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Tom Bartholomew^a; David Kensler^b

^a University of Medicine and Dentistry, School of Health Related Professions, Department of Psychiatric Rehabilitation and Counseling Professions, Scotch Plains, New Jersey, USA ^b Trenton Psychiatric Hospital, Trenton, New Jersey, USA

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Illness Management and Recovery in State Psychiatric Hospitals

Tom Bartholomew

University of Medicine and Dentistry, School of Health
Related Professions, Department of Psychiatric
Rehabilitation and Counseling Professions, Scotch
Plains, New Jersey, USA

David Kensler

Trenton Psychiatric Hospital, Trenton, New Jersey, USA

State psychiatric hospitals across the United States continue to use methodologies that predate the emergence of the evidenced-based practices movement and widespread adoption of the recovery model. The cultural legacy of state psychiatric hospitals is often heavily influenced by the era of custodial treatment with an emphasis on medication and the primacy of the medical model of care. Using a recovery and wellness philosophy, combined with practices that are evidence based, represents a vision for the future of these institutions (Smith & Bartholomew, 2006). This article describes the implementation of the evidence-based practice of illness management and recovery (SAMHSA, 2008) in a state psychiatric hospital. The role of this evidence-based program, as a way of operationalizing a recovery and wellness philosophy, is discussed in addition to some of the successful implementation strategies and program barriers. Directions for future work in this area are also discussed.

Keywords: Illness management and recovery; Implementation of evidence-based practices; Recovery and wellness; State psychiatric hospitals

Address correspondence to Tom Bartholomew, UMDNJ/SHRP, 1776 Raritan Road, Room 518, Scotch Plains, NJ 07076. E-mail: barthoth@umdnj.edu

State psychiatric hospitals in the United States have a reputation of providing custodial care based on patient control using a medical model of care (Goffman, 1961). Efforts to change this approach are often met with a host of institutional barriers such as hierarchical management structures that may disempower staff and clinical “silos” where staff report up their clinical department’s chain of command to off site supervisors possibly fragmenting the work of the treatment team (Smith & Bartholomew, 2006). These issues, coupled with factors such as hiring and promotions based largely on seniority and not merit and civil service protections can result in institutional cultures that are resistant to change. These cultural and bureaucratic mechanisms may usurp transformation efforts because vital roles can remain occupied by individuals not supportive of a more evidence-based, recovery approach. The purpose of this article is to describe a successful implementation of the evidence-based practice of illness management and recovery (IMR) within a state psychiatric hospital and discuss some of the strategies that may be used to address potential implementation barriers. The use of this evidence-based practice as a way to begin a larger recovery oriented transformation is also discussed.

EVIDENCE-BASED PRACTICES

The evolution of evidence-based practices (EBPs) in the treatment of mental illness portends a future where professionals can reliably achieve positive outcomes in the treatment of persons with severe and persistent mental illness (Drake, Merrens, & Lynde, 2005). This promise has been impeded by the difficulty involved in the implementation of these practices (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001). Lack of awareness that EBPs exist was the first and most pervasive barrier which has contributed to the ongoing multiyear gap between research outcomes and clinical practice (Institute of Medicine, 2001). This has been somewhat remedied as EBPs have begun to be disseminated through academic programs (Gill, Pratt, & Barrett, 1997). Unfortunately, even when the information is effectively disseminated, institutional change is not a forgone conclusion. Unfortunately, “knowledge about the empirical advantages . . . carry almost no weight . . . in convincing clinicians . . . to change their practices” (Dixon et al., 2001). There often exists the mistaken belief by staff of these institutions that they are already

engaged in these practices despite the complete absence of measures of fidelity to the EBPs. This is a difficult issue to address because confrontation of this fact generally elicits defensiveness.

The goal to have recovery oriented mental health services for individuals with severe mental illness has been adopted as the central goal for mental health services at the federal level with the President's New Freedom Commission Report (DHHS, 2003). The goal of engaging clients in directing their own recovery with support from mental health providers is often problematic in settings where services are mandated and service recipients have been committed to state hospitals due to dangerousness to self, others, or property. The problem of reconciling client choice and self direction with the realities of involuntary commitment requires that staff forgo some control and increasingly use relationships rather than rules to support recovery. Client centered EBPs can serve as an important medium for this recovery relationship to develop. EBPs and a recovery philosophy, while not identical constructs, can and should be unified (Frese, Stanley, Kress, & Vogel-Scibilia, 2001). State psychiatric hospitals that accept the challenge to actively transition from their current treatment practice, which may have less demonstrable efficacy, to a recovery and wellness philosophy based on EBPs will require strategies to implement and maintain clinical practices in this new direction. The IMR program is ideally suited to begin this transformation by serving as a medium to operationalize a recovery philosophy based on interventions with evidence of effectiveness.

