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# Barriers of Using Illness Management and Recovery with Adults with Severe Mental Illness

Jennifer Anne Brummer  
*University of St. Thomas, Minnesota*

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Barriers of Using Illness Management and Recovery with Adults with Severe  
Mental Illness

By

Jennifer Anne Brummer, LSW

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work

University of St. Thomas/St. Catherine University  
St. Paul, Minnesota

In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members

Dr. Rajean Moone, PhD., (Chair)

Lindy Fortin, LICSW

Dr. Steve Carlson, PhD.

This Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in ST. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

**Abstract**

Adults living with severe mental illness experience a broad spectrum of difficulties, such as visual and olfactory hallucinations, internal dialogue or hearing voices, depression, anxiety, homelessness, substance use, and difficulty managing daily activities and relationships. The Illness Management and Recovery curriculum has been revealed to be a useful evidence-based practice or approach to working with individuals with severe mental illness. The Illness Management and Recovery workbook promotes symptom management in adults by creating a vision and following a step-by-step problem solving process. This recovery model is tailor to the individual and requires their input on a step-by-step path to recovery. However, little research has been done to explore the barriers for practitioners when implementing Illness Management and Recovery with adults with severe mental illness. This study investigated the practitioner's barriers of using Illness Management and Recovery with individuals living with severe mental illness. By conducting a semi-structured interview with a mental health practitioners that specializes in utilizing IMR when working with individuals seeking recovery from a mental health diagnosis. Five major themes emerged from this data analysis: 1. training and supervision, 2. initiating mental health services with IMR, 3. practitioner and client engagement strategies, 4. the role of the practitioner, and 5. organizational support. The findings act as support to previous findings regarding Illness Management and Recovery. However, the findings also relate the barriers directly to the successful recovery of adults that have experienced severe mental illness and point to the need for continued efforts to provide effective training and supervision to practitioners in a national capacity.

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### **Introduction and Purpose Statement**

Adults living with severe and chronic mental illness experience a broad spectrum of difficulties, such as hallucinations, internal dialogue or hearing voices, depression, anxiety, homelessness, chemical dependency, and difficulty managing daily activities. Illness Management and Recovery has been revealed to be a useful evidence-based practice or approach to working with individuals with severe and persistent mental illness. Illness management and recovery promotes symptom management in adults by creating a vision and following a step-by-step problem solving process to recovery from mental illness. However, little research has been done to explore the barriers for practitioners when implementing Illness Management and Recovery with adults with severe and persistent mental illness. This qualitative study will investigate the barriers for practitioners in utilizing Illness Management and Recovery with individuals living with severe and persistent mental illness.

Social workers have a challenge working in today's society due to the broad range of social problems and wide range of possible mental health diagnosis amongst the patients we serve. Problems exist related to inequality, poverty, social justice, mental health, and comorbidity. Social workers must have a diverse and varied skill set from which to draw when working with individuals because of these varied social problems. One of the evidence-based practices for mental health practitioners to utilize in their efforts to help others is Illness Management and Recovery.

Illness Management and Recovery is a resource or tool kit for a self-help recovery process from a mental health diagnosis. The tool kit consists of 11 modules or steps in support of the recovery process, such as building social support and preventing relapse. The majority of the research and literature related to Illness Management and Recovery focused on the efficacy

of evidence-based practices and IMR in general. This article will describe the practitioner barriers to implementation of IMR, such as, training and supervision of practitioners, initiating mental health services with IMR, practitioner and client engagement strategies, the role of the practitioner, and organizational support. Also, the article describes the efficacy of the program. The literature review is followed by a review of the methods to be performed throughout this qualitative research process. This research is important to the profession of social work as it supports the principle related to providing human dignity to individuals suffering from mental illness. The purpose of this research project is to explore the barriers to mental health practitioners utilizing Illness Management and Recovery with individuals diagnosed with Severe Mental Illness.

## **Literature Review**

Available therapy for the chronic mentally ill has progressed over the years. A variety of non-pharmacological therapies have been developed to supplement pre-existing pharmacological therapy and encourage self-management for outpatients. Various studies in the field of mental health treatment have demonstrated that Illness Management and Recovery (IMR) as well as other related forms of treatment have shown much promise in terms of medical self-management among individuals suffering from chronic mental diseases.

### **Evidence-Based Practices as Supplemental Programs**

Mueser, Torrey, Lynde, Singer and Drake (2009) investigated the Evidence-Based Practices (EBP) for individuals suffering from severe mental illness (SMI). They postulated that the theoretical framework of Evidence-Based Practices has considerable promise when applied in combination with more traditional forms of treatment for individuals suffering from severe mental illnesses (Mueser et al., 2009). Their study described the different phases of an initiative to create a practical application of the EBP in real life. The pioneer initiative to implement an Evidence-Based Practice application for select volunteer populations undertook a three-phase implementation strategy (Mueser et al., 2009). In the study, phase 1 described the creation of viable and applicable EBP programs that were acceptable for facilities that provide therapy for individuals with SMI (Mueser et al., 2009). The second phase included the application of the developed Evidence-Based Practice and tentative implementation of the programs in participating facilities and institutions (Mueser et al., 2009). Finally, phase 3 included the widespread implementation of a range of variations of Evidence-Based Practices in different settings and locations across the United States (Mueser et al., 2009). In the study, 6 forms of EPBs were implemented that were proposed initially, and the findings of the research suggest



that there are more possible EBPs applicable other than the 6 mentioned in the study (Mueser et al., 2009). For this reason, the study concluded that the application of Evidence-Based Practice as a supplemental form of therapy for individuals afflicted with severe mental illness is advisable (Mueser et al., 2009).

### **Wellness Recovery Action Planning**

Like Mueser and colleagues, the focus of Cook, Copeland, Hamilton, Jonikas, Razzano, Floyd, Hudson, Macfarlane, & Grey's (2009) research was centered on investigating self-management programs. A form of evidence-based practice was initiated in several volunteer groups in Ohio (Cook, Copeland, Hamilton, Jonikas, Razzano, Floyd, Hudson, Macfarlane, & Grey, 2009). The Wellness Recovery Action Planning (WRAP) was implemented as an auxiliary program to coincide with regular therapy provided to participants with chronic mental disorders (Cook et al., 2009). Select participants were asked to participate in a trial WRAP program (Cook et al., 2009). The goal of the research was to determine the effects of implementing a form of Illness Management and Recovery program in addition to traditional medical management for people with SMI (Cook et al., 2009). Through regular interviews and self-reports, the findings of the study reveal that the WRAP program had a significant effect on the participants (Cook et al., 2009). In fact, participants who regularly participated in the Wellness Recovery Action Planning sessions reported an increase in their respective scores for positive attitudes measured in the study such as "...hopefulness, self-advocacy and self-perceived physical health..." (Cook et al., 2009, 248). The researchers suggest that the promotion of independence and self-responsibility in the WRAP program was the primary factor that led to the observed effect regarding the development of a positive mindset among the selected participants (Cook et al., 2009). Lastly, participants who benefitted most from the

WRAP program were those who had high attendance records and had strong support systems (Cook et al., 2009). This study suggests that programs that promote the principles of IMR are most effective when the participants show a willingness and commitment to the programs.

