

An Evidence-Based Psychiatric Rehabilitation Implementation: Illness Management and Recovery

Kanıtla Dayalı Bir Psikiyatrik Rehabilitasyon Uygulaması: Hastalık Yönetimi ve İyileşme

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Abstract

Illness Management and Recovery (IMR) is a curriculum based psychiatric rehabilitation intervention which is designed as a program on the basis of a recovery-oriented approach. In recent years, the definitions suggested on the term, recovery, has been seen to be discussed in two ways; clinical recovery and personal recovery. The committee constituted with the aim of developing the mental health service provision in the USA in 2002, issued a call for the necessity for the mental health system's comprehensive transformation. As a part of this transformation, the committee suggested a move towards mental health specialists' making decisions related to patient's mental health treatment in a collaboration with the mental health professionals rather than making conventional, hierarchical decisions. The significance of providing access to evidence-based applications for the treatment of mental illnesses was also stressed. Illness Management and Recovery (IMR) was developed and standardized as a treatment program which comprises empirically supported methods in order to train individuals how to manage their psychiatric disorders. IMR was developed on the basis of an extensive investigation of the researches upon teaching illness management to individuals with chronic mental illnesses. Having reviewed 40 controlled studies, in order to develop illness management, five empirically supported methods/strategies were determined. These are psychoeducation on psychiatric disorders and their treatments, cognitive behavioral approaches on drug compliance, training of preventing relapses, coping skills, and social skills training for developing social support. In this review, the birth of illness management and recovery-oriented program, the process of the program, and research related to illness management and recovery will be depicted. It is expected that the review will instructively contribute to practice and execution of Illness Management and Recovery Program within the scope of mental health services in our country.

Keywords: Evidence-based practice, psychiatric rehabilitation, illness management and recovery

Öz

Hastalık Yönetimi ve İyileşme (HYİ) iyileşme odaklı yaklaşımı temel alan bir program olarak tasarlanmış müfredat tabanlı bir psikiyatrik rehabilitasyon uygulamasıdır. Son yıllarda iyileşme kavramına ilişkin yapılan tanımlamaların klinik iyileşme ve kişisel iyileşme olmak üzere iki şekilde ele alındığı görülmektedir. 2002 yılında ABD'de ruh sağlığı hizmet sunumunun geliştirilmesi için kurulan komisyon ruhsal sağlık sisteminin kapsamlı bir dönüşüm yapması gerektiği yönünde bir çağrıda bulunmuştur. Bu dönüşümün bir parçası olarak komisyon; ruh sağlığı uzmanlarının tedavi konusunda geleneksel, hiyerarşik karar vermektense hasta ve ruh sağlığı profesyonelleri ile hastanın ruh sağlığı tedavisi ile ilgili işbirliğine dayalı karar vermesine doğru bir geçiş önermiştir. Ayrıca, ruhsal hastalığın tedavisi için kanıtla dayalı uygulamalara erişimin geliştirilmesinin önemine vurgu yapmıştır. Hastalık Yönetimi ve İyileşme Programı (HYİP), bireylere psikiyatrik bozukluklarını nasıl yöneteceklerini öğretmek için ampirik olarak desteklenen yöntemleri içeren bir müdahale programı olarak geliştirilmiş ve standartlaştırılmıştır. HYİP kronik ruhsal hastalığı olan bireylere hastalık yönetiminin öğretilmesi üzerine yapılan araştırmaların kapsamlı bir incelemesinden yola çıkarak geliştirilmiştir. Kontrollü 40 çalışmanın gözden geçirilmesiyle hastalık yönetiminin geliştirilmesi için ampirik olarak desteklenen beş yöntem/strateji tanımlanmıştır. Bunlar: psikiyatrik bozukluklar ve tedavisi hakkında psikoeğitim, ilaç uyumunu artırmada bilişsel-davranışçı yaklaşımlar, nüksleri önleme eğitimi, baş etme becerileri eğitimi ve sosyal desteği geliştirmek için sosyal beceri eğitimidir. Bu makalede hastalık yönetimi ve iyileşme odaklı programın ortaya çıkışı, programın işleyişi ve hastalık yönetimi ve iyileşme ile ilgili araştırma örneklerinden söz edilecektir. Derlemenin ülkemizde Hastalık Yönetimi ve İyileşme Programının ruh sağlığı hizmetleri kapsamında uygulanması ve yürütülmesine yol gösterici katkı sağlaması düşünülmektedir.

