

The Outcomes of Illness Management and Recovery on Severe Mental Illness: A Client's Perspective

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The present study explores the perceptions that individuals diagnosed with severe mental illness have of the treatment outcomes for the Illness Management and Recovery (IMR) curriculum. The study sample includes adults with severe mental illness who received IMR education based on the modules and handouts in the past. The qualitative data collected with a structured interview were utilized. Interview questions focus on perceptions of treatment outcomes. Results confirm that individuals find the illness management and recovery curriculum have a positive impact on their treatment outcomes in the domains of coping skills, self-management, social functioning, recovery outcomes (e.g., goal setting and attainment), and dual recovery. In particular, seven inter-related themes identified as positive outcomes include education, goals, improved mental health stability, increased self-value, improved relationships, more community involvement, and preexisting knowledge. Implications for social work practice, policy, and research are discussed.

The present study focuses on the question: What perceptions do individuals diagnosed with severe mental illness have of the treatment outcomes for the Illness Management and Recovery (IMR) curriculum? The IMR curriculum is an evidenced-based practice that is based on other evidenced-based practices such as cognitive-behavioral, psycho-education, and motivational interviewing strategies (Mueser, Meyer, Penn, Clancy, Clancy, & Salyers 2006; Substance Abuse and Mental Health Service Administration (SAMHSA), 2006). IMR is rooted in the recovery movement which seeks to empower individuals with mental illness to give them hope for building a meaningful life that encompasses their mental illness, but is not centered around it (Bond & Campbell, 2008; President's New Freedom Commission on Mental Health, 2004). The need for a standardized program teaching symptom management and relapse prevention was identified at the Robert Wood Johnson Foundation Consensus conference of National Institute of Mental Health (NIMH) staff, service researchers, advocates, and the Schizophrenia Patient Outcomes Research Team in 1997. After the need was identified, the National Implementing Evidence-Based Practices Project developed IMR curriculum and implemented it (Mueser et al., 2006).

A severe mental illness has been defined as a mental, behavioral, or emotional disorder that meets criteria of the Diagnostic and Statistical Manual of Mental Disorders. To meet the criteria an individual must have been diagnosed as meeting criteria for a disorder, not including developmental and substance use disorders, in the past year. The disorder must have resulted in functional impairments in at least one meaningful life domain (NIMH, 2011). Approximately one in four adults experiences a mental disorder in a given year; however, six percent of the population suffers from a severe mental illness (National Alliance on Mental Illness (NAMI), 2011).

This study seeks to build on a body of knowledge exploring the outcomes of IMR curriculum on severe mental illness. The purpose of the present study is to have individuals with severe mental illness describe the outcomes they have experienced as a result of participating in the IMR curriculum. Previous research primarily found positive outcomes for the IMR curriculum. A few studies found no difference in pre- and post-treatment or no significant differences between standard treatment and IMR curriculum interventions in some outcome domains (Färdig, Lewander, Melin, Folke, & Fredriksson, 2011; Hasson-Ohayon, Roe, & Kravetz, 2007; Levitt et al., 2009; Mueser et al., 2006). It is important to note that no negative effects of IMR curriculum have been found in any outcome domains. While this study does not address all of the research needs identified, it does seek to build upon the IMR research already completed. This present study explores the question what are the perceptions of the treatment outcomes of the IMR curriculum for individuals diagnosed with severe mental illness?

Literature Review

Mental Health Rehabilitation and Recovery

Mental health rehabilitation, frequently referred to as 'psychiatric rehabilitation' in literature, is the belief that individuals suffering from severe mental illness can learn to manage their illness and lead meaningful and productive lives (Bond & Campbell, 2008; President's New Freedom Commission on Mental Health, 2004). From the concept of mental health, rehabilitation has grown the term 'recovery.' Recovery from a mental illness is defined essentially the same as mental health and psychiatric rehabilitation. The concept of recovery, however, is ripe with its own richer, more complex definitions, assumptions, themes, dimensions, and outcomes.

Recovery has been defined in several different ways, particularly because recovery for each individual suffering from a mental illness is defined by that person (Jacobson, 2001; Llyod, Waghorn, & Williams, 2008; President's New Freedom Commission on Mental Health, 2004; Torrey, Rap, Van Tosh, McNabb, & Ralph, 2005). A commonly used definition comes from Patricia Deegan, recovery is defined as (Torrey et al., 2005):

a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, and

start again. The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution (p.15).

Deegan's definition expands on learning to manage an illness and leading meaningful and productive lives to describe a process or journey that is likely to be a life-long pursuit. Another commonly used definition comes from Anthony (1993):

Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose as one grows beyond the catastrophic effects of mental illness (p. 2).