The IMR program (Gingrich, Mueser, & coleaders of the development team, 2002) (Gingrich & Mueser, 2005) along with five other evidence-based approaches were developed into programs for the purposes of promoting greater dissemination and implementation of effective methods (Drake et al., 2001). "IMR is comprised of a broad set of strategies to help individuals with serious mental illness collaborate with professionals, reduce their susceptibility to their illness, and cope effectively with their symptoms." (Mueser et al., 2002). The program uses a manual for ease of dissemination and to aid in maintaining fidelity. It begins with an introduction to the program, the core values and the teaching principles involved. The core ingredients of the IMR program involves about 9 to 10 months of individual or group sessions held twice weekly and 10 educational modules covering a broad array of topics germane to illness management including relapse prevention, practical facts

about different illnesses, coping strategies, and so on. Staff providing IMR are expected to attend weekly clinical supervision focused on maintaining fidelity to the theory and practice of IMR. The IMR program involves staff trained in the program supporting consumers to identify what recovery means to them and setting and pursuing personal recovery goals that they, themselves, have chosen. These goals serve as the "fuel of recovery" meaning that they serve as motivation for clients to learn practical facts about their illness as well as skills needed to cope with their particular symptoms. Clients practice new skills in IMR sessions and complete home assignments developed together with practitioners. Significant others are involved, with the client's permission, in the program and the completion of home assignments. The relationship between recovery, which is conceived of idiosyncratically by each client, and illness management is an important focus of the program. Many clients believe that successful management of symptoms keeps their illness from taking them off the track from pursuing their goals.

University Affiliation

In January 2006 a university affiliation with a state psychiatric hospital was developed in an attempt to aid the hospital in its efforts to implement a number of EBPs and facilitate an increase in the number and pace of discharges from the hospital. IMR was the first practice implemented because of its reliance on the philosophy of recovery and wellness and the fundamental clinical strategies that can be used in the implementation of future EBPs. This effort was done in multiple steps over the course of 2 years, eventually involving groups throughout the entire hospital. The working hypothesis was that IMR's ability to operationalize the recovery model would result in a greater assimilation of these concepts into other areas of clinical practice within the hospital.

Project Planning

A generic project plan template was used (see Table 1), and adapted for use in the IMR pilot project; the plan was redone for each additional area of the hospital where IMR was to be implemented. This generic project plan template was later adapted for the implementation of two additional EBPs. The first phase of the plan was to establish the rationale for the program, the second phase

TABLE 1. Generic project plan

Phase 1: Establishing the project rationale

The leadership of the hospital (ideally, leadership at the state level) and midlevel hospital leaders delineate the rationale for the program. This group sets the expectation for the hospital and charges high-level administrators to participate in and oversee the implementation. A pilot site is chosen and phases 2–6, below, are completed. This process is then repeated as the project expands throughout the hospital.

Phase 2: Forming the project team

A number of orientation training sessions that focus on the nature of the program are presented, after which clinical and administrative “champions” are identified and their roles delineated. These champions select a broad range of stakeholders (volunteers are also solicited) to form an implementation team of staff in their area that will draft the basic implementation strategy within their unique area.

1. Implementation team meets weekly.
2. Champions also met with hospitalwide leadership monthly to discuss the project.
3. Implementation team drafts a project design detailing the elements below.

Phase 3: Designing the project

1. Identify the training and consultation needs of the project.
2. Identify how patients will be selected or how they will self-select.
3. Identify who will the cofacilitators will be* (ideally, one of them will have experience in running the program).
4. Determine when and where the groups will run.
5. Determine when and where the supervision will be.
6. Identify and problem solve additional communications and logistics concerns.
7. Determine outputs and outcomes to track

Phase 4: Training (for IMR)

1. All group or individual providers of IMR program will attend 2 full days of IMR training and receive the IMR workbook, practitioners guide, and group guide.
2. All facilitators will attend a full day of motivational interviewing.
3. All facilitators will attend a full day on cognitive behavioral interventions.
4. Administrators will identify need for and provide additional training as necessary.

Phase 5: Implementing the rollout

1. Have experienced clinicians model the practice (if possible).
2. Begin group or individual sessions.
3. Address administrative concerns in administrative meeting once week for first 6 months.
4. Address clinical concerns in clinical supervision weekly.
5. Use video or audio taping of clinical sessions in supervision.

