fidelity assessors should begin by reviewing the purpose for the visit and the schedule for the day. Explain that after the interview with the program leader, you will begin by reviewing charts and that the goal is to examine 5 progress notes for each of 5 IMR consumers (preferably ones who have received IMR training for several months) for each of 3 IMR practitioners. The schedule will then include interview with the 3 practitioners and with 1 IMR consumer for each practitioner.

The recommended schedule is as follows:

- Interview with program leader
- Review of progress notes and charts
- Observation of IMR session(s)
- Interviews with 3 IMR practitioners
- Interviews with 3 IMR consumers
- Final interview with program leader (to clarify information from the day; fill in gaps, etc.)

Tips:

- Tailor terminology used in interviews to the site. For example, if the site uses the term “client” for consumer, use that term. Similarly, if practitioners are referred to as clinicians, use that terminology. Every agency has specific job titles for particular staff roles. By adopting the local terminology, the assessor will improve communication.
- During the interview, record all the important names and numbers (e.g., numbers of practitioners, active IMR consumers, etc.) on the cover sheet.
- If discrepancies between sources occur, query the IMR program director/coordinator, practitioners, or program leaders to get a better sense of the program’s performance in a particular area. The most common discrepancy is likely to occur when the interview with the program staff gives a more idealistic picture of the program’s functioning than do chart reviews or consumer interviews. For example, on Item 5 (“Involvement of Significant Others”), the practitioners may report that involvement of significant others in the IMR program was a common practice, while the majority of the charts reviewed may not document involvement of significant others. To understand and resolve this discrepancy, the assessor may need to go back to the practitioners and say something like, “Involvement of family members or friends was rarely documented in the charts we reviewed. Since you had reported that you always try to involve significant others, we wanted your help to understand the difference.”
- Before you leave, check for missing data. The scale is designed to be filled out completely. If information cannot be obtained at time of the site visit, it will be important for you to be able to collect at a later date

After Your Fidelity Site Visit:

- If necessary, follow up on any missing data (e.g., phone calls to the program site).
- Assuming there are two assessors, both should independently rate the fidelity scale. The assessors should then compare their ratings and resolve any disagreements. Come up with a consensus rating.
- Tally the item scores and determine which level of implementation was achieved (See Score Sheet).
- Send a follow-up letter to the site. In most cases, this letter will include a fidelity report, explaining (to the program) their scores on the fidelity scale and providing some interpretation of the assessment, highlighting both strengths and weaknesses. The report should be

informative, factual, and constructive. The recipients of this report will vary according to the purposes, but would typically include the key administrators involved in the assessment.

- As fidelity is assessed over time, it is useful to create an Excel spreadsheet from which a graph of the total fidelity scores over time can be created and incorporated into the fidelity report.

Protocol: Item Definitions and Scoring

Initial Questions:

Which practitioners are providing IMR training? Which consumers have you identified as receiving IMR? The fidelity assessment refers only to these practitioners and consumers.

Note: The program leader identifies who is defined as the IMR sample. The fidelity ratings will be influenced by the definition of the target population of consumers receiving the IMR interventions. If the definition is inclusive, the site will have a high penetration rate but possibly a low fidelity rating. Conversely, if the group is restricted to a small number, the site will have a low penetration rate but possibly a high fidelity rating.

In the questions below, the wording of the program leader interview should be modified, prefaced with the phrase, *“Do the practitioners you supervise in providing IMR...”*

1. # People in a Session or Group

Definition: IMR is taught individually or in groups of 8 or less consumers.

Rationale: IMR can be taught using either an individual or group format, each of which has its advantages. The main advantages of the individual format include individualized pacing of the teaching and increased attention. Group format, on the other hand, provides consumers with more sources of feedback, support, role models, and may be more economical; however, if the group size exceeds 8 consumers, individualized attention and participation by all consumers are likely to be compromised.

Sources of Information:

a) Program leader and practitioner interviews.

- “Do you teach IMR both individually and in a group format?” [If yes] “On what condition do you provide individual sessions?”
- “How many consumers were in the largest group you have taught in the last 6 months?”

b) Consumer interview.