Both definitions explicitly state that a significant part of recovery is within an individual's own perceptions, and these perceptions play a significant role in that individual finding a purpose and meaning in life.

Recovery Themes and Assumptions. Recovery is clearly meant to empower individuals not blame them (Anthony, 1993; Campbell, 1997; Iyer, Rothmann, Vogler, & Spaulding, 2005; Torrey et al., 2005). Empowerment is a theme that is recurrent in recovery literature, as individuals suffering from mental illness frequently feel powerless over a severe illness (Torrey et al., 2005). Anthony (1993) states that the first assumption of recovery is that the individuals, not the professionals, hold the key to recovery. Professionals are not even required for recovery to occur. If they are part of an individual's recovery, then they are to fill a supportive role. Having supports that believe in and can encourage an individual, even when they themselves do not, is also assumed to be an important part of recovery. These supports offer what an individual suffering from mental illness sometimes lack, hope. Individuals suffering from mental illness suffer higher rates of suicide, involuntary interventions, trauma, homelessness, incarceration, poverty, loss of child custody, and unemployment (Torrey et al., 2005). Because of these negative life events, it is evident then that individuals suffering from mental illness must take steps to bring meaning back into their lives. Empowerment, hope, hope for a meaningful life, and meaningful life activities are all stepping stones from these life experiences toward recovery.

Anthony (1993) lists six more assumptions about recovery. It is assumed that recovery can occur without endorsement of a specific cause of the illness and with relapses of or ongoing symptoms. Building on this, it is also assumed that recovery itself impacts the course of the disorder and the symptoms experienced by an individual. As endorsed by Deegan's definition, recovery is not assumed to follow a linear process (Torrey et al., 2005). It is also assumed that recovery from the consequences of the illness can be harder than recovery from the illness. Finally, it needs to be assumed that individuals who have recovered are not an anomaly, but are the experts for recovery.

Recovery Process. Recovery is defined as a process. While this process is unique to each individual, common phases in this process have been identified in literature. Jacobson (2001) found four phases after analyzing thirty narratives on recovery. The first phase consists of defining the problem. The individual must identify what happened (name the illness), its causes, and the solution. The second phase is transforming of the self, in which the individual integrates the narrative with themselves and their personal recovery. The third phase is identified as reconciling with the system where the individual is able to use professional resources in a way that enables them to move forward in their recovery. The last phase identified is sharing their recovery and their personal process of recovery with others to give others hope and demonstrate it is possible.

Recovery Outcomes. Recovery literature looks at several different domains when exploring the outcomes of recovery and the recovery process. These domains include reduction of psychiatric symptoms, reduction in service utilization, cognitive improvements, increased ability to set and attain goals, improvements in social skills and supports, improved functioning in day to day life, and abstinence from or reduction in using non-prescribed mood altering substances (Bond & Campbell, 2008; Iyer, et al., 2005; Lloyd, et al., 2008).

Illness Management and Recovery

IMR is a curriculum-based approach to recovery taught either individually or in groups (Bond & Campbell, 2008; Mueser et al., 2004; Mueser et al., 2006; Roe et al., 2009). Psycho-education, cognitive-behavioral approaches to medication adherence, relapse prevention, social skills training, and coping skills training were five empirically supported interventions used to develop ten modules supporting recovery (Roe et al., 2009). There are ten modules covering: setting a recovery vision, psycho-education, social supports, use of medications, dual recovery, relapse prevention, and coping skills. Each module has a purpose, goals, and specified interventions and recommended suggestion for the number of sessions to cover (Mueser et al., 2006; SAMHSA, 2006). Interventions are based on motivational, educational, and cognitive-behavioral strategies. The educational strategies include summarizing the topics of each section and pausing for interaction and to check for understanding. Common motivational strategies include keeping the individual's personal recovery goals in mind and relating the information to the person's experience and recovery goals, while at the same time respecting the individual as an expert. It is also helpful to identify the individual's motivations for receiving treatment. Cognitive-behavioral strategies include helping the person identify how they can use the information in a practical and helpful way, and reframing previous experiences in relation to their symptoms. The Illness Management and Recovery Implementation and Resource Kit also recommends specific homework review questions and strategies, as well as addresses common problems encountered in each module. Educational handouts are included in the resource kit, which is downloadable from SAMHSA's website (SAMHSA, 2006).