Phase 6: Measure outcomes (for IMR)

1. IMR client and clinician rating scales
 2. Fidelity assessment
 3. Other measures as defined
 4. Results communicated to IMR facilitators and administrators
-

was to form the project team, the third phase was to develop the project design, the fourth to provide the trainings, fifth to roll out the program, and the sixth phase to measure and to provide feedback on outcomes to the clinicians and administrators.

Typically, hospital initiatives are sought out to correct the worst problems in the institution, and applications are tried untested with complex and frustrating situations (Smith & Bartholomew, 2006). This process significantly increases the chances that the project will fail to meet its intended objectives. It is for these reasons that a specific pilot site was selected to start the IMR implementation. This pilot site was not in crisis, and it had a stable, competent management team and intact infrastructure. The pilot phase of the project began with an 8-week cycle of two groups that included 16 patients with four volunteer clinicians and a university faculty consultant. The site for the pilot was a transitional unit of the hospital with all the patients deemed to be close to discharge to their own state-subsidized apartments. The pilot ran smoothly and ended with 14 of the 16 patients being discharged successfully. This project allowed university and hospital staff to identify numerous implementation barriers and allowed time to brainstorm solutions.

The next step of the overall implementation effort was to progressively use the project plan to design and run full cycles of IMR groups throughout the remaining four complexes (a complex contains approximately four 30–35 bed wards) within the hospital, starting with the transitional section of the hospital, moving next to two extended acute complexes, and, finally, to the admissions complex. Some specific strategies used in the six phases of the project plan are summarized in Table 2 and detailed below.

Project Plan Phase 1: Establishing the Project Rationale

Administrative Support. Securing the hospital administration's support was critical in establishing the rationale and expectation for the hospital to implement IMR. This support was not complete, however, as some members of the centralized leadership of the hospital had concerns about the effectiveness of the IMR program in a hospital setting; this threatened prolonged analysis of the program's applicability. The pilot program began despite this and resulted in positive word-of-mouth support by participating

TABLE 2. Strategies for successful implementation of IMR in a state psychiatric hospital

Design feature	Description
1. Administration support	The section administrator championed the program and was supported by the CEO. Their participation and explicit support helped overcome resistance to the project.
2. Volunteer group facilitators	The IMR group facilitators who participated in the pilot and subsequent phases of the implementation were largely volunteers. This increased the chance of "buying-in" and that clinicians would work in good faith to implement the program effectively.
3. Stakeholder participation	The volunteer facilitators and unit staff participated in all aspects of the implementation planning and problem solving with their respective administrators. This had the effect of increased "ownership" of the program by staff.
4. Patient self-selection	Patient participants in the program were asked to volunteer to participate after attending a presentation about the program. This empowered patients to internalize the rationale of the group and to take some ownership for their own recovery.
5. Focused training	Extensive multiday training was provided for the facilitators on the program while less intensive orientation was conducted for all other staff on the treatment team. This ensured that all staff had some familiarity with IMR.
6. Modeling of the practice	University faculty modeled the delivery of the program in the early stages of implementation, gradually handing over responsibility to hospital clinicians. This reduced the hospital staff's anxiety to participate in a new program.
7. Cross-discipline clinical supervision	Clinical supervision was provided by university faculty to all facilitators regardless of their professional discipline. This included videotaping sessions, role-playing, and clinical exercises. This improved the clinical and programmatic fidelity to the IMR model.
8. Strive for group homogeneity and attend to differences in group composition and functioning.	Facilitators were encouraged to deal proactively with group interfering behaviors and to pace and adapt the group appropriately to patients' needs. This allowed the program to be implemented in a wide variety of clinical situations and with groups with varying degrees of heterogeneity.
9. Support patient goals through homework and skill acquisition.	Patients' success at achieving their goals or acquiring new skills was facilitated by support outside the group by psychiatric rehabilitation interns, direct

(Continued)

TABLE 2. Continued

Design feature	Description
10. Encourage experimentation.	care staff, and professionals in other groups. This improved patient's follow-through on personal goals. Group facilitators were encouraged to engage patients in unique activities while maintaining programmatic faithfulness (fidelity) to the IMR implementation protocol. This allowed clinicians to use their creativity and helped maintain both staff and patient motivation.
11. Focus on clinical competence and programmatic fidelity.	Direct observation of clinical practice, ideally using videotaping, allowed for a more objective appraisal of clinical skills. This is important feedback for clinicians regarding their skills. Fidelity to the IMR program represents an important focus of implementation and program evaluation.

staff and patients. Because of this, the program expanded even as disagreements continued within the hospital leadership. Ultimately, it was the support of the CEO and ongoing discussions with the leaders who had concerns that allowed the project to eventually achieve broad support. Specific areas where the leadership and hospital CEO demonstrated support were by attending the IMR trainings, introducing the speakers, and discussing the value of the project in multiple settings. In addition, the CEO routinely read the minutes of the IMR supervision meetings and offered her thoughts along with words of encouragement to the staff providing IMR.