- “Do you attend individual or group IMR sessions? Did you have a choice between the two formats?”
- “How many consumers were in the largest group you have ever attended?”

Item Response Coding: If all IMR sessions are taught individually or in groups of 8 or less consumers, the item would be coded as a “5”. In some programs more than one practitioner may co-instruct a large group session. In such a case, the rating depends on the amount of individual attention given

during the session. For example, if 3 practitioners break up a class of 15 consumers into smaller groups of 5 for discussion and/or exercises, then the item would be coded as a “5”.

2. Program Length

Definition: Consumers receive at least 3 months of weekly IMR sessions or an equivalent number of IMR sessions (e.g., biweekly for at least 6 months).

Rationale: In general, between 3 and 6 months of weekly sessions are required to learn the information and skills in the modules of IMR, depending on the frequency/duration of sessions, the consumer’s prior knowledge and level of skills, and the presence of cognitive impairment or symptoms that may slow the learning process. Following completion of all modules, consumers may also benefit from booster sessions or support groups aimed at using and expanding skills. Note: Fidelity assessors should rate the scheduled duration of the training as planned by the practitioner. Consumers who drop out prematurely should be excluded from consideration of program length.

Sources of Information:

a) Chart review for consumers who completed the program.

Look for frequency of sessions and program length per consumer.

b) Program leader and practitioner interviews.

- “How long and how often are your IMR sessions?”
- “On average, how long does it take for a consumer to complete your IMR program?”
- “Do you find that some consumers only require a couple of sessions of IMR?”

c) Consumer interview.

- “How often do you attend the IMR sessions here? How long is a session?”
- “How long have you been with this program?” [If less than 3 months] “How long do you plan to continue with this program?”

Item Response Coding: If = or > 90% of IMR consumers receive weekly or an equivalent number of sessions for at least 3 months, the item would be coded as a “5”.

3. Comprehensiveness of the Curriculum

Definition: Curriculum materials for each of the following nine topic areas are available for IMR practitioners to use in their sessions:

- Recovery strategies
- Practical facts about mental illness and treatment
- The stress-vulnerability model (i.e., an illness results from an enduring
- Predisposition that interacts with environmental stress to cause illness)
- Building social support
- Effective use of medication
- Reducing relapses
- Coping with stress
- Coping symptoms

- Getting needs met in the mental health system

Rationale: Studies of professionally based IMR training programs have identified these 9 areas as key topics. The more comprehensive the curriculum, the more beneficial the program is to the participating consumers.

Sources of Information:

a) Program leader and practitioner interviews.

- “What kinds of topics are covered in the IMR sessions?”
- “Is there an established curriculum for the IMR sessions?” [If yes] Request a copy for review. “Who developed the curriculum?”
- [To Program leader] “Do you provide practitioners with training on the curriculum? How do you make sure that the practitioners follow it?”
- [To practitioners] “Have you received training on the curriculum?”

b) Educational curriculum and handouts review.

Look to see if the curriculum and handouts adequately cover the 9 areas.

Do handouts reflect program philosophy and critical ingredients of IMR?

Item Response Coding: If the IMR curriculum materials cover 8 or more topic areas, the item would be coded as a “5”.

4. Provision of Educational Handouts

Definition: All consumers participating in IMR receive IMR handouts.

Rationale: An educational handout summarizes the main teaching points in plain language and includes useful forms and exercises. These handouts can be reviewed in the session as well as outside the session (e.g., for homework assignments). In addition, consumers can share the handouts with significant others to inform them about IMR.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of provision of educational handouts.

b) Educational curriculum and handouts review.

Look to see if the curriculum and handouts adequately cover the 9 areas.

Do handouts reflect program philosophy and critical ingredients of IMR? Are they written in simple language, tailored to both consumers and their significant others (i.e. information specifically for consumers as well as information specifically for significant others), and visually effective (e.g. information is presented in an attractive and organized way)?

c) Program leader and practitioner interviews.

- “Do you provide consumers with educational materials? [If yes] Request a copy for review. “Who developed them?”
- “Do all IMR consumers receive them? When do you provide them (e.g. upon admission, in class)? How do you use them in the session?”
- “What do you provide for consumers who cannot read?”

d) Consumer interview.

