Illness Management & Recovery, an Evidence-based Practice for Person-Centered Mental Health Services.

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The need of person-orientation in services

The practice described in this article assumes a person-centered vision of mental health services, that adapts to people's aspirations and needs, rather than people having to adapt to the requirements and priorities of services. Person-oriented approaches are holistic and built on individual strengths. The principles underpinning person-centered mental health services are that people with severe mental illnesses are people like others, wanting to live in a decent home, have a decent job, friends, partners, and attend school. They have feelings and opinions, not just compulsions or delusions, answer questions and give an opinion on questions asked of them. Rather than being oppositional or resistant, they are not motivated to change but they can have meaningful personal goals.

Person-centered services consist of programs that are initially conducted in institutional settings and progressively move into social environments. Performance of valid and useful tasks and roles results in learning and practicing skills while the person is being brought closer to the context (resocialization). Finally, the culture of person-centered services not only emphasizes the formal titles of staff, but highlights the importance of their personal qualities, their capacity to instill hope, to take care of the person, to be realistic, to believe in resilience, and to connect with people. It also underlines the importance of social exclusion as a contributing factor to the emergence and persistence of mental health problems.

All of this implies a relationship between professionals and the person that is radically different from the traditional one, which is characterized by power and dependence. A shift from staff who are experienced as distant, because they are considered experts who have authority, to staff who behave more like personal coaches or trainers. Such coach or trainer type staff help the person to set personal goals, equip themselves with skills, build social networks and supports and help them access the resources needed for their life, while at the same time the coach or trainer learns from the person (Robert & Wolfson, 2004).

Illness Management and Recovery (IMR)

Illness Management and Recovery (IMR) is an evidence-based psychosocial practice, of which the primary objective is to provide service users with the knowledge and skills necessary to cope with aspects of their mental health problems while maintaining and achieving goals in their recovery. Personal meaning, choice, and everyday life troubles are key issues.

The principles by which IMR is inspired are the following:

- Recovery is defined by the person.
- The Stress-Vulnerability model provides a framework for illness management.
- Collaboration with caregivers and significant others helps service users to achieve their goals.
- Planning relapse prevention reduces their frequency and intensity as well as in-patient needs.
- Service users can learn new strategies to manage symptoms, cope with everyday life challenges and improve their quality of life.

IMR is based on research showing that by learning how to manage symptoms people can take important steps toward recovery. IMR helps the persons to learn more about everyday life challenges, reducing relapses, hospitalizations, and distress or discomfort resulting from symptoms, and take medication in a more informed manner.

The main components of IMR are 1) psycho-education, which provides basic information on mental illness and treatment options; 2) behavioral tailoring, which helps service users to manage their daily medication intake by proposing targeted strategies for remembering to take them; 3) relapse prevention, which teaches service users to identify triggers and warning signs of crisis by developing a prevention plan, and 4) coping skills training, which identifies skills for coping with psychiatric symptoms.

The core values of IMR are 1) building hope; 2) recognizing the person with mental health challenges as an expert; 3) emphasizing personal choice; 4) establishing a collaborative relationship, and 5) demonstrating respect. Rather than trying to convince service users that they have a specific disorder, practitioners respect their beliefs, while seeking common ground as a basis for collaboration and agreement on issues such as symptoms, distress, and the difficulty of having an independent life or achieving a desired goal.

The process of treatment follows a specific pathway:

- The participant is referred to an IMR program by the service and begins weekly or bi-weekly sessions (in a group, individually, or both).
- The professional:
    - introduces the program to the participant and assesses the participant, using the IMR Knowledge and Skills Inventory;
    - offers the information contained in the IMR program and helps the participant to put knowledge and skills in practice, using exercises and homework assignments;
    - helps the participant to set and pursue personal recovery goals, using the goal and exercise sheets;
    - helps the participant to build support by involving family members or significant others, and
    - records the participant's progress, using the IMR Progress Note.

If necessary, the professional meets weekly with a supervisor for group or individual consultation.