Weekly planning and implementation meetings took place with the hospital's section administrators and university consultants. This group in turn met with the hospital CEO on a monthly basis to update her on progress and plan for future IMR expansion. The administrator of the section where the IMR pilot project began was widely seen as one of the project's biggest champions. This administrator removed many barriers to implementation that were identified by the IMR facilitators, including finding program space, resolving scheduling concerns, and freeing up staff from other responsibilities. His leadership can be credited with a large measure of the success of the IMR program. His work, in turn, developed momentum for the rest of the hospital.

Project Plan Phase 2: Forming the Project Team

Volunteer Group Facilitators. One irony of attempting to implement a recovery-focused approach in a hierarchical system such as a state hospital is the danger that hospital staff will be forced to provide an empowering experience for patients while their personal experience feels like coercion. This is problematic because success or failure of new programs may be dependent on the good faith efforts of the staff involved (Corrigan & McCracken, 1997). Reconciling the balance between using administrative mandates and consequences (the stick) and seeking out and cultivating stakeholder “buy-in” (the carrot) is often lost in the numerous hierarchical layers of hospital management. Hospital clinicians repeatedly experience new programs as just another top-down administrative mandate.

In an effort to solicit commitment to IMR and lessen the possibility of staff’s feeling mandated, volunteers were sought to facilitate the first wave of IMR groups. Ideally, staff that had run one of the pilot groups would pair up with a staff member new to the program. This was done regardless of the clinical discipline of each staff. The idea was to continue developing confidence and competence in an evolutionary way, eventually spreading the IMR program throughout the hospital. It was common for these pairs to be on the same team and responsible for the same group of patients. This process involved “early adopters,” staff that are open to new ideas and to change. These staff later served as champions for the program when others in the environment were skeptical or negative about the program. Staff that did not initially volunteer were asked to run one of a number of other programs that fit the strategic plan of the hospital. Some examples were smoking cessation, social skills groups, and cognitive behavioral therapy groups. This maintained staff choice and buy-in while allowing the hospital to move in the direction of using EBP and a recovery philosophy.

Stakeholder Participation. The clinicians involved in the project worked with the university faculty, section administrator, and middle management in addressing the logistics and making the majority of decisions about the program’s implementation. Direct care staff are important culture carriers in state psychiatric hospitals, so were involved early on in discussions and trainings about the IMR project. Their role in supporting IMR homework

and skill acquisition is vital in an inpatient setting. This aspect of the program was accomplished sporadically but proved difficult to organize and maintain. The successes in this effort appeared related to the “organic” person-to-person relationships between group facilitators and direct care staff and not on predefined implementation plan or structure. Many hospital staff have seen numerous programs come and go that appear to have more to do with “administrative priorities . . . reflecting abstract political interests rather than the more pressing needs of the team and its clients” (Corrigan et al., 2001). Efforts were taken to elicit and address staff concerns when possible.

Project Plan Phase 3: Project Design

Patient Self-Selection. Patients cannot be forced to recover, so their voluntary participation is an important aspect of IMR’s client-centered orientation. To this end, a high energy, hope filled, patient presentation was provided (30–45 minutes) after which patients were invited to sign up to participate in the program. Depending on the area of the hospital, between 50% and 75% of patients attending the numerous presentations signed up voluntarily. This process appeared to increase the possibility for early success of the program by allowing patients to be self-directing and to decide for themselves whether to participate in the program. This process was later augmented with the treatment team’s identification of additional patients whom they believed would benefit from the program and encouragement for them to join through individual conversations. Lastly, as the program rolled out to the rest of the hospital, team members referred patients who did not self-select to an IMR group saying that they are welcome to drop out after giving the program a chance. This allowed patients to be exposed to the program’s first module, which was called “recovery strategies.” This module has been identified by patients as instilling hope for the future, and it may motivate patients to continue in the program.