- “Do you use an educational handout/text in the IMR sessions?”
- “When did you get the handout/text?”
- “How do you use the handout/text inside and outside the session?”

Item Response Coding: If = or > 90% of IMR consumers receive written (or alternative) educational materials, the item would be coded as a “5”.

5. Involvement of Significant Others

Definition: Significant others refer to family members, friends, or any other individual in the consumer’s support network excluding professionals. “Involvement” is defined here as at least one IMR-related contact in the last month between the practitioner and the significant other OR the significant other’s involvement with the consumer in pursuit of goals identified in the IMR plan, such as assisting the consumer with homework assignments.

Rationale: Research has shown that social support has been found to help people generalize information and skills learned in sessions to their natural environment, leading to better social functioning. Social support also plays a critical role in reducing relapse and hospitalization in persons with SMI. Because developing and enhancing natural support is one of the goals of IMR, consumers are encouraged to identify significant others with whom they can share the handout materials and who will support them in applying newly acquired skills. However, the decision to involve significant others is the consumer’s choice.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of involvement of significant others.

b) Practitioner interviews.

Go through the entire roster of IMR consumers. For each consumer, ask if a significant other(s) has had a least one contact with IMR staff in the last month or worked with consumer to attain IMR goals.

- “In what way do you involve consumers’ significant others? Then probe for specifics, e.g., frequency of contact, frequency of homework assignments that require participation of significant others.
- “What do you do if a consumer refuses to involve his/her significant others?”

c) Consumer interview.

- “Are your family members or friends involved in your treatment?” [If yes]
“In what way?”

- “Do they help you with your homework?”
- “Have they attended the sessions with you?”
- “Do they have regular contact with your practitioners?”
- “What has the program done to get them involved?”
- “Do you want them to be more involved?”

Item Response Coding: If = or > 90% of IMR consumers involve significant others (i.e., at least monthly contact reported by the practitioner, or involvement reported by the consumer), the item would be coded as a “5”.

6. IMR Goal Setting

Definition: Practitioners help consumers identify realistic and measurable goals. The goals should be pertinent to the recovery process and can be very individualized, but there should be linkage between the goal and the IMR plan.

Rationale: One of the objectives of the IMR program is to help consumers establish personally meaningful goals to strive towards. In addition to being teachers, practitioners are collaborators in helping the consumers learn how to cope with their illness and make progress towards their goals.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of IMR goal(s) and collaborative goal setting process. (Examples are given in the IMR practitioner workbook).

b) Program leader and practitioner interviews.

- “Please describe the process of IMR goal setting.”

c) Consumer interview.

- “What are your goals for IMR? Did your practitioner ask what your goals were?” Item Response Coding: If = 90% of IMR consumers have at least 1 measurable personal goal(s), the item would be coded as a “5”.

7. IMR Goal Follow-up

Definition: Practitioners and consumers collaboratively follow up on goal(s) identified in Item 6.

Rationale: A core value of IMR is to facilitate consumers’ pursuit of their goals and progress in their recovery at their own pace. Therefore, the goals and the steps to be taken toward the goals need ongoing evaluation and modification.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of follow-up on IMR goal(s) (Examples are given in the IMR practitioner workbook).

b) Program leader and practitioner interviews.

- “Do you review the consumers’ progress towards achieving their IMR goal(s) on a regular basis?” [If yes] “How often? Please describe the review process.”
- “What do you do if a consumer would like to change his/her IMR goal(s)?”

c) Consumer interview.

- “Do you and your practitioner together review your progress toward achieving your personal goal(s)? [If yes] How often? Please describe the review process.”

Item Response Coding: If =90% of IMR consumers have documentation of continued follow-up on their goal(s), the item would be coded as a “5”.

8. Motivation-Based Strategies

Definition: Practitioners regularly use motivation-based strategies, which include:

- Helping the consumer see how learning specific information and skills could help him/her achieve short and long-term goals
- Helping the consumer explore the pros and cons of change
- Helping the consumer put past experiences in more positive perspectives
- Instilling hope and increasing self-efficacy (i.e., belief that the consumer can achieve the goal).