Anahtar sözcükler: Kanıtla dayalı uygulama, psikiyatrik rehabilitasyon, hastalık yönetimi ve iyileşme

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ALTHOUGH recovery is a very important concept in terms of mental health, it is also a field for which it is equally difficult to draw the boundaries. This has led to an increase in discussions on the concept of “recovery” in the field of mental health in recent years. The definitions regarding the concept of recovery have put forward the clinical recovery and personal recovery distinction. Clinical recovery is defined as reduction or cessation of symptoms and “recovery of social functioning” by mental health professionals, whereas personal recovery refers to an ongoing holistic process that involves personal development, recovery, and self-determination and is defined by the individual undergoing treatment (Slade 2009).

With its most common definition, recovery is defined as a highly personal, unique process of change in one’s attitudes, values, emotions, goals, and skills and/or roles, and involves developing new meanings and goals that grow beyond the destructive effects of mental illnesses (Anthony 1993). Leamy et al. (2011) discusses recovery in five categories. These include connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. Rather than a result in which symptom relief and improvement in functionality are defined by clinical criteria, “recovery” is the process of learning how to live, for example, despite a persistent psychotic disorder (Davidson 2010).

“Recovery-oriented implementation” defines the mental health care approach that involves the principles of personal commitment and personal care (Anthony 1993). Recovery-oriented implementation emphasizes hope, social participation, setting personal goals, and self-management. Guidance or partnership relationship between mental health professionals and people who receive mental health services is at the forefront in a recovery-oriented implementation. In this relationship, individuals receiving mental health services are considered experts in their lives and experiences, while mental health professionals are accepted as experts in available treatment services (Victorian Government Department of Health 2011). The aim of the recovery-oriented approach in the provision of mental health service is to support individuals to create and maintain a meaningful and satisfying life and personal identity regardless of the ongoing symptoms of mental illnesses (Shepherd et al. 2008). In this article, the emergence of the illness management and recovery-oriented program, the functioning of the program, and the research samples about illness management and recovery were presented and the research results were discussed.

Psychiatric rehabilitation

Modern psychiatric understanding aims to follow the mental patient as an outpatient and in their living environment as much as possible and to make them fulfill their social functions at the highest level. Psychiatric rehabilitation, which is under the community mental health services, is a concept that includes all the services required for people with mental illnesses so that they can live successfully in the community and improve their quality of life (Pektaş and Çam 2002). Similar to physical rehabilitation, psychiatric rehabilitation aims to reduce or eliminate the negative experiences of individuals and the restrictions affecting basic life skills due to mental illnesses (Wallace 1993). The purpose of psychiatric rehabilitation is to

provide social support and to develop skills to enable individuals with mental illnesses to achieve their social, occupational, educational, and family roles, at least under professional help (Lieberman et al. 2000, Göka 2001).

Psychiatric rehabilitation has originated from the necessity that individuals who have a serious mental illness but have been treated should be provided with new opportunities to live, learn, and work in their communities. Psychiatric rehabilitation programs are a service that helps patients discharged from psychiatric hospitals to acquire necessary skills and to use environmental resources to live independently (Sundeen 1998). Three basic interventions are employed in psychiatric rehabilitation. These are developing the strength and potential of the individual, teaching life skills, and increasing environmental supports (Sundeen 1998, Öztürk and Uluşahin 2018). Psychiatric rehabilitation studies take a three-axis approach as a basis to reduce the individual's susceptibility to illness and enhance their resilience against stressors. These axes are as follows: choosing and maintaining an appropriate pharmacological treatment in a way that will neither cause distress or a secondary handicap to the person nor affect their daily life; helping the person to get equipped with skills that will facilitate individual and social life and to overcome the obstacles; arranging social supports so that the person can lead a healthy life (Yıldız 2004). Health professionals involved in psychiatric rehabilitation should focus not on symptoms, but on being healthy, providing care in an adult-adult relationship and the natural environment, improving the person's abilities, competencies, and functional behaviors, and making decisions with the patient in solving problems. In addition to these, they should focus on enhancing the patient's strengths and self-help and increase the patient's positive expectations by improving their environmental resources (Sundeen 1998, Bilge and Çam 2002).

Emergence of the illness management and recovery program

The commission which was established in the USA in 2002 to improve mental health service delivery made a call for a comprehensive transformation in the mental health system in 2003, guided by the vision of recovery as a legitimate treatment goal. As part of this transformation, the commission proposed a transition from the practice where mental health specialists make traditional and hierarchical decisions regarding treatment to a practice where they make decisions about the mental health treatment of the patient based on collaboration with the patient and mental health professionals. The commission also emphasized the importance of improving access to evidence-based practices for the treatment of mental illnesses (The President's New Freedom Commission 2003). Concurrent with the recommendations of the commission, the Illness Management and Recovery Program (IMR) was developed and standardized as an intervention program that includes empirically supported methods to teach individuals how to manage their psychiatric disorders (Gingerich and Mueser 2005).