Project Plan Phase 4: Training

Focused Training. All the IMR group facilitators, as well as the entire hospital leadership, received 4 full days of training, including 2 days on IMR and a day each of motivational interviewing and cognitive behavioral techniques training. This training was

reinforced with group facilitators during weekly clinical supervision (see below). All treatment team members not providing IMR received 2-hour overview training focused on the team's many roles in facilitating the success of IMR. Supervisory meetings were later used by university faculty to provide 1-hour training sessions focused on specific clinical issues that had become thematic or were of interest to the team.

Modeling of the Techniques. University faculty had offices in the treatment area of the hospital, permitting numerous opportunities for in vivo interaction and relationship-building with hospital staff. University faculty were available at the outset to model the techniques and spirit of IMR. This had the twofold effect of reducing the anxiety of the hospital staff by being able to observe the techniques and providing an opportunity to develop a relationship with the faculty member. The modeling and the opportunities for validation and for sharing experiences became important in the development of cohesion within the group of IMR facilitators. The university faculty helped direct implementation efforts to maintain a high level of fidelity to the IMR model. The use of role plays in supervisions served to highlight clinicians' skills.

Project Plan Phase 5: Rollout

Cross Discipline Clinical Supervision. All clinicians attended 1 hour of weekly supervision facilitated by a university consultant with experience in IMR. Participating hospital staff included staff of varying backgrounds and experience ranging from a high school diploma to a PhD level of education. Ten clinicians were the main facilitators of the IMR groups—two PhD-level psychologists, one doctor of psychology, one doctorate-level occupational therapist, one master's level occupational therapist, two master's level social workers (one, an administrator and the other, a direct-service social worker), two bachelor's level social workers, one master's level clinical nurse specialist with a background in marriage and family therapy and a direct-care staff person with a high school education and some college. Clinical supervision in the hospital, when it occurs, is done within the discipline "silo" of the clinician. This IMR supervision was focused on cross-discipline clinical issues and techniques with administrative issues being directed out of the meeting to the complex administrator (IMR's administrative champion). The university faculty that ran the supervision had no

authority over the clinicians. This supported the development of trusting relationships and an environment in which participants freely engaged in role plays, clinical exercises, and videotaping of sessions. Clinicians using the video are taped providing IMR in their groups, then the clinicians themselves choose to use or not use the tape for review by the supervisory group. In this way the anxiety of taping and the problems inherent in clinician's self-reporting their experiences are avoided and actual group work is observed. Client confidentiality during taping was addressed by having the patients sign a release in which the purpose of the taping is described and the focus of the camera is on the facilitator with only the patient's voices captured on the audio portion of the tape. If patients refused, taping did not occur.

IMR practitioners use three different teaching strategies, along with generic group-management strategies. These strategies include motivational strategies, educational interventions, and cognitive behavioral strategies. While it is outside the scope of this paper to discuss these strategies in depth, it is worth noting that those using these strategies require some advanced clinical skills. These skills are initially presented in the training sessions; clinicians describe that these skills noticeably improved with ongoing practice. Most clinicians had some experience with these techniques, and they reported an increased awareness that they had not previously used them. Most felt more comfortable after one full cycle of the IMR program. Each supervisory session opened with an update from the group facilitators at which time presentations could be made or themes identified. Group problem solving and discussion followed. In the latter part of the supervision, the clinical skills involved in IMR and generic group management strategies could be practiced. Clinicians were often encouraged to try an approach in the group and report back at the following week's supervision.

Strive for Group Homogeneity and Attend to Differences in Group Composition and Functioning. State hospitals often work with patients who are dealing with the most persistent and debilitating conditions, as well as some of the most acute conditions (in the admissions unit). IMR groups eventually began in every area of the hospital with a wide variety of patients. Here are examples of the IMR program's range: four groups were run in Spanish, three groups were run with patients having significant cognitive impairments, nine in the admissions wards with patients who were often

acutely symptomatic, five in areas where patients had been for a long time owing to persistent illnesses, and one in the drug and alcohol treatment unit. In all these areas, IMR was met with high levels of patient satisfaction (based on focus groups and patients' contributions to progress notes) and staff satisfaction (based on feedback in the weekly IMR supervisions). Staff noted that the barriers to providing IMR were no worse than those providing many other hospital interventions. There was considerable agreement from hospital staff that the focus on patients' recovery goals was clearly more effective at engaging patients than more didactic prescriptive approaches.