Rationale: Motivation-based strategies reflect the understanding that a therapeutic relationship must be established before attempting to address IMR. Furthermore, unless consumers view learning specific information or skills as being relevant to their own needs or desires, they will not be motivated to invest the necessary effort in learning.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of motivation-based strategies used in a session.

b) Practitioner interview.

For each of the motivation-based strategies checked in the recent progress/session notes, probe for details by asking open-ended questions, e.g., *“I notice you checked ‘explore pros & cons of change’ in 6 of 10 sessions. Could you describe the process you used with the consumer to ‘explore pros & cons of change’ in your most recent session.”*

c) Consumer interview.

For each of the motivation-based strategies checked in the recent progress/session notes, probe for details using a layperson’s language. For example, if the majority of the progress/session notes reviewed indicate ‘instilling hope & self-efficacy’ as a common practice, ask, *“Do the practitioners make you feel hopeful [confident]? Please describe how they made you feel that way in your most recent session.”*

Item Response Coding: If = or > 50% of IMR sessions use at least 1 motivation-based strategies, the item would be coded as a “5”.

9. Educational Techniques

Definition: Practitioners embrace the concept of and regularly apply educational techniques, which include:

- **Interactive teaching:** Frequently pausing when presenting information to get the consumer's reaction and perspective, talking about what the information means, and clarifying any questions that may arise.
- **Checking for understanding:** Asking consumers to summarize information in their own language rather than asking yes or no questions, such as, “Did you understand?”
- **Breaking down information:** Providing information in small chunks
- **Reviewing information:** Summarizing previously discussed information (both by the practitioner and the consumer)

Rationale: Educational techniques are the pillars in teaching basic information and ensuring that consumers understand. For example, interactive teaching not only makes learning an interesting and lively activity, but also conveys to consumers that they have important contributions to make to the learning process and that the practitioner is interested in what they have to say.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of educational techniques used in a session.

b) Practitioner interview.

For each of the educational techniques checked in the recent progress/session notes, probe for details by asking open-ended questions, e.g., “*I notice you checked ‘interactive teaching’ in 6 of 10 sessions. Could you please describe the ‘interactive teaching’ in your most recent session.*”

c) Consumer interview.

For each of the educational techniques checked in the recent progress/session notes, probe for details using a layperson's language. For example, if the majority of the progress/session notes reviewed indicate ‘checking for understanding’ as a common practice, ask, “Do the practitioners check your understanding of the material covered during the session? Can you think about your most recent session and describe how they made sure you understood what was covered in the session.”

Item Response Coding: If = or > 50% of IMR sessions use at least 1 educational technique, the item would be coded as a “5”.

10. Cognitive-Behavioral Techniques

Definition: Practitioners regularly use cognitive-behavioral techniques to teach IMR information and skills, which include:

- **Positive reinforcement:** Positive feedback following a skill or behavior designed to increase it or to encourage a consumer's efforts to use a skill.
- **Shaping:** Reinforcement of successive approximations to a goal. The practitioner recognizes the multiple steps and individualized pacing necessary for consumers to learn complex skills, and provides frequent reinforcement as they progress toward the goal.
- **Modeling:** Demonstration of skills.
- **Role playing:** A simulated interaction in which a person practices a behavior/skill.
- **Cognitive restructuring:** Practitioners help the consumer describe the situation leading to the negative feeling, make a link between the negative emotions and the thoughts associated with those feelings, evaluate the accuracy of those thoughts, and, if they are found to be inaccurate, identify an alternative way of looking at the situation that is more accurate.
- **Relaxation training:** Teaching strategies to help consumers relax.

Rationale: There is strong evidence for the efficacy of cognitive-behavioral techniques in helping consumers to develop and maintain social skills, use medication effectively, develop coping strategies for symptoms, and reduce relapses.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of cognitive-behavioral techniques used in a session.

b) Practitioner interview.