### **Testing a Combination of ACT and IMR**

In a study conducted by Salyers, McGuire, Rollins, Bond, Muesner and Macy (2009), the researchers investigated the effectiveness of a program that combines Assertive Community Treatment (ACT) and Illness Management and Recovery (IMR) (Salyers, McGuire, Rollins, Bond, Muesner & Macy, 2009). Since ACT has had considerable success in the rehabilitation of patients with severe mental illnesses in the community setting, researchers decided to investigate whether a combination of ACT and IMR would have a combined positive effect on participants (Salyers et al., 2009). In order to test their hypothesis, they divided participating physicians into two groups. The first group was asked to administer a combination of ACT and IMR, while the other group was encouraged to offer IMR alone to their patients (Salyers et al., 2009). The results of the ACT-IMR combination was low with only 47 participants signing up for the treatment program and with only 7 participants completing the 2-year study (Salyers et al., 2009). Moreover, the results and findings reveal that patients who undertook the ACT-IMR program did not have better results than those who participated in only the IMR program (Salyers et al., 2009). Above all, the results of the study reveal that participants that participated in the IMR program became progressively more independent and required less medical supervision over time than those who participated in the combination program (Salyers et al., 2009). This reiterates the findings of past studies that reveal that the ACT program does not promote independence and patient responsibility which leads to lasting results and an eventual recovery for patients (Salyers et al., 2009). The results and conclusions point to the challenges

and associated difficulties with the partial implementation of IMR as opposed to traditional IMR (Salyers et al., 2009).

#### IMR and Achieving Recovery Goals.

Over the past decade, a good deal of emphasis has been placed on the importance of recovery for patients suffering from diverse types of mental illnesses (Levitt et al., 2009). In a study conducted by Levitt, Mueser, DeGenova, Lorenzo, Bradford-Watt, Barbosa, Karlin, and Chernick (2009), the investigators stressed the importance of IMR programs in achieving recovery goals of survey participants in supportive housing (Levitt, Mueser, DeGenova, Lorenzo, Bradford-Watt, Barbosa, Karlin, & Chernick, 2009). A study with a research group was conducted to determine the impact of IMR on the achievement of their rehabilitative goals (Levitt et al., 2009). The results of the study show that participants of the IMR program did significantly better than those who did not participate in the program (Levitt et al., 2009). With the use of a self-rating scale, the participants of the study were able to rate their perceived improvement over a 6-month period (Levitt et al., 2009). Since the scale was based on self-reports by individuals with SMI, the results were grounded on self-perception rather than on actual measurable criteria based on actual clinical reports. Nevertheless, the study reflects important insight regarding the evaluation of Evidence-Based Practices because it provides better insight on the perceived impact of IMR on the recovery of individuals diagnosed with SMI.

#### **Narrative Evaluation of Intervention Interview Assessment Tool**

Research into programs and interventions created to improve therapy for patients with severe mental illness has generated interest in evaluating the effectiveness of these programs (Mueser et al., 2009). Since all forms of Illness Management and Recovery programs focus on empowering patients and making them co-managers of their own medical management, the

impact and effectiveness of these programs were measured through interviews with patients (Hasson-Ohayon, Roe & Kravetz, 2006). The interviews were mostly qualitative and quantitative measures of key success indicators of various programs (Hasson-Ohayon et al., 2006). One such study was conducted by Hasson-Ohayon, Roe and Kravetz (2006). The researchers developed an assessment tool comprised of 16 unstructured interview questions designed to investigate the effectiveness of therapy for individuals with SMI (Hasson-Ohayon et al., 2006). The specific tool is called the Narrative Evaluation of Intervention Interview (NEII) (Hasson-Ohayon et al., 2006). The questions included in the NEII focus on both the process and activities within the therapy in addition to the outcomes associated with the programs the respondents are participating in (Hasson-Ohayon et al., 2006). The researchers tested the development of variations of the NEII and the results demonstrate that modifications in the assessment tool were effective in creating a standardized measure to evaluate the effectiveness of various mental health programs involving people with severe mental illnesses (Hasson-Ohayon et al., 2006).

### **Self-Identity as an Indicator of Program Success**

Another assessment tool designed to measure the level of recovery of patients with severe mental illness is the recovery repertory grid (Buckley-Walker, Crowe, & Caputi, 2010). Researchers Buckley-Walker, Crowe and Caputi (2010) investigated the correlation of self-identity and recovery for individuals with severe chronic mental disorders. According to the authors of the study, self-perception and self-identification are essential elements in the recovery process of people with SMI (Buckley-Walker et al., 2010). Buckley-Walker and colleagues designed a longitudinal study that involved participants undergoing therapy for long-term severe mental disorders (n=40) (Buckley-Walker et al., 2010). The participants were asked to

determine whether they considered statements included in the assessment as describing themselves or others (Buckley-Walker et al., 2010). The statements included in the recovery repertory grid described conditions that reflect stages of recovery for people suffering from mental disorders (Buckley-Walker et al., 2010). The principle behind the study states that a patient's self-identity and self-perception are vital components and indicators of his or her wellness and level of recovery (Buckley-Walker et al., 2010).

Moreover, the researchers believe that recovery from psychological diseases involves 5 stages (Buckley-Walker et al., 2010). These stages involve heavy participation and involvement of the person with SMI. During the process of recovery, a patient undergoing therapy has to be able to redefine his or her identity and become an active agent in his or her recovery (Buckley-Walker et al., 2010). Unlike stand-alone pharmacological therapy, the use of integrated IMR and pharmacological therapy for people in recovery for SMI are provided the opportunity to participate actively in their recovery. The findings of this study reiterate the important role of patient participation in the rehabilitation of severe mental illness (Buckley-Walker et al., 2010). Self-report interviews reveal that self-concept and self-identification are important indicators of recovery and rehabilitation among patients with SMI (Buckley-Walker et al., 2010). Hence, tools that measure the self-concept of individuals in recovery for severe mental illnesses are helpful assessments that indicate the effectiveness of IMR programs.

### **Self-Insight as a Wellness Indicator**

A similar study on the impact of self-concept and personal insight was conducted by Korsbek in 2013. Like the earlier study of Buckley-Walker, Crowe and Caputi, Korsbek investigated the effect of self-insight and the construct of the self on recovery from severe mental illness (Korsbek, 2013). The investigation points out that aside from self-realization and self-

concept, a patient's understanding of his or her condition remains essential for determining the level of recovery from a severe mental illness (Korsbek, 2013). As a matter of fact, Korsbek stresses that the patient's understanding of his or her psychological condition and illness contribute to his or her recovery process (Korsbek, 2013). More importantly, it helps in the development of self-awareness and self-understanding. Like Buckley-Walker and colleagues, Korsbek believes that a patient's level of recovery from severe mental illness is measurable by his or her self-concept in relation to the patient's overall goals for recovery (Korsbek, 2013). The study's results have led to the conclusion that patient participation and reporting show promise as a viable and reliable measure of recovery among patients with severe mental illness. Based on the results, patients undergoing Illness Management and Recovery programs are able to measure their level of recovery through assessment tools that focus on identifying the patient's self-understanding and awareness of their mental condition.