There was complete staff agreement that IMR groups functioned best when there was relative homogeneity of patient functioning. When this was not possible, patients with differing levels of cognitive impairment or symptoms nevertheless met together in IMR groups. This was much more difficult, but it was still possible for facilitators to run an effective group. It was clear that more facilitator energy was required to address group management and balance patient participation with such heterogeneous groups. Staff adapted to different patient needs by adjusting the pace of the group, simplifying abstract concepts in the curriculum, and focusing on concrete concepts. In the admissions area, where patients tended to have more acute symptoms, a group goal was explored to focus the group's attention. This was often a general goal of interest such as the goal of discharge or employment. This appeared to lessen the impact of individual symptoms on group functioning. As patients' symptoms lessened, their goals became more individualized. It was also noted that a few patients who could model participation for others helped most of the group use the process. Attempts were made to seed the groups with folks who could support the groups' functioning in this way. Staff used a variety of learning strategies including writing on the board, recitation, role playing, and drawing. Other groups incorporated relaxation as well as activities of interest to the patients such as music and poetry to individualize the program. Group facilitators routinely met with patients who engaged in behaviors that interfered with the group's functioning and mutually developed plans so that they could continue. No patients who self-selected to participate in IMR were removed from the group in the first year.

Support Patient Goals Through Homework and Skill Acquisition. Success in the IMR program improves when

patients actively pursue their recovery goals and practice illness management skills outside of individual and group sessions. There is not enough time to accomplish this within a typical IMR session, so homework that is jointly agreed upon by patients and staff is assigned. Homework is individualized and generally is of two types. The first is the specific, individualized stepwise pursuit of recovery goals. The second is practicing skills necessary to manage one's illness. Inpatient settings often present barriers to the pursuit of personal goals such as locked wards, limited resources and space, and safety rules needed for a few patients that restrict all patients. It is for this reason that the mutually agreed-on, assigned homework was predominately the practice of illness-management skills, which could be done in the evening on the ward where patients spent the most time. This was a constant struggle because, to maintain patient motivation, it was vital that the group facilitator successfully make the connection between the need to master the skills of illness management as a necessary step toward accomplishing ones recovery goals. Staff were challenged to view the reaching of patient goals as the driving force of the program rather than using the goal to simply provide motivation to manage one's illness.

The university's hospital affiliation, described above, had the added benefit of providing us with interns from a bachelor's-level certificate program in psychiatric rehabilitation. These interns, along with some exceptional direct-care staff, worked to support patients to complete their IMR homework. These patients described more positive experiences in IMR. Utilizing direct care staff in this way occurred only sporadically; it is a major focus for the future of the hospital's IMR program.

IMR facilitators who fail to embrace the philosophy of IMR often run what devolves into a psychoeducational group in which patient goals are absent, are seen as token goals, or are thinly veiled, such as taking a shower or being less aggressive. When this happens, facilitators often stop assigning homework because patients are not motivated to complete it. Devout IMR facilitators expect participants to accomplish their individual goals—or at least make objective progress toward them—and to manage their wellness. Furthermore, they can communicate that expectation to their patients. This sense of hopefulness seems to correlate with higher levels of homework completion.

Encourage Experimentation and Adaptation. Fidelity “refers to the degree to which a particular program follows a

program model" (Bond, Evans, Salyers, Williams, & Kim, 2000). The concept of fidelity or "faithfulness" to an EBP does not mean that practitioners need practice in lockstep with a prescribed protocol. While it is important to maintain programmatic fidelity to the IMR program (see below), there exists a wide range of opportunities for clinicians to express their creativity when adapting to the patient's individual needs. Facilitators in this project used many strategies including, but not limited to, tai chi, deep breathing, and stretching as activities to help patients explore relaxation techniques. This also helped keep the staff motivated to do IMR. Trips outside the hospital were used to explore community resources including the local library, consumer-run drop-in centers, and ex-patient apartments. Patients were asked at the end of each session, "What, if anything, did the group have to do with your personal goal?" This was done to make sure that the group stayed focused on patient goals. Supervision and fidelity measurements (see below) were also used to make sure groups did not stray from the principles of the program.

