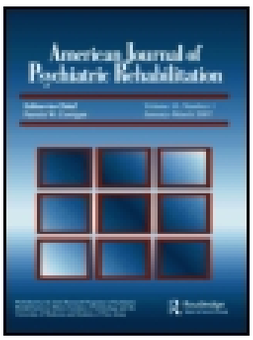

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Illness Management and Recovery: Generic Issues of Group Format Implementation

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Illness Management and Recovery: Generic Issues of Group Format Implementation

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A recent development in psychiatric rehabilitation is the identification and standardization of evidence-based practices (EBP). In this article we report on the implementation of one of the EBPs, Illness Management and Recovery (IMR), in a group format in two settings and cultures, Israel and the United States (North Carolina) to address generic issues of implementation that arise across settings. The unique characteristics of the group format, ways in which

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they can be both enriching and challenging, and the importance of considering local cultural influences when using a standardized EBP are discussed.

Keywords: *Evidence based practices; Illness management; Implementation; Recovery*

EBP became central to mental health services when researchers reviewed controlled studies and identified a sufficient body of research attesting to the effectiveness of five psychosocial interventions (Drake, Merrens, & Lynde, 2005; Mueser, Torrey, Lynde, Singer, & Drake, 2003). EBP is an intervention that evidence has shown to be effective in assisting clients achieve desirable outcomes (Drake et al., 2001) and in facilitating recovery and community integration (Bond, Salyers, Rollins, Rapp, & Zipple, 2004; Drake et al., 2001).

The National EBP Implementation Project, developed and spearheaded by the Psychiatric Rehabilitation Center at Dartmouth, was funded by the Substance Abuse and Mental Health Services Administration (SAMSHA). As part of the project, implementation resource kits were developed for the five psychosocial EBPs: supported employment, family psychoeducation, integrated dual disorder treatment, assertive community treatment, and IMR. The kits can be downloaded from the SAMSHA website at http://www.mentalhealthpractices.org. The purpose of this article is to describe and discuss the generic issues and cultural influences related to the group format implementation of one of the EBPs, IMR, at two locations, each in a different culture. One location was in Israel, the other in North Carolina, U.S.A.

IMR (also often referred to as ''Wellness Management and Recovery'') is a standardized curriculum-based approach to helping consumers acquire the knowledge and skills they need to manage their illnesses effectively and achieve personal recovery goals. The IMR intervention can be completed in an average of nine months. Sessions of approximately one hour duration are held once a week, often twice a week, in inpatient and day treatment settings. No clear criteria have been provided about the educational background and experience needed to administer the IMR program. To date, IMR has been implemented by practitioners whose background, education, and experience vary widely (Mueser, Meyer, Penn, Clancy, Clancy, & Salyers, 2006).

The IMR implementation resource kit contains five empirically supported interventions: psychoeducation (Goldman & Quinn,

1988; MacPherson, Jerrom, & Hughes, 1996), cognitive-behavioral approaches to medication adherence (Azrin & Teichner, 1998; Razali & Yahya, 1995), relapse prevention (Herz et al., 2000; Scott, Garland, & Moorhead, 2001), social skills training (Bellack, Mueser, Gingerich, & Agresta, 2004), and coping skills training (Leclerc, Lesage, Ricard, Lecomte, & Cyr, 2000; Lecomte, Cyr, Lesage, Wilde, Leclerc, & Wilde, 1999). Although IMR practice is based on evidence, the program as a complete intervention has not yet been rigorously evaluated. Recent pilot data do support its effectiveness, however (Mueser et al., 2006).

Based on the empirically supported interventions, nine modules have been developed: (1) recovery strategies, (2) practical facts about mental illness (schizophrenia, bipolar disorder, and depression), (3) the stress-vulnerability model, (4) building social support, (5) using medication effectively, (6) reducing relapses, (7) coping with stress (8), coping with problems and symptoms, and (9) getting your needs met in the mental health system. Recently a tenth module has been developed focusing on drug and alcohol use. Each module contains a guide for practitioners and a handout for consumers. It also includes checklists that summarize key points reviewed during sessions. The practitioner relies heavily on psychoeducation, motivational interviewing, and cognitive behavioral strategies to ensure that the requisite self-management skills are successfully learned. For example, in module 5, Using medication effectively, the practitioner may carry out the following activities with consumers: (1) review basic information on how medications work (psychoeducation); (2) weigh the pros and cons of taking medication (motivational interviewing); and (3) role play negotiating medication issues with physicians (cognitive behavioral techniques).