The Illness Management and Recovery Program was developed based on a comprehensive review of research on teaching illness management to individuals with chronic mental illnesses (Mueser et al., 2002). To improve illness management, 40 studies with controls were

reviewed, and five empirically supported methods/strategies were defined. These include psychoeducation about psychiatric disorders and their treatment; cognitive-behavioral approaches to enhance medication compliance; relapse prevention training; coping skills training; social skills training to improve social support (Gingerich and Mueser 2010). None of the methods in the 40 studies with controls (psychoeducation, cognitive-behavioral approaches, psychoeducation, coping skills, and social skills training) combined all in one intervention. IMR emerged to combine and integrate all of these empirically supported methods into one consistent program to improve illness management. (Mueser et al. 2013).

After the Illness Management and Recovery Program had been developed, it was revised twice, and finally, the third version was created (Mueser et al. 2002, Gingerich and Mueser 2005; Mueser et al. 2006; Gingerich and Mueser 2010). The third version of IMR will be explained in the following parts of the article.

The Illness Management and Recovery Program was developed between 2000 and 2002 as part of the National Implementing Evidence-Based Practice Project. The program was designed as an “Application Resource Kit” (e.g. handbook and notices, information brochures, promotional and training videos, compliance scale, and outcome measures) to encourage the use of IMR (Mueser et al. 2006).

Functioning of the illness management and recovery program

The Illness Management and Recovery Program is an evidence-based intervention that aims to improve patients’ skills to manage their psychiatric illness more effectively in collaboration with others to achieve recovery goals (Mueser et al. 2013). This program is a standardized, curriculum-based intervention in which individuals with chronic mental illnesses learn how to be active and knowledgeable participants in their treatment to regain control over their lives (Gingerich and Mueser 2010). Its main purpose is to authorize people with a chronic mental illness to manage their illnesses, to help them to set personal recovery goals, and to rehabilitate them by assisting their illness management and teaching the necessary knowledge and skills to help them to achieve these goals (Mueser et al. 2006; Dalum et al. 2011; Gingerich and Mueser 2010). This program can be used in the treatment of bipolar disorder, depression, and schizophrenia (Gingerich and Mueser 2005).

The Illness Management and Recovery Program stems from the experimentally supported Transtheoretic Model and Stress-Susceptibility Model (Mueser et al,2006) to teach self-management of the disease, as well as five illness self-management strategies, making up the core components of IMR, which have been combined within the body of IMR through the review of controlled studies. These core components include “Psychoeducation”, which provides basic information on mental illnesses and treatment options; “Behavioral guidance”, which includes managing daily use of medication and teaching patients strategies that make medication a part of the daily routine; “Relapse prevention” that teaches patients to recognize the triggers of previous relapses and early warning signs of an impending relapse; “Coping skills training”, which includes enhancing the use of existing coping strategies in coping with psychiatric symptoms or learning new strategies (Mueser et al. 2006, Gingerich

and Mueser 2010).

The Illness Management and Recovery Program begins with the investigation of the concept of “mental illness recovery” and what this concept means for each patient. Based on each patient’s definition of recovery, individual goals are set, they are broken down into smaller steps, and then maintained throughout the program. Later, specific knowledge and skills related to illness management are taught to patients to help them progress towards their goals (Mueser et al. 2006; Gingerich and Mueser 2010; Mueser et al. 2013). These goals serve as the “recovery fuel” and serve as a motivation for patients to learn practical facts about their illness and the skills needed to deal with specific symptoms. Patients apply new skills in IMR sessions and complete homework developed with practitioners (Bartholomew and Kensler 2010). People important to the sick individual (family members, friends, etc.) can be involved in the program and doing homework with the approval of the patient (Mueser et al. 2006). In this process, healthcare professionals help patients determine their recovery goals and to evaluate and monitor them throughout the program (Färdig 2012).

The Illness Management and Recovery Program practitioners can be social service workers, occupational therapists, case managers, counselors, nurses, and psychologists. IMR can be provided individually or in groups (in groups of eight or fewer patients) in any convenient location (e.g. community mental health center, correctional center, etc.) for professionals and patients. Sessions can usually be held as one or two sessions per week for 3-12 months, and one session takes 45-90 minutes. The most critical determinant of the duration of the session is the patients’ ability to stay engaged and learn relevant materials. Some patients may find it difficult to focus for more than 30 minutes due to attention and comprehension problems or severe illness symptoms. In such cases, 20-30-minute short sessions two or three times a week can be organized (Gingerich and Mueser 2010).