For each of the cognitive-behavioral techniques checked in the recent progress/ session notes, probe for details by asking open-ended questions, e.g., "I notice you checked 'cognitive restructuring' in 6 of 10 sessions. Could you describe the 'cognitive restructuring' in your most recent session."

c) Consumer interview.

For each of the motivation-based strategies checked in the recent progress/session notes probe for details using a layperson's language. For example, if the majority of the progress/session notes reviewed indicate 'role playing' as a common practice, ask, "Do you get to practice new skills with others in the session [or as a homework]? How often? Could you give us examples from your most recent session?"

Item Response Coding: If = or > 50% of IMR sessions use at least 1 cognitive-behavioral technique, the item would be coded as a "5".

11. Coping Skills Training

- Definition: Practitioners embrace the concept of, and systematically provide, coping skills training that includes:
- Exploring the coping skills currently used by the participant;
- Amplifying the current coping skills and/or teaching new coping strategies;
- Behavioral rehearsal of the coping skill;
- Evaluating the effectiveness of the coping skill; and
- Modifying the coping skill as necessary.

Rationale: Coping skills training is used to improve the ability of consumers to cope with persistent symptoms.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of coping skills training in a session.

b) Practitioner interview.

For each practitioner who checked coping skills training in the recent progress/ session notes, probe for details by asking open-ended questions, e.g., *“I notice you checked ‘coping skills training’ in 6 of 10 sessions. Could you describe the ‘coping skills training’ methods you used in your most recent session?”*

c) Consumer interview.

If coping skills training is indicated in the recent progress/session notes as a common practice, probe for specific components using a layperson’s language, e.g., *“Have you talked about or learned new coping skills in your recent sessions? Could you give me some examples?”*

“Do you feel more confident today in your ability to cope with symptoms?”

Item Response Coding: If all practitioners are familiar with and regularly practice coping skills training, the item would be coded as a “5”.

12. Relapse Prevention Training

Definition: Practitioners embrace the concept of and systematically apply relapse prevention training that include:

- Identification of environmental triggers;
- Identification of prodromal signs;
- Stress management;
- Ongoing monitoring;
- Rapid intervention when indicated

Rationale: Studies have shown that training in relapse prevention strategies is effective in reducing symptom severity, relapses, and rehospitalization.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of relapse prevention training in a session.

b) Practitioner interview.

For each practitioner who checked relapse prevention training in the recent progress/ session notes, probe for details by asking open-ended questions, e.g., *“I notice you checked ‘relapse prevention training’ in 6 of 10 sessions. Could you describe the ‘relapse prevention training’ methods you used in your most recent session?”*

c) Consumer interview.

If relapse prevention training is indicated in the recent progress/session notes as a common practice, probe for specific components using a layperson's language, e.g., *"Have you discussed ways that you can avoid going back to the hospital your recent sessions? What kind of things did you learn about relapse prevention?"*

"Do you feel more confident today in your skills in preventing relapse?"

Item Response Coding: If all practitioners are familiar with and regularly practice relapse prevention training, the item would be coded as a "5".

13. Behavioral Tailoring for Medication

Definition: Practitioners embrace the concept of and use behavioral tailoring for medication. Behavioral tailoring includes developing strategies tailored to each individual's needs, motives and resources (e.g., choosing medication that requires less frequent dosing, placing medication next to one's toothbrush so it is taken always before brushing teeth).

Rationale: Behavioral tailoring is especially effective in helping consumers manage their medication regime as prescribed.

Sources of Information:

a) Chart review (especially IMR progress/session notes).

Look for documentation of behavioral tailoring in a session.

b) Practitioner interview.

For each practitioner who checked behavioral tailoring for medication in the recent progress/session notes, probe for details by asking open-ended questions, e.g., *"I notice you checked 'behavioral tailoring for medication' in 6 of 10 sessions. Could you describe the 'behavioral tailoring for medication' methods you used in your most recent session?"*

c) Consumer interview.

If behavioral tailoring for medication is indicated in the recent progress/session notes as a common practice, probe for specific components using a layperson's language, e.g., *"Sometimes we miss taking medication and regret it later. Have you and your practitioner discussed what you can do at home to prevent that? Could you give us some examples of the strategies?"*

"Do you feel more confident today in taking medication as prescribed?"