Empirical Studies of Illness Management and Recovery

IMR curriculum is based on numerous recovery-oriented, evidenced-based practices that are discussed above. It is designed to assist individuals in learning skills to manage their illness, develop and reach recovery goals, and obtain other recovery outcomes (Bond & Campbell, 2008; Iyer et al., 2005; Lloyd et al., 2008; Mueser et al., 2004; Mueser et al., 2006; Roe et al., 2009). The research identified three common outcomes measured, and noted a fourth. Common outcomes were: first, coping and self-management, including looking at the areas of functioning and health; second, social functioning; and third, recovery oriented outcomes including the areas of hope, goal setting, and goal obtainment (Färdig et al., 2011; Fujita et al., 2010; Hasson-Ohayon et al., 2007; Levitt et al., 2009; Mueser et al., 2006; Roe et al., 2009; Salyers, Rollins, Clendinning, McGuire, & Kim, 2011). One follow-up study also found outcomes in the area of cognitive functioning (Roe et al., 2009).

Coping Skills and Self-Management Outcomes. Coping skills and self-management appears to be a common outcome analyzed in IMR. It was discussed in each study reviewed, although different terminology may have been used. Coping skills and self-management was measured with multiple scales within and across studies. Within the coping skills and self-management outcomes, data measured include knowledge of mental illness, symptom severity, use of coping skills, amount of distress experienced by individuals, impairments in functioning as a result of symptoms, relapse prevention, hospitalizations, and emergency room visits (Färdig et al., 2011; Fujita et al., 2010; Hasson-Ohayon et al., 2007; Levitt et al., 2009; Mueser et al., 2006; Roe et al., 2009; Salyers et al., 2011).

All studies that examined individuals' knowledge about mental illness found that IMR curriculum increased their basic knowledge about mental illness, their diagnosis, and recovery (Fujita et al., 2010; Hasson-Ohayon et al., 2007; Mueser et al., 2006; Roe et al., 2009). Studies stipulated that increased knowledge may also improve medication adherence for individuals. Mueser and colleagues (2004) reviewed research and found that in two of five studies psychoeducation led to improved medication compliance and in six of six studies cognitive behavior interventions increased medication compliance. Studies found that IMR decreased the severity of the symptoms experienced by individuals (Färdig et al., 2011; Fujita et al., 2010; Levitt et al., 2009; Mueser et al., 2006). Färdig and the colleagues (2011) studied the outcomes of IMR on individuals suffering from schizophrenia and found a decrease in positive and negative symptoms, as well as a decrease in depression and anxiety symptoms. At follow-up individuals also reported less suicidal ideation. Furthermore, they found that the individuals who participated in IMR developed more insight into their illness compared in a treatment as usual group. However, Levitt and colleagues (2009) did not find that IMR helped to decrease suicidal ideation or behavior. Overall the impact of IMR on symptoms outcomes has mixed results and further exploration is needed to explore these outcomes.

According to the SAMHSA (2006), coping skills can help reduce symptoms and relapses, as well as improve an individual's ability to achieve recovery goals.

All studies reviewed that analyzed coping skills outcomes after engagement in IMR showed an improvement in coping abilities (Färdig et al., 2011; Fujita et al., 2010; Hasson-Ohayon et al., 2007; Levitt et al., 2009; Mueser et al., 2006; Roe et al., 2009). Studies found an increase in the number of coping skills that individuals' used as well as individuals' ability to use coping skills to obtain a desired affect (i.e., relaxation) (Hasson-Ohayon et al., 2007; Mueser et al., 2006).

A few studies examined hospitalization rates to see if IMR would reduce hospitalization rates for individuals completing the program. Mueser and colleagues' (2004) review of research equated relapse prevention to preventing re-hospitalizations. They found that in four out of five studies relapse prevention interventions were more successful than standard care in preventing re-hospitalizations. Overall the outcomes for coping skills and self-management are mixed. Several studies found results that IMR improved positive outcomes in this area, but others shed doubt on the results. This doubt appeared to occur with the highest frequency when comparing IMR outcomes with other interventions.

Social Functioning Outcomes. Social functioning outcomes analyzes changes in social and interpersonal relationships, support and help received from others, finding support in the community, and incorporating supports into individual recovery (Färdig et al., 2011; Fujita et al., 2010; Hasson-Ohayon et al., 2007; Levitt et al., 2009; Mueser et al., 2006; Roe et al., 2009). Studies found varying results regarding social functioning outcomes of IMR participants. The majority of the studies found improvements in social functioning outcomes (Färdig et al., 2011; Fujita et al., 2010; Hasson-Ohayon et al., 2007; Levitt et al., 2009; Roe et al., 2009). Roe and colleagues (2009) noted that not only did participants improve their social relationships with supports outside the group, but that participants also noted that the support received from within the group was unique and beneficial for working toward recovery. Fujita and colleagues (2010) also found that the improvements in social functioning outcomes were equated in increases in quality of life.