The Illness Management and Recovery Program consists of five self-management strategies that will help individuals with chronic mental illnesses to cooperate with healthcare professionals, reduce their susceptibility to their illness, and cope with the symptoms of the illness effectively (Mueser et al. 2002). These five strategies are divided into 11 subjects and included in IMR. These subjects are taught using a combination of educational, motivational, and cognitive-behavioral teaching strategies during sessions, which make up modules. Each module has a purpose, specified interventions, and recommendations. Each module is organized as subject-related fields, including education brochures for patients and teaching guidelines for practitioners (Mueser et al. 2006, Gingerich and Mueser 2010).

The third version of the Illness Management and Recovery Program includes the following 11 modules (Mueser et al. 2013). Whitley et al. (2009) explained the modules as follows:

1. Recovery strategies: It helps people to define what recovery means to them, set recovery goals, and break them down into small steps.

2. Practical facts about mental illnesses: It provides information on schizophrenia, bipolar disorder, and major depression. It explains how diagnoses are made and the symptoms of

the disease and gives information about the prevalence. It gives examples of famous people with psychiatric disorders.

3. Stress-vulnerability model: It is the basis for treatment. It explains how psychiatric disorders occur biologically in nature and how they emerge. It emphasizes that the severity and course of the disease can be affected by stress, and provides strategies to minimize the effects of biological susceptibility (e.g. taking medication, avoiding drugs and alcohol) and stress (e.g. learning coping strategies and improving social support).

4. Building social support: It helps patients evaluate their satisfaction with their social support, and allows them to develop personal relationships strategies to meet people and enhance close relationships. It allows patients to use social skills training techniques to help them learn the skills they need.

5. Using medication effectively: It provides information about the role of medication and how medication use can help recover from the disease. It discusses the benefits and side effects of medication. It teaches patients to use strategies to handle their medication as a routine part of their daily life.

6. Drug and alcohol use: It provides information on commonly used substances and their effects. It defines the general causes of substance use by patients. It helps patients discover the pros and cons of substance use.

7. Reducing relapses: It helps patients to examine their past relapses to prevent future relapses. It identifies triggers and early warning signs of relapse. It helps patients develop their own relapse prevention plan. It encourages patients to share their relapse symptoms with healthcare professionals and other key people and helps patients rehearse elements of their relapse prevention plan.

8. Coping with stress: It helps patients recognize the sources of stress in their lives and learn their own physical and emotional responses to stressors. It teaches strategies for coping with stress (breathing smoothly, imagining a peaceful scene, and muscle relaxation, etc.), including relaxation techniques.

9. Coping with persistent/chronic symptoms: It teaches patients a step-by-step method of problem solving to deal with problems and symptoms. It helps patients identify and develop skills they already use to cope.

10. Getting your needs met by the behavioral health system: It introduces an overview of the mental health system, including services, and describes programs commonly offered by Community Mental Health Centers (CMHC) (e.g. social skills training groups and vocational services).

11. Healthy life: It explains the financial benefits that patients may qualify for (e.g. social security, disability income) and insurance benefits. It provides strategies for self-defense in the mental health system.

In the illness management and recovery program sessions, patients are taught a syllabus using a combination of different strategies, including educational and cognitive behavioral approaches (Mueser et al. 2013). Educational techniques are employed to a small extent in

the sessions. These can be any of the following techniques: interactive learning, control of understanding/comprehension, and listing the content of the knowledge. Also, at least one of the cognitive behavioral techniques, such as reinforcement, behavior shaping, modeling, role-playing, cognitive restructuring, and relaxation training, is used (Gingerich and Mueser 2010). Besides, motivational techniques are also used in sessions to help patients find meaningful motivations for changing their behaviors and have a sense of hope and support for their recovery (Salyers et al. 2010). The sessions of the program follow a standard structure, and the structured summary of the session is as indicated in the table below (Mueser et al. 2006, Gingerich and Mueser, 2010, Mueser et al. 2013).