The modules of the IMR program are designed to be presented in any order. With the exception of the first module, they are interchangeable. The logic for this is that the first module discusses the concept of recovery and encourages participants to identify a recovery goal and the steps needed to work toward it. State hospitals have limited resources, which makes managing the number of patients in the group an important consideration. Successfully keeping the number of patients in a group high enough to justify the time of the cofacilitators becomes difficult when new patients need to do the first module before moving to other parts of the program. Numerous strategies to do this were tried, including, the use of a "primer" group in which patients join an introductory group that presents the first module (recovery strategies) and attempts to motivate them to complete the rest of the program. Patients can then graduate to a group already running elsewhere in the hospital. This strategy has the advantage of providing a continuous flow of patients to keep groups filled to capacity. Its disadvantages are that it requires significant communication between the group leaders and that the relationship formed between the primer group facilitator and the patient does not continue. There is also the danger of negatively impacting the ongoing group's cohesion. A second strategy to address group attrition is to have groups combine as patients are discharged or transferred. The problems

of maintaining group cohesion and therapeutic relationships also exist as groups consolidate. A third approach is to have the IMR group itself orient new members to the first module. This might be empowering for group members, and it may allow for additional review time. When using this strategy, it makes sense to admit new members only at predefined intervals throughout the group to maintain the group's progress and minimize the effect on cohesion. Group members are encouraged to take a mentoring role for new group members in this process to prevent boredom.

Project Plan Phase 6: Measure Outcomes

Focus on Clinical Competence and Programmatic Fidelity. IMR clinicians use strategies that include motivational, cognitive behavioral, and educational approaches. The effective use of these strategies was the focus of role plays and discussion in supervision. Patient's IMR goals were central to case reviews, and specific interventions were developed in support of the achievement of these goals. Hospital staff were routinely asked to use strategies discussed in supervising their groups; staff would then report back to the supervisory group on the success of the strategies.

A distinction was noticed early in the implementation of IMR between programmatic fidelity as presented by SAMHSA (2008) and clinical competence, which was defined as the ability of individual clinicians to effectively use the clinical strategies that support IMR. An assessment of programmatic fidelity was done using the IMR fidelity scale provided by SAMHSA. It was performed by three university reviewers from other project sites also doing IMR. The IMR fidelity scale uses behaviorally anchored, measurable aspects of the IMR program in the rating of 13 items. The items are rated using a 1-to-5 response format in which a rating of 1 indicates no implementation of the fidelity item and 5 indicates complete implementation. At the time of the fidelity visit, the hospital was running 21 IMR groups involving as many as 39% of the patients of the hospital at one time. (See Table 3 for details on the findings of the hospital's fidelity review). According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "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

TABLE 3. IMR Fidelity Score Sheet

	2009 Hospital IMR fidelity visit scores	Reviewer No. 1	Reviewer No. 2	Reviewer No. 3*	Total score	Average final score
1	No. people in a session or group	5	5	5	15	5.0
2	Program length	5	5	2	12	4.0
3	Comprehensiveness of the curriculum	5	5	2	12	4.0
4	Provision of educational handouts	5	4	5	14	4.7
5	Involvement of significant others	1	1	1	3	1.0
6	IMR goal setting	5	3	4	12	4.0
7	IMR goal follow-up	2	3	4	9	3.0
8	Motivation-based strategies	4	3	4	11	3.7
9	Educational techniques	5	5	5	15	5.0
10	Cognitive-behavioral techniques	5	3	3	11	3.7
11	Coping-skills training	1	4	4	9	3.0
12	Relapse-prevention training	4	3	5	12	4.0
13	Behavioral tailoring for medication	4	1	1	6	2.0
Total score						3.62

*Reviewer no. 3 rated IMR on an admissions unit in which only three of the IMR modules (recovery strategies, using medications effectively, and reducing relapses) were used because the average length of stay was only 100 days.

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” (SAMHSA, 2008). The hospital’s average fidelity score for the 13 items on the scale was 3.62, indicating a moderate level of implementation fidelity to the IMR model (McHugo et al., 2007). Program fidelity is important in assessing IMR implementation, but for us it was not a sufficient objective measure in improving clinical supervisory skills and determining the relationship of fidelity to client outcomes. Assessing clinical skills requires a more granular approach capable of identifying small improvements in clinical practice over time. Ongoing group observations by the university faculty suggested that clinical competence in IMR varied

significantly across facilitators and areas of the hospital. This was largely missed by the fidelity reviewers, who observed only a sample of the groups and practitioners. Examples of clinical variability included clinicians who solicited patient's goals and then disallowed those goals as unacceptable or unrealistic. These clinicians readily gave advice and scolded or lectured patients, behaviors well outside the philosophy of IMR, though not specifically captured in the fidelity assessment. IMR, as a modularized program, is currently being researched, but its effectiveness likely depends on programmatic fidelity and on the clinical competence of its providers. The university IMR implementation team is currently working on ways to more reliably measure clinical competence in IMR and its relationship to program outcomes.