### **Clinical Competence Assessment Tool**

The success of an Illness Management and Recovery program is not merely measured through its success when aiding in the recovery of patients. More often than not, an evaluation of the program itself has to be conducted to determine the overall effectiveness of any IMR (McGuire, Stull, Mueser, Santos, Mook, Rose, Tunze, White & Salyers, 2012). A clinical competence assessment tool was developed by researchers McGuire, Stull, Mueser, Santos, Moo, Rose, Tunze, White and Salyers (2012). The evaluation test was developed to measure the integrity of the treatment as well as the effectiveness of the IMR programs (McGuire et al., 2012). As auxiliary programs, Illness Management and Recovery provides patients suffering from severe mental illness with an important role to play in their own medical management, thus enabling them to assume responsibility for their own recovery. As a result, IMR treatment

programs play an important role in the recovery of patients suffering from SMI (McGuire et al., 2012).

However, studies also reveal that an evaluation of IMR programs have been limited thus leaving a significant gap in the literature (McGuire et al., 2012). Since most rehabilitation programs for patients with severe mental illnesses are evidence-based, the need for a reliable and standardized tool for evaluation is necessary in evaluating IMR programs (McGuire et al., 2012). To accomplish this, the researchers developed the IMR Treatment Integrity Scale (IT-IS) to measure the reliability and integrity of sample IMR programs (McGuire et al., 2012). The scale is designed to measure the competence of practitioners of IMR as an indicator of the effectiveness of IMR programs (McGuire et al., 2012). In the investigation, the IT-IS was able to distinguish between actual IMR programs from control groups (McGuire et al., 2012). In addition, the test was found to have significant reliability (92 percent) across raters and across programs, which points to being a reliable measure for evaluating IMR programs (McGuire et al., 2012). Though IMR has become an important tool in the rehabilitation and treatment of patients with severe mental illnesses, there is yet a need for the development of reliable measures that evaluate IMR programs (McGuire et al., 2012). The available literature regarding the subject of program evaluations suggests that there is still a disparity between the number of IMR programs and the number of assessment tools to evaluate their effectiveness (McGuire et al., 2012).

### **Challenges and Opportunities in the Implementation of IMR**

Like McGuire and his colleagues, Withley, Gingerich, Lutz and Mueser (2009) identified the challenges and weaknesses of IMR. Their investigation focused on the opportunities and threats for the success of IMR programs in the field of mental health (Withley, Gingerich, Lutz,

& Mueser, 2009). In their study, the researchers focused on studying various factors affecting the successful implementation of IMR programs in 12 sample settings (Whitley et al., 2009). The two-year study revealed that the success of IMR programs across all 12 sample settings was dependent on the quality and dedication of the program's leadership, the culture of the institution, and the quality of the IMR program's staff (Whitley et al., 2009). Another vital factor uncovered by the researchers was the level of commitment of all parties involved in the IMR program (Whitley et al., 2009). Although all of the 12 participating centers offering IMR programs that were observed in the study had the same overall goals and methods, the rate of success varied (Whitley et al., 2009). The authors of the study noted that the four factors identified were key to the success or failure of the IMR programs in the study (Whitley et al., 2009). For the most part, programs that showed less of a success than others demonstrated poor performance and challenges under one or more of the four factors (Whitley et al., 2009). Among the four identified factors, weak leadership had the most significant impact on the success or failure of the IMR (Whitley et al., 2009). This is because leadership or management has a direct bearing regarding the choice of their employees, the supervision of staff, and the development of the organizational culture within the institution (Whitley et al., 2009). Conversely, quality management and control of these four factors can lead to better performance and successful implementation of IMR programs across different settings. In all, the study points to important themes and elements that may pose challenges to the successful implementation of IMRs.

### **Perception of Clinical Practitioners of IMR**

IMR programs are applicable to various settings and contexts in institutions and communities. Mental health practitioners that are trained to administer IMR to their patients have mixed beliefs regarding the use and application of IMR in their practice (Salyers et al.,



2008). To investigate the various obstacles and enablers that affect the use and prevalence of IMR as a sustainable therapy for patients suffering from severe mental illnesses, Salyers, Rollins, McGuire and Gearhart (2008) interviewed mental health practitioners (n=89). With the use of telephone interviews, the researchers asked psychiatrists to describe the extent to which they applied IMR in their practice (Salyers, Rollins, McGuire & Gearhart, 2008). For the most part, half of the participants used formal IMR and yet 23.6 percent of the participants confessed to not implementing IMR with their patients even though they had IMR training (Salyers et al., 2008). The focus of the study was to identify obstacles that affect the implementation of IMR among health care practitioners.

After the investigation, psychiatrists that implemented IMR only partially or who did not implement IMR cited the lack of patient participation, low patient motivation, and the lack of commitment from patients as the top three reasons why they did not integrate IMR in their patient management strategies (Salyers et al., 2008). Overall, this points to poor patient motivation as the primary reason for the failure to use IMR as part of medical management of patients with severe mental illness (Salyers et al., 2008). The conclusion of this study suggests that the IMR training facilitators may influence the willingness and dedication of mental health practitioners to practice IMR (Salyers et al., 2008). The findings of this study also point out an important challenge to the success of IMR as an accepted form of treatment for people with SMI. The study reveals that one important factor is the attitude, willingness and dedication of psychiatrists as well as other mental health professionals to apply IMR in their practice.

### **Fidelity Measures for Mental Health Programs**

Another study that focused on the effectiveness of Evidence-Based Practices (EBP) was conducted by Teague, Mueser and Rapp (2012). In their investigation, Teague and colleagues

intended to conduct a fidelity measurement regarding diverse mental health services for patients suffering from severe mental illness (Teague, Mueser & Rapp, 2012). In order to reach their goals, the investigators used the following tests: “Cognitive Therapy for Psychosis Adherence Scale, Strengths Model Fidelity Scale, Illness Management and Recovery Program Fidelity Scale, and the Tool for Measurement of ACT” (Teague et al., 2012). By using the aforementioned tests to measure the various aspects of mental health programs, a more complete and comprehensive assessment of EBP programs was developed by the researchers. Moreover, since the various fidelity measurement scales gauge the different themes and facets of a program, a combination of various assessment tools allowed the researchers to have an all-inclusive picture of a mental health program for people with SMI (Teague et al., 2012). This study highlights a weakness in program evaluation for multi-faceted programs like IMR and reveals that one single evaluation tool is wholly insufficient for gauging the effectiveness of mental health programs such as IMR and ACT.

Again, in another study conducted by Godfrey, Salyers, Mueser and Labriola (2007), IMR rating scales were used to measure the success of IMR programs as viewed by consumers and by clinicians (Godfrey, Salyers, Mueser & Labriola, 2007). Since one of the main limitations of IMR is the lack of evaluative studies on the effectiveness of the programs, the use of Illness Management Recovery Scales have led to a better understanding of the effectiveness and limitations of IMR (Godfrey et al., 2007). The rating scale designed to measure IMR has two versions: one for clinicians and another for consumers. Researchers of the study implemented both tests and found the result moderately correlated between the two tests (Godfrey et al., 2007). What is more, the multifaceted nature of IMR makes it difficult to reach consistent and reliable quantitative results across the different components of IMR (Godfrey et

al., 2007). Additionally, the findings of the study reveal that another obstacle to the accurate evaluation of IMR lies in the modules as well as the nature of the rehabilitation program itself (Godfrey et al., 2007). The results of the scales in Godfred and his colleague's study reveal a strong retest score correlation but moderate correlation between sample groups (Godfrey et al., 2007). Again, this could be attributed to the nature of the program itself thereby making quantitative evaluations of the entire IMR program difficult and challenging (Godfrey et al., 2007). Godfred and colleagues discovered that an evaluation of multifaceted recovery programs such as the IMR can be challenging and result in a low reliability of the evaluation results.