Table 1. Structured summary of an illness management and recovery program session

Structured summary of the imr session	Individual format	Group format
Socializing and identifying any major problems Clinicians and patients/clients use this time to establish relationships and discuss additional issues that need to be addressed at the end of the session.	1-3 min.	1-3 min.
Review of previous sessions The content of the previous session is reviewed to assess patients' understanding and recall of their knowledge and skills.	1-3 min.	1-3 min.
Review of the homework from the previous session Whether assignments are done is reviewed; patients' efforts for success or outcomes are reinforced; and any difficulties encountered are resolved jointly by the healthcare staff and the patient.	3-5 min.	5-10 min.
Tracking goals The progress of the patients towards their personal goals is evaluated; obstacles are determined and these problems are solved together; the success process is followed by determining and planning the next steps or setting new goals.	1-3 min.	5-10 min.
Current session agenda is set. A common agenda is set for the rest of the session.	1-2 min.	1-2 min.
New material is taught and new strategies are implemented. The material for the IMR program is reviewed and taught using a combination of educational, motivational, and cognitive-behavioral strategies tailored to each patient's reading ability, interests, prior knowledge, and goals.	30-40 min.	20-25 min.
Comparison of the new homework Healthcare professionals and patients agree on a homework assignment to review and apply the materials taught in the session or to take steps towards the patients' personal goals; the existence of any obstacles to completing the homework is assessed, and if there is an existing obstacle, the problem is resolved.	3-5 min.	5-10 min.
Making a summary of the process of the current session The problems addressed in the session are reviewed and the feedback of the patients is taken.	3-5 min.	3-5 min.

Studies on the illness management and recovery program

In a pilot study with no controls conducted by Mueser et al. (2006) on 25 patients with schizophrenia and schizoaffective disorder in Australia and the USA, 24 participants completed the program, and 17 participants completed their quarterly follow-up evaluations. After the treatment, participants increased illness management and recovery, perceived recovery, and global functionality scores. Moreover, patients showed significant

improvements in psychopathology, functionality, self-management activation self-reporting, quality of life, and self-efficacy in community life.

Hasson-Ohayon et al. (2007) conducted a randomized controlled study with 210 patients in 13 CMHCs in Israel to evaluate the effectiveness of IMR applied in a group format and reported that there was a significant increase in the outcomes of patients in IMR before and after the intervention compared to those who received standard treatment. Both groups showed a significant increase in coping, but no change in social support. After the treatment, patients in the IMR group scored significantly higher on the patient and clinician versions of the illness management and recovery scale. This study was the first randomized controlled study evaluating the effectiveness of IMR.

In the randomized controlled study conducted by Levitt et al. (2009) with 104 psychiatric patients to evaluate the effects of IMR on functional outcomes of people with mental illnesses and chronic mental illnesses receiving supportive accommodation services, the patients were assigned to the experimental and control groups and IMR was administered to the experimental group for six months. Evaluations done at the end of the six months included self-reports, non-blind clinical evaluations, and blind interview evaluations. These evaluations included the areas of illness management, symptoms, psychosocial functioning, hospitalization, and addiction. Participants assigned to the program demonstrated significantly higher improvements than the control group in illness management ratings (self-report and clinician evaluations), interview-based symptom ratings on the Psychiatric Rating Scale-Short Form, and interview-based psychosocial functioning rates on the Quality of Life Scale-Short Form. Participants in both groups indicated a decrease in self-assessment of disease symptoms and hospitalization and substance abuse rates during the study.

Roe et al. (2009) sought answers to the following questions in their qualitative study using the interview technique with 36 individuals with chronic mental illnesses who completed IMR a year ago: (1) investigating whether the participants perceived IMR as effective one year after completing the program; (2) if they did, investigating and explaining the areas of IMR they found useful; (3) investigating and explaining the differences of IMR they experienced from previous rehabilitation interventions. The analysis of the interviews was conducted by two experts who defined the themes independently. Participants in the study reported a high level of perceived helpfulness, and specified cognition, coping, and social support as three areas of development attributed to IMR. Five categories emerged regarding the uniqueness of the IMR intervention. These included learning new knowledge, social support, coping and self-management, program structure, and message of hope.

In the study conducted by Salyers et al. (2009) to evaluate the nationwide implementation of IMR with 324 psychiatric patients in 30 CMHCs in the USA, the result of the 6th and 12th month evaluations indicated that patients' self-management and hope increased, and service satisfaction was not affected by IMR.

Whitley et al. (2009) applied IMR for two years in twelve community mental health

centers in a study which aimed to investigate factors that supported or prevented the successful implementation of illness management and recovery. They supplemented the implementation with a practice resource kit and regular meetings with the help of a consultant trainer. The implementation work at each center was monitored by a supervised researcher (observer of the implementation) for two years. This researcher conducted qualitative interviews with key information sources every six months and frequently made routine patient observations to see the progress in the implementation. These qualitative data were collected in a database used to distinguish key barriers and facilitators to illness management and recovery implementation. Through the content analysis of qualitative data, four themes that significantly determined the success or failure of the implementation emerged. These included leadership, organizational culture, training, staff, and supervision. It was concluded that these themes worked synergistically in affecting the implementation.