IMR was first implemented in Ohio, New York, New Hampshire, and Vermont as part of the National EBP Project. It has since been implemented in many other states and countries. The implementation of innovative practices in established social systems, even those known to be effective, appears to be a complex task, and often interventions are not available to consumers who could benefit from them (Lehman & Steinwachs, 1998). The reported discrepancies between research knowledge and actual services provided have generated efforts to bridge the gap by studying the factors that promote and hinder implementation. The accumulating literature on efforts to implement EBPs in different settings (Torrey, Finnerty, Evans, & Wyzik, 2003; Torrey, Lynde, & Gorman, 2005) has led to

attempts to develop theoretical and empirical knowledge to facilitate the implementation of EBPs. The EBP Project (Drake et al., 2001; Torrey et al., 2001) was designed to investigate the implementation of EBPs. Research efforts have identified both state-level and site-specific factors that affect implementation. State-level factors include infrastructure funding, preparation, establishing standards, quality management, and technical assistance; site specific factors include leadership, staffing, mastery, stakeholder relationships, and communication (Magnabosco, 2006; Moser, Deluca, Bond, & Rollins, 2004). It has been argued that there is a need for clinical descriptions of EBP implementation efforts in a variety of settings, geographical locations, countries, and cultures so that clinical practice can inform the development and further dissemination of EBPs (Anthony, Rogers, & Farkas, 2003; The New Freedom Commission on Mental Health, Subcommittee on Evidence-Based Practices). This need for clinical descriptions of early experiences in implementation motivated a collaborative effort to describe parallel implementations of IMR in two widely different settings, Israel and North Carolina, U.S.A.

OVERVIEW OF THE ISRAELI AND NC IMR GROUP PROGRAMS

Background and Settings

Israel

Until recently, services for people with serious mental illnesses (SMI) in Israel included primarily psychotropic medication and limited psychotherapy provided by psychiatric hospitals and community mental health centers. Recent legislation concerning the rehabilitation of people with a psychiatric disability in the community specifies a set of services to be provided to persons who meet eligibility requirements. These services extend to areas such as work, recreation, study, social life, dental care, case management, and accommodation (The Rehabilitation of Mentally Disabled in the Community Act, 2000, Version No. 2782, p. 1 [in Hebrew]). No explicit standards or selection criteria have been defined for the services specified by the legislation. Therefore services were included based on the available professional, clinical, and personal experience of those who planned and implemented the legislation. The legislation did nothing, however, to expand awareness of the need to deliver services that have been proven by research to be effective.

Similarly, the legislation ignored the importance of monitoring fidelity—the degree to which actual service delivery matches the treatments that have been proven to be effective.

Two of the authors led a pilot IMR group starting the fall of 2003 at a day-care psychiatric rehabilitation center at Shalvata, a mental health center located in central Israel that treats 760 consumers with SMI. One of the group leaders (DR), a clinical psychologist, was trained in IMR at the Psychiatric Rehabilitation Center at Dartmouth. IMR services were subsequently delivered at Shalvata in collaboration with a senior occupational therapist (LB) in a group format. The materials were translated into Hebrew for the project.

U.S.

The U.S. IMR group was conducted in 2004, at Wake County Human Services (WCHS), a large mental health center in Raleigh, NC that serves over 1,400 individuals with SMI. The group leader, in collaboration with WCHS staff, conducted a pilot IMR group, led by three mental health professionals: a clinical psychologist (DLP), a psychiatrist (KH), and a licensed social worker (SR). WCHS has been active in seeking out new treatments for their clients, keeping abreast of the current research literature via their grand rounds program. Thus, it was easy to establish a collaboration between an academic (DLP) and mental health practitioners (KH and SR) and to find support for it at WCHS.

Participants

In Israel, after obtaining approval from the unit director and the Institutional Review Board of the Shalvata a mental health center and before beginning to recruit participants, the curriculum and rationale of the IMR were presented to the staff. A small number of consumers who were not enrolled in other groups, generally those with the most severe symptoms, were offered participation in the IMR. No exclusion criteria were used. Originally eight consumers were recruited; two left the group after the first two sessions and another at a later stage. The group was completed by five consumers. The majority were male ($n = 4$) and were diagnosed with a psychotic illness ($N = 5$).