In the study conducted by McHugo, Drake, Whitley, Bond, Campbell, Rapp, Goldman, Lutz, and Finnerty (2007), a long-term evaluation for Evidence-Based Practices to measure the fidelity of the programs was developed. Unlike other studies, research conducted by McHugo and his associates was conducted across a large sample of varied institutions (n=58) over a three-year period (McHugo, Drake, Whitley, Bond, Campbell, Rapp, Goldman, Lutz, & Finnerty, 2007). The evaluative study focused on assessing the dependability of Evidence-Based Practices offered to patients with severe mental illnesses (McHugo et al., 2007). The investigation conducted external assessments regarding the effectiveness of the programs from different facilities every six months (McHugo et al., 2007). The results show that more than 50 percent of the facilities demonstrated high fidelity ratings after the first year (McHugo et al., 2007). Unfortunately, the quality of the result tapered after the second year based on the fidelity test conducted by the researchers (McHugo et al., 2007).

On the other hand, the investigators cited the main limitation of their testing tool was the inability of fidelity tests to accurately measure non-quantitative achievements of mental health programs across the 58 sample programs (McHugo et al., 2007). As a matter of fact, the

researchers noted that the rate of customer or participant satisfaction with the EBP programs remained high even after the second year of participation in the various programs (McHugo et al., 2007). This is because their evaluative tool was designed to measure the fidelity of the program implementation as a measure of the achievement of the different Evidence-Based Practice program success (McHugo et al., 2007). Hence, other factors that could indicate success in implementation were not measured and not reflected in the evaluation results (McHugo et al., 2007). As a result, this points out yet another flaw in the implementation and evaluation of IMR and EBP programs because their multifaceted and multi-theme nature makes it difficult to create an evaluative tool that would accurately and fairly measure their true success or failure.

### **Qualitative Evaluation of IMR**

One integral part of the IMR program is the emphasis on empowerment of the patient and making them an important agent to their recovery. A study conducted by Thoreson in 2012 investigated the perceptions of participants of mental health programs regarding the effectiveness of the programs. By using a cross-sectional survey among the participants (n=28), the researcher was able to describe the overall opinion of participants with SMI concerning the value and efficiency of their IMR programs (Thoreson, 2012). The results of the study exposed an in-depth understanding of the perceived benefits of IMR from the perspective of patients (Thoreson, 2012). Overall, the interviews among the participants revealed a positive opinion regarding the IMR program. In particular, patients felt that the IMR program enhanced their self-value and self-image consequently leading to increased self-confidence and greater independence from their caregivers and mental health professionals (Thoreson, 2012). Although the study has not been tested for quantitative reliability, the survey demonstrates an overall trend towards the positive impact of IMR programs on the wellbeing and self-confidence of individuals with

severe mental illnesses (Thoreson, 2012). More importantly, it points to a flaw in evaluations of IMR programs. Qualitative researches such as the one created by Thoreson may not appear to be credible because of the lack of statistical support for the data collected in spite of the qualitative insight these types of investigations contribute to the study of IMR programs.

A similar study conducted by Hasson-Ohayon, Roe and Kravetz in 2006 also consisted of a qualitative investigation regarding the efficiency of Illness Management and Recovery programs. Like Thoreson, the researchers created a qualitative measure for their investigation with 16 unstructured-response questions provided to a sample population (n=64) of patients with severe mental illnesses (Hasson-Ohayon, Roe & Kravetz, 2006). The assessment tool was called Narrative Evaluation of Intervention Interview (NEII) based on the qualitative approach of the tool (Hasson-Ohayon et al., 2006). The results of the NEII assessment tool revealed a number of themes about the Evidence-Based Practices given to patients with severe mental illnesses (Hasson-Ohayon et al., 2006).

The themes provided researchers with better insight concerning how patients perceived the programs as well as the perceived benefits they gained from undergoing these programs (Hasson-Ohayon et al., 2006). The use of a grounded theory approach revealed a reliability that ranged from moderate to high (Hasson-Ohayon et al., 2006). This shows great promise for the applicability of the NEII as a qualitative evaluation measure for mental health programs designed for people with SMI. However, the study also points out a flaw regarding the present research on evaluations of mental health programs under the EBP classification such as the IMR. On one hand, there is a limit to the quantitative measure designed to evaluate programs in terms of depth and the comprehensiveness of the evaluative tool. On the other hand, qualitative measures that

provide in-depth insight from consumers and clinicians lack the statistical reliability due to their design.

### **Factors Affecting Implementation Success of IMR**

Since measuring the implementation success of mental health programs could be challenging, Kraus and Stein (2013), investigated the external and internal factors that affect the success of these programs. In their investigation, they interviewed 114 case managers and their clients (Krause & Stein, 2013). The results of their interviews revealed that the perception and job-burnout rate of case managers had a significant impact on the success of the program implementation for EBP and IMR (Krause & Stein, 2013). For one, the opinion and overall job satisfaction of case managers reflected the positive outcome of their work with their clients (Krause & Stein, 2013). Conversely, having a negative job outlook association with emotional exhaustion at work can lead to poorer results of the program (Krause & Stein, 2013). This study points to one often neglected factor in mental health program evaluations that could affect the outcome of the program's overall success.

### **IMR Program Improvement Research**

Torrey, Drake, Dixon, Burns, Flynn, Rush, Clark and Klatzker (2001) conducted the first of a series of studies regarding the effectiveness of implementing EMB programs. The researchers believed that it is essential for evaluative research to be conducted on EMB programs such as IMR in order to increase its application in the clinical setting (Torrey, Drake, Dixon, Burns, Flynn, Rush, Clark & Klatzker, 2001). To do this, they conducted a qualitative survey of existing literature on EBP programs and the merits of these programs (Torrey et al., 2001). Additionally, the authors created an ideal delivery plan that would increase the effectiveness of the delivery of EBPs to a generalized sample (Torrey et al., 2001). Finally, the researchers

investigated the impact of multi-media care delivery channels in traditional and new media that could supplement face-to-face delivery of care (Torrey et al., 2001).