In the study of Fujita et al. (2010) investigating the feasibility and results of IMR in Japan, 35 patients diagnosed with schizophrenia were assigned to experimental and control groups. The experimental group was administered the IMR program, and the control group was administered only a routine treatment program. The patients were evaluated before and after the intervention in terms of symptom severity, functioning, activation level in self-management, quality of life, satisfaction, self-efficacy in community life, and satisfaction with services. The IMR program administered to the experimental group was provided in an individual format with 60-90 minute sessions every one or two weeks. In more than two years, 25 patients completed the intervention. In the pretest-posttest comparison, it was reported that the participants in the experimental group showed significant improvements in symptoms and functions, personal management, self-reported activation, quality of life, satisfaction, and self-efficacy in community life.

Salyers et al. (2010) conducted a study by combining two evidence-based practices, namely, Assertive Community Treatment (ACT) and IMR, for adults with chronic mental illnesses. Two of the existing four ACT teams were randomly selected to administer the ACT to a group of patients, and the other two were randomly assigned to the groups to implement the IMR program. A total of 47 patients participated in the IMR program. At the end of the study, it was found that there was no difference in the results of the patients who received ACT, but the hospital visits of the patients participating in the illness management and recovery sessions decreased.

In an experimental design study (Randomized, evaluator-blind, multicenter) conducted by Dalum et al. (2011) to evaluate the functionality levels of patients after IMR program in 200 patients followed-up with schizophrenia and bipolar disorder diagnosis who were receiving treatment in two community mental health centers in the Danish Capital Region, the experimental group was subjected to IMR program for nine months. Evaluations were done at the end of the 9th and 21st months. In the experimental group, it was stated that at the end of the treatment and at the follow-up after 21 months, the level of functionality increased, the use of alcohol/drugs decreased, the individual meaning of

recovery and hope increased, and hospital admission and outpatient clinic admissions decreased.

In a study conducted by Färdig et al. (2011) to evaluate the effects of IMR on symptoms and psychosocial functioning in 41 individuals with schizophrenia or schizoaffective disorder who were receiving treatment in six psychiatric outpatient rehabilitation centers in Sweden, participants in the experimental group were involved in IMR program for nine months, and the control group received standard therapy. Evaluations at the outset, post-treatment (9 months), and in the follow-up (21 months) were based on self-report and clinician (non-blinded to treatment) ratings, such as illness management, psychiatric symptoms, recovery, coping, quality of life, hospitalization, insight, and suicidal ideation. According to the self-report and ratings of the non-blind clinicians, the patients in the experimental group showed significantly more improvement in illness management than the participants in the control group. Psychiatric symptom ratings done by non-blind clinicians using the Psychosis Assessment Tool and Psychosocial Functioning Scores reported in Coping Questionnaires also showed significantly higher results than those of the control group.

Salyers et al. (2011) conducted a retrospective cohort type study between July 1, 2003 and June 30, 2008 to examine the effect of IMR on healthcare use. They found that patients who completed the IMR program had fewer emergency department visits and hospitalization days compared to those who received ACT.

Färdig (2012) studied the effectiveness of IMR by training patients with schizophrenia and schizoaffective disorder to help them better manage their illnesses and to encourage recovery. They divided 41 patients who were receiving treatment in six psychiatry outpatient clinics in Uppsala, Sweden into experimental and control groups, and included the patients in the experimental group in 40 sessions of IMR. Then, they compared 21 participants in IMR to 20 participants in routine treatment group. IMR participants were found to have more progress in self-management of the disease and to show a decrease in psychiatric symptoms, an increase in coping skills, and a decrease in suicidal ideation. In the same study, possible relationships between neurocognitive function and ability to acquire illness management skills in 53 participants who completed IMR were examined. It was concluded that neurocognitive difficulties did not affect the participants' opportunities to learn illness management according to the IMR model. In the same study, the severity of schizophrenia symptoms as a result of IMR was examined in 52 participants who completed the program. The results showed that significantly more participants met the post-treatment remission severity criterion and that the participants did not reach the post-treatment severity criterion but benefited from IMR.

In a qualitative study conducted by Thoreson (2012) to investigate the perceptions of individuals diagnosed with chronic mental illness about treatment outcomes for IMR curriculum, the participants reported that the illness management and recovery curriculum had a positive impact on treatment outcomes in the areas of coping skills, self-management, social functioning, recovery outcomes, and dual recovery. In particular, seven interrelated

themes identified as positive outcomes were determined. These were education, goals, improved mental health stability, increased self-worth, improved relationships, more community engagement, and pre-existing knowledge.