Recovery Outcomes. Recovery outcomes are specifically looking at area of increased hope and goal orientation (Fujita et al., 2010; Hasson-Ohayon et al., 2007; Levitt et al., 2011; Mueser et al., 2006; Roe et al., 2009). The most basic improvements were seen in individual's ability to set, pursue, and achieve personal goals (Fujita et al., 2010; Hasson-Ohayon et al., 2007). Mueser and colleagues (2006) not only found improvements in goal orientation, but also found increase in hope. Both improvements were measured qualitatively and quantitatively. They indicated that these improvements also led to individuals' feeling that their lives were less controlled or dominated by their symptoms. Another study found that the emphasis on setting and pursuing goals also had a positive impact on other outcomes mentioned, particularly on social functioning (Levitt et al., 2011). Roe and colleagues (2009) also found that these improvements in goal orientation and hope led to individuals feeling empowered in their recovery.

Cognitive Improvements. Roe and colleagues (2009) found one outcome that was unique to their one-year follow-up study that was not found in other studies. They found that half (50%) of their respondents reported improvements in cognitive functioning. Cognitive functioning included improved attention span and learning skills. They felt confidence may have played a role. As individuals are learning or doing new things, their confidence increases. As a result they may be more likely to engage in future activities resulting in improved cognitive functioning.

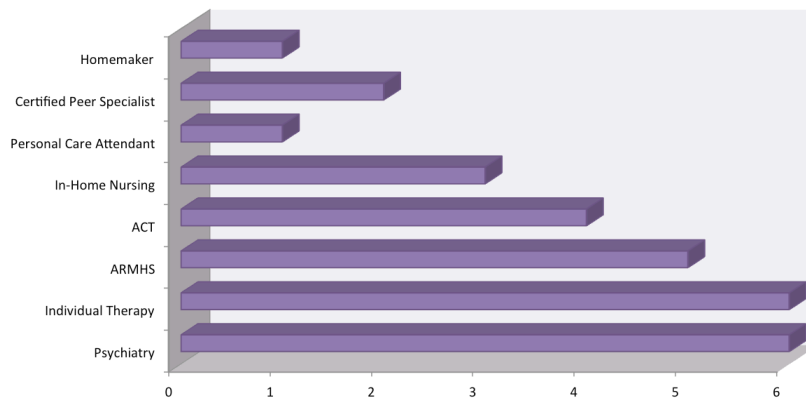
Methods

Research Design and Sample

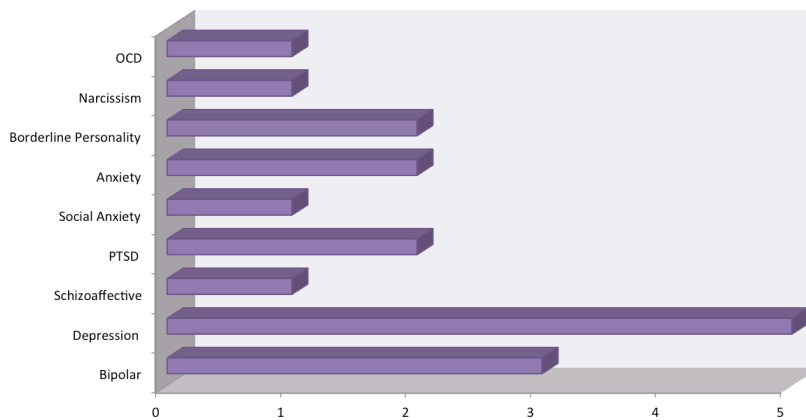
This present study used a cross-sectional survey research design. Demographic data collected included information about participation in the IMR curriculum among other standard demographics. The qualitative data collected utilized a structured interview and focused on perceptions of treatment outcomes. The sample included adults with severe mental illness who previously received IMR education. A non-probability, convenience sampling method was used. All individuals lived in southwest Minnesota and are receiving or have received services from a mental health practitioner. Mental health practitioners familiar with the sample population were asked to identify appropriate adult candidates and refer these individuals for the sample. One limitation to this method is that it is difficult to determine whether progress or improvements reported by an individual are due to the IMR curriculum or due to other services an individual received during the same timeframe. Due to the small sample size, limited geographical area, and referral process the data collected has no generalizability. Prior to any data collection, the IRB approval was obtained. In addition, agencies where data was gathered had given approval for their involvement in the project.