Another study that sought to improve the implementation of IMR and other EBP programs was conducted by Torrey, Rapp, Van Tosh, McNabb, and Ralph in 2005. The study was designed to improve the effectiveness of recovery programs specifically designed to help people suffering from severe mental illness (Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005). Present mental health rehabilitation programs do not consider findings from research. Because of this, Torrey and colleagues propose that mental health programs for individuals with SMI should both consider the feedback of their clients suffering from SMI as well as evidence from available research (Torrey et al., 2005). In fact, the study points out the merits of EBPs such as IMR, which is an evidence-based program that has had success in rehabilitating patients with SMI (Torrey et al., 2005). The researchers stress the need for clinicians and institutions to promote the use of Evidence-Based Practices as supplementary programs (Torrey et al., 2005). The investigation reveals that Evidence-Based Practices have important contributions to the field of rehabilitation and therapy for patients with severe mental illness. Although traditional pharmacological therapies are effective and cannot be eradicated from the rehabilitative process, supplemental programs such as IMR offer considerable merit for patients suffering from SMI.

The literature completely reviews the Illness Management and Recovery tool kit and modules while providing information related to the evidence-based practices it supports. However, there is insufficient information regarding the barriers to practitioner success when implementing Illness Management and Recovery to individuals living with severe and persistent mental illness. The literature discusses materials rather than specific client behaviors that may impede on the implementation of the modules, homework and successful outcomes of the Illness

Management and Recovery tool kit. The big research question for this qualitative study is: what are the barriers for practitioners when implementing the IMR modules with individuals with severe mental illness?

### **Conceptual Framework**

This study sought to explore barriers related to the practitioner's implementation of Illness Management and Recovery with individuals with severe mental illness. No conceptual models existed that have explored the multiple barriers of IMR implementation among practitioners. As such, this study was exploratory.

Based on the literature review, barriers from the practitioner perspective can be seen to exist from two main sources: patient and provider. From the patient perspective, the following barriers have previously been identified: supportive housing (Levitt et al., 2009), willingness and commitment (Cook et al., 2009; Salyers et al., 2008), and level of patient participation (Buckley-Walker et al., 2010). The literature suggests the following barriers from the provider perspective: degree of implementation (Salyers et al., 2009), commitment (Withley et al., 2009), leadership (Withley et al., 2009), quality management and control (Withley et al., 2009), attitude toward IMR and patients, (Salyers et al., 2008), job outlook (Krause & Stein, 2013).



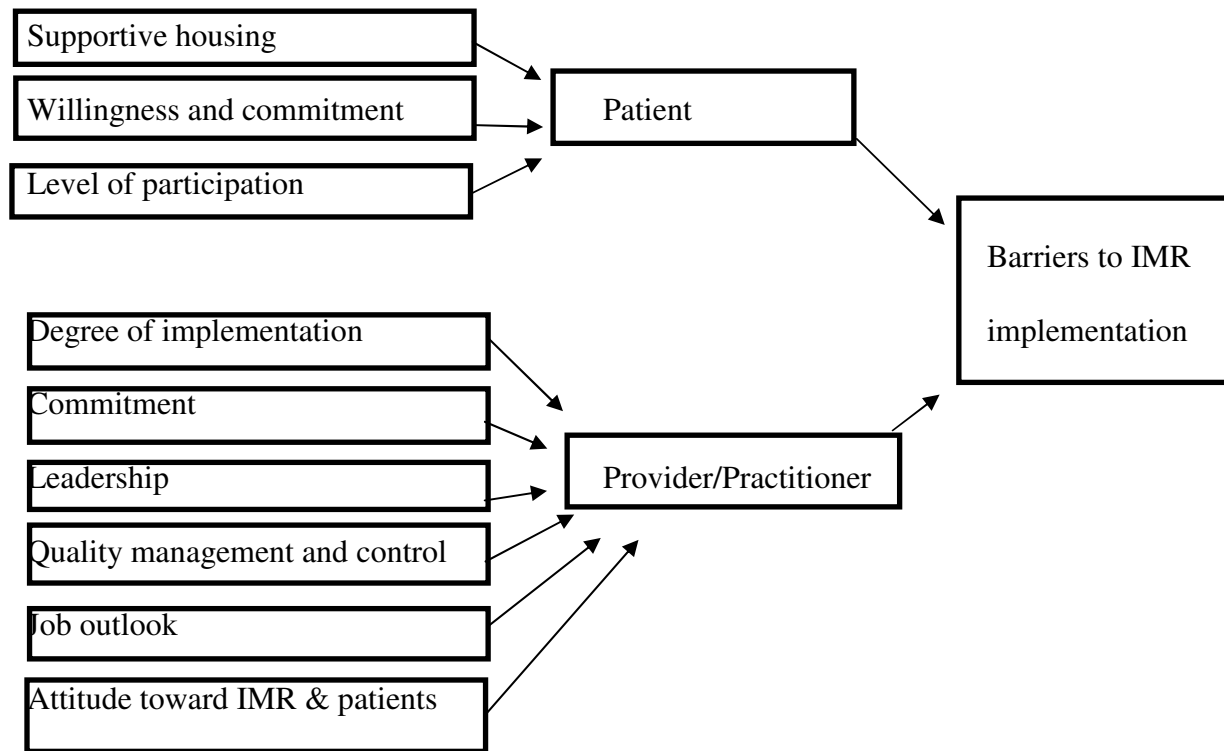


Figure 1. Proposed conceptual model of barriers to IMR based on previous literature.

## Methods

Within this section of the proposal, the researcher reviewed the purpose and research question. Also the design of the research, sample of participants, data collection and analysis and a brief review of the strengths and limitations of the design of the research that was conducted. Specific attention was and will be given to the protection of the participants protecting their confidentiality according to the Institutional Review Board.

## Research Design

The design of this study was qualitative in nature. By using semi-structured interviews

with mental health practitioners that are involved in the utilization illness management and recovery for adults with mental illness, data collected was related to the barriers practitioners experience when providing the IMR curriculum to adults with severe mental illness. The literature reviewed identified the need for further exploration into the practitioner's barriers to providing successful IMR to adults with severe mental illness.

### **Sample**

A total of ten social work practitioners were interviewed that were within the Minneapolis and St Paul area. The practitioners varied in levels of experience, training and expertise to IMR. The practitioners interviewed were of LGSW or LICSW licensure and be trained in IMR. Potential participants were identified in an iterative process. First, agencies who utilize IMR were identified through the MN Department of Human Services. Mental Health Practitioners and Clinicians employed at IMR facilities were asked to participate in the study. Potential participants were invited to participate via telephone, letter, and email.

### **Protection of Human Subjects**

The St. Catherine University Institutional Review Board approved the research proposal prior to the methods of gathering of data from human subjects. The committee members that reviewed the proposal and data collection assisted in ensuring that risks to participants were minimized and address appropriately, if any should occur throughout this research. Some of the identified potential risks to participants is that they may have experienced a distressing memory, emotion or other mental health symptoms related to the questions being asked were of a personal nature or related to their own recovery from mental wellness issues.

The researcher ensured that the participants were provided with additional resources if needed. There are no known benefits to participants in this study. To protect participants they

were provided informed consents related to the study. Each participant reviewed and signed the consents prior to initiating the qualitative interview process. Upon carefully reading the informed consent and signing with their approval, the researcher asked if the participants had any questions before we began. None of the participants had any questions or concerns related to their protection which were stated prior to beginning the recorded interview.