The key role of the person

The involvement of the person and building partnership is an ongoing process and starts the moment the person is referred to the program. It is, however, difficult to interest the person in a treatment process in a meaningful way if practitioners do not know the needs and goals of the person, as well as those of their family members, and if services are not sufficiently attentive and available to spend time on this. To this aim, IMR practitioners meet the user (or other supporters) to understand their needs and to describe the program.

The involvement process never stops. Every time the practitioner meets the person to learn more about their interests, aspirations, and goals. Keeping the users involved means continuing to help them in a way that is meaningful to them. It may, however, take some time for the person to realize that the program is offering something different from what they have received in the past from mental health services.

It is also very important to explore the person's experiences, knowledge, and skills both in conversations and by using the Strengths and Knowledge Assessment Questionnaire. This focuses on the person's positive characteristics, rather than problems or deficits. It is advisable to build a good relationship with the person, be respectful and interested in their life situation, gather information in a friendly and respectful manner, ask questions calmly so that they don't feel interrogated, and allow time for discussion without declaring that every issue should be resolved. At the end of each session, it is recommended to ask for feedback on which parts of the program were most interesting to reinforce the involvement process.

IMR Program

The IMR Program consists of eleven modules, which are generally carried out in the order indicated: Recovery Strategies, Practical Facts on Mental Illness, Stress-Vulnerability Model and Treatment Strategies, Building a Social Support System, Effective Use of Medications, Drug and Alcohol Use, Relapse Reduction, Coping with Stress, Coping with Persistent Problems and Symptoms, Getting Responses to One's Needs from the Mental Health System, Healthy Lifestyles.

However, for some service users, it may be important to tailor the program to meet their individual needs. For example, when they are distressed by specific symptoms, Module 9 "Coping with Persistent Problems and Symptoms" is suggested. Yet, professionals should always use their own clinical judgment to define the order of topics to be addressed.

The IMR Program also provides the Practitioners Guide and Participant Handouts. The former, available for each module, provides a quick review of the general objective, topic, and recommended structure for each session, as well as pointing out exercises to do, stimulating links between the information contained in the Participant Handouts and personal recovery goals, and suggesting homework assignments that consolidate the knowledge and skills learned.

The Practitioner's Guide also suggests motivational, educational, and cognitive-behavioral strategies, appropriate to the subject area, and directions for conducting sessions in both individual and group formats. Participant Handouts, attached to each module, are distributed to the person, and reviewed with them during the sessions. They contain practical information and examples of skills they can use in the recovery process. They are written in a user-friendly language and include an information text, summary sheets, probing questions, and exercises to learn knowledge and skills, always related to the personal recovery objective.
Regarding the format of the sessions, the IMR program can be offered either in individual or group format or in a combination of the two.

Homework is essential to help service users to practice and to apply what they learn. With sufficient practice, they can integrate the new skills into their behavioral repertoire so that they become automatic and can be implemented naturally. When homework consists of practicing a new skill, it is useful for service users to make a specific plan of how this will happen. They should also be helped to overcome obstacles that might interfere with completing the task, which gives them some options and helps them to avoid distress.
The activity of monitoring assigned tasks involves asking service users to share their experiences of how they tried to complete them, praising them for their efforts, and asking them the following exploratory questions: What were you able to do? What were you not able to do? What could you do differently in the future to perform the tasks? If service users did not complete a homework assignment, identify obstacles they may have encountered, using problem-solving to overcome them.

As already pointed out, setting and pursuing personal goals is an essential part of the recovery process. In IMR, service users define what recovery means to them and identify personal recovery goals. The first IMR module, Recovery Strategies, contains specific information on goal setting. However, throughout the program, the focus on personal goals and their achievement is constant. In each IMR session, there are exercises to help service users define or review their goals and establish steps to pursue them, and in the case of multiple goals, there is a scorecard on which the total number of goals established during the IMR Program and the steps in achieving those goals are recorded. These should be monitored in each session and, if IMR is being offered in a group format, the goals of two or three service users can be discussed during each session. It is important that all group members can review their progress each week.
Another key element of IMR is to reward participants' achievements and, if it is delivered in a group format, applaud them for such successes and consider other rewards such as certificates or gifts. It is very important to keep service users' goals in mind throughout the IMR program and correlate them with any information and skills, discussed in the different sessions, that are useful to achieve them.