Data Collection

The study collected information about participation in the IMR curriculum. This included if the study participant completed the IMR curriculum and the number of months since completing the curriculum. For those who responded ($N=9$), only two met the original request for individuals who were about to complete the curriculum or who completed it in the past six months. One participant had completed it eight months ago, and the other five participants completed it two to three years ago. Two participants did not answer this question. The participants were also asked whether they participated in the curriculum in individual or group format; again two responses were unknown, and the rest of the participants completed the curriculum individually. To identify other potential factors that might influence outcomes encountered during the interview participants were asked to identify other services received concurrently as participating in the IMR curriculum (see figure 1).

FIGURE 1. Participants' Co-occurring Services ($N=9$)

To provide general information regarding the sample, additional demographic items were requested from participants. These items included age, gender, race, and educational attainment. The participants were asked to identify their primary mental health diagnoses, any dual diagnosis disorders if applicable, and number of years since first diagnosed with a mental illness. Seven out of nine participants provided this information, and all but one reported more than one primary diagnosis (see figure 2). Four participants also reported a physical disability, one reported having co-occurring chemical dependency, and one other reported having epilepsy. The years since first diagnosis were as follows: three, seven, fourteen, eighteen, twenty, twenty nine, and thirty four years. Again, two responses were missing. As with other information collected answering of these questions was completely voluntary.

FIGURE 2. Participants' Diagnoses ($N=9$)

Measurement

Based on preliminary research completed, there is only one instrument currently available to measure outcomes of IMR curriculum. However, this instrument, the IMR scale (SAMHSA, 2006), is designed for pre- and post-test to measure individual scales before and after receiving education based on the curriculum. This test is a fifteen-item rating scale that is to be completed by the client independently. The Client IMR Scale has been shown to have satisfactory internal reliability, test-retest reliability, and convergent validity with other scales and inventories (Mueser, et al., 2006). This scale was used to create open-ended questions assessing individual client outcomes following or during involvement in the IMR curriculum. Data on the perceptions of outcomes were collected in a qualitative, interview format. Fourteen short-answer questions have been created that center around the fifteen-item rating scale. An additional five questions have been identified to address areas not covered by the rating scale. The participants were also asked to comment on their perceptions of the IMR curriculum itself (not their outcomes), based on what they liked about it and what changes they would like to see being made to it. Most clients answered all questions. One client chose not to answer questions about alcohol and drug use, and another stopped answering questions after the tenth domain.

Data Analysis

The analysis of the data primarily relied upon grounding techniques. The information was coded by going line by line through a transcript and identifying key words and concepts. The key words and concepts were then combined, in a content analysis, to form themes (Berg, 2009). The data analysis followed this process, but did not go back to identify to which theme every code belongs to as is commonly done. Many of the themes were simply codes that repeated themselves consistently throughout the transcript. Certain codes may have been combined into a broader theme. For example, identified codes highlighted during the content analysis included “taught,” “learned,” “educated,” and “gave me knowledge;” these codes were then combined into the theme education.

Strengths and Limitations of this Study

This study is qualitative in nature and provided deeper understanding of outcomes of the IMR curriculum for the participants involved. One of the limitations is that the sample size was small, nine participants, and located in a small geographic location. The survey is limited to face-validity, as the validity has not been tested internally, using test and retest, or comparability. However, the purpose of qualitative research is to understand and uncover, so that the survey is designed to meet the specific needs of this project.

Researcher bias includes prior exposure to and experience with the IMR curriculum. The researcher was involved, as a mental health practitioner, in the implementation of the curriculum at two local treatment centers in southwest Minnesota. This bias has influenced the ability to interpret the respondents' statements in a completely objective manner. In addition, it may have limited the ability to see different point of views and objectively analyze them. However,

it is also be true that the researcher's own experience and beliefs will be a vantage point to gain deeper insight in the outcomes identified during the interviews.

Findings

Through the data analysis, seven inter-related themes were identified. These themes include education, goals, improved mental health stability, increased self-value, improved relationships, more community involvement, and preexisting knowledge.

Education

The first theme, education, was common throughout all but one of the interviews. Statements in this category range from broad: "it [IMR] educated me on a lot of things" to narrow "I learned take the 0.5 [mg of an as needed medication] and wait an hour before taking more." The education spanned across multiple themes, including learning to identify triggers and early warning signs. "It [IMR] educated me on what to look for to make sure I'm not getting worse" and "I know that it [depressed mood] will go away with the skills that I have learned" are two examples of this. Education was obviously an important part of IMR: "that is where I learned the most about everything, also about my bipolar and my depression and all my medications. I learned everything through IMR, otherwise, I would have been totally lost."

