

## ILLNESS MANAGEMENT AND RECOVERY

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### Overview

Severe and distressing symptoms, sensitivity to stress, relapses, and rehospitalizations can interfere with the ability of people (or “consumers”) with a mental illness, including those involved in the criminal justice system, to become integrated, contributing members of their communities. Learning more effective strategies for dealing with one’s psychiatric disorder is an important ingredient to leading a productive and fulfilling life or all people with a major mental illness. The Illness Management and Recovery (IMR) program is an evidence-based intervention aimed at improving the ability of consumers to manage their psychiatric disorder more effectively in collaboration with others in order to achieve their recovery goals. This brief (1) describes the IMR program, (2) summarizes recent research on the IMR program, and (3) considers benefits and potential adaptations for providing IMR to individuals involved in the criminal justice system.

### The Illness Management and Recovery (IMR) Program

The IMR program (also referred to as Wellness Management and Recovery) is a standardized, curriculum-based intervention in which individuals with a serious mental illness learn how to become active and informed participants in their own treatment in order to regain control over their lives (Gingerich & Mueser, 2010; Gingerich & Mueser, 2011). IMR can be provided in either an individual or group format, in any location convenient for providers and consumers (e.g., community mental health center, community setting, correctional facility), and usually requires participation in 40–50 weekly or twice weekly sessions over 6–12 months. The program can be implemented by either trained behavioral health practitioners, consumers, or (for group format) a combination of the two.

The IMR program begins with an exploration of the concept of *recovery* from mental illness and what it

means to each individual consumer. Based on each consumer’s definition of recovery, personal goals are set, broken down into smaller steps, and then pursued over the course of the program. Specific information and skills related to illness management are then taught to help consumers progress towards their goals. The curriculum is organized into modules or topical areas, based on an expanded version of the stress-vulnerability model (Mueser & Gingerich, 2011; Mueser et al., 2006; Nuechterlein & Dawson, 1984), with each module including educational handouts for consumers and teaching guidelines for practitioners. The 3<sup>rd</sup> edition of IMR includes the following modules (Gingerich & Mueser, 2011):

1. Recovery Strategies
2. Basic Facts About Mental Illness
3. The Stress-Vulnerability Model
4. Building Social Support
5. Using Medication Effectively
6. Drug and Alcohol Use
7. Reducing Relapses
8. Coping with Stress
9. Coping with Persistent Symptoms
10. Getting Your Needs Met in the Behavioral Health System
11. Healthy Lifestyles

The curriculum is taught using a combination of different strategies, including *motivational* (e.g., exploring how learning a skill could help the person achieve their goal), *educational* (e.g., providing information verbally and in handouts, adapting language as needed), and *cognitive-behavioral* (e.g., modeling, role playing, positive and corrective feedback) approaches. Home assignments are collaboratively set at the end of each session. Significant others are involved in the program, with consumers’ permission.

## Research on the IMR Program

The IMR program was developed approximately a decade ago, based on a comprehensive review of research on teaching illness management to people with major mental illnesses (Mueser et al., 2002). This review of 40 controlled studies identified five empirically supported methods for improving illness management:

- psychoeducation about psychiatric disorders and their treatment
- cognitive-behavioral approaches to improve medication adherence
- relapse prevention training
- coping skills training
- social skills training to improve social support

None of the programs reviewed incorporated all of these methods into a single intervention. IMR was created to integrate all of these empirically supported methods for improving illness management into one cohesive program (Gingerich & Mueser, 2010), with the vision of recovery from mental illness (Anthony, 1993; Deegan, 1988; President's New Freedom Commission on Mental Health, 2003) serving as the unifying theme and motivation for individuals to change their behavior.

Since the initial development and dissemination of the IMR program, it has been widely adopted, translated into over 10 languages, and has been the focus of significant research (McGuire, Kukla, Green, Mueser, & Salyers, in press). Studies have shown that IMR can be successfully implemented in a range of inpatient and outpatient treatment settings (Bartholomew & Kensler, 2010; McHugo, et al., 2007; Mueser et al., 2006; Roe et al., 2007; Salerno et al., 2011; Salyers, et al., 2009). Three randomized controlled studies, conducted in the U.S., Sweden, and Israel, have shown that IMR improves illness management and related outcomes significantly more than traditional services (Färdig, Lewander, Melin, Folke, & Fredriksson, 2011; Hasson-Ohayon, Roe, & Kravetz, 2007; Levitt, et al., 2009). Research suggests that IMR reduces use of high cost psychiatric services such as inpatient hospitalization and emergency room visits (Salyers, Rollins, Clendenning, McGuire, & Kim, 2011).