Item Response Coding: If all practitioners are familiar with and regularly practice behavioral tailoring, the item would be coded as a "5".

COVER SHEET

Date: _____

Rater(s): _____

Name: _____

Address: _____

Contact Person: _____ (Title:) _____

Phone: _____ Fax: _____

E-mail: _____

Names of the IMR Practitioners:

Number of consumers identified as receiving IMR services: _____

(The IMR questions refer to these consumers.)

Sources Used:

- _____ Progress notes
- _____ Chart review
- _____ IMR curriculum review
- _____ Interview with IMR Program Director/Coordinator
- _____ Interview with IMR Program leader
- _____ Interview with IMR practitioners
- _____ Interview with consumers

Number of IMR practitioners: _____

Number of IMR consumers served in preceding year: _____

Date program was started: _____

Illness Management and Recovery Fidelity Scale	1	2	3	4	5
1. # People in a Session or Group: IMR is taught individually or in groups of 8 or less consumers.	Some sessions taught with over 15 consumers	Some sessions taught with 13-15 consumers	Some sessions taught with 11 or 12 consumers	Some sessions taught with 9 or 10 consumers	All IMR sessions taught individually or in groups of 8 or less
2. Program Length: Consumers receive at least 3 months of weekly IMR sessions or equivalent (e.g., biweekly for at least 6 months).	<20% of IMR clients receive at least 3 months of weekly sessions	20%-39% of IMR clients receive at least 3 months of weekly sessions	40%-69% of IMR clients receive at least 3 months of weekly sessions	70%-89% of IMR clients receive at least 3 months of weekly sessions	•90% of IMR clients receive at least 3 months of weekly sessions
3. Comprehensiveness of the Curriculum: <ul style="list-style-type: none"> • Recovery strategies • Mental illness facts • Stress-vulnerability model • Social support • Using medication • Preventing relapse • Stress management • Coping symptoms • Mental health system 	Curriculum materials include only 1 topic, or educational handouts are not available	Curriculum materials include 2 or 3 topic areas	Curriculum materials include 4 or 5 topic areas	Curriculum materials include 6 or 7 topic areas	Curriculum materials include 8 or 9 topic areas
4. Provision of Educational Handouts: All consumers participating in IMR receive IMR handouts.	<20% of IMR clients receive educational handouts	20%-39% of IMR clients receive educational handouts	40%-69% of IMR clients receive educational handouts	70%-89% of IMR clients receive educational handouts	•90% of IMR clients receive educational handouts

Illness Management and Recovery Fidelity Scale	1	2	3	4	5
5. Involvement of Significant Others: At least one IMR-related contact in the last month OR involvement with the consumer in pursuit of goals (e.g., assisting with homework assignments).	<20% of IMR clients have significant other(s) involved	20%-29% of IMR clients have significant other(s) involved	30%-39% of IMR clients have significant other(s) involved	40-49% of IMR clients have significant other(s) involved	•50% of IMR clients have significant other(s) involved
6. IMR Goal Setting <ul style="list-style-type: none"> • Realistic and measurable • Individualized • Pertinent to recovery process • Linked to IMR plan 	<20% of IMR clients have at least 1 personal goal in chart	20%-39% of IMR clients have at least 1 personal goal in chart	40%-69% of IMR clients have at least 1 personal goal in chart	70%-89% of IMR clients have at least 1 personal goal in chart	•90% of IMR clients have at least 1 personal goal in their chart
7. IMR Goal Follow-up: Practitioners and consumers collaboratively follow up on goal(s) (See examples in the IMR Practitioner Workbook)	<20% of IMR clients have follow-up on goal(s) documented in chart	20%-39% of IMR clients have follow-up on goal(s) documented in chart	40%-69% of IMR clients have follow-up on goal(s) documented in chart	70%-89% of IMR clients have follow-up on goal(s) documented in chart	70%-89% of IMR clients have follow-up on goal(s) documented in chart
8. Motivation-Based Strategies: <ul style="list-style-type: none"> • New info & skills • Positive perspectives • Pros & cons of change • Hope & self-efficacy 	<20% of IMR sessions use at least 1 motivation-based strategy	20-39% of IMR sessions use at least 1 motivation-based strategy	30-39% of IMR sessions use at least 1 motivation-based strategy	40-49% of IMR sessions use at least 1 motivation-based strategy	•50% of IMR sessions use at least 1 motivation-based strategy