Garber-Epstein et al. (2013) conducted a study on 210 CMHC patients to examine the effects of IMR practitioners on patient outcomes and investigated the effects of IMR practices of mental health experts, recovery guides, and professional assistants. In the study, it was concluded that regardless of the professional background of the IMR practitioner, IMR could be applied well and produce positive results when it was presented by practitioners with adequate training and supervision.

In their study investigating the relationship between the time of attending IMR in a State Psychiatric Hospital and psychiatric readmission rates after discharge, Bartholomew and Zenchner (2014) reviewed 1.186 archive data and indicated that there was a 1.1% reduction in the risk of returning to the hospital for each hour of IMR.

In their qualitative study, Brummer (2014) conducted semi-structured interviews with health professionals to investigate the obstacles they faced while using IMR with individuals with serious mental illnesses. As a result of the study, five main themes emerged regarding the obstacles encountered. These included training and supervision, initiation of mental health services with IMR, strategies of practitioner and patient/client engagement, the role of the practitioner, and organizational support.

In their study evaluating the effectiveness of IMR, Salyers et al. (2014) assigned 118 patients with schizophrenia spectrum disorder, including 56 patients from Veterans Affairs Department Medical Center and CMHC, to the IMR group (N=60) or to the weekly problem-solving intervention group (N=58). Participants in the IMR group met once a week for nine months. Clinical evaluations were done at the outset and along 9 and 18 months by measuring symptoms and assessing functioning, self-management of the illness, medication compliance, subjective recovery experiences, and service utilization. As a result of the study, no significant differences were found between IMR and problem solving groups. Participants in both groups progressed significantly over time in terms of symptom severity, illness management, and quality of life, and had fewer emergency room visits. Participation rates in both interventions were low. Also, 28% of the participants in the IMR group and 17% of those in the problem solving group participated in more than half of the scheduled groups, and 23% and 34%, respectively, did not attend any sessions. However, this study was the first randomized controlled IMR study to report negative findings.

In the study conducted by Beentjes et al. (2015) to evaluate the development of an e-health application for E-IMR and its effect in the cluster randomized controlled study, at the end of the six-stage electronic development process, self-management, recovery and general health perception were observed to increase as a result of the E-IMR intervention developed based on the qualitative evaluation of IMR.

Färdig et al. (2016) investigated the relationship between neurocognitive functions and the acquisition of illness self-management skills in 53 patients with schizophrenia or schizoaffective disorder who completed the IMR program. In the study, they could not

determine the relationship between neurocognitive functions and IMR and acquiring illness self-management skills.

Van Langen et al. (2016) carried out a phenomenological study with 14 patients diagnosed with schizophrenia or psychotic diseases, who had completed the IMR program 13 or 19 months ago in a psychiatric outpatient clinic in the Netherlands, to determine how individuals who completed IMR program defined recovery from their own perspective and the contents that improved recovery. In the study, they sought answers to questions, such as “You have participated in an IMR program. Could you tell us your experiences?” and “What does recovery mean to you?” Five main themes were determined at the end of the study. These included goal setting skills, symptom management skills, sharing peer information, learning IMR from a textbook, and learning practical skills. This study was the first phenomenological study on the experiences of people diagnosed with schizophrenia or psychotic illness who completed IMR on how IMR improved personal recovery.

In their experimental study conducted to evaluate the effectiveness of IMR in terms of reducing symptoms, re-hospitalization rates, and social functioning according to the current care standard, Tan et al. (2017) administered the IMR program to the participants in the experimental group, and provided standard care to participants in the control group given by community psychiatric nurses for 12 months. It was determined that the participants in the experimental group presented to hospitals less, they had a shorter hospital stay, their Psychiatric Rating Scale-Short Form scores decreased, and that their scores of the Illness Management and Recovery Scale and Global Rating Scale increased significantly.

In their randomized controlled multicenter study conducted to investigate the effectiveness of IMR in Danish patients with schizophrenia or bipolar disorder compared to standard treatment, Dalum et al. (2018) provided standard treatment to the control group, and administered IMR to the experimental group in group format in one-hour sessions per week for nine months. At the end of the study, IMR was found to have no significant effect on functionality, symptoms, substance use, and service use.