Goal Setting

The most education codes were seen in the area of goal setting. One participant stated, "I know that we sat down and we wrote out my goals; and it gave me a better outlook of what I could reach instead of just having them in my head and not thinking that I really could do them, but could see them on a piece of paper." This was echoed by other participants: "It helped me to realize to make small goals instead of big goals all the time, and to make them small so they could be attainable," "I was able to make goals and reach them," and "[IMR] helped me to break down goals so I could gradually accomplish them."

Stability

This goal setting, along with education, contributed to improved mental health stability. Four of the nine participants report not having had a relapse since completing the IMR curriculum. Other participants noted, "It affected my understanding of how I need to cope as far as putting ideas into action," and "It goes back to recognizing what the triggers are and trying to have it already in my mind or even a written list of how I would deal with each one of those if they came up." While not all were able to eliminate relapses, most of the other participants noted a reduction in relapses or improved ability to cope with relapses. One participant noted the prior to IMR she was having two to three hospitalizations and now is averaging one a year, "So that has really been reduced. It has

helped a lot.” Participants also noted stability that was linked to other areas as well, such as improved relationships: “My personality is more stable and does not make people nervous like I used to.”

Awareness

This stability can be directly linked to increased awareness of self, others, and situations. Many of the statements above used words indicating improved understanding, increased recognition, as well as increased awareness: “I am more aware of symptoms and vulnerabilities,” “I feel I understand them [my symptoms] and can recognize them better,” “It has affected my understanding of how I need to cope,” and “I am more aware of the need to be on medications and stay with the regimen and not do something foolish like having a beer.”

Self-value

Three of the participants also noted increases in their self-value. This increase in self-value frequently took the form increased respect for their own opinions and values. “It [IMR] helped me to get...I can't find the word I want...I did not feel so inferior and that anybody was better than me, like I used to.” This increase in self-value encompasses an increase in confidence: “Doing IMR and getting more confidence has gotten me into places such as consumer survivor network...it all goes back to giving me the confidence I needed” and “It gave me like a boost of confidence and self-assurance.” Increase in self-worth also was linked to self-advocacy: “I feel that I can be a part of that now, planning my treatment and making decisions” and “I never questioned before I would just take them [medications] as the doctor knows what they are doing, but I can question them now. And if I don't understand it, then I don't take it until I do.”

Relationships

Seven of the nine participants also reported improved relationships with others. “[IMR] helped them [family and friends] to understand me better and helped me to be better able to communicate with them.” Some of this improvement can be attributed to improved communication and understanding: “It definitely is helping in my relationship with my partner... Communicate better... it helped me to understand him much better.” Part of improved relationships includes meeting more people to form relationships with: “One it got me out of the house which seems to be everybody's goal. It gave me the opportunity of meeting other people that maybe I would not have always met in general.”

Community Involvement

Along with improved relationships, the same number of participants also reported more community involvement. This community involvement took the form of employment, volunteering, taking classes, and forming and joining support groups. “I have gotten a job since then, a part time job. It has helped me to get more involved in the community such as the LAC (Local Advisory Council), the

CSN (Consumer Survivor Network), and a local political party,” “I volunteer at a Daycare Center and work closely with the person in charge of infants,” “I will be taking online classes for medical transcribing,” and “Since IMR, I went and joined DBT, I joined LAC, and eventually I joined depression group.” Some of this involvement also means increased participation: “I can be in a group now and I can share, which is really, really unique, because I have not been able to even in narcotics anonymous. All the years I have been in there I never really shared much until lately.” IMR also helped participants make improvements in areas they were already involved in: “My boss said since my diagnosis and I started up medications and therapy I have become a more valued employee.”

Pre-Existing Knowledge

The last theme noted was pre-existing knowledge. Many clients noted that: “The IMR was kind of repetitive of stuff I already knew.” For most clients this then became a chance to: “bring back some of the stuff that I may have forgotten it was about. It refreshed my memory, I guess is how I would put it.” One client, however, found it: “boring because it was just kind of repetitive because it was more of common sense thing for me.” Despite having the knowledge and skills already, another client found: “it is good for me personally to go back and reread stuff even though I think I know everything about it, just that one little thing that *oh yeah that is right.*”