Raising the awareness of significant others should also not be neglected, as enhancing natural supports is an objective of the program. Indeed, when family members or significant others are involved, they are more supportive of their relative or friend's journey. Although there is a specific module, module 4 - Building Social Support, it is necessary to return to the topic of building a support network in each IMR session, starting with the orientation sessions, where the benefits of a support network and the different ways to build it should be explored. For example, families could be encouraged to participate in specific IMR sessions, where they could be guided to carry out the following supportive actions:

- Helping service users to review and to master the program information;
- Helping service users to practice the skills they have learned, and.
- Taking a role in the steps necessary for service users to reach their personal goals.
- Assume a role in the Relapse Prevention Plan, Plan for Managing Persistent Symptoms, or Plan for Coping with Stress.

Another possibility is to have a monthly group for service users, family members, and other supporters, where they can discuss how to enhance what their relatives or friends are learning in the IMR program. After each IMR session, the IMR Progress Note form should be completed to document the services and information provided, the type of interventions used (motivational, educational, cognitive-behavioral), the skills being taught (coping skills, relapse prevention skills, and behavioral tailoring skills), and the type of homework.

As in any evidence-based psychosocial practice, particular importance is given to the attitudes of the practitioners. They have to be able to empathically explore the service user's point of view about their situation, current life, and short and long-term personal future goals; come up with an explanation of the problems or obstacles identified by the service user as interfering factors in their current life; express the desire and pleasure in being with them, in a spontaneous and authentic way; emphasize the positive results that service users can produce in their daily life; identify obstacles that prevent the service user from participating in the group, and helping them to overcome these obstacles.

To quote what Liberman writes in his text, The Recovery from Disability, "Accentuate the positive aspects and praise the progress extensively, no matter how modest the steps may be. In your work you should function as if you were using a magnifying glass, to see the small progress made by patients. The practitioners' task is to catch something normal, good, appropriate, or useful that the person does or says for him/herself or others... and to tell the person how it made you feel. When using this intervention, be authentic and spontaneous in communicating appreciation, with a warm, confident tone of voice, maintaining eye contact, and praising the specific behavior, not the person in general" (Liberman, 2008).

From theory to practice

The decision to implement the IMR program in the Ferrara Department of Mental Health (DSM) was prompted by a strong push for change. This push for change was accelerated by the worsening of a number of critical issues, including the massive recourse to residential facilities, demonstrated by the annual increase in the number of people with mental health problems labeled hopeless, and relationships where people had no decision-making power or choice, were infantilized and considered only because they were diagnosed. Another critical issue was the scarcity of supported employment and housing programs, as discharges from residential facilities were few, and long stays, even for life, prevailed. For these reasons, the DSM management decided to introduce the practice of IMR in order to initiate a radical change in the culture of the service, starting with staff training that involved all the practitioners assigned to the service where the treatment was implemented.

From 2017 to 2021, 17 treatment groups were established in five mental health centers, four substance abuse services, three residential facilities, two day centers, one psychiatric acute ward, and one food behavior disorder center.

In 2018, the cross-sectional departmental group, made up of all the IMR practitioners (approximately 60 professionals), was established. It meets quarterly with the DSMDP director to monitor the implementation and its results, as well as to support and supervise the professionals. Since the start of the implementation process, around 300 people with mental health conditions have been supported through the program.