In NC, after obtaining IRB approval, recruitment began primarily through referrals by clinicians. No exclusion criteria were used and the clients who were referred to the IMR group generally had a long history of chronic mental illness. The group consisted of nine

consumers. The majority were male ($n = 6$), and were diagnosed with a psychotic illness ($N = 6$).

Format of Sessions

In Israel the group was coled. In NC the group leader's role was rotated with the two other mental health professionals serving as co-leaders and facilitators. Sessions followed a standard format:

Recapping the Previous Session; Soliciting Questions and Remarks about the Current module

Frequent questions were an indication that group members were processing the material between sessions.

Reviewing Home Assignments and Following up on Goals

This was challenging for clinicians and consumers alike. Active involvement in these tasks varied considerably between participants. In NC, both group leaders and consumers had home assignments. This was believed to improve group cohesion and provide models for home assignment attainment. Home assignments were developed collaboratively and were linked either to the specific module or to the individuals' broader goals.

Working on the New Module, Reading the Material, and Discussing it

Compared with other groups, which were more open-ended, the IMR often had more of a classroom feel because of its structure, the use of educational handouts, and home assignments. In half the sessions in NC, the IMR material was reviewed using PowerPoint. Participants in both groups often commented favorably on how they were ''really learning,'' that they were ''like students,'' and that the program was ''like university.''

Ending the Session

This included reviewing the group discussion and planning home assignments.

Completing the Program

As the groups progressed, we observed that members became more comfortable and closer to one another. This was evident from the

informal interactions before and after groups and from the level of disclosure and sharing during the groups. Members frequently provided emotional support and shared practical advice, which contributed to the cohesiveness of the group. In Israel the group met over a six-month period, and each session lasted 75 minutes; in NC it met for 10 months, each session lasing 50 minutes. Occasionally a group member, and very rarely two, missed a session and were offered make-up sessions. The last session was devoted to sharing the experiences of the group. In Israel the group celebrated with snacks and a group photo; the NC group enjoyed lunch at a local restaurant.

Case History of a Participant

The following vignette is a composite of several participants created to illustrate how the five evidence-based strategies in IMR [psychoeducation, cognitive behavioral therapy (CBT) for medication adherence, relapse prevention, coping skills training and social skills training] were integrated.

Tony, in his late 40s, had schizophrenia of the paranoid type and a history of alcohol dependence. He had not been employed for over 10 years and continued to struggle with anxiety and delusional ideation. Tony readily took to the IMR group. After about one month, he mentioned during group how much he enjoyed learning about recovery, which gave him hope for the future. He was an active participant during sessions, sharing his own concerns and supporting other group members.

Tony's initial recovery goal was to strengthen his hobbies, having noticed that with free, unstructured time his anxiety level increased, which led to an increase in paranoid thoughts. Much of his paranoia involved concerns that the government would take away his financial support and that he would end up destitute and homeless. Tony's initial goal was to read more, which he enjoyed before he became ill. However, his attention would often wander, making it difficult for him to concentrate. Using the problem-solving attainment model, which emphasizes and helps structure an active solution-focused approach, Tony identified a first step of reading one magazine per week. Using Socratic questioning and input from the group, Tony decided that the goal was too ambitious, and he undertook a more modest initial step,

reading one magazine article per week. This proved to be a better goal and it reinforced for him and for group members the importance of taking a ''shaping'' approach to goal attainment. Tony continued to work on recreational goals, including listening to his records again, which caused him pleasure.

Tony developed a new personal goal during Module #8, Coping with Persistent Problems and Symptoms. He reported that he became very anxious in the afternoons when he started to worry about his finances, his station in life, and his future. As Tony was quite distressed by these fears, part of a session was devoted to applying the problem-solving model to his concerns. Tony and the group members generated various strategies for managing the situation, some of which were feasible (e.g., using relaxation exercises to calm down) and others were not (e.g., having Tony take a class to distract him, which he could not afford). During this exercise Tony was reminded of how stress can lead to relapse (Modules #3 and #7) and how social support can be an important buffer against stress (Module #4); therefore, when feeling anxious, Tony was to use a variety of coping strategies (e.g., relaxation, getting out of the house, calling a friend) that had been effective in the past. To make sure Tony would feel comfortable calling a friend he performed a role-play of it in group with another member playing the role of his friend.