Other Suggestions

The two last questions addressed what participants liked and what they would like to see changed to the IMR curriculum. Multiple participants noted that the curriculum covered a large subject area: “I liked the fact that it covered a lot of territory.” As noted above, this led to some participants finding it repetitive, as the topic areas are interrelated: “It just seemed kind of repetitive and if somebody was going to do IMR with somebody they should make it more specific towards that person not so generalized.” Areas noted where more information was desired were practical facts about different mental illnesses, substance abuse not being limited to illegal drugs and alcohol, and medications. Another participant requested: “information on how like living situations, family situations; how these can affect recovery... other factors might help people realize where some of the problems might be coming from” be included in the manual. Other areas that participants appreciated: being able to keep the curriculum book: “I enjoyed having the full package in front of me so I was able to choose as I was reading stuff and then go back and reread the book cover to cover,” that it was “easy to understand,” and had practical suggestions.

One client found that a lot of things interrupted IMR for her, and suggested to have: “another person fill in so that the caseworker can work on IMR.” However, at the same time, she found it helped significantly to have a good connection with her caseworker. This was echoed by another person, “they are not like *oh you can't because have bipolar or because you have depression.*” Sitting down with somebody that says *no you can do this and this is a goal* and seeing it on that piece of

paper.” This evidences the power of someone who believed in the participants.

Discussion

As stated previously, the recovery movement seeks to empower individuals with mental illness to give them hope for building a meaningful life that encompasses their mental illness, but is not centered around it (Bond & Campbell, 2008; President’s New Freedom Commission on Mental Health, 2004). Jacobson (2001) found four phases after analyzing thirty narratives on recovery. Although a phase order was not identified, each phase can be found in this research study. Participants noted the importance of setting goals (which acknowledges that something needs to be changed), an increase in confidence, the importance of professionals, and increased community involvement.

Recovery literature focuses on several different domains when exploring the outcomes of recovery and the recovery process. These domains include reduction of psychiatric symptoms, reduction in service utilization, cognitive improvements, increased ability to set and obtain goals, improvements in social skills and supports, improved functioning in day to day life, and abstinence from or reduction in using non-prescribed mood altering substances. Participants did not note a reduction in symptoms, but instead an increased ability to cope with the symptoms they experience. Several participants reported a resulting decrease in service utilization, particularly a decrease in hospitalizations. No cognitive improvements were noted, but all but one participant reported an increased ability to set and obtain goals, along with improved social skills, supports, and increased participation in structure activities. No participants reported that IMR led to abstinence or reduction in non-prescribed mood altering substances, however, those who had already achieved abstinence found the curriculum supported their commitment.

The IMR studies discussed in the literature review were noted to be completed across multiple geographical locations and settings. Common outcomes noted in these studies included coping and self-management, social functioning, and recovery oriented outcomes (Färdig et al., 2011; Fujita et al., 2010; Hasson-Ohayon et al., 2007; Levitt et al., 2009; Mueser et al., 2006; Roe et al., 2009; Salyers et al., 2011). While the present research was limited to a two-county area in southwest Minnesota, participants themselves noted similar positive outcomes.

Coping skills and self-management outcomes were found to have varying results, however, IMR appeared to have an overall positive effect on the domains (Färdig et al., 2011; Fujita et al., 2010; Hasson-Ohayon et al., 2007; Levitt et al., 2009; Mueser et al., 2006; Roe et al., 2009; Salyers et al., 2011). The results of the present study were in accordance with this finding. In the themes, positive improvements were noted in managing symptoms due to education and newly learned coping skills, and in preventing relapses. In the literature, coping skills and self-management outcomes, while addressing a variety of outcomes, did not address functioning areas that included self-care, housing and apartment management, travel, budgeting, and other basic activities of daily living. One participant, a stay at home mother, did note that the IMR helped her to identify daily goals for self-care, household management, and family activities. Other

participants experienced improvements in employment and volunteering. While these activities could also be noted as improvements in social functioning, they are also activities of daily living for a healthy individual.

Previous studies did note improvements in social functioning. Social functioning outcomes analyze changes in social/interpersonal relationships, support and help received from others, finding support in the community, and incorporating supports into individual recovery (Färdig et al., 2011; Fujita et al., 2010; Hasson-Ohayon et al., 2007; Levitt et al., 2009; Mueser et al., 2006; Roe et al., 2009). The present study found positive results in all these areas. Specific examples include better communication with family members, friends, and significant other; participating in support groups; and utilizing supports to prevent relapses.

Research also found recovery outcomes specifically in the areas of increased hope and goal orientation (Fujita et al., 2010; Hasson-Ohayon et al., 2007; Levitt et al., 2011; Mueser et al., 2006; Roe et al., 2009). Likewise in this study eight of the nine participants noted improvements in the area of goal setting.