### **Data Collection Instrument and Process**

An interview guide was developed with interview questions (see Appendix B). Interviews were digitally recorded and transcribed by the researcher. The recording device was locked with all other data. Also, the audio recordings of interviews were kept on a password protected recording device, and the recorded device was also locked in a secured cabinet with other data. No data included identifying information, such as names of participants. All transcripts will be destroyed upon completion of the research project or on June 1, 2014 at the latest. The transcripts involved will be reviewed by chair and committee members to check the validity of themes and outcomes to be identified during analysis. Thus, the information or data collected will be encrypted, locked up in a storage container and deleted by July 2014.

The 10 interviews were conducted for this qualitative research assignment in Minnesota. The interviews took the form of a semi-structured discussion consisting of preapproved questions related to the implementation of Illness Management and Recovery when working with individuals with mental illness and symptoms (see Appendix B). The questions were developed under the advisement of a committee. The review and approval from committee members ensure the questions met the standards required by the IRB (see Appendix A).

The interviews were recorded using a small, hand held recorder to allow for transcription, analysis and coding after the interviews were completed. The interviews lasted approximately

one hour, which included the preapproved questions prepared by the interviewer. The list of preapproved questions can be found in Appendix B.

The questions for the interview were developed by using particular attention to the formulation and wording of the questions. The interviewer also considered the sequence in which the questions were asked. The respondents were not given the list of questions prior to the interview, in order to prevent or influence the responses. This allowed for spontaneous and unrehearsed responses from the interviewees. The purpose of the interview, qualitative research related to Illness Management and Recovery as an evidence based practice for mental health practitioners, was revealed prior to conducting each interview.

### **Data Analysis Plan**

The analysis of the data obtained through semi-structured interviews were transcribed and coded by utilizing key concepts identified in the transcriptions. The coding and concepts developed from the transcription and themes related to the research. Themes were developed by analyzing the key concepts and developed into a larger theme.

### **Data Analysis Technique**

Upon completion of the interviews, the researcher immediately transcribed the interviews into a typed dialogue for further analyzing and coding. This research was based on the raw data from the interview. The researcher then developed codes, themes and categories from the raw data. This is done by reading the transcript and tuning in to the relevance of certain words and ideas being related during the interview process.

### **Strengths and Limitations**

A strength of this research is it was intended to provide a qualitative research study to assist mental health practitioners from overcoming barriers preventing the success of the useful

resource of Illness Management and Recovery toolkit. A limitation of this study was that the sample size of participants interviewed was small. Limitations that were considered were the willingness and knowledge of the practitioners in conducting individual Illness Management and Recovery with a diverse range of individuals with mental illness. Each practitioner seeking to implement recovery or mental wellness through the IMR modules had experienced their own level of strengths and limitations as they strive to assist individuals in recovery. Another limitation of this study is that it does not include data from the client's or participants of IMR. Therefore, the strengths are related to assisting practitioners while working with individuals with mental illness as they strive for recovery.

### **Findings**

Upon completion of the interviews and data collection and transcriptions, the information collected was coded by the qualitative researcher. The researcher evaluated the transcriptions by going through each of them, line by line, multiple times. By carefully reading each transcript and combing the documents, the researcher was able to identify categories, key words and concepts. By combining these words and concepts, that were formulated, themes emerged. Through the analysis of data and emerging information, several interrelated themes have been identified.

The identified themes related to practitioner barriers in implementing the IMR curriculum are: 1. training and supervision, 2.the role of the practitioner, 3.initiating mental health services with IMR, 4. practitioner and client engagement strategies, and finally 5.organizational support and structure. These themes came from various agencies and were reviewed and supported with quotes from the data collected that identified codes which emerged during the process of content analysis. The themes were then combined into the primary overarching theme for research,

practitioner barriers to using Illness Management and Recovery toolkit and curriculum with adults living with severe mental illness.

All of the themes presented within this article are interpretations made by the qualitative researcher. The categories and codes emerged from the raw data. These themes are all components of the qualitative research or Illness Management and Recovery curriculum topics discussed by the respondent in the semi-structured interview process. The themes represent ideas and topics that are necessary for practitioners to understand when implementing IMR successfully. By understanding the themes, practitioners may be able to overcome some of the barriers to implementation of Illness Management and Recovery with individuals living with mental illness. Thus, providing a more stable and mentally well society.

The following excerpts from interviews with participants provide examples of the range of responses that were coded and formed into themes related to practitioner barriers to implementing the Illness Management and Recovery curriculum.

### **Training and Supervision**

The first theme, training and supervision, was the most commonly mentioned barrier throughout all interviews. Thus, most barrier codes were related to training and supervision. These codes were so prominent that they became their own theme, one practitioner stated, *“There is only half-day training on IMR available for all employees, but uh, there is supervision appointments, at least monthly, and they are crucial to discussion and progress with clients and strategies to implement IMR”*, another practitioner stated, *“There is a formal training as well as the instructions with the IMR”* and *“in the two day training, we learned that inclusion in the Treatment Plans and active implementation in session on weekly basis is the only way we don’t get lost or forget about IMR”* and *“I think it would be helpful to have a longer training on*

*using the IMR module currently this training is a half day, and it only provides information that is a broad overview. Other training days are full days, and I think it would be more helpful to have at least one full day.*” These respondents suggest that further training may be necessary for successful implementation of the curriculum.

Other interviewees suggested a different viewpoint, such as, *“We are encouraged to attend IMR training given by the Department of Human Services and the toolkit is free online”*, and *“IMR is integrated into treatment plans which are regularly discussed during individual supervision, and reviewed each six months in individual supervision, or amongst the team.”* Also, another interviewee stated *“we are required to discuss and review treatment plans which include IMR recovery modules on a weekly basis.”* An in depth 2 day training seminar is taught by the Department of Human Services in relation to the implementation of Illness Management and Recovery in the State of Minnesota. Also, it is suggested, that the trainees also receive at least one year of supervision from an expert in Illness Management and Recovery. This supervision can be done in a variety of methods, such as conference calls or Skype, a form of virtual communication.

### **Role of practitioner**

The second theme found was that the role or participation and commitment of the practitioner plays a crucial role in developing the recovery vision and process for individuals living with mental illness. The practitioner must be aware of the individual’s specific symptoms and visions of the consumer as he or she guides the individual through the IMR curriculum. The literature supports this theme, for one, the opinion and overall job satisfaction of case managers reflected the positive outcome of their work with their clients (Krause & Stein, 2013). And conversely, having a negative job outlook association with emotional exhaustion at work can

lead to poorer results of the program (Krause & Stein, 2013). The relationship between the IMR participant and the clinician is crucial when utilizing this foundational recovery tool which promotes mental wellness. Some of the goals or modules of IMR's focus is to help the person learn more about their specific diagnosis/mental illness, decrease their symptoms, reduce hospitalizations, and make progress towards personal goals and recovery.