Tony was moved that the group devoted time to addressing his concerns. Group members commented that the exercise helped them put into practice topics they had been learning.

Upon completion of the IMR groups in both settings, the practitioners of each team reviewed their observations and processed their experience of the group in an attempt to identify and implement what has been learned. The initiators of the two groups (DR and DPL) then shared, compared, contrasted, and integrated what has been learned and summarized the results in five sections: (1) Ways in which the group format can enrich the delivery of IMR; (2) Factors that facilitated conducting the groups; (3) Dilemmas for the practitioners delivering IMR in a group; (4) Cultural influences on implementation; and (5) Future plans based on the acquired experience. The draft was then critically reviewed by the practitioners who coled the groups. Discussion with the coleaders provided further input that was used to improve the validity of the reported findings. Following is a discussion of the five themes:

LESSONS LEARNED

Ways in which the Group Format can Enrich the Delivery of IMR

Personal Experiences as an Enhancing Context for Acquiring Skills

IMR contains educational handouts to help inform consumers and teach them a range of skills that may help them better manage their illness and move toward their recovery goals. The group format and informal exchange facilitated the emergence of the therapeutic factor referred to as ''universality'' (Yalom, 1985), which is the realization that others often face similar circumstances and challenges. This realization in turn set a more personal and intimate context for learning and practicing new skills.

For example, while working on module 4, ''Building Social Support,'' a participant in the Israeli group described his reluctance to initiate conversations with other people (referring primarily to other parents at his son's school) because of his concern that it would lead to the discovery of his mental illness or to the need to reveal it. In the discussion that ensued most of the participants shared similar incidents in which disclosure of their mental illness was followed by stigma, discrimination, and rejection. Social skills training acquired a new flavor in the context of these personal real-life stories. Exploring and practicing more effective and gratifying ways of interacting, while considering the complex social context in which these interactions occur, seemed to enhance participant motivation and the relevance of materials.

Sharing Feelings Evoked by Learning about Illness and Recovery

Although treatment manuals are standardized, the way in which they are experienced varies considerably. Learning about illness management and facts about mental illness facilitated discussion of personal stories in both groups. These stories were often accompanied by intense sadness evoked by experiences with illness and the profound challenges it posed. Sharing these experiences often generated support, a sense of comfort and relief, and internalization of what had been discussed and learned in the group.

For example, in the Israeli group, where the vision of recovery is not widespread, for most participants recovery was considered as a

viable possibility for the first time. The discussion of recovery evoked intense emotions of hope accompanied by fear, possibly because it held a risk of disappointment from which participants were protected as long as they did not consider a potentially better future. A similar experience was present in the NC group, where members had been previously exposed to a model that was more medical nature, in which the clients were passive recipient of services, and where outcome was measured more by symptom remission than by goal attainment. The discussion of recovery, together with the sharing of intense emotions, appeared to contribute to a growing intimacy between group members.

Receiving and Providing Support

In both groups, the increasing extent and nature of sharing over time suggested an emerging cohesiveness and increased understanding and acceptance, which are common, well-documented group processes (Yalom, 1985). What seemed unique about the IMR groups was the shared journey of growing cohesiveness together with the learning and practicing of skills. For example, many participants in the NC group acknowledged their tendency to isolate themselves when becoming ill. They believed that this was because of increased paranoia and self-consciousness about their illness. As a group, they were able to provide social support while generating strategies to combat isolation. The social support served as a buffer against the vulnerability to relapse and contributed further to the group cohesiveness.

Factors that Facilitated Conducting the IMR Groups

Multiple Group Leaders

There are many advantages to using more than one group leader. In addition to the opportunity to provide modeling, having more than one group leader makes it possible to break up into smaller groups or work with participants individually when necessary. This was particularly valuable when performing highly individualized tasks such as following up on goals, role-plays, and reviewing and planning home assignments. Finally, having more than one leader ensured continuity because groups could meet even when one of the leaders was absent.

Communication with Other Staff Members

The groups' focus of instilling a recovery-oriented vision proved challenging not only for participants but for staff members as well. In Israel, some staff members did not feel comfortable with a practice in which the organizing themes were the core values of recovery, such as shared and informed decision-making and self-determination.