The IMR client- and clinician-rating scales (Salyers, Godfrey, Mueser, & Labriola, 2007) were also administered at baseline and every 6 months to assess the self-reported impact of IMR on patients and the perspective of the IMR clinicians as to the impact of IMR on the same patients. Results from the pilot and first year showed positive trends, although incompleteness of the data due to discharges and periodic failure of hospital staff to complete the scales left the sample too small to achieve statistical significance.

Ongoing Barriers

Facilitators in all the groups identified that the IMR program embraced a philosophy that was not fully accepted or practiced by other members of the treatment team. It was suggested that some other team members engaged in practices that contradicted what was practiced in the IMR group. For instance, an IMR clinician used role-playing in an IMR group on how to negotiate and partner with a patient's psychiatrist regarding medication adjustments. The physician later disregarded the patient's concerns. A second example is a patient's wanting to be discharged to his father's house, wherein the treatment team stated that he needed a more supervised setting. An IMR practitioner suggested that the team reconsider and focus its efforts on making the discharge to the father's house more likely to succeed by addressing the skills and resources needed in that environment. Eventually, after many discussions, this was done successfully. Patients in many state hospitals are affected by the pervasive culture of custodial care and control in these institutions. This appeared to have a nullifying

effect on the patients beyond the presence of negative symptoms. Comments from patients included, "When they let me out, I'll think about my recovery" and "I can't do anything unless the team grants me permission." A patient who was recently informed that the treatment team had decided to move him expressed it well when he said, "I thought I was a member of the treatment team!" These situations are compounded by institutional barriers that prevent patients from free access to hospital resources. For example, patients needed escorts, who were often unavailable, to gain access to a computer lab, weight room, gym, or library to pursue their recovery goals. When staff advocates intervened on the patient's behalf these obstacles were readily overcome. Unfortunately, this requirement of staff intervention does not result in the same sense of self-efficacy for patients as doing these things for themselves. Staff worried that this meant that IMR was too resource intensive. It is true that offering resources and supports outside the formal IMR process requires an additional commitment on the part of administrators and staff. This process represents the consolidation of resources in the direction of a recovery-and-wellness approach in which IMR serves as the focal point. Integration of IMR into the hospital structure requires the systematic inclusion of patient recovery goals within the patient's treatment plan. Without this, only IMR facilitators know the individual patient goals. This results in IMR's existing in a treatment "bubble" in which patients within the IMR group can be engaged and motivated in meaningful ways while the rest of the treatment team remains unaware and, at times, working at cross-purposes with the patient.

CONCLUSIONS

The process of implementing new practices and a new treatment philosophy presents significant challenges to any health care organization. State hospitals often have additional barriers that serve to insulate them from the need for change (Smith & Bartholomew, 2006). Addressing these barriers directly with a focused set of strategies may result in new programs that achieve greater operational success. The IMR program is uniquely suited for a state hospital that wishes to integrate the concepts of the recovery model while using an evidenced-based approach. Further stepwise developments can flow naturally from this

marriage of philosophy and practice, including an increase in patient's shared decision making through person-centered treatment planning (Singh & Tosh, 2005) and patient self-selection of programming. Connections with direct-care staff can be reinforced through effective team communication to support patients' skill acquisition and pursuit of their recovery goals. IMR provides a foundation of person centeredness on which the implementation of additional and future EBPs can be built. The value of the IMR program, when practiced with a high degree of fidelity and clinical competence, holds the promise of going well beyond its role as an additional group in the hospital's schedule. Activating IMR can serve as a comprehensive, concrete mechanism for a system's transformation by operationalizing many of the necessary staff attitudes and behaviors that underlie the spirit of a recovery philosophy within a state psychiatric hospital.

This article has described the implementation of IMR in a state hospital. The limitations of the article involve the reliance on largely anecdotal information from which conclusions were drawn about the effect of different implementation strategies. The need for a more formal evaluation of these approaches is necessary. The impact of the IMR project on the transformation efforts of the hospital from a medical model of care toward a recovery model also needs to be formally evaluated.

Future research in this area is needed to examine the impact of specific IMR implementation strategies on programmatic fidelity as well as their effect on the development of clinical competence by practitioners. Measures that can reliably assess the clinical competence of the providers of IMR are necessary. This can also help determine if higher degrees of clinical competence in providing IMR result in better clinical outcomes. The use of IMR as a transformational tool that can aid institutions in moving their organizations in the direction of a recovery and wellness orientation also needs to be empirically examined.

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