Roe and colleagues (2009) found that half (50%) of their respondents reported improvements in cognitive functioning including improved attention span and learning skills. While no specific cognitive functioning improvements were noted in this study, several participants identified the educational component of IMR exceedingly important. It would not be a far stretch based on the findings, that education is the basis for the other themes. Refer to the following diagram in figure 3.

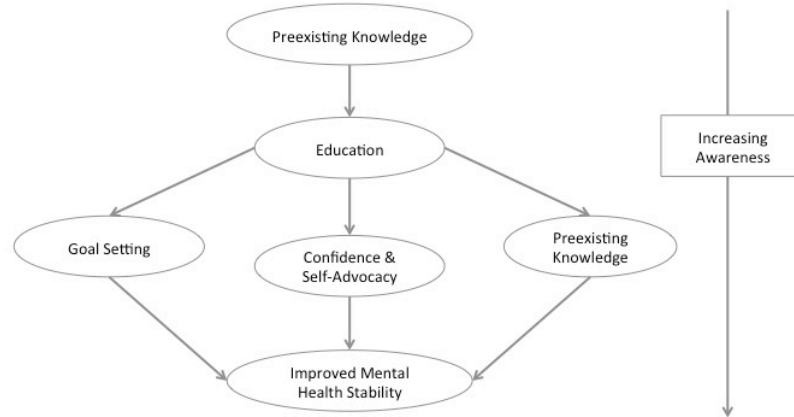


FIGURE 3. Relationship between Themes

This possible relationship between themes demonstrates how cognitive functioning, if equated to education in this figure, may be overlooked in some studies. Instead the outcomes of the education may be what are being focused on. As noted in the literature review, detailed research is needed to explore the relationship between the domains, not just the outcomes themselves.

It is important to note that negative effects of IMR curriculum were not noted in any outcome domains during the literature review. While there were comments about what individuals disliked about the curriculum, there were no instances where IMR did any harm. One participant expressed that the curriculum was completely common sense and redundant, but still did not report suffering any negative outcomes from going through the curriculum. Overall, the perceptions of individuals diagnosed with severe mental illness have of the treatment outcomes for the IMR curriculum support the outcomes found in research. In other words, the outcomes identified by researchers about the positive results of the IMR curriculum are being noticed by the clients themselves as well.

Implications for Social Work Practice, Policy, and Research

There are multiple implications for social work practice. The first that may be noticed is the use of the curriculum itself. The IMR curriculum appears to have positive results across multiple domains, which result in improved mental health stability. This curriculum also appears to have no negative results, even for individuals who did not particularly enjoy or gain much from the curriculum. As a result this is a curriculum that could be widely distributed and utilized by the social work profession. Different elements of the curriculum can be utilized as well. This could begin with education. If education is indeed the first step toward mental health stability as speculated, then education about the different domains should be implemented. What is unique about this is social workers can choose to educate on specific domains from the curriculum, skipping ones or only briefly reviewing ones the client is already knowledgeable about. Furthermore, the social worker can and should probably bring in educational pieces from different sources as well: books, websites, and workbooks. This would include making recommendations and supporting the other elements: goal setting, confidence and self-advocacy, and social connectedness.

One of the difficulties noted in this study was in recruiting participants. This could be due to a only a limited number of practitioners involved are actually teaching the curriculum or are teaching it to a limited number of their clientele. It is also possible that there was not enough incentive for potential participants to participate, unknown barriers for potential participants, or potential participants not feeling like their opinion matters. Of these the most concerning is if potential participants feel their voice does not matter. This is supported by a number of participants asking at the end of the interview, when the recorder was turned off, if their answers were helpful. Each participant was reassured that their answers were appropriate and important. If clients truly feel that their opinions do not matter or are not as valid as other individuals, then social workers need to work hard and advocate for this to be changed. Social work ethics dictates that social workers challenge social injustice, advocating for social change. This includes “meaningful participation for all people (NASW, 1999, p.5).” Social workers need to create opportunities for individuals to advocate for themselves and role model and advocate to others the importance of listening to these individuals.

Social workers also need to build on the research that has already been

completed. As identified before the interconnectedness of domains is one subject area that requires further study. The links between the domains are important to be identified, because once they are identified, it would give social workers better insight into what topic areas to cover, what referrals to make, and better insight into the client and the social worker's own interventions. In addition, all of the participants were receiving at least one other intervention in addition to IMR. The results could also be attributed to these interventions. Further research is needed here.

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