The IMR program has been adapted to meet the needs of special populations and settings. For example, to

address the common problem of medical comorbidity in people with serious mental illness (Chwastiak et al., 2006), Integrated IMR was created to teach consumers how to manage their psychiatric and medical disorders to achieve their recovery goals (Bartels et al., in press; Mueser, Bartels, Santos, Pratt, & Riera, 2012). To facilitate the teaching of illness management to persons with intellectual disability and a psychiatric disorder, an adapted version of the IMR program was developed, the Happy and Healthy Life Class, to condense and simplify the curriculum making it more accessible to consumers (Gingerich, Arnold, & Mueser, 2009). Abbreviated versions of the IMR program have also been developed for the acute care, inpatient setting to prevent rehospitalization (Lin et al., in press).

## IIMR for Justice-Involved Adults

Improved illness management can facilitate community integration for all people with a serious mental illness. Additional benefits may accrue to the increasing number of individuals with a mental illness who are involved in the criminal justice system (MacKain & Mueser, 2009). Training in illness management for incarcerated persons with a mental illness has the potential to improve their ability to understand and follow rules and to reduce disciplinary problems and victimization (James & Glaze, 2006; Lovell & Jemelka, 1998). For example, among people living in the community, engagement in behavioral health services and possession of psychotropic medication following psychiatric hospitalization predict a lower likelihood of arrest (Van Dorn, Desmarais, Petrla, Haynes, & Singh, 2013).

At the present, there are no reliable statistics on the extent to which the IMR program has been implemented with individuals involved in the criminal justice system, either in the U.S. or abroad. Numerous state behavioral health departments specify the provision of IMR to incarcerated persons with a serious mental illness as a goal, and anecdotal evidence suggests that it is becoming more widely available. The preliminary results of one randomized controlled trial of the IMR program with incarcerated persons with a mental illness indicated positive effects on illness management outcomes and related behavior and disciplinary problems compared to traditional services (Levitt, 2013).

While IMR appears to be beneficial to individuals involved in the criminal justice system, adaptations to the program addressing the unique needs of this population could make it even more effective. A pilot jail diversion research project was conducted by the Bronx TASC Mental Health Court Program, funded by the Substance Abuse and Mental Health Services Administration Targeted Capacity Expansion Grant Initiative, in which IMR was provided as part of a full range of supportive services to improve functioning and reduce recidivism. Based on the pilot project, Mueser and Gingerich (2007) suggested four possible adaptations.

**Finding:** The authors noted that being incarcerated can be psychologically traumatic, leading to avoidance or minimization of experiences related to incarceration and thereby limiting motivation to avoid them in the future.

**Adaptation:** To remedy this, suggestions were provided to help individuals process their experiences during incarceration through a combination gentle exploration and an emphasis on the personal strengths used to cope with their experiences.

**Finding:** Rotter et al. (2005) observed that individuals in jail or prison sometimes make adaptations that are useful while incarcerated but counterproductive after community reentry (e.g., not revealing personal problems to others, emphasis on self-reliance and avoiding dependence on others, taking a day at a time instead of planning ahead). Adaptations such as these can interfere with learning how to manage one's illness in collaboration with others and setting and pursuing personal goals.

**Adaptation:** Practitioners can become aware of these adaptations and, when they appear to be present, explore them with the individual to evaluate their utility, both in jail or prison, as well as in the community.

**Finding:** It has been observed that some individuals, through a combination of personality, personal hardships, and traumatic experiences early in life or when incarcerated, develop thinking styles or beliefs that may increase their risk for engaging in criminal behavior (e.g., "The rules of society don't

apply to me," "All that matters is looking after #1," "I'm entitled to a free ride because of what I've been through") (Skeem, Manchak, & Peterson, 2011). These *criminogenic* thinking styles can interfere with developing close and mutually supportive relationships with others and can prevent people from learning from their experiences, contributing to less effective illness management.

**Adaptation:** The recognition of criminogenic thinking styles can enable practitioners to employ *cognitive restructuring* (Beck, 1995) to explore and help individuals challenge these maladaptive beliefs by carefully examining the evidence for and against them and changing them accordingly.

**Finding:** People with a mental illness who are involved in the criminal justice system often have difficulty coping with negative feelings, especially anger, frustration, and boredom. These challenges can lead to aggressive, impulsive, or destructive behavior and interfere with illness management.

**Adaptation:** Social skills training (Bellack, Mueser, Gingerich, & Agresta, 2004; Deffenbacher, 1988), problem-solving training (Novaco, 1997), and other strategies for effectively dealing with these types of negative feelings can be incorporated into the IMR program.

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