For example, a participant from the Israeli group, whose family had a devastating experience with mental illness was eager and curious to learn more about his diagnosis. But several staff members were concerned that this might be overwhelming for him in light of his family history, and opposed the idea, causing much turmoil. The IMR group and its leaders were actually accused of arousing the participants' curiosity about their diagnoses. A meeting between the IMR group leaders and the rest of the staff provided an opportunity to discuss these conflicting approaches, reduce tension, and improve communication and coordination. This incident illustrates how a recovery-oriented intervention, such as IMR, can affect not only the participant receiving the service and the practitioner delivering it but other staff members as well. It also demonstrates the importance of routine coordination between the IMR group leaders and other staff members.

Dilemmas of the Practitioners Delivering IMR in a Group Format

Reviewing IMR Modules: To Read or not to Read?

The issue of whether to read or not is particularly complicated in a group, where individuals' abilities in these areas vary. In Israel, group leaders first introduced the topic of the current module, after which participants took turns reading the material (except one who was illiterate), which then led to group discussion. The NC group leaders found that, although this strategy ensured comprehension, it slowed the process and toward the last third of the intervention they changed the routine: group leaders introduced a topic, paraphrased the material, and led a discussion on the topic without the participants reading the material during sessions. This helped accelerate the pace of the sessions and made them seem more like a group and less like a class.

Teaching vs. Treating

The IMR material consists of a structured curriculum of useful and personally relevant information delivered by various therapeutic techniques. IMR can be viewed and used primarily as a teaching guide or as a therapeutic tool, which raises the question of what should be emphasized and how should practitioners balance the two. In our experience, some participants were repelled by the idea of attending another group but were attracted by the idea of taking on a student role. Other participants responded to the material primarily as a stimulus to sharing and discussing their personal experiences. Groups become particularly challenging when participants vary on this issue, creating a false division between the two. The IMR contains elements of both teaching and treatment, which are not separable or dichotomous. But to the extent that the perception of a teach/treat dichotomy exists, it can pose a real challenge to the group: Some consumers may be more motivated by a teaching approach, others by a treatment approach. But the classroom feel seemed to appeal to most, perhaps because it was experienced as more novel than other groups they had attended.

Addressing Individual Goals

A core element of IMR is goal setting and helping consumers pursue their personal goals. This is more challenging and time-consuming in group IMR, where the group leaders must follow up on several personal goals simultaneously. Leaders in both groups tried to address this issue by reserving ample time at the beginning and end of sessions for individual goals and home assignments, but this reduced the time available for reviewing new material during sessions. Balancing the presentation of material on illness self-management with reviewing the progress of participants toward their individual goals can be difficult. A crucial component of this balance is the continuing effort to identify and emphasize the meaningful ties between the two.

Cultural Influences of Implementation

Israel is a young country with a unique culture that includes a marked religious orientation and is home to immigrants from regions as diverse as the U.S., Southern Asia, Europe, Russia, and Ethiopia. The definitions and manifestations of illness, recovery,

and treatment vary between these cultures, influencing help-seeking patterns and the degree of stigma attached to mental illness (Greenberg & Witztum, 2001; Kirmayer & Corin, 1998). For example, Greenberg and Witztum (2001) point out that ultraorthodox Jews in Israel often view the mental health system as a source of secular influence that can lead the client away from the right religious path. IMR, which encourages the exploration of the personal meaning of recovery, is likely to bring religious influences to the surface, particularly when carried out in a group format. The psychoeducational component of IMR, which focuses on facts about mental illness, can also elicit religious feelings and beliefs. This potential conflict should be taken into consideration and discussed openly. For the ultraorthodox, the scientific model might be identified with the secular model (Greenberg & Witztum, 2001) and scientific findings deemed inconsistent with religious beliefs.

The role of religion was a much less significant issue in NC. Participants in the NC IMR group were religiously heterogeneous, and most of them rarely mentioned religion. The exception was a participant whose goal was to become more socially active, which she felt she could achieve by attending church more often. The denomination of the church was not mentioned, and group members uniformly supported this strategy.