The practitioner guides the individual living with mental health symptoms through each recovery strategy. Also, the practitioner must use engagement techniques and rapport building, to engage the individual involved in making it an interactive and fun exercise. The main topic areas for the practitioner to cover are recovery strategies, practical facts about their specific diagnosis, treatment strategies, building social support, using medication effectively, drug and alcohol use, reducing relapses, coping with stress, coping with symptoms and problems, and getting your needs met in the mental health system. An additional module is living a healthy lifestyle. The following quotes support this theme: *“my role is to immediately provide education on diagnosis and empowerment to achieve recovery”* and *“The IMR is a tool for explaining diagnoses to clients and to help both practitioner and client assess strengths and needs. I sometimes complete the worksheets in session with the client and other times give the worksheets as homework. Our role is to provide the information and help clients address barriers to completing the worksheets.”*

All of these recovery strategies have the theoretical underpinnings of a broad combination of recovery theories and are combined to form the Illness Management and Recovery curriculum. Obviously, the practitioner plays a heavy role in engaging the clients, teaching strategies, modeling and practicing coping skills, and also identifying homework that motivates the individual receiving supports. Supporting this theory are the following quotes:



*“Providing education on diagnosis and empowerment to achieve recovery”* and *“The IMR is a tool for explaining diagnoses to clients and to help both practitioner and client assess strengths and needs. I sometimes complete the worksheets in session with the client and other times give the worksheets as homework. Our role is to provide the information and help clients address barriers to completing the worksheets”* also stated as a barrier was the, *“lack of worksheets for diagnoses such as anxiety, PTSD and borderline personality.”* and *“The modules are designed to be used as an entire module rather than a series of worksheets. If I leave the entire module with the client so he/she completes certain pages, the entire module might be lost, thus losing a few weeks’ worth of work. It would be great if each module was broken down into subsections that could be handed out and collected at each session. Right now, one section might be on pages 3-5 with the next section starting on the bottom of page five.”* These quotes support the idea that the role and organizational skills of the practitioner is a major barrier in implementation of the IMR curriculum.

Another interviewee stated *“My favorite part about IMR groups is being a participant along with the member, I don’t share too much information, but I do take a turn to promote discussions sometimes it has to be done”*, so the leader or practitioner models participation to support the idea that all individuals have a state of mental wellness.

### **Initiating Supports with Illness Management and Recovery**

The understanding is that the client may work harder for a recovery vision given a sense of suffering from symptoms because this suffering is a strong motivating factor in recovery. If a client can identify a vision or goal for their future, it makes their individual diligence toward recovery more meaningful, observable, and achievable. The principle behind the study states that a patient’s self-identity and self-perception are vital components and indicators of his or her

wellness and level of recovery (Buckley-Walker et al., 2010). This quote supports the theme that initiating supports with IMR is important in the recovery process.

A third theme found was the recovery from mental illness or mental health related symptoms requires a recovery vision or goal that the individual finds personal, important to them, and achievable. The following are quotes from data collected regarding initiating services by developing a vision with the individual: *“I review IMR and recovery strategies with each client. Upon opening a new client I always review IMR recovery strategies handout one. Depending upon the new client I may choose other educational handouts to review later on that are more specific to their diagnosis, such as IM are handout to be: practical facts about bipolar disorder.”* And another interviewee responded, *“Reviewing modules 1 & 2 with clients as they begin services. Discuss recovery through IMR lens. Coaching on skills from stress/vulnerability modules with some clients struggling with anxiety.”* Also quoted was, *“I have used the IMR 1 with every client to assess their needs and strengths and help them identify goals. I use other IMR modules as needed, often breaking them into smaller sections or doing the worksheets during sessions with the client. Sometimes, for clients with learning or cognitive functioning, I address the information in a more informal way.”*

Another respondent stated that a barrier for implementation is lack of knowledge on how to implement the curriculum with varying diagnosis. This interviewee stated, *“It would be helpful to have a module on anxiety disorders. As far as I know, there is not one”*. Therefore the data collected supported the need for adapting the modules based on cognitive functioning and varying diagnosis.

## Engagement

A fourth theme found was the need for engagement or promoting interest in the program. The relationship between the individual in the recovery process and the practitioner, again affects this theme. It is important that clinicians utilize a style or interaction that encourages success and optimism toward the client goals and future. The data collected also reflects a lack of interest in the curriculum. Interviewees stated, *“Materials can be dry and boring for clients if not supplemented with other activities, especially with lower functioning clients. It would be beneficial for practitioners to include ideas for activities to supplement IMR modules.”* Another respondent stated, *“Viewing IMR modules as boring, not knowing how to integrate into treatment and client sessions. Lack of activities to encourage client engagement in IMR.”* *“It is word heavy for people with lower intellectual functioning. It needs more illustrations and simplified language”*, and *“Often clients lose homework worksheets between sessions.”* It is understandable that individuals would be more successful implementing recovery strategies if they are engaged in the process. The willingness of the consumer to believe successful recovery is a possibility for some relief from symptoms is necessary for conducting IMR.

Other respondents stated a different point of view. The following quotes depict the importance of instilling hope and belief in the client’s abilities: *“It is important for practitioners to believe in recovery and instill hope in clients. IMR can be utilized to give clients a choice in recovery and determine what recovery would look like for them”* and another quote to support this theme was, *“The principles and concepts are directly applicable to my clients and are useful tools in their process of recovery; However, I do not use them as a worksheet or direct assignment. I use IMR as a guiding tool for conversations on treatment strategies and goal setting in a relational context.”*

Another barrier mentioned in the data collection process was the level of cognitive functioning of the consumer's living with severe mental illness, such as schizophrenia. One interviewee stated, *"Sometimes working with the modules can be tedious for clients, even though there are examples and exercises"* and, *"Difficulty in its similarity to school work or homework. Most clients lack the motivation or skills to use the handouts directly but are more responsive to conversations around adapting the concepts to fit their challenges."* Therefore, engagement with the individuals we serve is crucial to the success of the recovery process when utilizing the IMR curriculum.

### **Organizational support**

The fifth and final theme was the barrier of organizational support when implementing the IMR curriculum. As discovered in the literature, a two-year study revealed that the success of IMR programs across all 12 sample settings was dependent on the quality and dedication of the program's leadership, the culture of the institution, and the quality of the IMR program's staff (Whitley et al., 2009) Several interviewees endorsed full support from their agency, including upper, middle and lower management. However, there was also responses that stated the support from the national level is lacking. The following are quotes from interviewees regarding their organizational support they have experienced, which ranges from no perception of organizational barriers to a macro level of organizational support from the federal government. Some interviewees stated, *"I do not perceive any barriers. IMR is encouraged within my organization"* and *"No organizational barriers are seen because my supervisor is very supportive"* and, *"No. The organization is committed to the principles in their adaptation for practice" and bring up issues as needed during supervision."* These respondents work for an organization which very readily supports the struggles with implementation of IMR.

While other respondents stated that, *“It would be nice to see a roll-out of the IMR curriculum on a national or federal level. I think that would assist in overcoming the barrier of upper management endorsing the curriculum as an evidence-based practice.”* The range of responses indicates barriers of varying types of training, supervision, and commitment among different agencies. Therefore, a national movement towards the promotion of IMR would be beneficial in overcoming this barrier. All practitioners should be mandated to complete the DHS two day training and 18 months of biweekly supervision with DHS trainer.

### **Discussion**

This qualitative research study investigated the barriers of practitioners when implementing the IMR curriculum with adults with severe mental illness. A major theme of the new movement of recovery is empowering the individual to see a vision for themselves and their choices in the recovery process. The clinician or mental health practitioner assists and guides the individual or groups by taking small steps to reach the larger goal. The barriers that the practitioner may experience can be related to the training and supervision, role of the practitioner, initiating support with IMR, engagement between clinician and individual with a diagnosis related to severe mental illness, and finally, organizational support.