Conclusions

IMR can be implemented in different contexts and adapted to the specific needs of the person involved. The results obtained so far are encouraging, as they have confirmed the expected outcomes listed in Table 1. Interestingly, categories of service users hitherto not included in the research studies and different types of services were involved, and telemedicine was also used, confirming that IMR is suitable for different types of users and different healthcare contexts. Moreover, it appears to be a flexible and customizable model. However, further studies with control groups and a more structured assessment of clinical indicators (symptom severity scales, user experiences and satisfaction and use of health resources), caregiver burden, and intervention outcomes on persons having diagnoses other than those originally foreseen in the manual, are needed. A substantial knowledge base already exists, however, from other research literature, especially from the review on IMR (McGuire, 2014), in which 33 studies (including countries such as the USA, Netherlands, Israel, Denmark, Sweden, Taiwan, Japan, Singapore, Norway, Turkey, Australia), totaling a sample of 3,393 persons, with an average age of 43.6 years and with the most frequent diagnoses of schizophrenia, psychotic disorder, schizoaffective disorder (46.12% of the sample) were examined. The dimensions assessed were self-management, knowledge of mental health problems, and clinical, functional, personal, and social recovery. From this review we know that IMR has positive effects on people's perception of recovery, that it produces an improvement in the knowledge and management of mental health problems, that it can be implemented with good fidelity to the model in various settings with heterogeneous people, that the most frequent format is group-based (60.6%), the average duration is weekly sessions for 8-12 months, and the drop-outs variable (average 26%). Inconsistent results are shown with regard to hospitalization rates and it remains to be further investigated on which specific dimensions of recovery the effect is the greatest and which categories of persons with mental health problems can benefit the most.

Table 1

Measured and expected outcomes.

- Progress toward objectives.
- More knowledge and awareness of own problem.
- Utilization of the involvement of family and friends in the rehabilitation process.
- Increased number of contacts with people outside the family.
- More time engaged in structured roles.
- Less intensity and frequency of symptoms.
- Improvement of functioning.
- Reduction of the number of relapses.
- Reduction of the number of psychiatric admissions.
- Learning coping strategies.
- Involvement in self-help activities.
- Effective use of medication.
- Coping better with alcohol use.
- Coping better with drug use.

But the best conclusions seem to be those reported by service users and practitioners who have experienced the benefits of the IMR program. Some reports by service users and practitioners:

Service users
"I understood what bothers me and new strategies to avoid them!"
"The best group I have ever done! A bit difficult though..."
"Understanding the stress-vulnerability model has changed my life!"
"I finally got back in touch with a dear friend of mine."
"I am actively working to improve..."
"I understand what Recovery is and how I can finally achieve mine!"

Practitioners
"It finally allowed us to talk about Recovery!"
"We felt it was a useful tool to help users to set their goals and acquire skills to achieve them."
"Very useful the worksheets proposed by the manual, they are a good starting point for psychoeducation and coping strategies."
"We were able to inform about the importance of pharmacological and psycho-educational treatment, so as to develop more confidence and hope in the support provided."
"It was helpful for users to recognize triggers and relapse signals, so they were able to avoid more unpleasant episodes."
"It allowed the users to get to their goal faster."

The data acquired from the research, my direct experience in training staff and conducting IMR groups, and the voices of practitioners and persons further convinced me that the principles of recovery and the centrality of the person can be transferred to an entire Mental Health Department, demonstrating how, despite the difficulties that emerged, such as individual and system resistance, difficulty in abandoning the old way of operating, cultural prejudices, and lack of human resources, remarkable and significant results can still be achieved.

Above all, what struck me most was the change of lens of the service staff, who began to see the person behind the patient, the strengths behind the deficits, the emotions, and not just the symptoms, increasingly marginalizing the diagnosis while progressively focusing on what service users have in common with all other people. This serves to increase the motivation of those who had become disaffected and see themselves as guardians of the chronic people, forced to constantly repeat the same actions without significant results. And once again my Master Mark Spivak was right: "…. There are no intractable persons with mental health problems. Instead, there are helpless and hopeless practitioners because they lack the basic tools of intervention. There are partial and half-hearted programs, that need to be strengthened and corrected. There are oppositions and ideological blindness that avoid addressing the complexity of mental health problems. These are the conditions that produce "hopeless patients" (Spivak, 1987).

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