Illness Management and Recovery Fidelity Scale	1	2	3	4	5
9. Educational Techniques: <ul style="list-style-type: none"> • Interactive teaching • Checking for understanding • Breaking down info • Reviewing info 	<20% of IMR sessions use at least 1 educational technique	20%-39% of IMR sessions use at least 1 educational technique	30%-39% of IMR sessions use at least 1 educational technique	40%-49% of IMR sessions use at least 1 educational technique	•50% of IMR sessions use at least 1 educational technique
10. Cognitive-Behavioral Techniques: <ul style="list-style-type: none"> • Reinforcement • Shaping • Modeling • Role playing • Cognitive restructuring • Relaxation training 	<20% of IMR sessions use at least 1 cognitive-behavioral technique	20%-39% of IMR sessions use at least 1 cognitive-behavioral technique	30%-39% of IMR sessions use at least 1 cognitive-behavioral technique	40%-49% of IMR sessions use at least 1 cognitive-behavioral technique	•50% of IMR sessions use at least 1 cognitive-behavioral technique
11. Coping Skills Training: <ul style="list-style-type: none"> • Review current coping • Amplify current coping or develop new coping skills • Behavioral rehearsal • Review effectiveness • Modify as necessary 	Few or none of the practitioners are familiar with the principles of coping skills training	Some of the practitioners are familiar with the principles of coping skills training, with a low level of use	Some of the practitioners are familiar with the principles of coping skills training, with a moderate level of use	The majority of the practitioners are familiar with the principles of coping skills training and use it regularly	All practitioners are familiar with the principles of coping skills training and use it regularly
12. Relapse Prevention Training: <ul style="list-style-type: none"> • Identify triggers • Identify early warning signs • Stress management • Ongoing monitoring • Rapid intervention as needed 	Few or none of the practitioners are familiar with the principles of relapse prevention training	Some of the practitioners are familiar with the principles of relapse prevention training, with a low level of use	Some of the practitioners are familiar with the principles of relapse prevention training, with a moderate level of use	The majority of the practitioners are familiar with the principles of relapse prevention training and use it regularly	All practitioners are familiar with the principles of relapse prevention training and use it regularly

SCORE SHEET

Program: _____ Date of Visit: _____

Informants – Name(s) and Positions: _____

Number of Records Reviewed: _____ Rater: _____

		RATINGS				
1.	# People in a Session or Group	1	2	3	4	5
2.	Program Length	1	2	3	4	5
3.	Availability of Educational Handouts	1	2	3	4	5
4.	Provision of Educational Handouts	1	2	3	4	5
5.	Involvement of Significant Others	1	2	3	4	5
6.	IMR Goal Setting	1	2	3	4	5
7.	IMR Goal Follow-up	1	2	3	4	5
8.	Motivation-Based Strategies	1	2	3	4	5
9.	Educational Techniques	1	2	3	4	5
10.	Cognitive-Behavioral Techniques	1	2	3	4	5
11.	Coping Skills Training	1	2	3	4	5
12.	Relapse Prevention Training	1	2	3	4	5
13.	Behavioral Tailoring for Medication	1	2	3	4	5
	TOTAL SCORE					

PROGRESS NOTES

Name: _____ ID# _____ Date: _____

Name of significant other(s) involved in session: _____

Problem or goal specified by the treatment plan that is the focus of the person's treatment:

Personal goal that was set in this session or followed up in this session:

TREATMENT/INTERVENTIONS PROVIDED:

Motivational interventions (check all that apply):

_____ connect info and skills with personal goals

_____ promote hope & positive expectations

_____ explore pros and cons of change

_____ re-frame experiences in positive light

Educational interventions (check the topic(s) that were covered):