Israeli culture strongly emphasizes the traditional family and structure. This emphasis, which includes reliance on the family for support, living arrangements, and coping with difficult problems, produces a set of powerful contextual variables that should be taken into account when implementing IMR. In addition, there are strong societal expectations to marry and have children, which are also encouraged by various laws and social services. Another major part of Israeli culture is coping with stress caused by many years of conflict and violence in the Middle East.

The NC group differed from the Israeli one in this respect. Although family life was important to group members in NC, some of them lived away from their families or had only one family member in the area, which resulted in such goals as strengthening relationships with the local family member or finding other social support persons in the area. The stress that concerned group members in NC, other than that pertaining to symptoms, focused mainly on financial worries. Thus, in NC the conversation often revolved around worries about transportation, paying bills, managing health-related costs, and similar topics.

Finally, the culture of a country also includes the specific characteristics of that country's mental health system. In Israel, most practitioners working in psychiatric rehabilitation are clinicians with backgrounds in social work, occupational therapy, psychology, and nursing. Their training is generally characterized by a psychodynamic orientation rather than an emphasis on psychoeducation, cognitive behavioral therapy, or motivational interviewing. As a result, practitioners implementing IMR must learn new skills and adopt, or at least integrate, a new or modified professional identity. For those involved in the IMR project in Israel, this process took place at the individual level as well as the broader level of the rehabilitation practitioners' community, including the diverse clinical contexts in which the practitioners work; therefore, when trying to implement a new EBP, it is important to take into consideration the culture of the local mental health system and the way in which it interacts with training.

The culture at the mental health facility in NC was more eclectic. Although psychiatrists still receive psychodynamic training during their residency, many of them, including one of the co-authors (KH), are experienced in cognitive behavioral techniques such as DBT. Moreover, the state of NC is committed to offering EBP, with delivery of mental health services at local settings.

DISCUSSION AND FUTURE PLANS

To be able to address the generic issues of implementation that arose across settings, we described the implementation of IMR in a group format in two settings and cultures, Israel and the United States (North Carolina). This pilot implementation revealed several ways in which the IMR group format can enrich the delivery of the intervention. Integrating goal directedness within a supportive environment and balancing learning with the exploration of personally relevant topics produced a highly effective mix. Sharing feelings and experiences helped create an environment that facilitated the acquisition of skills needed to better manage illness, explore recovery, and work toward it. At the same time, the group format required a larger staff, greater coordination, and raised specific dilemmas for the practitioners, such as balancing teaching with treating and reviewing material while working on the multiple goals of the participants.

Our increasing cumulative involvement in IMR training has helped us appreciate the fine balance that has to be struck between the essential ''new'' skills practitioners must acquire in order to administer an IMR program (for example, motivational interviewing, CBT, and educational strategies), and the resources they had acquired in the course of their education, supervision, and experience. The degree to which the new and old skills are complementary or incongruent varies; therefore, to improve the implementation of IMR and possibly other EBPs, it is important to develop strategies to assist practitioners in integrating existing clinical skills with newly acquired ones while sustaining a sense of competence, self-efficacy, and positive professional identity.

An unexpected observation in Israel was related to how implementing an IMR program affected the local mental health system and even the broader one. One such influence had to do with generating more recovery-oriented thinking and practice. This was evident in the increased use of the ''recovery jargon'' by both staff and consumers, in the request for additional IMR groups and their implementation, and in emerging staff discussions about policies related to sharing information with consumers and responding to cases of dissatisfaction with their prescribed medication.

In NC a wave of enthusiasm followed the IMR pilot group, as evidenced by the large number of social workers and psychiatrists who inquired about the next group. Dissemination of information and the training of new therapists followed. A second IMR group was started in May 2005, and the mental health center agreed to become a site for a grant investigating the efficacy of IMR.

More information is needed on how to train practitioners from diverse educational backgrounds to conduct IMR within a variety of settings. Studies should be carried out to determine who benefits most from IMR and what resources are required to sustain the intervention. In addition, it is necessary to continue exploring the process by which EBPs can help change programs that have not emphasized hope, client-centered care, choice, self-management, and functional outcomes, and increase the recovery orientation of mental health systems. Finally, while the description of our pilot IMR implementation provides some social validity for IMR, future efforts should be directed toward evaluating social validity by the same objective scientific methods that were used to evaluate treatment outcomes. It is necessary to implement well-designed social validity assessments with increased consumer involvement.

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