In their study evaluating whether there was an improvement in clinical-personal recovery and illness management in patients with schizophrenia or bipolar disorder who participated in IMR after intervention and in one-year follow-up, Jensen et al. (2019) recruited 198 patients from three community mental health centers in the capital city of Denmark. In this randomized controlled study, the experimental group received IMR and standard therapy in group format, while the control group received standard therapy. All results of the participants were evaluated at the outset, post-intervention, and during one-year follow-up. Long-term outcomes were classified according to clinical recovery (e.g. symptoms, global functioning, and hospitalization) and personal recovery (e.g. hope and personal recovery). There was no significant difference between the intervention group, which received IMR, and the control group, which did not receive IMR, one year after the intervention, and there was no significant difference in symptoms, number of hospitalizations, emergency room visits, or outpatient treatment, either. It was determined that the current IMR study did not have a significant effect on clinical and personal recovery in one-year follow-up.

Discussion

Although recovery is a very important concept in terms of mental health, it is equally difficult to draw the boundaries. This situation has led to increased debates on the concept of “recovery” in the field of mental health in recent years. The Illness Management and Recovery is a curriculum-based psychiatric rehabilitation practice designed as a program based on a recovery-oriented approach. After the commission which was founded in the USA in 2002 to improve mental health service delivery made a call for a comprehensive transformation in the mental health system in 2003, guided by the vision of recovery as a legitimate treatment goal, the development of strategies and guidelines related to topic started. In this context, studies have started to investigate the effectiveness of IMR. The examination of the results of the studies on the illness management and recovery program has indicated that there are similar and disparate study results on the subject.

In studies evaluating the effectiveness of IMR, the following results were reported: increase in illness management and recovery and perception of recovery and global functionality scores, increase in social functionality, quality of life, psychosocial functioning rates, increase in recovery, satisfaction, and self-efficacy in community life, and decrease in psychopathology (Mueser et al. 2006, Hasson -Ohayon et al. 2007, Levitt et al. 2009, Fujita et al. 2010, Färdig et al. 2011, Dalum et al. 2011, Thoreson 2012); decrease in hospital use of patients and fewer hospitalizations (Salyers et al. 2010, Dalum et al. 2011, Salyers et al. 2011, Bartholomew and Zenchner 2014, Tan et al. 2017); decreased alcohol/drug use and increased individual meaning of recovery and hope (Dalum et al. 2011); more progress in the self-management of the disease, decrease in psychiatric symptoms, increase in coping skills, and decrease in suicidal thoughts (Färdig et al. 2012, Thoreson 2012); increase in the areas of self-management, recovery results, and dual recovery (Thoreson 2012); increase in self-management, recovery, and general health perception in the experimental group as a result of E-IMR intervention (Beentjes et al. 2015). Contrary to these findings, in other studies conducted to evaluate the effectiveness of IMR, no relationship was found between neurocognitive functions and IMR and gaining illness self-management skills (Färdig et al. 2016), IMR had no significant effect on functionality, symptoms, substance use, and service use (Dalum et al. 2018), and there was no significant difference between symptoms, number of hospitalizations, emergency department visits, or the number of outpatient treatment (Jensen et al. 2019). Salyers et al. (2014) conducted a study on patients with schizophrenia spectrum disorder to evaluate the effectiveness of IMR, and they administered IMR to one group and problem-solving skills to the other group. As a result of the study, it was reported that there was no significant difference between IMR and problem solving groups and that participants in both groups made significant improvements over time in terms of symptom severity, illness management, and quality of life and visited emergency department less. In a qualitative study conducted by Roe et al. (2009) using the interview technique with 36 individuals with chronic mental illness who completed the IMR program, participants reported a high level of perceived helpfulness, specified cognition, coping, and social support as three areas of development attributed to IMR, and described the emergence of leadership,

organizational culture, training, staff and supervision as four themes that significantly determine the success or failure of the implementation. In studies conducted on the topic, the reasons for the different research results were thought to have stemmed from the fact that the applications were carried out in different mental illness groups, the scales used in the measurements were different, and the cultural characteristics of the individuals included in the studies were dissimilar. Since studies on IMR are applications that have recently been introduced, there is a need for more studies on this subject and presentation of research results with meta-analysis studies and systematic reviews.

Conclusion

The illness management and recovery program is a psychiatric rehabilitation practice that focuses on recovery as a process, is individual-centered, and emphasizes personal recovery. In line with the studies conducted so far, it is possible to say that the program can be successfully implemented in inpatient and outpatient clinic treatment. Given that the illness management and recovery program supports individuals to create and maintain a meaningful and satisfying life and personal identity, regardless of whether the mental illness has continuing symptoms, and therefore contribute to the illness self-management, it is obvious that the program can be part of the implementation in the provision of mental health services. Therefore, it is thought that mental health professionals will contribute to the protection of the mental health of our society and the personal recovery of the patients by realizing the importance of the issue and taking the lead in the implementation of the illness management and the recovery program.

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