_____ Recovery strategies

_____ Practical Facts about Mental Illness

_____ Stress-Vulnerability

_____ Social Support

_____ Using Medication

_____ Reducing relapses

_____ Coping with Stress

_____ Coping w/ Symptoms & Problems

_____ Mental Health system

Cognitive-behavioral interventions (check all that apply):

_____ reinforcement

_____ shaping

_____ modeling

_____ role playing

_____ cognitive restructuring

_____ relaxation training

Specific evidence-based skill taught (identify which one(s))

coping skill for dealing with symptoms: _____

relapse prevention skill: _____

behavioral tailoring for medication: _____

Homework that was agreed upon: _____

OUTCOME (person's response to info, strategies & skills provided in the session)

Person's perspective: _____

Practitioner's perspective: _____

PLAN for next session: _____

Person's signature: _____ Practitioner's signature _____

USING FIDELITY SCALES FOR EVIDENCE-BASED PRACTICES

What is fidelity?

Fidelity refers to the degree of implementation of an evidence-based practice (EBP). A fidelity scale measures fidelity. Such scales have been developed for each of the six EBPs included in the Implementing EBP Project (assertive community treatment, supported employment, integrated treatment for dual disorders, illness management, family psychoeducation, and medication guidelines). Each scale assesses approximately 15 to 30 critical ingredients of the EBP, based on its underlying principles and methods. The scale items provide concrete indications that the practice is being implemented as intended. For example, one item on the Supported Employment Fidelity Scale concerns rapid job search. This item is rated as fully implemented if the consumers in a program average one month or less between admission to the supported employment program and their first job interview.

Why measure fidelity?

Several assumptions underlie the use of fidelity scales. First, a fidelity scale should adequately sample the critical ingredients of the EBP to differentiate between programs that follow the practice and those that do not. Research suggests that fidelity scales for supported employment and for assertive community treatment do accomplish this. Second, fidelity scales should be sensitive enough to detect progress in the development of a program from the start-up phase to its mature development. There is some evidence that fidelity scales achieve this goal as well. Third, high-fidelity programs are expected to have greater effectiveness than low-fidelity programs in achieving desired consumer outcomes. Several studies comparing fidelity ratings to outcomes also support this assumption.

One key use of fidelity scales is for monitoring programs over the course of their development (and even after they are fully established). Experience by implementers suggests that routine use of fidelity scales provides an objective, structured way to give feedback about program development. This is an excellent method to diagnose program weaknesses and clarify strengths for providing positive feedback on program development. Fidelity scales also provide a comparative framework for evaluating statewide trends and outliers. The strategic use of repeated evaluations of programs using fidelity scales, either on an individual program or statewide level, is based on the general principle that whatever is paid attention to is more likely to be improved.

How are fidelity scales used?

In the Implementing EBP Project we have developed fidelity scales that are simple to understand. EBP items are rated on a 5-point response format, ranging from 1 equaling no implementation to 5 equaling full implementation, with intermediate numbers representing progressively greater degrees of implementation. The response alternatives are behaviorally anchored, identifying measurable elements of the practice. Independent evaluators using multiple sources of information make the most valid ratings. Sources of information include interviews with staff, observation of team meetings, review of charts, and intervention observations. A daylong site visit is the optimal method for acquiring this information. Interviewers should be familiar with the EBP being rated. Although we recommend outside raters, fidelity scales can also be used by program managers to conduct self-ratings. The validity of self-ratings (or any ratings, for that matter) depends on the knowledge of the person making the ratings, access to accurate information pertaining to the ratings, and the objectivity of the ratings. We encourage the use of self-ratings, with appropriate caveats regarding potential biases that could be introduced by raters invested in seeing a program look good or

who do not fully understand the principles of the EBP. In addition to the scales developed for independent evaluators and program managers, companion fidelity measures intended for consumers and family members are under development for some EBPs.

Graphing fidelity ratings

We recommend that programs implementing an EBP graph their fidelity ratings over time, using their total fidelity score. By graphing this score, a program can see its change over time. When the program shows greater fidelity over time, this serves to reinforce their efforts. Another feature of graphing fidelity is to examine the cut-off score for full implementation. A program can use this score as a target and measure accordingly.