The literature reviewed in this research process uncovered many different domains of barriers in the delivery of Illness Management and Recovery modules. Primarily the research indicated two primary factors which may impact the success of the IMR curriculum, client perceptions and practitioner perceptions. The conceptual framework related to this study does support the categories, codes, and themes in accordance with the research that was conducted. This study uncovered similar data related to the conceptual framework in Figure 1.

From the literature, conceptual framework and data collected, one can deduce that the practitioner delivering the IMR curriculum may have multiple barriers to overcome. The categories, codes and themes related to the data suggested barriers are experience at varying levels of training and supervision, initiation of services with IMR, role of the practitioner, engagement of the individual, and levels organizational support.

Research on IMR as an evidence-based practice has been highly researched. However, the barriers of implementing the IMR curriculum is somewhat limited. Both data and literature suggest that Illness Management and Recovery is an evidence-based practice and recovery tool. This foundational tool is intended for management of mental illness symptoms and recovery strategies related to improving mental health. Data suggested the number one barrier to delivery of Illness Management and Recovery is the lack of adequate quality training and supervision.

Literature suggests barriers are related to development of manuals, funding, training and supervision, and proper implementation of the modules. These barriers are very concrete but do not represent the individual practitioner and client barriers related to behavioral tailoring, motivational interviewing, and other barriers related to the person versus the materials. The researchers stress the need for clinicians and institutions to promote the use of Evidence-Based Practices as supplementary programs (Torrey et al., 2005). One respondent suggested that the literature is not necessary for successful implementation. The manuals, books, handouts, and homework can actually prevent the client from feeling a personal touch or attachment to the practitioner if the practitioner is overly focused on the materials versus the person.

Both data and literature suggest that Illness Management and Recovery is an evidence based practice or step-by-step process for individuals to recover from mental illness and persistent systems. These therapeutic steps allow individuals the ability to make a vision for

themselves by learning recovery strategies, practical facts about mental illness, treatment strategies, building social support, using medications effectively, drug and alcohol abuse, reducing relapse, coping with stress, coping with symptoms, and getting needs met in the mental health system.

This study reveals multiple implications for the social work practice when serving individuals with severe mental illness. The utilization of the illness management and recovery curriculum appears to have indicated good results across multiple diagnoses which is improved overall stability and mental health recovery for individuals with severe mental illness. It also appears to reduce hospitalizations and relapses. The illness management and recovery modules do appear to have positive results and could be widely used by the social work profession and other disciplines. If an assertive effort is made by supervisors to provide quality training of IMR strategies to individuals living with mental illness, the primary barriers uncovered by this research could be overcome. Thus, providing a more comprehensive system of managing mental wellness in the United States. Also, these practitioner barriers could begin to be overcome in implementation of the modules. Additional research must be conducted related to the long term success of this evidence-based practice, however, the data demonstrates the usefulness of the recovery curriculum. Also, additional research could benefit social work researchers identify additional areas of assisting individuals to manage their mental wellness successfully. The following is a summary of this research project, as it identifies the difficulty with implementation of illness management recovery.

### **Summary**

This qualitative research project asked the question: What barriers do practitioners have in implementing Illness Management and Recovery modules, handouts, and curriculums with

people living with severe mental illness? It was expected that practitioners found the curriculum to have positive impact on the treatment outcomes of the individuals they serve. This research project found that not only did the majority of the practitioners experience difficulties in training and supervision, but that other barriers were related to the outcomes of the recovery movement as well. Another emerging barrier was the role of the practitioner in the creative delivery of the recovery curriculum. Also, the data suggested initiating supportive mental health services with IMR can improve the success of the model. Overall, Illness Management Recovery has barriers to overcome as social workers join together in implementing evidence-based practices. This qualitative research project was conducted to promote awareness and solutions in overcoming the practitioner barriers of implementing the IMR recovery curriculum. Also, an important component of this research project was to promote the idea that a national rollout of Illness Management and Recovery may be a solution to assisting individuals in managing their mental wellness and reducing violent incidents in today's society. In the future, social workers and policy makers may require standardizing the supervision and training curriculum of IMR to benefit practitioners implementing IMR and the individuals they serve.



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Appendix A  
**Consent Form**  
**University of St. Thomas**  
**GRSW681 Research Project**

**Practitioner Barriers of Illness Management and Recovery as a successful therapeutic intervention tool for Adults Living with Severe Mental Illness**

I am conducting a study about the impact of Illness Management and Recovery as a successful tool for practitioners when working with adults with severe mental illness. I invite you to participate in this research. You were selected as a possible participant because you are a Practitioner utilizing IMR within your agency. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Jennifer Brummer, LSW, a graduate student at the School of Social Work, Catherine University/University of St. Thomas and supervised by Dr. Rajean Moore, PhD., a faculty member at the school.

**Background Information:**

The purpose of this study is to research the practitioner's barriers to the impact and effectiveness of Illness Management and Recovery as a therapeutic intervention tool for practitioners when working with adults with mental illness.

**Procedures:**

If you agree to be in this study, I will ask you to do the following things:

- Schedule and participate in a one time, approximately 30-45 minute, audio-taped interview
- Agree to this interview being transcribed by the researcher and have the findings of the research presented publicly without any identifying information.

**Risks and Benefits of Being in the Study:**

The study has no risks. The study has no direct benefits.

**Confidentiality:**

The records of this study will be kept confidential. Research records will be kept in a locked file. I will also keep the electronic copy of the transcript in a password protected file on my computer. I will delete any identifying information from the transcript. Findings from the transcript will be presented within my final research document. The audiotape and transcript will be destroyed by June 1, 2014.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be utilized in this study.

**Contacts and Questions**

My name is Jennifer Brummer, LSW. You may ask any questions you have now. If you have questions later, you may contact me at 612-638-7360 or my faculty research advisor, Dr.Rajean Moone at moon9451@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

**You will be given a copy of this form to keep for your records.**

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

\_\_\_\_\_  
**Signature of Study Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Study Participant**

\_\_\_\_\_  
**Signature of Researcher**

\_\_\_\_\_  
**Date**

## Appendix B

### Interview Questions for Qualitative Research Project

My BIG research question:

*What are the barriers for practitioners when implementing Illness Management and Recovery with adults with severe and persistent mental illness?*

Qualitative Research Interview Questions:

- Describe your experiences of utilization of the Illness Management Recovery model?
- Do you perceive any obstacles to patients utilizing the IMR model?
- Do you perceive any barriers within your organization? In your view what would help overcome those barriers, if any?
- What is the role of the mental health practitioner in relation to utilizing Illness Management and Recovery with clients living with mental illness?
- How are practitioners trained and supervised in Illness Management and Recovery?
- What are practitioner requirements for supervision when implementing the Illness Management and Recovery modules with consumers with Serious Mental Illness?
- What are practitioners' barriers to Illness Management and Recovery's success?
- What other factors should be considered for mental health practitioners to deliver successful Illness Management and Recovery strategies to those living with mental illness?